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Risk Reduction Technologies in General Practice and Social Work

Abstract: General practitioners (GPs) and social workers (SWs) are professions whose professional autonomy and discretion have changed in the so-called risk and audit society. The aim of this article is to compare GPs' and SWs' responses to Evidence-Based and Organizational Risk Reduction Technologies (ERRT and ORRT). It is based on a content analysis of 54 peer-reviewed empirical articles. The results show that both professions held ambivalent positions towards ERRT. The response towards ORRT differed in that GPs were sceptical whilst SWs took a more pragmatic view. Furthermore the results suggest that SWs might experience professional benefits by adopting an adherent approach to the increased dissemination of risk reduction technologies (RRT). GPs, however, did not seem to experience such benefits.

Keywords: profession, risk, social worker, general practitioner, risk reduction technologies, evidence-based practice/medicine

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General practitioners (GPs) and social workers (SWs) are two professions encountering an increasing pressure to work according to standardized manuals, procedures, guidelines and evidence-based practices in the rise of the «risk and audit» society (Beck, 2007, 2010; Møldrup & Morgall, 2001; Power, 2010; Webb, 2006).

A central aspect of the risk society is a heightened uncertainty regarding a complex and an uncertain future and whether scientific knowledge and professional expertise have the ability to predict and manage the «unintended consequences», and side effects of modernity and industrialization (Beck, 2007, 2010; Giddens, 2004, 2010). Reduced trust in science has resulted in the expertise of professions being challenged to a greater extent (Freidson, 2004; Svensson, 2011a). Within human service organizations, the introduction of risk reduction technologies have been an influential strategy used to handle reduced trust in professions' expertise (Giddens, 1994). Professions, such as SWs and GPs, are expected to adopt different forms of risk reduction technologies (RRT), such as evidence-based practice, in order to reduce uncertainty, complexity and standardize the outcome of professional practice (Evetts, 2010; Svensson, 2011b). Therefore, the use of RRT brings to fore issues around the conditions of professional practice (Molander & Terum, 2010). Hence the focus of the article is to elucidate general practitioners' and social workers' response to various kinds of RRTs.

Increasingly, organizations tend to handle risks related to professional work through regulation, proceduralization, fragmentation and management by object-

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ive (Berger, 2010; Fook & Gardner, 2007; Heyman, Shaw, Alaszewski & Titterton, 2010; Webb, 2006). From a theoretical perspective, New Public Management (NPM), Evidence-Based Medicine (EBM), Evidence-Based Practice (EBP) and Audit may therefore be seen as technologies for handling (Hasenfeld, 2009) and reducing risks (Hasselbladh, Bejerot & Gustafsson, 2008; Power, 2010; Sekimoto, Imanaka, Kitano, Tatsuro & Osamu, 2006).

The increased demands for guidance and control through rituals of verification, accountability, transparency, quality assurance, audit and liability assignation entails significant changes to professional work. The introduction of RRT has affected the boundaries of professional jurisdiction (Abbott, 1988) and imposed limitations on professional discretion (Bellamy et al., 2006; Berger, 2010; Fook & Gardner, 2007; Hasselbladh et al., 2008; Howitt & Armstrong, 1999; Lewis & Tully, 2009; Manuel, Mullen, Fang, Bellamy & Bledsoe, 2009; Molander, 2011; Morago, 2010; Pope, Rollins, Chaumba & Risler, 2011; Power, 2010; Sekimoto et al., 2006; Veldhuis, Wigersma & Okkes, 1998; Webb, 2006).

Theoretically, the expansion of RRT may be viewed as an expression of how organizational professionalism has been given a more prominent position compared to occupational professionalism. Occupational professionalism, which is based on collegial authority, has lost ground in relation to the organizational professionalism, where the managerial principles rest upon a bureaucratic and rational-legal basis for authority (Evetts, 2010, pp. 129-130; Freidson, 2004; Lipsky, 2010; Svensson, 2010).

In this article we distinguish between evidence-based risk reduction technologies (ERRT) and organizational risk reduction technologies (ORRT). ERRT refers to technologies aiming at controlling professional groups' knowledge utilization, primarily to ensure the use of «evidence-based knowledge» such as treatment methods, diagnostic instruments and guidelines for the treatment of individuals. ORRT refers to technologies aiming at making professional groups work in accordance with organizational principles rather than occupational (Freidson, 2004; Lipsky, 2010; Rose, 2000). In this article, ORRT refers to prioritizations, supportive instruments for decision-making, bureaucratic legislation, organizational guidelines and procedures.

