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The Ambiguity of Idea Bearers

A study of a Translation Process within the Swedish Health Care System

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Abstract

The journey of ideas has fascinated researchers within the management field with different beliefs concerning its stability or unpredictability. Hitherto, studies have been made to explore the journeys' complexity with focus on their different phases and results. However, it is argued that the role of the actor responsible for spreading an idea has been disregarded. In this article, by using a descriptive approach, an idea's travel from an international context to local care units in Sweden is followed, with the aim to illuminate how organisations act when spreading an idea and the effects they may have on the development of the original idea. The findings display ambiguities in the organisations' roles as one of the actors takes part in the implementation process. This diverges from the traditional actions of an idea bearer, hence, the organisation's status as an idea bearer can be questioned. As an implementer at the care units, the organisation's role is shaped by different factors, which in the end influence the development of the idea being spread, and especially the degree of freedom in the terms of translation.

Key words: idea bearers, translation process, experience-based co-design, quality assurance and health care system

Introduction

The health care system, as most other public and private sectors, is under continuous pressure to improve its quality (Erlingsdóttir, 1999). According to the Swedish health care legislation (the Swedish parliament, 2012) hospitals are required to offer services of high quality that matches the national definition of *"good care"* (VGR, 2013a), which require the health care services to be; safe, patient-centric, knowledge-based, equal, efficient and easily accessible. These factors mirror the ideologies that have circulated in the society at different times, and with inspiration from the New Public Management (NPM) and its economic and administrative focus, the concept of quality assurance was introduced in the 1980s (Erlingsdóttir, 1999; Bohlin and Sager, 2011). Hitherto, no clear national directives for how to measure quality have existed (Lindberg and Erlingsdóttir, 2005; Erlingsdóttir, 1999); hence, different methods have been tested through the years. However, as the medical profession by tradition controls the health care system, quality assurance has mostly been focused around medical aspects (Öfverström, 2008; Donabedian, 2003). Also as a response to the increasing flow of ideas from other areas and the medical profession's concerns for the impacts on the quality of the medical treatment (Olson, 2009; Bohlin and Sager, 2011), the concept of *Evidence-Based Medicine* was introduced during the 1990s. It aims at assuring that hospitals use the best available medical scientific knowledge (Bohlin and Sager, 2011), as assessed by the Swedish Council on Health Technology Assessment (SBU) and is today an institutionalised paradigm supported by the Swedish legislation (SBU, 2013; SOU, 2007:10).

The introduction of ideas into new contexts with its unique traditions, culture and actors is anything but a linear process, and the complexity of the process has been illuminated in *translation theory* (Czarniawska and Joerges, 1996; Czarniawska and Sevón, 1996). Studies have shown that ideas connected to local traditions and norms are more likely to be institutionalised, as they may not be perceived as a threat to the organisation's identity (Czarniawska and Joerges, 1996; Wærness, 1990). Often are ideas brought into organisations by the management, and critiques have therefore been made towards how the decisions to a large extent are affected by the manager's preferences (March, 1987; Brunsson, 1985). This may, hence, also affect what methods that are accepted when working with quality assurance. All these aspects have been apparent when the Swedish health care system recently, with start at local cancer care units, was introduced to a new approach towards quality assurance that deviates from the traditional values of the medical profession. *The Centre for Organisational Development* in the region of Västra Götaland has created a 4-step model, which originates from the ideas of *Experience-Based Co-Design (EBD)* (Maher and Baxter, 2009*)* that values patient involvement along with knowledge based on the patients' and carers' experiences as part of quality assurance. The ideas of patient involvement in the designing of health care routines and development of quality measurements was introduced after inspiration from the NPM movement (Hill and Wilkinson, 1995; Lindquist and Persson, 1997; Juran 1989), however, experience-based knowledge represents something new in the medical field, as it by tradition is highly committed to evidence-based facts (Bohlin and Sager, 2011). Hence, it is of interest from a translation perspective to study how the 4-step model and EBD are welcomed in this type of context as it partly represents the opposites to the values of the medical profession. Earlier studies have been made in trying to describe the translation process of

ideas with focus on its different phases (Røvik, 2008; Czarniawska and Joerges, 1996; Lindberg and Erlingsdóttir, 2005), and the actors involved have been described as idea bearers and idea users. Some ambiguity is, however, displayed in regard to the idea bearer‘s influence on the original idea (Røvik, 2008) and Lindberg and Erlingsdóttir (2005) have in their studies seen that the idea bearer is responsible for spreading the idea, whereas it is up to the receivers to decide upon how to use it. These aspects have been an inspiration for the purpose of this article, where the aim is to follow the journey of experience-based co-design as materialised in the 4-step model, and how it is implemented at local care units with focus on the roles of the idea bearers. The aim will be to study how organisations act when spreading an idea, and how their roles affect the development of an idea.

Theoretical overview

There is a continuous flow of ideas circulating in today's society, whose journeys have been of interest to study for many years and within various traditions (Røvik, 2008). The traditional view of describing the process of idea spreading is often through the *diffusion model*, where the context and its actors are characterised as stable and homogeneous. The ideas are, hence, believed to be retained intact and follow the same direction as intended by the initiator of the transmission, if not meeting any resistance (Rogers, 2003; Latour, 1986). Even so, this resistance is only deflecting or slowing down the pace of the spreading, and does not affect the idea's content or characteristics. This philosophy is questioned by the Scandinavian institutionalism, which rather illuminates the power of the actors receiving ideas, who may adapt the ideas to make them fit with a certain context and situation (Latour, 1986; Røvik, 2008). Consequently, the process is likened to a translation process where an idea can take unexpected shapes depending on local contexts and the actors involved. Latour (1986) illustrates the importance of the receivers of an idea with the paradox of possessing or exerting power *"When an actor simply has power nothing happens and s/he is powerless, when, on the other hand, an actor exerts power it is others who perform the actions"*. The initiator of the idea is thereby dependent on other receivers' support for the idea, in order for it to spread across other contexts.

