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De- and Recoupling and Public Regulation

Martin de Bree
Erasmus University Rotterdam, Netherlands

Annemiek Stoopendaal
Erasmus University Rotterdam, Netherlands

Abstract

The concept of decoupling refers to the gap between the formal and the actual world in organizations in which a policy is formally introduced but not actually implemented and effective. Although the phenomenon of decoupling in organizations has been studied widely since the late 1970s, little is known about the reverse process of recoupling. Little is also known about the abilities of public regulators to discover decoupling in regulated organizations and to promote the recoupling that is necessary to diminish the gap between the formal and the actual world.

In an experimental project of the Dutch Health and Youth Care Inspectorate, we ethnographically followed how this public regulator changed the focus from prescriptive regulation based on quality and safety indicators to the supervision of the management system of a regulated organization. We call this type of regulation system-based regulation.

We found that, by using system-based regulation, a regulator can identify several forms of decoupling that have not been recognized in earlier research. Interestingly, we found indications that, by applying SBR and thus recognizing decoupling, a process of recoupling was supported. With SBR the government can reclaim its influence on the meta level while maintaining the level of freedom of management at the organizational level. Instead of aiming for more or stricter regulation, the government could shift its role to meta-regulation, meaning that the public regulator redefines its role as an assessor and stimulator of the quality of governance in terms of self-regulation. Implications for theory and practice are discussed.

Keywords

decoupling, healthcare, institutional theory, organizational learning, recoupling, supervision, system-based regulation

Corresponding author:
Martin de Bree, Rotterdam School of Management, Erasmus University, PO Box 1738, Rotterdam, 3000DR, Netherlands.
Email: mbree@rsm.nl

Introduction

> We will check ourselves if we comply with the rules and if everything goes according to regulations. And if there is a problem, dear inspectors, we will call you.[1]

Despite this statement and the regulation stipulating that healthcare organizations must implement management systems for patient safety and quality assurance, risk control has not always been sufficiently implemented in Dutch hospitals.[2] The statement illustrates the tension between the accountability of the management and the role of the regulator.

If, in a period dominated by self-regulation, the systems that are used by the management of organizations do not always appear adequately to assure public values such as patient safety and healthcare quality, the government often starts to reclaim its influence. The regular scenario is a struggle for power between regulatees and regulators. The government starts to promulgate new and detailed regulation, public regulators gain more formal power and the management of regulated entities often experiences this as a frustrating burden that makes little contribution to the desired effects.

Scholars have recognized the growing influence of external forces on companies (Dahler-Larsen, 2012; Power, 1997), including regulation (Scott, 1995). The same processes occur in healthcare (Ferlie & Shortell, 2001). In their attempts to achieve improvements, government, regulators and managers all try to find ways to gain control over healthcare professionals (Levay & Waks, 2009; Stoopendaal & van de Bovenkamp, 2015; Mintzberg, 2017). These attempts regularly result in a one-dimensional discussion about more or less regulation.[3] In this article we describe an alternative scenario. Instead of aiming for more or stricter regulation, the government could shift its role to meta-regulation. By meta-regulation we mean that the public regulator focuses on the quality of self-regulation. We think that this approach to regulation offers opportunities to shift the focus of the regulator from compliance to the letter of the law to situational regulation, which better fits healthcare and the aim for quality and patient safety, which is sometimes considered the best thing to do (Rowley & Waring, 2011).

However, gaining control over all the involved layers in the healthcare system (van de Bovenkamp, Stoopendaal, & Bal, 2017) may involve some difficulties. Despite protocols, guidelines, governance codes, codes of conduct, certificates and accreditations promising ethical behaviour, the actual practices persist in differing significantly from the bright and shining world that seems to exist mainly on paper. This phenomenon has been well known in the scholarly literature as 'decoupling': a policy is formally introduced but is not actually implemented and effective (Meyer & Rowan, 1977). In addition to examples in the financial sector, recent examples in the automotive industry, the food industry, the chemical industry and education indicate a substantial and enduring gap between the formal and the actual world.

Given the obvious importance of decoupling, it is surprising to find that only a few scholars (Egels-Zanden, 2014; Hallett, 2010; Jackson & Stoel, 2011; Tilcsik, 2010) have investigated the reverse process of decoupling: recoupling. Furthermore, the role of external sources in discovering decoupling and promoting recoupling has hardly been the subject of scholarly work. While organizations are generally assumed to be open systems that are influenced by external factors, we still do not know whether and, if so, how regulators may be able to influence the processes related to de- and recoupling within regulated organizations. In the search for more effective strategies, some regulatory agencies are experimenting with non-traditional process-oriented regulatory instruments. An example of such a strategy has been described as system-based regulation (SBR) (Bennear, 2006).

The research question that we seek to answer is whether an external public regulator can identify decoupling and stimulate recoupling. In this article we describe an experimental project using

SBR as a new method of inspection in Dutch healthcare and its effects on the processes of de- and recoupling. First, we describe the theoretical causes and forms of decoupling and reveal what is known from former research about recoupling. Second, we explain SBR as a novel attempt by public regulators to assess and stimulate the assurance of the safety and quality of healthcare in regulated organizations. Third, we describe how the Dutch Health and Youth Care Inspectorate (DHYCI) applied this strategy. We therefore analyse data from an observational study of a pilot project conducted by the DHYCI. Fourth, we discuss the findings with regard to decoupling and recoupling, and fifth, we draw conclusions.

Theory

Decoupling

Decoupling was first described in the 1970s (Meyer & Rowan, 1977) and has since been the subject of intensive research. Among the aspects of decoupling that have been studied over the years are the circumstances of decoupling (Edelman, Petterson, Chambliss, & Erlanger, 1991), the reasons for decoupling (Westphal & Zajac, 2001), the process of decoupling (Tilcsik, 2010) and the intentions behind decoupling (Crilly, Zollo, & Hansen, 2012; Sandholtz, 2012). Decoupling refers most frequently to the process whereby an organization adopts a formal policy to gain legitimacy from its social environment without implementing this policy in daily practice. Decoupling implies a business problem because there is a gap between work as imagined and work as done (Clay-Williams, Hounsgaard, & Hollnagel, 2015) or, as Argyris (1976) described it, espoused theory versus theory in use.