The aim of the article is to describe and analyse GPs and SWs' response to ERRT and ORRT within peer-reviewed articles. Key questions are:

- What similarities and differences exist in GPs and SWs' response to ERRT and ORRT?
- How are these similarities and differences to be explained?

Methodology

The article is a content analysis based on a literature review of SWs and GPs' response to RRT. Content analysis is a method for analysis of information, content and themes in written or symbolic material. The choice of content analysis is based on an open approach to the material and a desire to make comprehensive use of the empirical data (Graneheim & Lundman, 2004; Neuendorf, 2002).

Data consisted of peer-reviewed articles gathered from the databases: Ebsco, Medline, Pubmed, Web of Science, EBM, JSTOR, LIBRIS, SocINDEX, Sage Journals online and Diva-portal. The following search terms (also in Swedish) were used: risk assessment, risk management, social workers' and general practitioners' use/utilization of knowledge, decision making, clinical reasoning, knowledge utilization/use in general practice/social work. The search resulted in 130 articles. After carefully reading the 130 articles, only 54 were considered relevant in the sense that they dealt with professionals' knowledge utilization in relation to risk (see Table 1).

Table 1
Number and type of journals used in the study

| | Number | Methodology | Year | Journals | Countries | Regions | Length |
|-----------|--------|-----------------------------------|------------------------|----------|-----------|---|---|
| GP | 29 | Quant: 10 Qual: 16 Mixed: 3 | 2000s: 18 1990s: 11 | 14 | 11 | Europe: 19 North. Am: 5 Asia: 2 Oceania: 3 | Shortest: 4 pages Longest: 19 pages Average: 7 pages |
| SW | 25 | Quant: 12 Qual: 13 | 2000s: 25 | 17 | 8 | Europe: 13 North. Am: 9 Oceania: 2 Asia: 1 | Shortest: 7 pages Longest: 23 pages Average: 13.5 pages |

To put it differently, only articles about GPs' and SWs' response to RRT were chosen, the rest was excluded. The selected articles were read through twice in order to get an overall picture of how SWs' and GPs' responses to risk were described. Content analysis was initiated and developed from raw data to large meaning units, from large meaning units to condensed ones, from the condensed meaning units to the categorization of meaning units and finally from categorizing to the analysis and interpretation of the meaning units (Granheim & Lundman, 2004; Schilling, 2006). Response to risk, risk situations and risk reduction technologies exemplify the codes used in this phase. This phase resulted in large quote based meaning units. Finally the material was categorized into five main categories i.e. the professionals' generally positive attitude towards ERRT, their ambivalent attitude to ERRT, their patient or client-related response to ERRT and their response to ORRT (Granheim & Lundman, 2004; Schilling, 2006).

Our methodological approach means that we, as authors, make an analytical interpretation of the content of the original articles. The results in this article are more than a summary of the reviewed articles. Therefore, all quantification, categorizations and depictions of SWs' and GPs' response to RRT are based on the authors' interpretations of the empirical data.

Results

This section begins with a presentation of the GPs' response to RRT, followed by a presentation of the SWs' response. The presentations are equally structured; opening with an account of the response to ERRT, followed by an account of the response to ORRT.

GPs' mainly positive but ambivalent response to ERRT

The most common form of Evidence-Based RRT that GPs encounter is Evidence-Based Medicine (EBM). The data showed that physicians had a generally positive view of EBM (Allery, Owen & Robling, 1997; Fairhurst & Huby, 1998; Gupta, Ward & Hayward, 1997; Lewis & Tully, 2009; Mayer & Piterman, 1999; McColl, Smith, White & Field, 1998). Despite this generally positive view, some studies emphasised that GPs did not incorporate EBM in their practice (Fairhurst & Huby, 1998; Gupta et al., 1997; Mayer & Piterman, 1999; McColl et al., 1998; Young & Ward, 2001). One suggested explanation to this was that GPs encountered barriers which obstructed their implementation of EBM. Such barriers included lack of resources and time, unfamiliarity with the EBM-terminology, difficulties in interpreting statistical data, critically assessing and determining the quality of the evidence as well as organizational limitations in terms of managers' attitudes towards ERRT (Andersson, Lindberg & Troein, 2002; Andersson, Troein & Lindberg, 2005; Beaulieu et al., 1999; Carlsen & Frithjof, 2005; Freeman & Sweeney, 2001; Gabbay & May, 2004; Hannes et al., 2005; Howitt & Armstrong, 1999; Lewis & Tully, 2009; Lineker & Husted, 2010; Sekimoto et al., 2006; Shual et al., 2007; Veldhuis et al., 1998).