Due to the unpredictability in the utilisation of an idea and the number of actors involved in a translation process, it is difficult to foreseen its results. There is, hence, an interest among researchers (Røvik, 2008; Czarniawska and Joerges, 1996; Lindberg and Erlingsdóttir, 2005) to create an understanding for the translation process's different phases and what factors that influence the development. The *translation model* designed by Barbara Czarniawska and Bernward Joerges (1996) describes how ideas circulating in the society between time and space are translated into objects. In turn, these objects lead to some kind of actions, which if being supported might become institutionalised, and later spread and translated into new ideas. However, as translation does not occur in closed systems, but is continuously affected by external and often uncontrolled powers, the model is not to be seen as a linear process that follows a standardised receipt (Czarniawska and Joerges, 1996; Lindberg and Erlingsdóttir, 2005; Latour, 1986; Røvik, 2008).

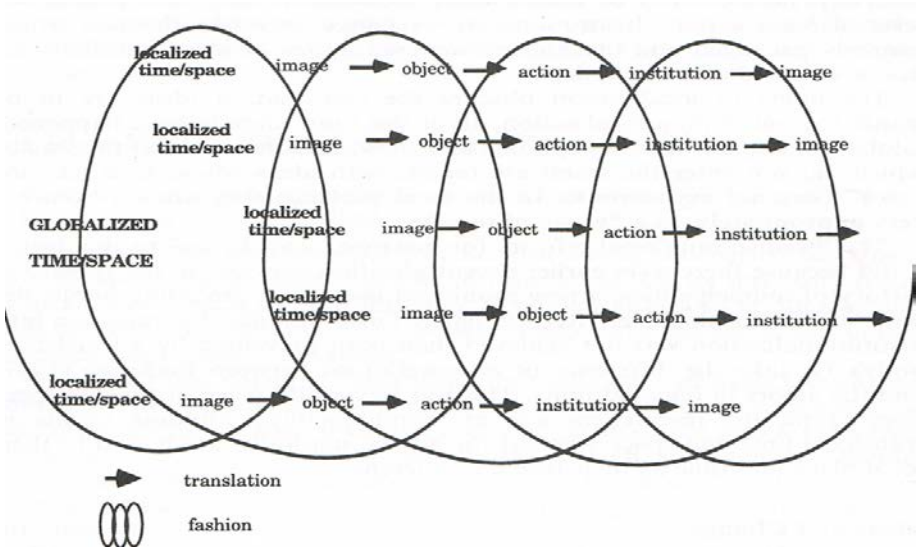

Fig.1 Travel of ideas (Czarniawska and Joerges, 1996, p. 46)

Lindberg and Erlingsdóttir (2005) have in their studies used the translation model by Czarniawska and Joerges in an attempt to describe the translation process's different phases (see fig.1). The first step is to disembed an idea from one setting and remove its context specific characteristics, so that it can be applied in other fields that may not share the same values and characteristics. To attract new users, the idea is often materialised into a model or instructions that present solutions to a communicated problem (Sahlin-Andersson, 1996). In order to function in various settings, the idea should, however, be as generalised as possible and leave space for local interpretations. When an idea is implemented into new contexts it encounters cultural aspects and traditions regarding routines, leadership and formal structures. In addition, Sevón, (1996) highlights the importance of identities when organisations decide what new ideas to welcome, which is complicated by the fact that actors tend to hold several identities that changes depending on the situation. Together, these factors mentioned are all affecting the organisation's actions and if it embraces the idea (Lindberg and Erlingsdóttir, 2005; Fernler, 2011). Consequently, for an idea to become institutionalised it needs to be seen as a natural part of the organisation's culture and daily procedures (Meyer and Rowan, 1977).

Translation processes are often described as free and creative, however, Sahlin-Andersson (1996) argues for the influence that social control, conformism and traditionalism have on the process. An idea's position is often strengthened by legislation or traditions in the context where it is applied (Erlingsdóttir, 1999). Additionally, those ideas that successfully manage to win support in the society are often linked to what Czarniawska and Joerges (1996) refer to as *master ideas,* or have appeared in people's mind prior to its introduction (Forty, 1986). Master ideas are described as links between temporary trends and institutions and represent historically important success factors within specific fields, such as norms and traditions that may affect the survival of new ideas. As people tend to value things differently, but at the same time are influenced by organisational culture (Sandberg and Taragama, 1998); the norms and traditions in turn affect how the organisational actors value new ideas and thereby

choose to embrace or reject them. Together with the receiving context, the receiver of ideas is seen as an important factor affecting their longevity (Latour, 1986). However, these two factors have traditionally, according to Røvik (2008), been given too much focus, which has resulted in neglect of the actor responsible for spreading the idea and its responsibilities.