Decoupling may be deliberate when the management or professionals have no intention to implement the adopted policy and just wish to enjoy the advantages that accompany symbolic policy adoption. The rationale of intended decoupling is that executives gain legitimacy from stakeholders and can mitigate conflicts with stakeholders (George, Chattopadhyay, Sitkin, & Barden, 2006). Other possible benefits of decoupling are derived from gaining ISO certification (Heras-Saizarbitoria, Dogui, & Oliver, 2013) or a green reputation (Lyon & Montgomery, 2013). Although decoupling may have short-term benefits, in the long run it may backfire fiercely on the organization (Harrison, Lopez, & Andrew, 2015).

Crilly et al. (2012) and Sandholtz (2012) argued that decoupling is not always a deliberate choice. A lack of consensus may lead to poor implementation, meaning that the formal policy may aim to achieve compliance but, if the actual 'mise-en-pratique' by individuals within organizations is not suitable, compliance is not accomplished (Perezts & Picard, 2014).

Whereas these forms of decoupling indicate a gap between policy and practice, Bromley and Powell (2012) expanded the conception of decoupling to a second form, so-called means–ends decoupling. In means–ends decoupling 'policies are thoroughly implemented but have a weak relationship to the core tasks of an organization'. This form of decoupling concerns situations in which the practices implemented have an unclear relationship to the outcomes. This may be the case when working in accordance with procedures, such as a periodical cleaning protocol, becomes an end in itself. Means–end decoupling arises from embracing wishful social narratives about control in which the pressure to conduct evaluation is stronger than the pressure to conduct good evaluation (Dahler-Larsen, 2012).

Considering the practice of management systems that has been used by many organizations as a foundation for the design of their core processes, the linear model proposed by Bromley and Powell (2012) raises some questions. In this article we define a management system as the framework of documented processes, procedures and instructions used by an organization to ensure that

it can fulfil all the tasks required to achieve its objectives. Although the use of management systems is probably not the only way to improve the health system, the cyclical character of continual learning as induced by management systems may improve our understanding of decoupling in a more dynamic setting than the linear models proposed by Meyer and Rowan (1977) and Bromley and Powell (2012).

This form of learning often implies an ongoing series of activities. First, a set of goals is set and specified. Second, a management system is designed, including all the kinds of intended organizational measures and procedures as a means to achieve the goals. Third, all these measures and procedures are implemented. Fourth, these activities generate a real outcome that is supposed to equal the goals. Current management system standards, like ISO 9001, require a management review to check whether the activities yield a real outcome that is equal to the goal.[4] The 'real outcome' is sometimes difficult to measure, especially in healthcare, because goals such as patient safety and quality of healthcare are relatively vague. An example may help to clarify the difference between goals and real outcomes. If the goal of an organization for elderly care is for instance to reduce the number of falls to fewer than 40 per month in year A by implementing certain reduction measures and the actual number turns out to be 35 falls per month in year A, we call 35 falls in year A the real outcome. As vague goals may easily lead to goal displacement (Abramson, 2009), a danger of management systems to be avoided is that numbers and indicators can become goals in themselves as opposed to really achieving safety and quality as experienced by patients and staff.

If we compare the model proposed by Bromley and Powell (2012) with this basic design of management systems, two points are remarkable. First, Bromley and Powell started their ideal-type causal model with the conception of formal policy as what has formally been chosen to be 'work as imagined'. In the term formal policy, the potential gap between goals and planned actions is missing. In quality management it is recognized that the planned actions may not be sufficient or suitable to achieve the goal.[5] Second, it seems illogical that the model proposed by Bromley and Powell concludes with the intended outcome, which confusingly appears to resonate more with the point of departure from the formal policy. We would rather expect the real outcome to be shown at the bottom of the model, for this is the actual result in terms of quality and safety as perceived by nurses, doctors and patients.

Resuming, we expect that decoupling may occur between the goals and the management system and between the management system and the practice. Bromley and Powell's model fails to recognize these two forms of decoupling. As a management system can be perceived as an organization's attempt to design actions for achieving its goals or 'work as imagined', we expect our modification to be relevant for practically all organizations. Furthermore, and in contrast to the model of Bromley and Powell, we introduce the term real outcome instead of intended outcome as a result of goal setting, designing actions (management system) and daily practice. Therefore, we propose an adjusted model (Figure 1).

Recoupling

The main body of research about decoupling focuses on the problem, its conditions and its causes. Although there is a substantial body of research about implementation, only a few scholars have specifically investigated recoupling or the factors that may influence recoupling.

Both internal and external factors that have a positive effect on recoupling have been recognized. Among the internal factors are internal scripts, such as the business strategy, attitude towards future business growth and attitude towards planning and survival (Jackson & Stoel, 2011), and accountability used by a manager towards teachers (Hallett, 2010). Diamond (2012) finds that holding teachers accountable may lead to teachers playing the system instead of recoupling.

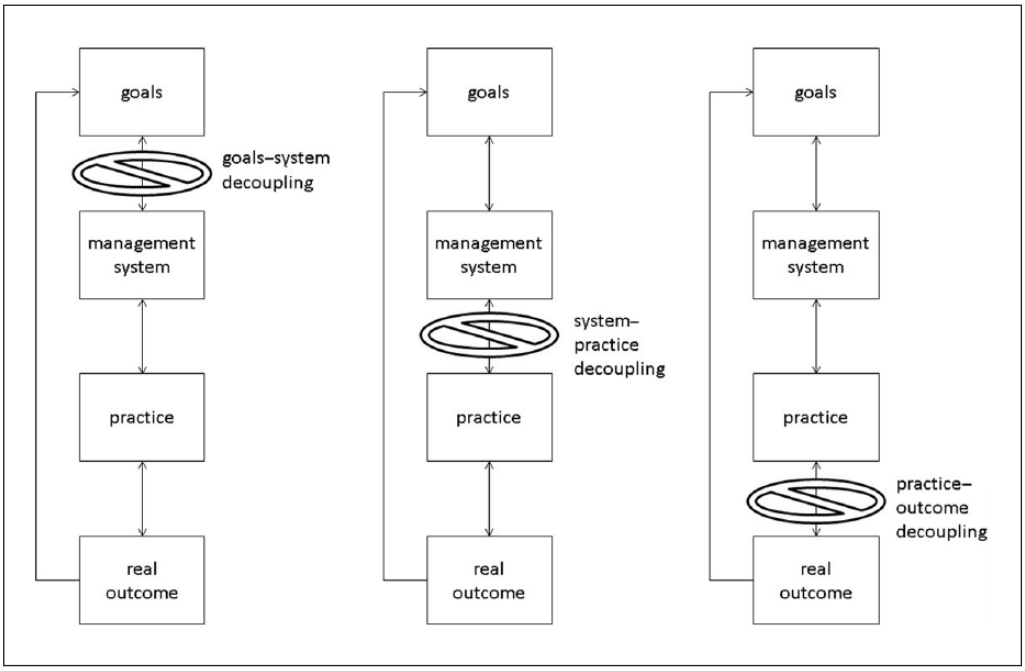

Figure 1. Path from goals to real outcomes and the potential points of decoupling.