However, data also gave reason to describe GPs' response to ERRT as ambivalent. Their view of EBM was positive, but they seemed to experience difficulties adhering to EBM in its entirety. This ambivalence took two main forms of expression, the first concerned difficulties in combining EBP with patient-centred practice. The following two sections provide a more detailed account of such ambivalence.

GPs' patient-related response to ERRT

Regarding physicians' patient-related response to ERRT we could distinguish three variants of ambivalence: 1) the difficulty in applying statistical risk assessments on concrete individual cases, 2) the experience of ERRT as a threat to the doctor-patient relationship, 3) the perception that ERRT could fail to capture the complexity of the patient's clinical picture (Beaulieu et al., 1999; Beaulieu et al., 2008; Cabana et al., 1999; Carlsen & Frithjof, 2005; Grol & Grimshaw, 2003; Howitt & Armstrong, 1999; Lewis & Tully, 2009; Lineker & Husted, 2010; Sekimoto et al., 2006; Shual et al., 2007; Veldhuis et al., 1998). The first expression of this ambivalence was particularly evident when GPs perceived that a strict implementation of ERRT might constitute an apparent risk to the patient's health. Hence, faced with the risk of missing a diagnosis, GPs sometimes chose to ignore evidence-based guidelines (Beaulieu et al., 1999; Cabana et al., 1999; Lewis & Tully, 2009).

A second expression of ambivalence could be found in GPs' perception that a strict implementation of ERRT might jeopardize their relationship to patients (Beaulieu et al., 1999; Carlsen & Frithjof, 2005; Lewis & Tully, 2009; Veldhuis et al., 1998). This might occur when they assessed patients' preferences regarding treatment to be incompatible with ERRT. This could involve situations where patients resisted evidence-based recommendations and demanded those that lacked support in ERRT (Cabana et al., 1999; Carlsen & Frithjof, 2005; Howitt & Armstrong, 1999; Lewis & Tully, 2009; Sekimoto et al., 2006). Physicians' responsibility towards the patient made them prone not to act against patient's wishes

(Beaulieu et al., 1999; Carlsen & Frithjof, 2005; Lewis & Tully, 2009; Veldhuis et al., 1998).

A third expression of ambivalence came out of GPs' notion that ERRT did not offer guidance in how to treat patients with comorbid symptoms, a common situation in general practice. There was a perceived discrepancy between the complex clinical picture experienced in the doctor's practice and evidence-based guidelines. The physicians choose to deviated from EBG when they perceived that adherence to evidence-based guidelines to a limited extent reduced the complexity of the patient's clinical picture (Beaulieu et al., 2008; Putnam, Twohig, Burge, Jackson & Cox, 2002).

GPs' response to ERRT in relation to clinical expertise

The other way ambivalence was expressed was through physicians' difficulty in combining ERRT with clinical expertise. Here, too, it was possible to distinguish three variants of ambivalence: 1) the difficulty in applying EBM when it clashed with personal experience, 2) the experience of EBM as a top-down model that left limited or no room for the GPs' own clinical expertise, 3) the difficulty of assessing and applying EBM when the sources of knowledge behind the evidence were numerous and not always unanimous (Andersson et al., 2002, 2005; Beaulieu et al., 1999; Cabana et al., 1999; Carlsen & Frithjof, 2005; Gabbay & le May, 2004; Grol & Grimshaw, 2003; Hannes et al., 2005; Lewis & Tully, 2009; Lipman, 2000; Shuval et al., 2007).

A first expression of this kind of ambivalence that we found was connected to difficulties in applying statistical risk onto the situations of individuals. Such a situation might e.g. arise when there was a demand on GPs to prescribe evidence-based drugs that they had no earlier experience of. The limitations of ERRT when it came to covering the full spectrum of symptoms or vague medical conditions constituted yet another example of a tension between ERRT and GPs' clinical expertise. GPs further perceived difficulties in applying ERRT to elderly patients as this group seldom was recruited for evidence-focused research (Gupta et al., 1997; Lewis & Tully, 2009).