Idea bearers

Various terms have been used in the literature to define the actor in charge of spreading an idea. Røvik (2008) uses the term translator, whereas Sahlin-Andersson (1996) refers to the actor as an editor, and Czarniawska and Joerges (1996) use the term idea bearing organisations. According to Røvik (2008) the opinions diverge whether the translator should have an active or passive role in the spreading of an idea. The proponents of an "invisible" translator see the original idea as a masterpiece, which main message must not be changed, but be spread as it is. The translator should only translate the idea into a different "language" without changing the content of the message. Others would rather see the translator as a unique factor that by contributing with changes to the idea may improve its original characteristics. Sahlin-Andersson (1996) supports the thoughts of seeing idea spreading as an active process, and describes the participants as editors. Their involvement can re-shape the idea's design and even change its original meaning, as the editing process is directed by local norms and traditions. Consequently, the originator of an idea risks losing control over its original design and purpose, as the idea is adapted to local circumstances and pressure from its users. Meyer (1996) illuminates the idea bearers' limited responsibility over the utilisations of ideas and the implications that organisational behaviour may have on their outcomes. The same thoughts can be found in Lindberg and Erlingsdóttir's (2005) studies of translation processes within the Swedish health care system. Their results show that the actors in charge of spreading the idea focused on packaging, spreading and legitimising it, while it was up to the idea users to decide what actions to take. Leaving the control of an idea's future development to local hospitals, on the other hand, resulted in their study that the original idea was disregard and never became institutionalised as a natural part of the hospital's routines.

To succeed with a translation process, meaning that the idea will function in its new context, is illuminated by Røvik (2008) to not only be connected to the role of the translator, but more importantly its competences. To succeed in spreading an idea, the translator should be knowledgeable about the local traditions and circumstances in the contexts from which the idea is collected but also implemented in order to know if the idea is appropriate to use in new contexts and what the needs for adjustments are. The idea bearing organisations are, hence, often professional consultants, who are knowledgeable about the area in specific and are likely to have the right tools and techniques to use (Czarniawska and Joerges, 1996). As an idea bearer, according to Røvik (2008), it is also crucial to gain authority and legitimacy when spreading an idea to new actors. The easiest way to achieve this is by being the founder of an idea instead of a secondary idea bearer. The actor is than automatically given the status as *insider*, which thereby facilitates its work.

Methodology

The introduction of experience-based co-design (EBD) and the 4-step model represents a meeting between a management idea and a tradition-bound medical context. In order to understand the complexity of the process, as well as the role of the actors spreading the idea and their influences, interviews and observations have been performed to collect empirical material. Further, the translation model by Czarniawska and Joerges (1996) has been used as an analytical tool and to organise the presentation of the empirical findings. Another aspect to be noticed is that different terms are used in the literature to describe the actor responsible for spreading an idea. However, in this article the term idea bearer will be used, which is connected to Czarniawska and Joerges' (1996) term idea bearing organisations.

Collecting of empirical material

The first part of colleting empirical material started with the reading of a handbook illustrating the Swedish 4-step model, which gave a first impression of the model's design and aim. This knowledge came to be very helpful when preparing for upcoming interviews and observations, which were the main techniques used to collect data. The collecting of empirical material can be explained as being divided into two different focus areas, however, conducted simultaneously with the aim to complement each other. To fulfil the purpose of the study a need was felt to cover both the different steps of the idea's travel as well as creating an understanding for the context where the idea was implemented. Consequently, one care unit working with the model has been studied more deeply, by using an ethnographic approach (Silverman, 2006), to capture cultural aspects within the hospital setting as well as the employees' attitude towards experience-based co-design. Culture as explained by Van Maanen (2011) consists of language, concepts, categories, practices, rules and beliefs (p.13), which all have an impact on the actors within the context. The reason why culture has been one of the focus areas is to enable an understanding for what factors that shape the translation process and especially the role that the actors responsible for spreading the idea are ascribed. This can be related to another implication from using a translation perspective, where the intention is not to judge whether the process has been successful or not, but rather to study the process's different parts and the impacts on it (Czarniawska and Joerges, 1996).

Interviews and observations

The studying of an idea's travel by using a translation perspective is not uncomplicated, but gives implications in terms of the restricted part of the journey that can be studied (Czarniawska and Joerges, 1996). Due to the limited time of this study, it was only possible to observe the initial phases of the implementation process of the model at one care unit. Consequently, interviews were needed to cover additional parts. Further, as in line with a translation perspective and its belief in heterogeneity and the difficulties of generalising the outcomes of a translation process (Czarniawska and Joerges, 1996), the aim with this study is not to present any generalizable findings. On the contrary, a descriptive approach (Bryman and Bell, 2011) is used based on the perspective of two idea-bearing organisations and their experiences from spreading an idea, together with some carers' opinions from working with the 4-step model at this moment. The reliance to stories of the idea bearers and idea users allowed for an in depth understanding for how the translation process was shaped and what

roles the different actors played in this specific setting and timeframe. In addition, to cover as many aspects and perspectives as possible, interviews were performed with people of different professions and who worked at different organisational levels. With respect to the on-going process and communicated desires, however, no contact has been taken with the participating patients except from observations. Even so, the picture gained from observations and from previously been working at one of the care units I believe have given me a fair insight of their perspective as patients.

Being a previous employee has also facilitated the performing of interviews, and especially at times where the interviews were not booked in advance. The respondents were chosen both on the basis of their position, but also through convenience sampling (Bryman and Bell, 2011), where the interviews with the managers and the initiators of the 4-step model were booked in advance, while the carers were chosen based on their availability with respect to their workload for the day. In average, the booked interviews lasted for 60 minutes, whereas the unplanned interviews where kept shorter, approximately 20 minutes, to attract the carers despite their busy schedule. In total, 15 respondents were interviewed by using a semi-structured approach (Bryman and Bell, 2011). As one of the aims with the interviews was to create an understanding for the individuals' sense making of their social context, it was important to perform conversation-like interviews. The respondents were encouraged to talk freely around a few predefined themes, but at the same time, space was given to enable the detection of areas of interest that could not be foreseen prior to the interviews. All conversations were recorded, except from two telephone interviews where notes were taken. Subsequently, the recordings were carefully transcribed in order to give an overview of the material and to minimise the risk for leaving some parts out due to limitations in memory (Bryman and Bell, 2011). In addition to interviews, observations were made during departmental meetings and a project meeting connected to the 4-step model, where the intentions of this study were explained in beforehand. Further observations were made through "shadowing" (Czarniawska, 2007), where opportunities were given to follow some of the carers' work routines at one care unit. During the observations field notes were taken, which together with the recorded and transcribed material were helpful when going back and reflecting upon the stories and observations in the analytical work.

