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How Different Stakeholders Make Use of Policies in an Ongoing Digital Archiving Project for Patient Records?

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Abstract. While CSCW increasingly acknowledges the essential role of policies in technology adoption, more research should be conducted on their role in ongoing digital transformation projects. Current retrospective accounts lack information on how the actors interpret and mobilize policies to conduct such projects and achieve their agendas. Our study aims to take part in the effort to address this gap through a qualitative inquiry into an ongoing patient records digitization project within a general hospital service. We emphasize how each actor, from administrative staff to physicians, accounts for different policies to motivate their actions and decisions on the framework of this digitization project.

Introduction

The density of the legal and regulatory environment of digital technologies is rising (e.g., GDPR, Digital Act). In this context, the designers and actors of digital transformation projects can no longer escape the issue of compliance with policies because regulation bodies are late by nature. This trend is expected to grow over the long term as digital technology supports more activities and domains (e.g., work, healthcare, leisure, and social media). The policies and rules are increasingly targeting directly the practices and tools that support them (Jackson et al., 2014).

Computer Supported Cooperative Work (CSCW) research also calls for a better account of the influence of policies in technology-supported cooperation settings, in particular in the healthcare domain (Fitzpratick & Ellingesen, 2013). A growing number of studies are tackling the issue and provide important conceptual frameworks and retrospective accounts about the influence of policies in digital transformation project (Plegat & Lewkowicz, 2025 ; Centivany, 2016 ; Jackson et al., 2014).

However, we know little about how stakeholders use policies in an ongoing digital transformation project. Therefore, our research question is : how different actors in a digitization project approach the policy issue to guide their practices and decisions ? Our work draws from cases of digital archives projects in France where national policy and public regulations on the subject are well defined (Rolland-Blin et al, 2024).

In the qualitative study presented in this paper, we highlight the policies and regulatory elements that count for the different stakeholders within the scope of a digital archiving project of patient records in an hospital seeking to transition from entirely paper-based patient records to digital patient records. After introducing in more detail previous research on policies in CSCW and the digital archive's policies for patient records at stake in our case, we present the context of our fieldwork. Our findings emphasize the different policies that our stakeholders mention and use to guide their actions throughout an episode of this digitization project, as well as the role of their current policy-related practices in their involvement in the project, and considerations about the tensions, mutual ignorance, and inconsistencies between these policies. Finally, we discuss how stakeholders use *selective compliance* and *strategic delays* as pragmatic ways to negotiate the status quo and avoid deadlock. We also reflect on how sociotechnical modeling could help surface these hidden negotiations and support learning and alignment across successive projects addressing compliance with the regulatory framework.

Related work

Research in CSCW has begun to further the analysis of policies in technology development and appropriation. Through our study of the case of digital archives for patient records, we seek to contribute to this emerging corpus of research, in particular on the role of policies in ongoing digital transformation projects.

Previous Analysis on the Role of Policies in Digital Transformation Projects

While often set as a background element in the study of technology mediated cooperative practices, the key role of policies in the initiation and deployment of technology is better recognized (Jackson et al., 2014 ; Centivany, 2016 ; Cormi et al., 2020).

Jackson et al. (2014) and more studies have called for understanding their impact on appropriation and design in CSCW. Fitzpatrick and Ellingsen (2013) especially call for a better understanding of the role of policies in healthcare technology where an important part of technological changes and implementation are initiated on the behalf of local or national policies aimed at improving healthcare organization for the benefits of the patients (Cormi et al., 2020). Jackson et al. (2014) propose to understand technology design, practice and policy as interdependent elements of a policy knot. On the ground of two cases of technology mediated social practices that have been compromised by policy makers, they highlight how policy can shut down a potentially harmful platform as an aftermath or counter the top-down development of a product unduly imposed by a major firm.

Centivany (2016) supplement this corpus of research cases with a study on a digital library agreement about document sharing. The author emphasizes how, over the long-term, initial choices made during policy making can have a major impact on the spaces that are opened or closed for technology development and social practices later in the implementation of related projects.

These studies clearly show that policy can have a critical impact on sociotechnical practices and their technological supports. However, so far they deal more with retrospective accounts and little has been said about the role policies are playing in ongoing digital transformation projects. The precise nature of the relationship between the terms of the policy knot is considered open (Jackson et al., 2014) and calls for generating more hypothesis and approaches at this level (Plegat & Lewkowicz, 2025).

This raises interesting and important questions about the possible roles of policy in ongoing digital transformation projects. We think it is worthwhile to better characterize how involved actors deal with policy frames in these projects, in order to gain more understanding of how policies can play an active role in this context.

Digital Archives Policies for Patient Records

Health records are related to several policy compliance issues which also apply to digital health records. One concern during a digitization project may be their legal value, often related to digital signatures. Digital documents present some particularities, as for paper documents their legal value is linked to their authenticity, trustworthiness and integrity. However, unlike them, the perfect preservation of the medium is not enough to guarantee digital records integrity. These records are easy to modify and sensitive to auto-deterioration. Their preservation requires dedicated resources to prove that the document has not been unwantedly modified, a register of modifications with their authors, and software capable of managing these mechanisms. Furthermore, proving the authenticity of digital documents is more complicated compared to paper. Authenticity covers both the identity of the authors or signatories and the date where the document was produced or signed.