Examples of external factors are the pressure of the local school council on the school manager (Hallett, 2010), external scripts, such as changes in the local community or local economy (Jackson & Stoel, 2011), and trusting relationships with stakeholders that put pressure on suppliers to implement a code of conduct accompanied by demand and auditing (Egels-Zanden, 2014).

Tilcsik (2010) studied the generic internal process of recoupling and argued that recoupling between policy and practice may take place through five steps. First, the formal policy is symbolically adopted. Second, new organizational members, such as quality managers and compliance officers, enter the organization with the skills to implement the formal policy. Third, these new members attempt to spread their vision of organizational rationality. Fourth, a new vision of organizational rationality triumphs, which dissolves the rationale for decoupling. Fifth, the formal policy and actual practice are coupled.

Perezts and Picard (2014) studied the micro-politics of the effort exerted by different actors to accomplish regulatory compliance. These authors showed that, from an objectivist viewpoint, compliance often refers to ticking a box and certifying that someone has complied with something. However, they argued that it is one thing to proclaim regulations but another thing to put them into practice. The proliferation of external regulations is often declared to be counterproductive and is considered to be one of the major reasons for non-compliance. Perezts describes how coupling between regulatory policy and organizational practices takes place. Regulators and representatives of a regulated organization create ‘comfort zones’ in which they verbalize institutional and ethical work. Such zones offer space for (re)coupling, ensuring day-to-day conformity and compliance.

In this scarce literature, recoupling is mostly related to the gap between the policy and the practice and not to the gap between the means and the ends. Moreover, the relationship between the regulator and the regulatee with regard to de- and recoupling remains largely unexplored.

Regulations have, according to Dahler-Larsen (2014), an important 'performative power' that shapes organizational practices. The attention paid by the public regulator to recoupling may well cause regulated organizations to recouple for reasons of coercive isomorphism, as the regulator uses its power to force regulated organizations into a certain organizational form (Dimaggio & Powell, 1983).

Our study intends to inform de- and recoupling theory by introducing the role of a management system. We argue that by closely focusing on how organizations translate goals into a management system and put this into real action we can enhance our understanding of de- and recoupling processes.

The Project: System-Based Regulation

What is system-based regulation?

Traditional regulation is sometimes experienced as prescriptive and outcome oriented. Moreover, traditional public regulatory supervision may be perceived as retrospective, reactive and punitive, and its learning effect seems to be limited (Bree & Ruessink, 2015). In the effort to overcome these disadvantages, a new approach in regulatory practices has been introduced and tested.

In many industries organizations use management systems to help them to achieve their objectives. In healthcare, management systems enable organizations to organize the quality and safety of care systematically (Herepath, Kitchener, & Waring, 2015). The main operating mechanism of management systems is typically based on a cyclic process of plan, do, check and act. It implies that the organization should not only plan and carry out actions to achieve its goals but also monitor the implementation and effectiveness, correct deviations and learn from deviations – both wrong and right – by adjusting the system. Dahler-Larsen (2012) described this as the learning model of organizations that uses (often too many) evaluation practices to learn and improve. Unmistakably, the use of evaluation as a feedback loop in a learning organization is designed to yield recoupling, given its explicit steps of identifying and closing gaps between the goals, the management system, the practice and the real outcome. In the light of the regular occurrence of decoupling, this cyclic heuristic of learning may be a mythical simplification of reality.

A new approach in regulation is to invite organizations to use their existing management system, which may originally have been meant to assure quality,[6] to assure regulatory compliance (Wengle, 2016). This form of regulation can be qualified as 'process-oriented regulation' that mandates and monitors an organization's capacity for self-evaluation, design and management of its primary processes and its internal governance and control systems (Gilad, 2011). Following Gunningham and Johnstone (1999), we call this form of regulation system-based regulation (SBR).

SBR is a form of public regulatory supervision that takes the management system of the regulated organization as a focal point. The underlying assumption is that regulatory compliance in healthcare will lead to safe care of good quality. The new element of SBR is that, unlike principle-based regulation and private management system certification based on ISO and COSO standards, the regulator applying SBR aims to stimulate the regulated organization to focus on its own management systems to assure regulatory compliance (Meerman & de Bree, 2014) and as a result better care. This means that, unlike traditional regulation strategies, SBR is based on a proactive and preventive approach rather than an incident-driven reactive approach.

There are several reasons for public regulators to focus on management systems. First, the management system is the operating system of the organization, which is designed to transform the organization's objectives into practical behaviour in such a way that the objectives are achieved. If the management system lacks certain critical functionalities, such as evaluative procedures to

monitor changes in regulatory requirements or procedures to manage risks, this may be a predictor of poor, non-compliant performance. Focusing on these types of fallacies in the functionalities of the system to restore them might imply a more proactive method of public supervision to build lasting compliance than traditional forms of supervision.

Second, because the management system can be perceived as an intermediate stage between the organization's goals and its actual behaviour, it is 'the place to look' if inconsistencies between formal policy and daily practice are to be identified and understood. In other words, it is the level on which policy–practice decoupling may be understood.

Third, regular management systems[7] typically include a requirement for management review. This functionality is meant to make the management evaluate whether the management system yields results.

Fourth, the management system contains the blueprint of organizational conduct. Thus, putting the focus on the management system may well invoke a form of double-loop learning (Argyris, 1976) that is more sustainable than that in traditional output-based regulation.

The project

As a formal representative of the Dutch Government the DHYCI is the public body that is responsible for regulatory supervision of the Dutch healthcare industry as far as quality and safety are concerned. The DHYCI operates as an external party for the healthcare organizations.

In 2011 the DHYCI initiated an experiment to determine whether the assessment of the management systems of healthcare organizations could make supervision more effective. The approach of system-based regulation that the DHYCI used for this experiment was earlier developed and tested in the chemical industry. The basic idea behind this was to focus not on compliance but on compliance assurance. In other words, the focus was not on the desired outcome but on the effort exerted to achieve this outcome. The term 'system' in 'system-based regulation' refers to the organization's management system. The pivotal question during the inspection was how safe care of good quality was organized in this specific context. The trial was a one-year process in which a new kind of inspection was situated in the healthcare context and involved inspectors, experts from other regulatory sectors, scientists, healthcare directors and quality managers.