Respondents	Number of interviews
2 persons at RCC	3
2 departmental managers	5
2 doctors	3
9 nurses, assistant nurses & kitchen assistants	9

Table 1. Interview overview

Analysis of the material

The empirical material was, after it had been collected, coded and compiled into two main groups containing different concepts (Martin and Turner, 1986). Implications for using this technique is that the coded material might lose the connections to its original context, hence, as a researcher, precautions needed to be made to assure that the story was kept as true as possible and mirrored the perspective of the storytellers (Bryman and Bell, 2011). Consequently, the material has been carefully revised when being divided into different concepts. The first group was labelled contextual factors, which included for example cultural aspects at the care units and the carers' descriptions of the context. Whereas the second group displayed stories and observations connected to aspects concerning the 4-step model itself. As no prior theories were used to guide the study, the different concepts were compared to see if the stories and actions displayed at the care unit could be used to describe events of the development of the 4-step model. Subsequently, earlier studies were searched for, as in line with an inductive approach (Bryman and Bell, 2011), to see how the findings of this study could be explained by and complement other results and theories within the field of translation studies.

Findings

Background

Quality assurance has played an important role in the Swedish health care systems since the 1980s (Erlingsdóttir, 1999). As it is today there are no clear national models for how to follow the directives of "good care". Consequently the methods used and their results vary within the country. This was illuminated a few years ago, in 2009, when the government presented a strategy with directives for how to improve the national cancer care. The focus of the strategy was to offer a more equal care among the country's different districts. For the purpose to chart the health care's quality, six regional cancer centres were created, which were also to function as knowledge centres supporting the local hospitals with new information and techniques for how to organise the cancer care (Regeringen, 2009; RCC, 2013a). One of these centres is the Region of Västra Götaland and Halland's regional cancer centre (RCC). As a link between RCC's mission and the hospitals' daily operations, a process owner was appointed within the different cancer types. He or she is responsible for quality improvement in their specific medical field and works with goals that are connected to medical innovation, improvements of organisational shortcomings and resource optimisation, which all should be focused around the patient's needs (RCC, 2013b).

Recently, RCC was introduced to a new model and the concept of *experience-based co-design* (EBD) by the *Centre for Organisational Development* in the Region of Västra Götaland (hereafter referred to as *Development Centre*) as a new method for quality assurance. The model has hitherto been implemented at two care units by RCC, and to fulfil the purpose of this study, the translation process and utilisation of the model has been studied with focus on the roles of the actors involved and how the idea has been implemented in practice.

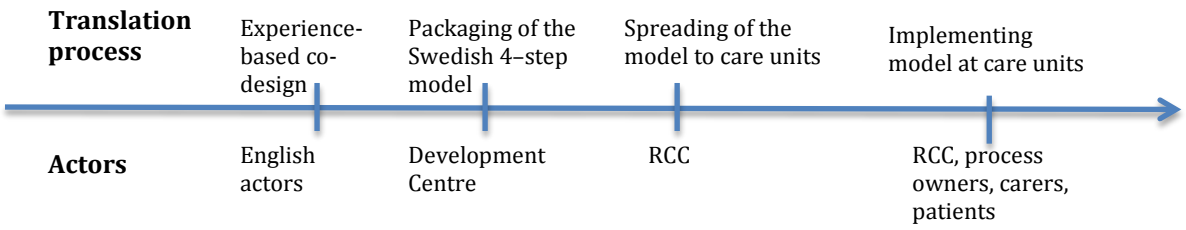

Fig 2. The travel of the idea

Experience-based co-design and the translation into the 4-step model

In the continuous work with quality assurance, different measurements and techniques to value health care services are used. As communicated by people of different professions and at different organisational levels at the hospital studied, they often perceive the quality indicators as standardised and connected to financial objectives or medical aspects like the number of days spent at the hospital and the loss of blood during surgery. These factors are referred to as hard quality indicators and may give an indication of how well the hospital performs, as they can be used to compare the results with those from other hospitals. However, as expressed by some employees, they do not reveal the complete picture, as various actors define quality differently. In an attempt to explore this further, the *Institution for Innovation and Improvement* in England was the first actor to introduce a model based on *experience-based co-design* (EBD) to the health care system. The concept introduced a belief in deepened patient involvement and the appreciation of softer quality indicators. This inspired one of the originators behind the Swedish model, who works for the *Development Centre*, when she first heard about EBD in a course held at the University of Chalmers. During this course the participants also visited Luton and Dunstable Hospital in England, where EBD first was used and where a model was developed for implementing EBD at local care units. The model aimed at improving the patient's journey from when first visiting the hospital to where he or she is today in their treatment by stepping away from the dominating medical focus. To be able to design the health care system to make this journey as comfortable and safe as possible, the experiences from the patient and the carers played the key roles. To capture these experiences, the English model constituted of four steps that were designed to identify touch points showing similarities or disparities in the individuals' stories connected to a certain care situation and where they may experienced negative as well as positive emotions.