The second form of expression identified was connected to the fact that physicians occasionally perceived ERRT as a top-down model that left little room for their clinical expertise. GPs perceived that advocates of ERRT underestimated the importance of GPs' own clinical expertise (Gabbay & le May, 2004; Gupta et al., 1997; Lewis & Tully, 2009).

The third form of expression that we could distinguish referred to GPs' difficulties in assessing the sources of the evidence-based knowledge (Närhi, 2002; Regehr, Bogo, Shlonsky & LeBlanc, 2010). They perceived themselves as having inadequate competence to critically evaluate the evidence behind ERRT. For example when physicians experienced that they received contradictory information from different pharmaceutical stakeholders regarding what drugs were most efficient (Beaulieu et al., 1999; Cabana et al., 1999; Hannes et al., 2005; Lewis & Tully, 2009; Morago, 2010).

GPs' response to ORRT

GPs had a sceptical view of Organizational RRT, especially when it came to evidence based guidelines, needs assessment and rationing of healthcare services, which were regarded as regulating practice and limiting their discretion. Furthermore physicians felt uncertain about the intentions behind ORRT or viewed them as negative to practice (Beaulieu et al., 1999; Beck, 2010; Cabana et al., 1999; Kortteisto, Kaila, Komulainen, Mäntyranta & Rissanen, 2010; Murie et al., 2000). Their scepticism was expressed in their reluctance to follow and apply the guidelines, arising from ORRT. Particularly ORRT that aimed to replace established behavioural patterns appeared to be difficult to adhere to, compared to those aiming at developing new lines of conduct.

Data suggested, as mentioned in preceding section, that one aspect of ORRT causing scepticism was needs assessment. There seemed to be a conflict between the physicians' professional assessment of patients' need for care and the often scarce healthcare resources. The physicians often viewed needs assessment as gatekeeping which could block patients' access to other types of specialist care (i.e. hospital or inpatient care). They also raised critique towards the lack of evidence to support any benefits of the needs assessment (Beaulieu et al., 1999; Cabana et al., 1999; Murie et al., 2000). They argued that needs assessment belonged to the realm of politics and fell outside the core of their jurisdiction (Lipman, 2000; Murie et al., 2000). GPs further stated that they lacked appropriate training in needs assessment and that it increased their workload. However, some studies indicated that physicians were positive towards needs assessment (Murie et al., 2000; Petchey, 1994; Willems, 2001).

Similar to needs assessment, rationing constituted yet another form of management that regulated professional practice. What differentiated these two forms of management was that needs assessment focused on physicians' assessment of patient needs, whilst the focal point for rationing was scarce resources (Carlsen & Frithjof, 2005). Their sceptical view of rationing appeared to be connected to their professional role, discretion and jurisdiction. Rationing of healthcare services seemed to lead to a dilemma and conflict between physicians' roles as 'gatekeepers' and as patient advocates. Yet, some articles suggested that in most cases GPs had no problem balancing these two roles, for instance through informing and discussing rationing with the patient (Ayres, 1996; Carlsen & Frithjof, 2005; Petchey, 1994; Willems, 2001).

SWs' mainly positive but ambivalent response to ERRT

SWs, in line with physicians, generally had a rather positive attitude towards Evidence-based RRT (Aarons, 2004, 2006; Bergmark & Lundström, 2002, 2007; Mauel et al., 2009; McDonald, Postle & Dawson, 2008; Morago, 2010; Pope et al., 2011). Similar to general practice, it was predominantly EBP that exemplified ERRT in social work. Studies showed that SWs' positive attitude toward EBP seemed to have increased over time (Bergmark & Lundström 2002, 2007; Bergmark & Lundström, 2008). Some studies suggested a growing optimism among SWs towards policy documents, procedures and guidelines as a basis for making professional decisions in social work. Data indicated however that there was a group of SWs that adopted a more univocally negative view of ERRT. They

seemed to view the technologies as deterministic and incompatible with the complexity characterizing the practice of social work (Bergmark & Lundström, 2008; Morago, 2010).

Similar to physicians, SWs appeared to adopt an ambivalent position. They saw difficulties combining ERRT with clients' preferences and their clinical expertise. The discussion of these forms of ambivalence is developed below.