The project group developed a conceptual framework, tools and methodologies. They discussed them first during an expert meeting. The project was kicked off with an invitation to healthcare organizations to participate in a conference at which the project was explained and some suggestions from healthcare organizations with regard to the text of the standard were adopted. Six different healthcare organizations – two general hospitals, two organizations for mental care, one organization for elderly care and one organization for care for the handicapped – agreed voluntarily to take part in the experimental project. The participating organizations were audited by a team from the DHYCI and their management systems scored on a model containing four levels of maturity and effectiveness. The findings, the conclusion and the level were reported in draft to the organizations with a request to comment. After processing the comments, the reports were finalized. Following the evaluation of the first three experimental inspections, the SBR concept, tools and methodologies were adjusted and then re-applied in the second series of inspections, a process that gradually refined the conceptualization and instrumentation. The development was thus an iterative process during which several meanings, experiences and consequences contributed to the shaping of SBR. Finally, the organizations were invited once more to evaluate the project. It is important to notice that in this project the desired behaviour was not enforced by imposing regulations. In contrast to this traditional regulatory approach, the DHYCI started a dialogue (Sabel & Zeitlin, 2008; Stoopendaal, de Bree, & Robben, 2016) about how improvements could be achieved.

Methodology

Bromley and Powell (2012, p. 519) suggested 'more studies on the shaping of systems of reporting, monitoring, and evaluation, in ways that are more directly linked to the organization's core activities', and they argued for 'research on bottom–up practices, in which organizations relate external demands more directly to their daily activities'. Resonating with this suggestion, the trial of SBR by the DHYCI was followed by a qualitative study to reach a profound empirical understanding of how a new form of regulation is, and can be, deployed in the everyday practices of inspectors and how it relates to or affects daily work in healthcare organizations. We followed the project in an ethnographic manner, using participant observation and semi-structured and conversational interviews, and we collected and analysed the inspection reports and other documents that were produced during the project.

As a more specific method of qualitative investigation, we used formative evaluation, a systematic and critical inquiry aimed at giving feedback to project members and thus helping in shaping the project (Scriven, 1996; Tessmer, 1994). Nichter, Quintero, Mock and Shakib (2004, p. 1954) defined formative evaluation as: 'a type of systematic inquiry focused on context, conducted with the goals of developing, monitoring, and critically assessing all interventions throughout their development, implementation, and evaluation phases'. Wholey (1996, p. 147) stated that formative evaluation can be used in public administration 'to assist in the much more frequent policy and management decisions that result in incremental changes designed to improve existing policies and programs'. Formative evaluation is process driven and iterative. Data collected at one point in time influences research conducted at a subsequent point in time as new research questions emerge. In this project, formative evaluation guided the development of the concept and the instruments as well as reflection upon the effects and consequences of this new kind of regulation. In formative evaluation, evaluators do not keep their distance from the processes they evaluate, but they are engaged in an ongoing learning dialogue. This gave us the opportunity to collaborate closely with the members of the project group in finding ways to translate the concepts of SBR into practice.

Collection of data

The collection of empirical data took place in four phases.

Phase 1:

All six members of the project group were interviewed by author 2 at the start of the project to become acquainted and to build 'rapport'. Rapport involves trust in and respect for the interviewee and establishing a safe and comfortable environment for sharing the interviewee's personal experiences and attitudes as they actually occurred (DiCicco-Bloom & Crabtree, 2006). Author 1 was invited by the DHYCI as an advisor due to his knowledge of SBR and had already built rapport beforehand. Author 2 was able to perform formative research due to her knowledge on governance of healthcare. Being trusted as advisor and researcher, we were invited to share and observe all activities of the project group.

Phase 2:

The project group was observed during all its activities from December 2011 to November 2013. In total 40 hours of observation were conducted. We were also allowed to join and observe the preparatory expert meeting and invitational conferences.

Phase 3:

We were invited by the project leader not only to observe the experimental inspections in the selected organizations but also to participate in the inspection team. Our involvement in the project so far provided us with knowledge that we could use in this participative observation. The six experimental inspections all lasted for one day and were prepared and debriefed, leading to approximately 100 hours of observation in total. The transcripts of the observation of the six experimental inspections helped the project group in memorizing and reporting its findings.

Phase 4:

The organizations that were involved in the project were visited in the year after the project. They looked back on the inspection and what happened thereafter in their own organization. In these case studies, we interviewed the members of the board and the quality managers of the healthcare organizations about their experiences during and after the trial and asked them what changes had been made after they had received the report of the trial. We asked them whether those changes were observable or tangible in some way. As all the organizations evolved in their own way, we were allowed to observe different kinds of meetings: a quality conference, a meeting of a board and the quality committee and the construction of a risk management system. They all showed us the changes made after the trial on their dashboards and management systems. All six case studies were based on approximately 25 hours of interviews and 15 hours of observation.

We organized member checks by presenting our findings and interpretations not only in the project group but also in several monthly DHYCI colloquia and in meetings of the board of the DHYCI. An advisory scientific committee helped us to scrutinize our findings, asked us regularly to reflect critically on our own role as formative researchers and stimulated us to use a substantial body of theory to interpret our data.

The healthcare organizations that were asked by the DHYCI to participate differed in their size and in the kind of care that they provide. We, as researchers, had no influence on the sample, but we embraced the differences, which gave us the opportunity to describe the outcomes of the experiment with SBR and to focus on the different forms of decoupling and recoupling in a theoretically generalizable way.

Data management and analysis

All the interviews with regulators, providers and professionals were conducted in an open, narrative way and, with the permission of the interviewees, were recorded and transcribed verbatim. Observations were written down immediately after the events in field notes. The original Dutch material was translated for this paper. We made use of Atlas.ti to store and analyse the data. We began the analysis by reading and rereading all of our transcribed interviews, informal conversations, field notes and documents. In total we included 31 primary documents, and we developed 56 inductive codes for 731 quotations. Through a process of category clustering (Corbin & Strauss, 2008), we abstracted our reading of the data to a more conceptual level of interpretation, integrating the inductive codes into different themes.

The first theme was the meaning of SBR: the kinds of questions that were asked during the inspection visits and the kinds of observations that were discussed in the meetings afterwards and in the reports of the inspections. We saw that organizations were trusted by the inspectors when their systems worked and when every respondent described the same methods of organizing. The inspectors were not satisfied when they recognized gaps – the second theme – between the management and the

shop floors or between the systems in theory and the real-life practices. We decided to use the theoretical concept of decoupling to describe this phenomenon of gaps. Moving back and forth between the literature and our empirical data, the data moreover revealed a form of decoupling, practice–outcome decoupling, that we had not yet read about in the theory of decoupling.