Disembedding and packaging

When starting with the translation of the English model, the Development Centre chose to keep the model's main attributes, as it had been tested before with positive results and was already adapted to function in a hospital setting. Some adjustments were, however, made to make it fit with the Swedish directives for good care and the national legislation, as well as the Development Centre's own preferences for how these directives best could be achieved. Due to their opinion, the English process was more top-down directed and formed as a project with a beginning and an end. "*We wanted the process to be a continuous learning process formed like a circle instead, as the improvement work is a natural part of the care units' daily*

work and never ends", as mentioned by one of the originators. Another aspect modified concerned an intensification in patient involvement by letting them be a part of the team from the very beginning and not only stepping in after the process had proceeded for a while, as made in England. As one person working for RCC explained it *"the importance of intensifying the involvement degree of both the patients and the staff is to get them motivated and understand that this is their journey, their shared process and that it is dependent on their mutual commitment"*. As she saw it, the Development Centre and RCC are just a helping hand, which are there to initiate the work and share their learning with the users. Even so, in the first projects, RCC has been more involved than they are planning to be in the future. The reasons for their intensive involvement, one of the originators behind the Swedish model explained to be to really get the users to understand the model and its purpose. Another reason mentioned by her colleague, is that when the model is spread to other actors the Development Centre is unable to follow the translation of the model and, hence, cannot evaluate its results. However, in the case of RCC and the spreading of the model to local care units, they can through the process owners enter the care units and observe the process. The connection between the care units and Development Centre is than retained by having an employee, who also is the originator of the model, working as a project leader for RCC with the model and who also is the one observing the journey of the model at the care units.

Further, when asking one person at RCC why she thinks the model would function in Sweden, she explained that *" The time has come, the Swedish market is ready"*. According to her the trend of patient-centric care has circulated in the society for a while now, and it has been relied upon to different degrees. She continued by telling that the term "patient involvement" has come to be misused today. To externally communicate a belief in patient-centric care has become a trend and to say that one is working with patient-centric care when distributing standardised questionnaires to patients where they are asked to rank their level of satisfaction is not an acceptable level of patient involvement according to her beliefs. The new model, represented by the Development Centre and RCC, is, hence, according to her a technique for ensuring that the patients are taken more seriously.

The 4-step model

With changes made was the concept of EBD packed into a new but very similar model, which was removed from its original context and ready to be spread to other organisational settings. The idea was materialised in 2011 by the Development Centre in the creation of a handbook, named "Rethinking in four steps", or "the 4-step model". It consists of a receipt for how care units may design their improvement work through patient involvement and by using experience-based knowledge. As accentuated by one originator of the model, it is not intended as a standardised model. Instead, its receipt should be adapted to the ingredients present in the context where it is used. To attract users, the model is also designed to coincide with the national definition of good care; nevertheless, it does not have any predefined goals as these are to be developed in collaboration between the patients, the carers and the management. However, one of the originators of the model stated that the model aims at unifying the classical perspective of focusing on medical aspects with a deeper understanding for other factors within the system that directly or indirectly affect the design of the health

care practices and people's level of satisfaction. They have therefore chosen to put more administrative areas in focus, such as; communication, personal treatment, service and environment, as they have proven to be of importance from the patient's point of view if looking at the numbers of complaints that the region of Västra Götaland's *Patient Support Committee* receive each year. The originators of the 4-step model therefore hope that the model can be used to investigate the underlying reasons behind those complaints further, by relying upon knowledge sharing and storytelling. A second goal of the model is to let the experiences of patients and the carers direct the process instead of only relying on evidence-based facts or letting the hospital management alone decide what factors that are of importance. One process owner illuminated the reflecting upon a health care situation from more perspectives as advantageous, as it is not self-evident that a successful treatment result automatically makes a patient satisfied with the hospital stay. The patients' and the caregivers' stories should therefore be used to identify touch points representing situations where the parties develop negative or positive emotions and where energy and resources are wasted. To enable mapping of the touch points, the 4-step model is divided into four different phases (see fig. 3), in which the patients should be a central part. In addition, so called "experience books" are used, where the carers and patients are supposed to write down their experiences, and which subsequently should direct the improvement work.

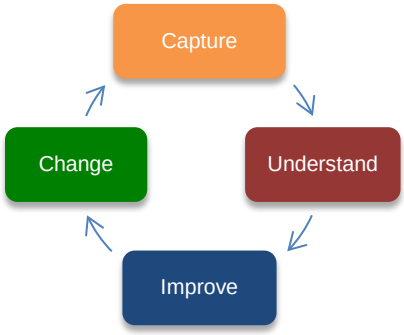

Fig 3. The 4-step model (Patriksson, Ringheim & Jenssen, 2011, p.10)

Receiving and acting

The introduction of the 4-step model to local care units has in its first two projects been made by RCC together with the process owners, who also are doctors at the care units. In the early stages of the process there was scepticism especially among the doctors towards the approach and what results it may give, which indirectly also created scepticism towards RCC as the messenger. Two aspects that frightened many people were the time-consumption and the uncertainty that new methods raise. One nurse explained it as they are continuously targeted by the management with new information and changes to be made, and it can easily get too much. In order to motivate the staff, one departmental manager believed that if the staff afterwards can see the results as something they themselves have created, the results of the process would also be more successful. As the process had proceeded for some time and the carers came to play a greater role in the different steps, the questioning declined, even though it still exists to some degree. At one of the department where the model is in use the care unit manager welcomed the idea of putting effort into improving the nursing care as well and not

just focusing on the medical treatments. "*We are world leading when it comes to the number of surgeries and the techniques used there, but when it comes to the practices and routines in caregiving there is often a resistance towards trying new things"*. This was also heard among the nursing staff, where the majority of them perceived a professional hierarchy at the department and where the doctors' knowledge and opinions are prioritised or at least more respected. Despite some questioning, the work could start relatively fast since the process was built on attracting those showing an interest for the model and its mission. At one care unit, the nursing staff and the secretaries were asked to announce their interest, and the management later decided who was accepted in order to secure that "new blood" and energetic people was brought into the group. The doctors on the other hand were chosen based on their specialisation since the model was to be used in one specific medical sector of the department. Further, some patients were also asked if they were interested in taking part of the process. The 4-step model thereby created a forum in which all categories of people at the care unit; patients, carers, administrative staff and management in collaboration could create a strategy for what changes to make and how these could be achieved. This was something that otherwise is described as a serious problem among the ward staff. They perceived that the organisational structure and the accustomed routines have set up restrictions for the communication, especially between the nurses and doctors.