SWs' client-related response to ERRT

Concerning SWs' client-related response, we could identify two forms of expression for this ambivalence. We found that ERRT might cause tension in SWs' relationship to their clients, leaving SWs with an ambivalent attitude towards ERRT. One expression of this ambivalence was when clients rejected evidence-based interventions or demanded those that lacked support within ERRT (Bellamy et al., 2006; Manuel et al., 2009; Morago, 2010; Nelson, Steele & Mize, 2006). Ambivalence might also be caused by SWs' worry to stigmatize clients by applying ERRT. A typical example was when guidelines required SWs to assess young children's mental status, which might lead to stigmatization of these children (Woodcock, Hooper, Stenhouse & Sheaff, 2009). Ambivalence also occurred in situations where SWs perceived ERRT as political instruments for financial management, rather than as tools for helping clients (Bellamy et al., 2006; Manuel et al., 2009; Morago, 2010; Nelson et al., 2006).

A second expression of ambivalence was related to SWs' view of ERRT as sometimes incompatible with clients' complex problems. Studies showed that ERRT were occasionally regarded as "cookbook attempts" failing to recognize the complexity that characterized work and insensitive towards variations between different clients' contextual and cultural backgrounds. Many evidence-based programmes focussed on short-term treatment irrespective of its (un)suitability for all clients (Bellamy et al., 2006; Manuel et al., 2009; Morago, 2010; Nelson et al., 2006).

SWs' response to ERRT in relation to clinical expertise

Concerning SWs' expertise-related response, it was possible to distinguish between two forms of ambivalence. We linked the first form to their difficulty to assess evidence-based sources of knowledge. The second might be linked to the difficulty of relating to and integrating various forms of knowledge. Data pointed at two forms of expression of ambivalence concerning ERRT and SWs' personal clinical expertise. The first form could be linked to SWs' difficulty in assessing evidence-based sources of knowledge. SWs' assessment of ERRT, similar to GPs', seemed to be hindered by a lack of access to primary research, complicated academic language and hard-to-interpret statistical research. This meant that SWs found it problematic to appraise the reliability of ERRT and its relevance to decision-making, policy and planning (Barratt, 2003; Bellamy et al., 2006; Chagnong, Pouliot, Malo, Gervais & Pigeon, 2010; McLaughlin, Rothery, Babins-Wagner & Scheleifer, 2010; Nelson et al., 2006).

The second form of expression could be related to SWs' difficulty in integrating evidence-based knowledge with experience-based knowledge. Seen from the perspective of the SWs, evidence-based knowledge did not always appear relevant

to their professional practice (Barratt, 2003; Chagnong et al., 2010; McLaughlin et al., 2010; Nelson et al., 2006).

SWs' response to ORRT

Data suggested that SWs' response to organizational RRT was more ambivalent and pragmatic compared to the GPs' (Broadhurst, Hall, Wastell, White & Pithouse, 2010; D'Cruz, Gillingham & Melendez, 2009; Dorsey, Mustillo, Farmer & Elbogen, 2008; Gillingham & Humphreys, 2010; Kjørstad, 2008; Littlechild, 2005; McDonald et al., 2008; Regehr et al., 2010; Woodcock et al., 2009; Wörlén, 2010).

SWs viewed ORRT as both an asset and a limitation. The procedures were regarded as an asset when it could be used as an instrument for clarifying the jurisdiction and the responsibility of the SW. In particular, this applied to situations where they might be accused of malpractice. If a SW in such a situation could refer to having acted in accordance with organizational procedures, ORRT could be experienced as an asset. In other words, ORRT in the form of regulations and standardizations, were regarded to provide protection in situations where SWs' practice was criticized and audited (Davidson-Arad & Benbenishty, 2010; McDonald et al., 2008; Woodcock et al., 2009).

Data point to that SWs' trust in their professional knowledge had decreased as a result of their growing trust in procedures and bureaucratic systems, and that ORRT increasingly were viewed as instruments to strengthen their professional status (Bergmark & Lundström 2002, 2007; Bergmark & Lundström, 2008; McDonald et al., 2008; Morago, 2010). Nevertheless, several SWs seemed to experience ORRT as a complement rather than an alternative to their expertise and ORRT as a limitation of professional discretion and autonomy (D'Cruz et al., 2009; Gillingham & Humphreys, 2010; Kjørstad, 2008; McDonald et al., 2008). ORRT could be an administrative burden that distracted SWs' attention from their core task, i.e. relational work with clients, and an instrument for accountability rather than as a tool in support of SWs' professional decision-making (Gillingham & Humphreys, 2010; Kjørstad, 2008; Woodcock et al., 2009).