To describe the effect of the SBR inspections – the third theme – that we encountered when we visited the organizations during the fourth phase of our research, we used three inductive codes: 'learning from the project', the 'effect of SBR' and 'DHYCI as stimulator'. We were surprised that the case studies showed that all six organizations actively improved their management systems after taking part in the project. We decided to use the concept of recoupling to describe those observations. We then used the three different types of decoupling that we found, deductively to describe the reversed processes of recoupling. In this article we have used both an inductive and a deductive approach. Through combining the literature and the empirical findings, we have inductively developed new forms of decoupling and then used all three forms deductively as a heuristic to describe the processes of de- and recoupling in our empirical findings.

Findings Regarding Decoupling

For this paper we have structured our empirical findings analytically around three forms of decoupling, namely decoupling between goals and system, between system and practice and between practice and outcome.

Goals–system decoupling

During the inspection visits, the intentions of the healthcare organizations with regard to safety and quality were the prominent concerns of the DHYCI. The Dutch governance code of healthcare, which has been signed by the vast majority of organizations, stipulates that healthcare organizations should be compliant and should control their risks.[8] All the participating organizations have signed this governance code. During the SBR visit, the DHYCI inspectors frequently referred to this code and asked how the organizations are practically trying to achieve these goals to be compliant and to control risks with regard to patient safety and quality. The most general question about being in control was the main subject of the inspection visits. The DHYCI team asked the same questions at the start of every inspection visit in the pilot project:

> How do you know you are in control? How do you do that? What mechanisms are there in your system? Are there internal audits?

It became clear that the organizations were used to talking about the outcome, but they were not used to talking about the systems that they had developed to comply with the regulations and to investigate and mitigate their risks. During the inspections the DHYCI asked questions about the system of the organization, that is, the legal frameworks, vision and behaviour, quality requirements, self-critical attitude and continuous improvements, internal control and proactivity (risk management), openness and annual reports, screening of employees and reporting of incidents by the staff.

Patient experience is considered to be an important indicator of quality of care. In one of the hospitals, the quality manager explained how patient satisfaction is measured:

> We measure things like individual plans, food, arrangements with medical staff, hygiene, living conditions and activities. We also wanted to know whether the accommodation was important for client satisfaction. (pilot inspection hospital B, Feb. 2013)

Measuring client or patient satisfaction was one part of the system that the organizations used to control the care provided. Risk management was another more proactive subject during the inspection visits. Patient safety may be threatened by several dangers, as was discussed. Risk management was not yet developed strongly in all the organizations:

Member of the DHI inspection team:
How do you measure risks?
Board member:
We started that a couple of years ago. We have let the location managers analyse that. Patient safety is an extensive subject.
(pilot inspection organization for elderly care, Jan. 2013)

Organizations often related patient safety to risk management, that is, the risks that might endanger patient safety, but they did not seem to know how to systemize their risk detection well:

DHI inspector:
You could focus more on risks and try to quantify them. We have seen risk detection on parts …
Board member:
What kind of risks do you mean?
DHI inspector:
For example sexual abuse is not yet included.
Board member:
We have to analyse potential risks in more detail. We do have a company culture in which people give notifications right away and open things up. Sometimes time is needed to get used to each other and get things done.
(pilot inspection organization for care for the handicapped, Nov. 2012)

At the end of the inspection visits in the pilot project, the inspectors reported the results. In the organization for care for the handicapped, the inspector gave an impression of the pros and cons of the internal procedure and arrangements, in other words the system, of the organization:

> We have got a good impression of the vision, the transparency and the structures. We noticed an agreement at all levels; the organization is very consistent. We perceived an open attitude. Employees love to work here. Although a lot of processes and legislations are written down and worked out, we did not see enough checks. You could zoom in better on your specific risk and you could also make attempts to quantify your risks. (pilot inspection organization for care for the handicapped, Nov. 2012)

In most of the organizations, the inspectors noticed that the last two phases of the PDCA cycle were missing. The quality manager in the organization for elderly care, which was visited a year after the pilot, still perceived the organization's struggle on that point:

> We are still there looking to find ways to close the circle. We are going to talk about this in the afternoon during the meeting of our safety committee. How are we going to ensure that we are truly in control and how can we close that circle? How to link it all together? (case study organization for elderly care, Oct. 2014)

These findings indicate decoupling between the goals and the organizational arrangements included in the management system. It is one thing to set goals with regard to compliance and risk control, but it is another to design suitable structures, integration between fragmented parts of the organization

and recognizable guidelines and instructions as part of an effective management system actually to achieve these goals. In this respect the management system is not likely to serve as a suitable means to realize the goal once implemented.

System–practice decoupling

Another question is whether the designed guidelines and instructions, the descriptive part of the management system, are actually carried out in daily practice. Sometimes the amount of protocols is just too big to be workable for practitioners.

DHI inspector:
There are protocols, about 1100; do nurses know how to find them? Is this covered in some kind of cycle?
Quality manager:
No, that is not included.
DHI inspector:
Conclusion is that it is not assured within the organization, but is it assured within the experience of the employees?
Quality manager:
We are with a team of experienced and less experienced people.
DHI inspector:
Yes, it is assured within you as an individual, but there may be blind spots. We do not see the cycle. Are you working in accordance with the protocol? What does the protocol prescribe and where to find it?
(pilot inspection hospital A, Nov. 2012)

We can see in this transcript that there is a system but that it is not used in an optimal way; there are many protocols, but it is not clear whether they are known and used by the practitioners. Moreover, it is unclear how the use of protocols is checked.

The directors of the organization for mental care were highly ambitious; they made many plans for providing high-quality care. Nevertheless, it became clear during the inspection that the plans had not yet been translated into actions. Furthermore, there was no check to determine whether the policies were followed by action:

> We see that the Board of Directors has a high level of ambition. Quality management in terms of 'plan' and 'do' is working. 'Check' and 'act' seem to work less well. We formulate improvement measures, but prioritizing them and then organizing the follow-up, we do not quite know how to provide that. (pilot inspection organization for mental care, Nov. 2012)

The inspectors of the SBR project concluded at the end of the inspection that the story at the top of the organization sometimes differed from that on the shop floor, thereby signalling a distance between managers and professionals. This distance originates between managerial layers, both in behaviour – some managers are not proactive, and directors do not correct managers – and in a lacking system – team leaders do not receive systematic information, for example about the education of caregivers.