After having set up a team of participants the first actions towards mapping the carers' and patients' experiences started. Firstly, and as in line with the 4-step model, the carers and patients met to decide the design of the patients' experience books. Opened questions were formed to match with the patient's journey through the health care system and what aspects they thought would be valuable in order create meaning and track emotional experiences and touch points. RCC was also participating in the meeting and with help from these books they could chart the stories when compiling the material, which was their responsibility. Two people from RCC read all the books separately and highlighted those quotations that they thought stood out as strong emotional stories, but at the same time were connected to similar opinions. The quotations were then cut out and collected under the same themes. This means that a sorting process took place, where stories that were not directly linked to the five non-medical categories mentioned in the handbook were removed. The quotations were later used in the workshops, which was the forum for sharing and learning about each other's experiences and where additional patients where invited. Based on the discussion about the quotations, the patients and carers did agree upon what changes to prioritise through voting. The themes with most votes in the model's first projects has been; information, psychosocial support, support to kindred, waiting time and the desire for having a contact nurse. Based on these, the carers and patients created an "improvement team" to start improving the issues mentioned at the workshop. At this stage of the process, RCC was more passive in its participation, leaving the decisions and improvement work to the local staff, while simultaneously pushing for the completion of the process.

Stabilisation

While the work with stabilising the utilisation of the model at the care units continues, the Development Centre and RCC have noticed an increased interest for their work, both

regionally but also nationally. By visiting conferences and offering seminars, they have tried to spread the model to other actors that have announced their interest for taking part of the model. Already, the model has been spread to other organisations, however, as the Development Centre is not the owner of other organisations' results and improvement work, they have not been able to follow its result and is uncertain about how far the model actually has reached. Rather, the users of the model have taken on a greater role in translating the model and adapting it to their local context. When reflecting upon the factors that have played a crucial part making the idea attractive within the medical world, the proponents illuminated three factors: its simple design, the timing and the support from well-merited doctors. As the ideas of patient-involvement and patient-centric care have circulated for some time already, they believed that the market is ready to take it one step further. At local levels, where the idea has met the practices at the care units, the process owner is mentioned as another aspect. Their commitment to the model and connection to the medical profession, RCC believed to be a valuable factor in terms of winning the doctors' acceptance and to make them see the model as a legitimate complement to the otherwise dominating belief in evidence-based knowledge. Despite some scepticism, the response towards the 4-step model has overall been positive and many nurses and the management see the model as a first step in increasing the degree of patient involvement. They talked about other projects that they plan to implement in the future where the patient is to take on a greater responsibility in the design of its journey through the health care system and where the indicators for quality is to be based on softer values. Based on existing thoughts like these, the proponents of the 4-step model are optimistic in terms of the model's future. However, it remains to see if it can win the same degree of acceptance as evidence-based medicine and become institutionalised.

Discussion

The intention of this paper has been to follow the translation of experience-based co-design (EBD), represented by a model, from an international context to local care units of a regional health care organisation in Sweden. As acknowledged by translation theory the spreading of an idea is anything but a linear process (Czarniawska and Joerges, 1996; Latour, 1986; Røvik, 2008; Lindberg and Erlingsdóttir, 2005). Depending on the actors involved and contextual factors, the translation may take unexpected turns as the ideas are shaped to match with local preferences and traditions (Sahlin-Andersson, 1996). The complexity of a translation process has also been apparent in this study, especially in regard to the idea bearer, whose role is shaped by many factors.

Two idea bearers – two different roles

The results from the empirical findings show that the translation of EBD took different shapes depending on the time and context as well as the proponents of the model. In the process of spreading the idea, two main actors can be tracked; the Development Centre and the regional cancer centre, RCC. These two actors have been afforded different roles in the translation of the model and thereby affected its design and use in various ways. Which in turn also affect the on-going translation. The Development Centre, as the first actor who got in contact with the English model, assumed a more prominent role in the beginning of the process when translating the ideas behind EBD into the 4-step model. If looking at the definition of an idea

bearer and how it has been characterised in earlier studies, it matches well with how the Development Centre has acted. Czarniawska and Joerges (1996) describe the idea bearer's responsibility as translating an idea into an object or instructions, which is then to be spread in the society. In addition, this means that the idea bearers are not involved in the utilisation of the idea in practice, but instead it is up to the users to interpret it and decide what actions to make (Meyer, 1996). However, while the Development Centre has been focusing on packaging, spreading and legitimising the concept of EBD through the 4-step model, RCC has come to play a different role in the translation process. Instead of only focusing on introducing the idea to other actors, RCC has also been involved in implementing the model at local care units. Thus, RCC deviates from the traditional pattern (Czarniawska and Joerges, 1996; Lindberg and Erlingsdóttir, 2005) and its status as idea bearer can be questioned. Through its involvement in the implementation of the idea, it can be argued that RCC partly assumes the role as idea user or at least a controller of the ideas users' actions. Even though RCC has not been involved in the actual improvement work it has been present and overviewed the process so that the receipt of the model is followed. The effects this may have had on the translation process will be discussed in a separate part, however, first the possible aspects behind RCC's role will be analysed.