However, there were individual studies that argued that the increased use of ORRT had strengthened SWs' autonomy and discretion (Jessen, 2007) and that SWs' professional practice remained relationship-based as informal processes remained to play an important part (Broadhurst et al., 2010).

Summary

The results illustrated that GPs and SWs were in relative agreement in their response to ERRT (see Figure 1) even if minor differences existed (see Figure 2). The response to ORRT differed, however, in terms of GPs regarding ORRT with a relatively large level of scepticism whilst SWs had adopted a more pragmatic view to ORRT.

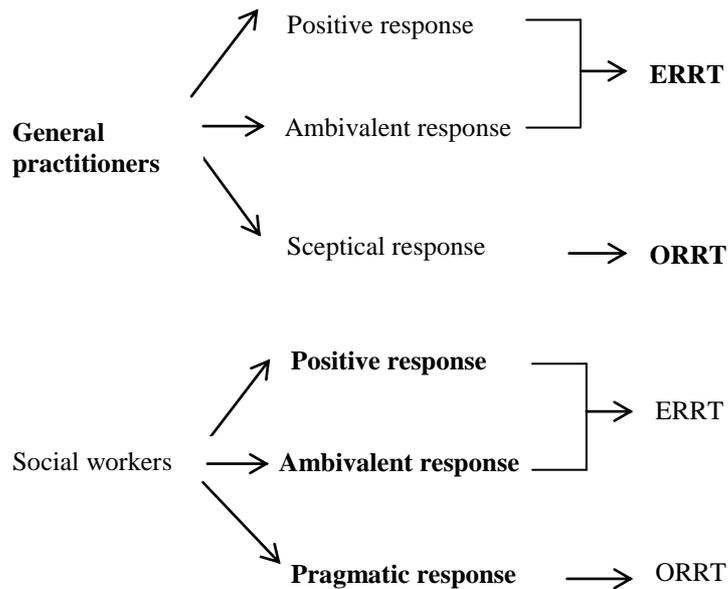


Figure 1. General practitioners and social workers' response to ERRT and ORRT

As previously mentioned, both professions adopted a generally positive view of ERRT. Simultaneously, they expressed ambivalence regarding the potential effects of an overly strict implication of ERRT. Both expressed worries regarding the potentially negative impact of ERRT upon relationships to patients and clients. The professionals were also critical towards the possibility of improperly implementing ERRT which might result in neglecting the complexity often characterizing patient and client problems. GPs and SWs also expressed that the sources of knowledge that ERRT rested upon were not always transparent and easily accessible, which made it more difficult to assess their reliability for the professional practice.

However, the results also suggest that small differences existed between GPs and SWs in their response to ERRT (Figure 2). Primarily, these refer to GPs in certain situations, who might perceive that they were exposing their patients to an increased medical risk by following guidelines and recommended measures stemming from ERRT. Furthermore, GPs expressed to a greater extent than SWs that ERRT sometimes was forced upon them and that, behind ERRT, a “top-down” model for implementation was often concealed. The SWs, on the other hand, tended to experience more difficulties than GPs in integrating evidence-based knowledge with knowledge that followed from practical professional experience.