These findings indicate the possibility of decoupling between the management system, consisting of guidelines, instruction and protocols 'on paper', on one side and daily practice on the other. It is one thing to design suitable guidelines and instructions as part of an effective management system to achieve these goals, but it is another thing actually to carry out the work as designed.

When practitioners create usable workarounds in the case that the protocols do not fit their practices, this is not reflected in an adaptation of the system. The system and the practice stay decoupled.

Practice–outcome decoupling

The inspection team not only investigated the alignment of goals, management system and daily practice but also compared it with the actual results. In the pilot inspection of the organization for mental care, the medical director indicated that he investigates suicides but that it is a difficult subject, because there seems to be no clear pattern.

DHI consultant:
How do you use attempts to commit suicide, i.e. near misses, in your analysis?
Medical director:
In our organization there are 4 or 5 attempts per day. The question is often: is it an auto mutilation or attempt to commit suicide? Every serious attempt is reported to the DHYCI.
DHI inspector:
But notifications depend strongly on the preparedness to notify. How is that?
(pilot inspection organization for mental care, Nov. 2012)

The inspection team addressed this observation afterwards during one of its internal evaluation meetings:

> It must be said that separations here [in the visited organization for mental care] are exceptionally low; the organization is great with regard to treatment and results. The medical director is very competent, but he is having difficulties to control patterns of suicides. They have carried out only 15 PRISMA investigations[9] with regard to a lot of notifications. (observation meeting project group DHYCI, Nov. 2012)

The DHYCI inspectors noticed that the systems and the results were not always aligned. In the case above, some results (amount of separations) were very good, while others, suicides, needed more systematic attention. Sometimes systems were considered to be suitable but generated the wrong outcomes; sometimes the situation was the other way around. The most common observation was that systems were not integrated: there were many different systems focusing on different parts of the organization. The quality manager in the organization for elderly care described how the organization developed several systems to reach different consecutive goals:

> In the beginning we talked a lot about the financial side of care. That's the easiest to control. Then we tried to find ways to get a grip on the quality of care, but that was difficult. We organized accreditation, but that won't do … Then we focused on safety, but what is safety? We started with fire security and the safety of the buildings. We are now elaborating that, trying to get a complete picture. (Case study organization for elderly care, Oct. 2014)

The fragmentation of the system does not give an integrated picture of the quality and safety of care in the organization. Sometimes the system seemed to be more important than the result 'good care'. This is what we coded as decoupling between practice and outcome: in the words of Bromley and Powell (2012), means–end decoupling.

Findings Regarding Recoupling

We used three forms of decoupling in a reversed mode to describe the recoupling that we encountered in our case studies. The data from the six case studies provide a considerable amount of material showing whether and how recoupling took place after the SBR inspections.

Goals–system recoupling

In the participating organization for elderly care, the quality manager reflected on the way in which the inspection visit was experienced:

> That was something I noticed immediately when you left. People thought that they were required to fill in all kinds of tick boxes. The funny thing was that my colleague and I did not perceive it in that way. We understood: 'You should have a system, organize single- and double-loop learning and be in control that way.' So we developed an idea to show that you can be in control on a micro level and add a bigger loop on top. (case study organization for elderly care, Oct. 2013)

In the same organization, a new 'safety steering group' was established. In an observation of the meeting of the steering group, we were recognized in the discussion about how the plan–do–check–act cycle could be improved:

Manager:
I doubt whether the 'act' should be controlled separately. If you, for example, observe during an HACCP audit[10] that there is food in the refrigerator that has passed its expiry date, management should take action. If the same problem arises at the next audit, then we know that the 'act' is not working well, otherwise there would no problem. … So this is a management problem.
Quality manager:
Yes, and the tool we now use is a dynamic improvement plan, saying that you should do your own checking. And this check is, according to my own findings, not sufficient for the several locations. … We received some tips from SBR with regard to these dynamic improvement plans when they visited us.
Manager:
If we consider this discussion, it means that we should include the 'act'.
Employee:
Yes, but it should be organized in a different way.
Manager:
Yes, and we should describe how we must organize it and make arrangements about it. Leaving it out is no solution.
(case study organization for elderly care, Oct. 2013)

The quality manager of this organization emphasized the effect of the pilot inspection. She noticed a performative effect: the same questions are now asked on every level of the organization.

The organization also started working on a system of risk analysis.

Quality manager:
We have scored the risks per department on a scale of 1 to 5. That gives a lot of insight. First of all, that these items are all discussed between colleagues, but it was also effective for the managers to become more aware of the risks. Funny to find out that some risks are not red after all. After that they go on with the red risks and implement improvement measures.
(case study organization for elderly care, Oct. 2013)

Moreover, it searched for integration of all the fragmented means to improve quality and safety by constructing an integral management system. To create an overview, it scrutinized the possibilities to integrate all the parts of the system into an electronic system that could provide a dashboard view. It therefore visited the hospital that scored best in the pilot:

Quality manager:

The purpose was that we were looking for an electronic system to put our safety management system in. This means the improvement issues, our processes, the dependencies between things, risks. And that we can see the connection and how we should organize. … They have told me how they use their system, showed some things and told me how they have constructed their risk management and who were involved. Yes, that was very instructive for us.

(case study organization for elderly care, Oct. 2013)

In our case studies, we encountered the same developments as in the organization for elderly care. During the pilot inspection, one of the hospitals told its story of how it started designing and implementing risk management. The quality manager explained:

Quality manager:

Initially, we did not have any numbers, but risk analysis is more and more objectively underpinned.

DHI consultant:

Are you going back to your assumptions to verify them?

Quality manager:

Yes, when control measures are implemented the risk obviously changes. Some issues take more time and effort to solve.

DHI consultant:

Is your goal to mitigate all red dots?

Quality manager:

Yes, then we have a residual risk; when they are executed and implemented, they are placed in the group of implemented risks.

(pilot inspection hospital B, Feb. 2013)

System–practice recoupling

On one occasion in one of the organizations for mental care, we saw that the procedures in difficult situations – such as dealing with aggression – were well known by the professionals, though they did not know where they could find the written protocols. They knew how to act, because they had been trained properly and they evaluated every incident. The team consisted of experienced and less-experienced caregivers. Protocols were more frequently offered to new colleagues in a narrative form than in a written form. According to professionals and managers, this way of working aligns well not only with the organizational culture but also with the kind of problem: in cases of aggression, one has to react immediately in the right way.