Aspects influencing an idea bearer's role

Like a translation process symbolised by uncertainty and dependency on local factors (Czarniawska and Joerges, 1996), the results of this study shows how the role of the actor spreading an idea are just as unpredictable. The organisations' differences in actions and RCC's deviation from the traditional definition of being an idea bearer can be linked to several aspects displayed in the empirical findings. Firstly, as mentioned by one of the actors, the Development Centre and RCC have consciously chosen different focus areas of the process, where RCC was to evaluate the utilisation of the model at local care units. Consequently, there has been a wish to extend its presence in the process. If that had not been the case, RCC would possibly have left the process before the implementation phase, as the actors did in Lindberg and Erlingsdóttir's study (2005). Instead, RCC's participation in the implementation phase, leads into becoming more of an idea user and controller of the process, which can be connected to Sevón's (1996) acknowledgement of the tendency for actors to change role and identity depending on the current context and local circumstances. This means that RCC's own desire to assume a certain role in the implementation phase is decided upon by more factors than its own intensions. As people tend to value and interpret things differently, other actors may construct a role for RCC that differs from its own intentions and perception of itself (Sandberg and Taragama, 1998) Consequently, deciding what role RCC would assume is related to the local context with its traditions and how they shape the local actors' values and perceptions.

In addition, to enter an organisation as an external actor can be challenging, and in order for RCC to participate in the implementation at the care units, it was dependent on the carers' acceptance for entering their "territory". As illuminated in translation theory the complexity lies in the meeting between ideas and contexts, where the ideas need to be designed to match their new environment (Czarniawska and Joerges, 1996; Lindberg and Erlingsdóttir, 2005).

Through the results of this study it can be argued that the same could be applied to the case of the idea bearers, and especially in regard to the values they are representing. The study shows that the way people make sense of an idea also influences the way they make sense of the idea bearer. Hence, the background and the values of the idea being spread are to be seen as a second aspect crucial for the construction of an idea bearing actor's role. Since the carers perceive the medical profession, as to a large extent controlling the values and practices of the care units, RCC might have met an even greater resistance due to the nature of the 4-step model as diverging from the traditional perspective and approaches. This challenge, where ideas coming from outside risk to be perceived as a threat to the organisation's identity, is illuminated by Czarniawska and Joerges (1996), and Wærness, (1990). As the 4-step model represents a belief in experience-based knowledge instead of evidence-based facts, a sense of threat can explain the existing resistance, and the challenge of legitimising the model. However, as patient involvement, which is the other main element of experience-based co-design, has been communicated as an important part of the health care since the New Public Management movement in the 1980s (Hill and Wilkinson, 1995; Lindquist and Persson, 1997; Juran 1989), the timing of the idea is beneficial. Forty (1986) illuminates how ideas that existed in people's minds prior to their introduction have a greater chance to become supported. Consequently, if the idea had been introduced earlier, the resistance towards RCC and the 4-step model probably would have been stronger.

Further, as highlighted by Sahlin-Andersson (1996), traditionalism and social control play crucial roles in the determination of a translation process. To win acceptance for one's ideas, Røvik (2008) see the idea bearer's possession of the status as *insider* as crucial in gaining support for ones ideas. In this case, RCC may be a secondary actor (Røvik, 2008), however as one of its employees is the originator of the Swedish 4-step model, RCC has a greater chance to achieve a higher status. Even so, RCC's position alone seems to not have been enough in order to gain the local employees' support. Instead, the process owner's intercession and the authority among the other doctors and carers, was expressed by one actor at RCC as very valuable to the implementation process. Additionally, the fact the model is represented by one of the doctors in the role of a process owner, together with RCC's help with administrative tasks, like collecting and compiling the experience-books, can explain why RCC has been allowed to play the role of an idea user despite scepticism and resistance. The need for support from the process owner is even so a sign of the challenges for an idea like experience-based co-design to survive in this type of context. Consequently, RCC may have needed to assume the role as an idea user and controller of the process, in order for allowing a committed testing of the 4-step model's all steps.

The idea bearers' roles and their effects on the translation process

When looking at the two actors, RCC and the Development Centre, the latter has been more explicit in its translation of the original idea of experience-based co-design. When adapting the model to personal preferences and national directives for good care, by making it more into a circle-like process with a deepened patient-involvement, the Development Centre ascribed meanings to the model that did not exist to the same extent in its original form. In that sense, the activities of the Development Centre can be seen in light of translation theory

(Czarniawska and Joerges, 1996; Lindberg and Erlingsdóttir, 2005), where all ideas are shaped differently along their journeys due to the interaction with various actors and contextual aspects like traditions. However, when looking at the role that RCC has been ascribed in spreading the 4-step model to local care units, some interesting and diverging aspects are displayed when using a translation perspective. Even though the actors at RCC are aware of that they are taking a more active role at the moment in spreading the model, it is unclear whether they or the carers are aware of the implications it has on the translation process. As communicated by one person, RCC is to function as a helping hand. However, only through its presence and by clarifying the content of the model to the carers, it risks influencing the degree of freedom concerning the interpretation and utilisation of the 4-step model, if so unconsciously. As acknowledged by Sandberg and Taragama (1998), individuals tend to value things differently, but at the same time they are influenced by the values communicated by their surroundings. Hence, when clarifying the model's purpose and helping the carers in their process, RCC may influence the users' interpretation and utilisation of the model and makes it more in line with its own intentions. One actor at RCC stressed that the aim is not to offer a standardised model, but that it should be adapted to each unique situation. Even so, when reflecting upon the actions made, and especially in regard to the role that RCC has assumed, aspects can be tracked that create restrictions for a free development of the model.