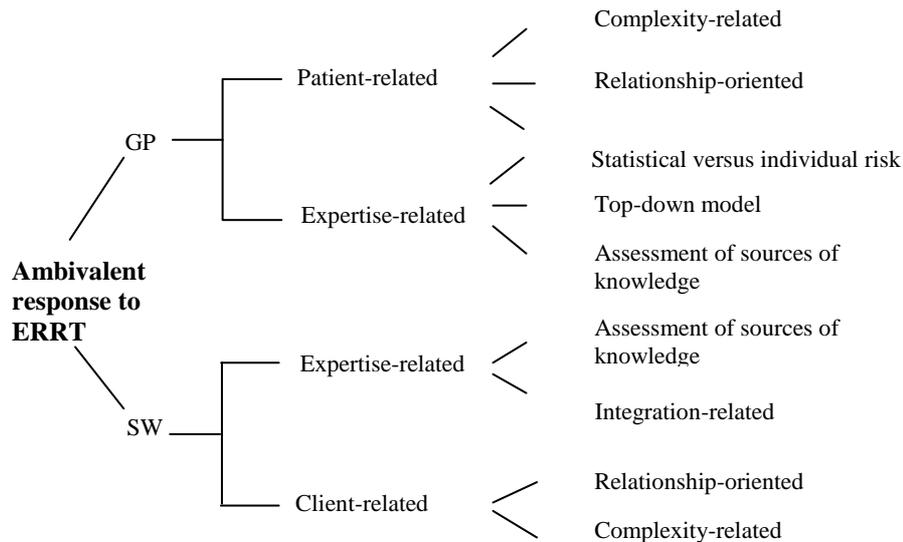


Figure 2. General practitioners’ and social workers’ ambivalent response to ERRT

Compared to the SWs, the GPs tended to demonstrate a greater level of scepticism towards ORRT, which were seen to contribute to circumscription of the profession’s discretion and jurisdiction. The fear of ORRT eroding discretion and jurisdiction was not as apparent among SWs. Rather, there was a tendency among SWs to view ORRT as something that might contribute to clarifying jurisdiction within their professional practice and protecting the individual SW from criticism.

Discussion

In this section we discuss the similarities and differences in GPs’ and SWs’ ambivalent response to ERRT. We also discuss potential benefits and disadvantages of the two professions’ response to ERRT and ORRT by using theory of professions.

Similarities and differences in the response to ERRT

Similarities between GPs and SWs’ ambivalent response to ERRT (see Figure 2) may be viewed in relation to three factors. 1) One factor, applicable to both professions, is that they viewed their practice as too complex to be governed by ERRT. In order to handle the often vague symptoms that were manifested in patients and clients, GPs and SWs believed that they needed practical and clinical knowledge going beyond standardized schedules for assessment and measures provided through ERRT. 2) GPs’ and SWs’ practice involves considering relational and emotional aspects in meeting with patients and clients (cp. Vindegg, 2009). Nevertheless, an overly strict way of managing the professional practice through ERRT risks confining GPs’ and SWs’ discretion with regard to consider client/patient-specific aspects when choosing what measures shall be applied. The decreased discretion following from ERRT was viewed by the professionals as a possible risk for the patients’/clients’ safety, while at the same time it risked diminishing their professional legitimacy. It has been argued that, though

discretion can mean arbitrariness, unpredictability, abuse of power and illegitimate violation of individuals' privacy, it is nevertheless necessary when general knowledge and rules are to be applied to individual cases (cp. Kåre Hagen in Ogden, 2012, p. 3) Both GPs and SWs perceived that ERRT, as sources of knowledge, must be complemented by clinical experience and expertise. Still, this should not be interpreted as questioning ERRT as sources of knowledge; rather, it expressed dissatisfaction with the fact that ERRT, in some contexts, ERRT had been given the aura of impeccability.

The differences between these professions' ambivalent response to ERRT involved three aspects. 1) GPs' ambivalence towards ERRT was based on the difference between statistic and individual risk (Vandik, 2009). That is, a medical risk that is located on population level does not necessarily apply to a specific patient. We see two reasons, in particular, why it was only GPs that voiced ambivalence regarding this aspect. First, the professional practice of this group is to a larger extent diagnostic in character. Second, GPs' knowledge is to a larger extent based on evidence-based studies on population level that provide a foundation for calculating risks statistically. Thus far, such studies are scarce in the area of social work (Bergmark, Bergmark & Lundström, 2011, p. 2) Another ambivalent aspect that primarily seems to exist among GPs concerns the view of ERRT as a top-down model. One reason for this may be that physicians' professional self-image is generally characterized by high status, a robust knowledge base and a high level of discretion and autonomy. Given this professional self-image, ERRT tends to be regarded as a form of top-down management, limiting physicians' discretion. The literature does not show the perception of ERRT as a top-down model as being equally widespread among SWs. This may be explained partly by a weaker professional self-image; it may also be partly explained by the fact that in many countries (such as in the Nordic countries), most SWs are employed within the publicly organized and politically governed organizations. Consequently, a lot of SWs are used to get directives from politicians and senior officials regarding how the work should be conducted (cp. Vindegg, 2009, p. 3) An ambivalent response to ERRT that primarily applied to SWs involved the "integration issue". This involved researchers (producers of knowledge) and SWs (users of knowledge) as working within different contexts, with partly different views on the practice of social work and what type of knowledge that is relevant. SWs tended to experience evidence-based knowledge (primarily standardized and manual-based measures) as difficult to integrate with experience-based knowledge and theory.