The directors of this organization have the intention to introduce a prospective risk management programme into the organization, but it is not complete yet and the managerial actions on quality and safety are still mostly enacted ad hoc after incidents or problems are discovered during regular DHYCI inspections based on the analysis of the indicators. The judgement of the DHYCI was used by managers as leverage to improve quality and safety through the development of a risk management system.

The quality manager in the organization for elderly care explained how SBR has provided the motivation to continue with risk management:

… and it has helped us. In this way we can make it manifest and it [SBR] helps us to select. A kind of awareness. That was good for us in any case, and it gave a boost to go on. And furthermore, tasks that have been issued, in short: improvement processes. … We have finished risk profiles of every part of the

> organization. In 2012 we did this for the first time and now we are updating them. That is almost finished and this year we plan to have unity in the risk profiles. Another path is that we are deriving risk profiles from main processes like complaints or incident notifications. (case study organization for elderly care, Oct. 2013)

Practice–outcome recoupling

Although most of the attention was given to how goals were translated into the system and how the system was implemented, sometimes the outcome was also discussed. We coded this form of recoupling as *practice–outcome recoupling*. An example of how practice and outcome were recoupled emerged in an interview in the case study in Hospital B with the director and the quality manager. We tried collaboratively to describe the consequences of the improved system:

> *Director:*
> The people who are involved [in the construction of a risk management system] are employees from various layers in the organization; we noticed that they started to think in a different way. This also affects the normal work, what they do on the shop floor.
> *Researcher:*
> Could you explain that? What is different?
> *Director:*
> Well, people will start looking at, in this case their own areas and facilities: what could possibly go wrong? And as it is discussed in staff meetings, then you can be proactive.
> (case study Hospital B, Oct. 2014)

In the case study at the organization for elderly care, the quality managers visited the locations to implement risk management. One of them explained:

> In the case of 'location X' it was very interesting: the discussion about why it was all yellow, how they came to this conclusion and others did not. There developed a lively discussion about safety and risks. In this way the employees got insights into the risks, and for department managers and team managers it resulted in a better understanding about the parts in the process with the biggest pitfalls.

> *Board member:*
> Oh, that's good, and did that result in comparable levels that are yellow and red or was that very different?
> *Quality manager:*
> Well, yes, that is, in the practical execution.
> *Board member:*
> … and then in the same process?
> *Quality manager:*
> I think … I think with regard to medication, about this … [she collects some papers]. Let me look … they are a bit more extreme in their expression, especially one. And about this person I thought, this one was very green at the start, so I thought: this one has everything on one, and then suddenly there appeared a lot of red.
> (case study organization for elderly care, Oct. 2013)

The discussion continued about how different people have different perceptions about safety and risks and how these processes help the organization to focus on the relevant issues.

Board member:

> This is very interesting. Because if you go through all this and focus on safety this way, you can just apply it to other issues in management and organization as well. That's why I always say, let's talk about safety, which is already hard enough. This forces us to get a more profound analysis.

(case study organization for elderly care, Oct. 2013)

In one of the organizations, it was decided to develop a risk analysis for each location, because it was realized that every location has its own characteristics and thus risks.

Quality manager:

> So now we have done a proposal to make a risk analysis per location. … So we have decided, we will make a risk analysis on a location level because we often see that risks for employees are similar to risks for clients. If the air quality is not good, for example, both the employees and the clients may be affected; if there is much violence, it is a risk for both employees and clients.

(pilot inspection organization for mental care, Nov. 2012)

We coded the actions described above as *practice–outcome recoupling*, and we could see that practices like risk management are adjusted to achieve the organizational goals better with regard to quality and safety of care.

Discussion and Implications

The first contribution of this article is the role of management systems with regard to decoupling, which has been overlooked by institutional theory in general and Bromley and Powell (2012) in particular. Healthcare organizations operationalize goals regarding safety and quality into management systems containing detailed protocols, procedures and rules (Bromley & Powell, 2012, p. 489). This is because just the formulation of a goal does not provide sufficient guidance to employees to know what specifically they should undertake to achieve these goals. A management system is an essential and generic tool for organizations to move from 'what we want to do' to 'what we should do'. As our empirical work clearly demonstrates, the adequate operationalization of general goals into a detailed management system is far from self-evident and subject to decoupling. Furthermore, our empirical work reveals decoupling between the management system and daily practice. The identification of the management system as a focal point for analysis opens new opportunities for researchers and practitioners to improve their understanding of the decoupling and recoupling phenomena.

Another contribution of this article informs the model of Bromley and Powell with regard to the difference between the goals and the real outcome. Means–end decoupling has been described as symbolic implementation (Bromley & Powell, 2012, p. 497). In other words, policy and practice may be coupled, but they result in a real outcome that deviates from the original goal. There is a clear difference between the goals, indicated as the 'intended outcome' in the model of Bromley and Powell (2012, p. 497), and the real outcome of safety and quality experienced by patients, doctors and nurses in the real world. We therefore propose the use of the term real outcome as the conception from which policy and practice may become decoupled.

Furthermore, in this empirical study, we have found clear indications that, by applying SBR, the inspection may stimulate recoupling. Apparently, when the external inspector discloses inconsistencies in the organizations, the regulated organizations tend to initiate actions to recouple. Recoupling may significantly contribute to the performance of these organizations in terms of quality of care and

patient safety, making SBR an interesting alternative for regulators if they are looking for effective strategies. In terms of learning, we have found indications that SBR stimulates double-loop learning (Argyris, 1976), as it feeds back into the goals, system, practice and outcome, aiming to promote the recoupling of decoupled layers. These findings are consistent with recent work in governmentality in healthcare indicating that public policies and regulation may affect quality improvement in healthcare organizations (Ferlie & Shortell, 2001). The precise mechanisms of the different forms of recoupling are yet to be investigated but beyond the scope of this article.

Moreover, SBR seems not only to stimulate double-loop learning but also to challenge organizations to assess the level of recoupling and manage the process of recoupling between layers, a form of learning that may be perceived as triple-loop learning. This effect may be due to the focus of the SBR approach on the level of self-control and self-correction of inconsistencies between goals, system, practice and outcome. The function for self-control and self-correction is assessed thoroughly in terms of competencies, responsibilities, positions and resources available. This function has been recognized to be an important factor in the recoupling process (Tilcsik, 2010). As SBR anticipates the presence of management systems and the motivation of the organization to control risk and assure compliance proactively, SBR might be not so effective in fields in which these conditions are not met.