A translation process, as argued by Sahlin-Andersson (1996), is mistakenly perceived as a free and creative process. Instead, traditionalism is one of the aspects illuminated as controlling the development of the idea or model being spread. In this case an additional aspect is displayed as affecting the implementation phase, and that concerns the involvement of the actors spreading the idea. On one hand, the degree of influence that RCC has on the process is controlled by the care units' local traditions, norms and routines. However, through its strong relationship with the process owners, RCC has managed to gain a legitimate position in working with the implementation, which makes its control over the model's receipt more evident in terms of directing the utilisation of the model. If RCC would have left the process when its work of being an idea bearer as defined by Lindberg and Erlingsdóttir (2005) was over, the local traditions and the preferences of the carers would completely have decided the utilisation of the 4-step model and thereby its outcomes. And as some carers questioned the model, it can be speculated whether the care units would have tested the model's four steps, or if it had been rejected before being finalised. Even so, through RCC's presence and willingness to complete the whole process, all steps have been worked with and resulted in some changes for the carers. Based on these aspects a paradox arises concerning the 4-step model's communicated aim and its actual outcome. As mentioned, the model is to be anything but a standardised. Instead, it should be adapted to each context depending on the local actors' needs and mission with the model. The local adaptations seen today are the formulation of the experience-books and the suggestions for changes, however, that has so far not affected the design or utilisation of the model itself. Consequently, the translation process is to be seen as more one-way directed where the carers have limited impact on the model, and instead need to adjust to the model and RCC's game rules. In addition, as the model's receipt is followed very thoroughly, the process thereby shares more similarities with a

diffusion process than a translation process. The activities undertaken and actions produced contradict with the translation theory's belief in the power of the users, at least when it comes to implementing the model as the actor sharing it is present. As ideas move between time and space, the study of their journeys is restricted. Consequently, the pattern may look differently in future projects, when RCC predicts that they are going to be less involved due to the increased interest for the model and its limited resources. Even so, at this point, RCC's widespread participation has controlled the process in different ways and the only influence the carers' resistance have had on the utilisation of the model, is by momentary slowing down the pace of the process, which is also mentioned by Latour (1986) when differentiating between a diffusion of translation process.

An additional aspect that makes the implementation process more reminiscent of a diffusion process is seen in the celebration of the process owner as a single actor that is vital for the support of the idea. As seen in Latour´s (1986) paradox of power, the survival of an idea is dependent upon the support from its users and to what degree they embrace it. Hence, RCC's and the process owners' promotion and guidance, would not have been seen as crucial factors for the carers' commitment to the 4-step model if using a translation process. Instead, the carers' actions and interpretations would have been the valuable aspects in the development and stabilisation of the model. This aspect will be more evident in the future utilisation of the model, due to the increased interest for the model, which at the same time forces RCC to take one step back as there are not enough resources to participate to the same degree in all future projects. Consequently, RCC will be more dependent on other actors and idea users support of the model, which may lead to changes in the model's design and use.

Conclusion

In this paper the journey of experience-based co-design from an international context to local care units of a regional health care organisation in Sweden has been followed, with the aim to illuminate its complexity and the roles of the actors in charge of spreading the idea (the idea bearers). In earlier research it is argued that the role of the idea bearer has been disregarded (Røvik, 2008), hence, by following two idea-bearing organisations this article contributes with a deepened understanding for the roles of these actors and the effects they have on the translation process.

By using a translation perspective the development and utilisation of an idea are seen as very unpredictable, as its travel is shaped differently depending upon the local contexts and actors that the idea encounters (Czarniawska and Joerges, 1996; Lindberg and Erlingsdóttir, 2005). This study argues that the roles of idea bearers too are ambiguous and varying. The two organisations studied have assumed different roles and responsibilities, which can be related to various aspects and depends upon what phases of the idea's journey that is observed. Whereas the actor responsible for the first part of the translation process matches well with the traditional definition of being an idea bearer, RCC has played a different role by taking part of the implementation phase as well, hence, its status as idea bearer can be questioned. Due to RCC's high degree of participation, it has been an interesting actor to study more in depth in regard to the complexity that arises in the meeting between an actor and its ideas

with local contexts. Based on the empirical findings, this article argues that an idea bearer's role is not only shaped by its own intentions and activities, but also by contextual factors and other actors' sense making. The first factor influencing the role of an idea bearer is related to the background and values of the idea being spread. This study shows that the way people make sense of an idea also influences the way they make sense of the idea bearer. The creation of the idea bearer's role, hence, depends on how the idea bearer and its idea match with the local actors and their current values.

Uncertainties are not only found in terms of the construction of the idea bearers' roles, but also in regard to their actions. By reflecting upon the actions of the actors studied, it appears that the idea bearer's involvement does not necessary need to end with the introduction of an idea to new users, as traditionally defined, but may continue during the implementation phase as well. The participation and guidance in the utilisation of the idea and model on the other hand affected the degree of freedom in terms of translation; hence, the process appeared more similar to a diffusion process than a translation process (Rogers, 2003; Latour; 1986; Czarniawska and Joerges, 1996). Consequently, the process that from its very beginning looked like a translation process, and where the idea and model being spread are communicated as having an adaptive character, thereby represents an example of the two traditions within the management field.

Based on the findings in this article, which display further complexities and uncertainties in the process of translation, further ideas have appeared that can be of interest for future research. With regard to the unspecified role for RCC in the future, and the fact that experience-based co-design is implemented in a context that partly questions its values, it would be interesting to follow the idea's continuing journey. Aspects to study may be connected to whether the idea has a chance to become institutionalised, and how it has developed at the local care units since RCC in the future probably will not be able to assist and control the process to the same degree as today. Further, as this study only represents one example showing the ambiguities of idea bearers, the studying of other contexts and actors could contribute with additional aspects in order to increase the understanding of their roles.

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