Possible benefits and disadvantages of different responses to RRT

As previously pointed out, SWs' response to ERRT and ORRT seemed to be more positive than GPs'. Unlike SWs the GPs exhibited a considerable inclination to associate ERRT and ORRT with restrictions placed upon their professional discretion and jurisdiction, whilst SWs might perceive that compliance towards ERRT and ORRT could provide an opportunity for clarification of the profession's jurisdiction and professional status. One way of understanding this difference may be to look at both groups' professional position in more detail.

One central difference between the two professions is that GPs are to be considered a virtual archetype for a profession. A central aspect of GPs' professional

position involves enjoying a significant level of discretion and autonomy in their practice. Hence, it is not surprising that GPs associate any restriction of discretion and autonomy as a potential threat to their status as it rests upon the principle of occupational professionalism, rather than organizational professionalism. Compared to GPs, the SWs constitute both a younger and more heterogeneous profession. SWs still appear as a profession in the process of attempting to clarify their jurisdiction. It is perhaps against this background that we may understand the SWs' positive view of ERRT and ORRT. From the view point of sociology of professions, the introduction and implementation of RRT may be regarded as 'standardization' and a way of clarifying the practice of social work (Bergmark et al., 2011; Freidson, 2004; Svensson, 2011b; Vindegg, 2009). Viewed from this perspective, ERRT and ORRT may contribute to the clarification of the jurisdiction within social work. Hence, adherence to RRT does not constitute a threat in the same way as it may do to GPs.

Unlike GPs, SWs do not carry a professional self-image as a high-status profession claiming to manage and distribute other professions' work. On the contrary, SWs appear to have a relatively weak professional self-image (Närhi, 2002; Svensson, 2011a, Vindegg, 2009). Thus, it is reasonable to assume that maintaining a compliant approach towards RRT constitutes a larger threat to GPs' professional status than to SWs'. Theoretically, it is questionable whether adherence to RRT would allow for SWs' professional status to increase. Hence it is worth considering whether compliance towards RRT may entail a protection against a further decrease of the professional status. SWs are often subject to public criticism and government authority audits (Webb, 2006); maintaining a level of compliance regarding RRT may allow for them to "cover their backs" to a greater extent as their practice is audited.

The idea that GPs' practice is based upon a scientifically rooted knowledge base is connected to their high professional status. In a similar way, SWs' relatively low status may be linked to the eclectic knowledge base within social work. The knowledge base that general practice is based upon is considered more homogeneous and empirically rooted, which may form the basis for GPs' higher level of scepticism towards the implementation of RRT as it may imply knowledge management. Medical history is said to offer several examples on GPs' cautious approach to new knowledge (Vandik, 2009). This cautiousness may be an expression of a form of "healthy scepticism" (Rose, 2000). For SWs with their more eclectic knowledge base, it can be less threatening to implement RRT, as these do not, as for GPs, appear as incompatible with the professional knowledge base. For SWs, ORRT and ERRT may appear as further sources of knowledge in an already eclectic knowledge base.

SWs' greater level of compliance towards RRT does not, however, necessarily imply an undermining of their discretionary power. SWs' tendency to be adherent to RRT may rather be interpreted as a way of adapting to the professions' changed working conditions in the «risk and audit» society (Beck, 2007, 2010; Power, 2010). Compliance towards RRT satisfies the requirements within the risk and audit society for control and government through accountability, while the level of adherence simultaneously offers protection for SWs. Thus an 'either-or situation' does not seem to prevail, in terms of SWs' view of organizational and occupational professionalism. On the contrary, from a theoretical perspective, it appears as

though SWs are attempting to establish their profession in relation to both organizational and occupational professionalism (Svensson, 2011a). In this respect, the results from the SWs in this study point in the same direction as those of the sociology of professions that challenge the idea that organizational and occupational professionalism would be in opposition to one another (Evetts, 2010; Freidson, 2004; Lipsky, 2010; Svensson, 2011b). However, for the GPs with their roots in the occupational professionalism, RRT, and particularly ORRT, appears as an increased and unwanted bureaucratic way of managing the professional practice (Freidson, 2004; Rose, 2000).

Our findings illustrate that SWs might experience professional benefits by adopting a compliant approach towards the increased level of RRT as following from the establishment of organizational professionalism. GPs, however, did not seem to experience such benefits. Their focus was, in contrast, on trying to preserve the principles around collegial management and autonomy that is part of occupational professionalism.

The use of RRT is likely to increase both in social work and general medical practice, not least with regard to the continued efforts to implement EBM and EBP. The way in which the professionals will respond to this should not, however, be taken as given. Therefore, following this continued development constitutes an important task for research on professions.

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