One of the questions outside the scope of this article is whether SBR should be backed by legal requirements. Such a formal approach would make recoupling part of a regulation pillar (Scott, 1995), which would give healthcare organizations little choice but to recouple, for ignoring this requirement would mean a formal violation of the law. Legally enforced recoupling relates to coercive isomorphism (DiMaggio & Powell, 1983) and may hold the danger that regulated organizations recouple only because the DHYCI forced them to do so. Stucke (2014) argued that, if external forces like regulators evoke compliance and ethics programmes, these may turn out to be ineffective, because the organizations are not really intrinsically motivated but rather tick the box because the regulator says they must. Too much focus on compliance may lead to goal displacement, compliance becoming the new goal but endangering resilience. This is especially so if authorities tend to micro-manage on regulations. The healthcare organizations described in this study participated in the project voluntarily, and there were no formal legal requirements demanding recoupling. The feedback was given in an atmosphere of informal openness rather than formal top-down law enforcement (Stoopendaal et al., 2016). These conditions obviously limited the coercive pressure put on the organizations to recouple and left relatively large space for the organizations to choose otherwise. The research by Perezts and Picard (2014) suggested that such a voluntary, informal approach is a more suitable way to maintain a proactive attitude of the regulatee than the use of coercive top-down law enforcement. SBR, as a strategy to stimulate compliance assurance, therefore seems to resonate more naturally with a horizontal, voluntary participation-based supervision strategy.

Although we have been able to shed light on the forms of recoupling, more research is required to find out exactly how recoupling is taking its course and exactly how it is influenced by external forces in general and public inspectors in particular. It seems likely that different forms of recoupling require different forms of interaction between organization and inspector. Presumably, goal–system recoupling is related more to formal organizing and knowledge while system–practice recoupling is more concerned with implementation skills and organizational culture. We used the theoretical types of decoupling to describe the processes of recoupling.

More research is also required to clarify the possible limitations of SBR. For example, it is as yet unclear whether recoupling supported by SBR will last autonomously in the regulated organizations and, if not, which forms of external scrutiny are required to maintain coupling.

Furthermore, more research is necessary to determine how the effectiveness of SBR depends on the levels of motivation and professionalism in the targeted organizations, given the fact that the participating organizations in this study were all perceived as fast learning. Finally, a plausible concern is that the SBR approach is based too much on a linear sequential model of goal realization. More research is needed to gain a better understanding of the influence of SBR on organizational learning, taking into consideration the conditions for dynamic learning and the interaction between goals, system and practice.

This article is built on a combination of earlier scholarly work and empirical data and proposes a model for decoupled layers in organizations. This model may be typical of the healthcare organizations dealing with compliance and risk management. It is likely, however, that the model is applicable to organizations beyond healthcare because it is based on the notion of quality management system standards, which are widely used. Further research is required to identify the degree to which these findings can be generalized.

Practitioners may benefit from the insights that this article provides in several ways. The model offers an analytical tool to understand failures in achieving goals such as safety, quality and compliance and may thus serve both the organization itself as well as an external party such as a public regulator. For inspectorates this model may be helpful in designing regulation policies aiming at the assessment and activation of self-regulation in a more advanced and responsive way.

SBR is probably most effective if it is part of a multiannual regulation policy. If only tested for a short period, as in this pilot, SBR may be less effective when existing forces for decoupling may take over in the absence of external attention to coupling and internal forces, for the coupling is not strong enough. It is likely that the SBR policy's effectiveness in practice may benefit from accommodating enforcement arrangements for participating organizations, anticipating a higher level of self-monitoring and correction.

It seems to be quite clear that an adequate analysis of decoupling by the inspector is necessary to be able to give valuable feedback and stimulate recoupling. Obviously, the abilities of the inspector to identify the specific forms of decoupling and to explain them convincingly to the regulated organization are essential to be able to stimulate recoupling. As these abilities are significantly different from those required for traditional inspection, this may turn out to be a serious challenge for the practical implementation of SBR.

Conclusion

This article informs institutional theory by describing two forms of decoupling that have not yet been uncovered in scholarly work. These forms, decoupling between the goals and the management system and between the management system and the practice, contribute to the understanding of decoupling. The model proposed in this article may help managers, regulators and supervisors to develop a shared understanding of de- and recoupling processes.

When incidents happen, there is often much discussion along the line of 'more or less public regulation'. This may not be a very productive way forward, for it may result in an endless process of regulation, deregulation, reregulation and so on. Our article offers an alternative approach in the form of system-based regulation. In this approach the regulator does not just impose more or fewer rules on the regulated organization but shifts to a meta-position, engaging in a process of constructive feedback with regard to the level of coupling within the regulated organization. Incidents may no longer be perceived as isolated events that fuel the call for public intervention and more regulation, but as opportunities for learning.

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Notes

1. Interview with Marcel Levi, Chairman of the Board of the Amsterdam Medical Centre (AMC), on 23 January 2013. Retrieved from www.nu.nl/gezondheid/3010675/amc-topman-levi-hekelt-talloze-inspecties.html
2. Only 12% of the hundred biggest Dutch healthcare organizations were found to prioritize risks, and only 4% quantify these risks (KPMG, 2011).
3. See for example the recent deregulation agenda in the United States of the new administration in 2017.
4. ISO 9001:2015 Quality Management Systems – Requirements. Retrieved from www.iso.org (accessed 11 April 2016).
5. For instance, an organization could aim to achieve full regulatory compliance, but, if it does not make a plan for monitoring the continuously changing legal requirements and defining who is responsible for carrying it out, goal achievement is not very likely.
6. Based on standards such as ISO 9001.
7. For example, based on ISO management system standards such as ISO 9001.
8. Although signing and complying with this code is voluntary, the DHI uses it as a standard for good governance.
9. PRISMA stands for Prevention and Recovery Information System for Monitoring and Analysis, a commonly used method in healthcare to analyse incidents with the aim of prevention.
10. Hazard Analysis and Critical Control Points, a risk inventory for food safety.

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Author biographies

Martin de Bree is senior researcher and manager of the Erasmus Institute of Business-Regulation Management at the Rotterdam School of Management Erasmus University. His research interest lies in the dynamics between public and private parties with regard to regulation in areas like education, safety, finance, environment and transport.

Annemiek Stoopendaal is assistant professor at the Institute of Health Policy and Management of the Erasmus University Rotterdam, The Netherlands. She is an organizational anthropologist in healthcare. Her research interests are management, regulation and governance of healthcare. She is involved in the Dutch Academic Collaborative Centre on Supervision in Healthcare.