In the European Union, Iceland, Norway, and the United Kingdom, this question is one of the objects of the Electronic Identification, Authentication, and Trust Services regulation (eIDAS). It also covers electronic seals and time stamps. The regulation defines three levels (simple, advanced and qualified) corresponding to three degrees of confidence in the author's identity and the accuracy of the time stamp. All levels have legal validity, but only the qualified level is considered equal to handwritten signatures. It is important to note that these levels imply a choice by the actors seeking to implement digital authentication solutions.The eIDAS regulation's aim is to ensure cross-border validity to facilitate commercial exchanges and specify the conditions for electronic signatures to be legally valid but, it only applies to EU citizens. This regulation also reinforce digital documents' legal value.

As the study is conducted in an hospital in France, we will consider the French legal framework in more detail. Since 2000, French legislation has recognized the probative value of digital signatures and digital documents (Wack et al., 2002). This position was confirmed in a 2016 order affirming that digital records are equivalent to paper records, provided that their authorship is clear and that they are preserved to prevent integrity loss (Article 1366 du Code Civil, 2016a). These requirements for the validity of digital documents are quite flexible, with several solutions available to meet them. However, the level of certainty associated with each solution can vary, with greater confidence often being linked to more costly or challenging solutions to implement.

French law defines "*archives*" as all the documents produced or received by a person while practicing an activity (Article L. 211-1 du Code du patrimoine, 2016b), which encompasses the English "archives" and "records". Under certain circumstances, the archives' status implies a designated management. For example, French laws indicate mandatory preservation periods for health records (Article R. 1112-7 du Code de la santé publique, 2018). Another significant criterion is if they have been created or received during a public activity. This last case involves control of the preservation of the concerned archives, a procedure often managed by territorial archives. Most healthcare organizations are in this situation, either being public organizations themselves or being associated with public services because of their public health missions (Cornu, 2016). In addition to an internal management process, they must communicate with territorial archives to transfer them a sample for long-term preservation and obtain authorization to eliminate records after the mandatory preservation periods (Leroy et al., 2017). Health records imply medical responsibility, but also matters related to privacy and patients' rights (Monnier & Fiorentino, 2016). This overlap makes their management much more complex. Moreover, the legal stakes surrounding medical records are quite high, as they are likely to be presented as evidence in case of trials.

Methodology and context

This paper draws on a qualitative field study of a digital archiving project conducted in a French public hospital, which aims to transition from paper patient records to digital ones. However, the reasons for involvement and the objectives pursued vary according to the actors. The project began in March 2023 (Rolland-Blin et al., 2024) and went through various phases, with periods of intense work followed by long breaks caused by changes in institutional priorities and internal conflicts. Our inquiry spanned nearly two years and sought to document how different stakeholders (clinical staff, administrative personnel, and policy actors) mobilize, interpret, and negotiate policy requirements in practice.

We collected empirical material through a combination of ethnographic observations and meetings. Throughout the project, we attended ten meetings related to the digitization initiative (lasting between one and two hours), including steering committees, technical consultations, and cross-institutional exchanges. We also observed the activities in the urology department's secretariat, which helped us gain insight into everyday practices for producing and circulating patient records. These observations showed how the documentation process is integrated into the department's daily routines and administrative tasks. Our fieldwork evolved as the project progressed. Initially, the focus was on digitizing records in the gynecology-obstetrics (G-O) department to improve sharing information with a nearby maternity hospital. However, disagreements regarding software choices halted the work in this field. Instead, the urology department initiated a similar project, which was the center of our study. The hospital's medical information department and archives department, coordinated the project and played important roles in determining the direction and regulatory environment of the project.

Throughout the study, we documented how decisions unfolded in meetings, how stakeholders engaged with national and institutional policies, and how technical, legal, and practical concerns were weighed. Notes from these events were systematically analyzed using a collaborative thematic analysis approach, supported by the Cassandre software (Lejeune, 2010). We entered the field notes into the software, then each author carried out an initial thematic coding. The results were discussed during a common meeting, the themes were established and then a second wave of coding was carried out by the authors on this basis. In February 2025, a last update meeting confirmed that the temporary work process devised by the urology department had been abandoned, while the conflict with the G-O department was partially resolved.

This longitudinal engagement offers insight into the situated, negotiated, and, at times, contested nature of policy implementation in healthcare infrastructure projects.

Findings

Our analysis sheds light on how stakeholders involved in the digitization project perceive policies in relation to their practices. How they engage with policy frameworks and the means by which they overcome their different approaches. It is possible to group stakeholders according to the policy frames to which they attach most importance. These groups are mostly coherent with practices and professional communities.

The Healthcare Professionals of the Urology Department

For the urology department the main regulatory objective is to comply to the legal transmission delays for the referral letters (transmitted to external general practitioners and integrated in patient records) while maintaining the current working cooperation within urology and with other medical departments. A goal that can be reached in the perimeter of the digitization project. “The problem is that the current delay in typing letters (one and a half months) exceeds what is legally permitted.” *Field note based on the Head doctor of the urology department (HDUro) comments.* The reason of this delay includes the management of the paper patient records (moving them where they are needed, reorganizing and adding documents). Urology is the department with the most daily exchanges of records with the archives and the majority of the files are stored in medical secretaries’ (MSec) office. The number of records is increased because of the delay itself as records are in stand-by in this office until the letter is added to the records. This amount of records increase the time required for each search of file or information.

> “The aim is to stop requesting patient records from the archives for consultations. On the other hand, all the members of the urology department present agreed that the records should necessarily continue to circulate for hospitalizations, as certain documents must be integrated into the paper files.” *Field note based on discussions during the global meeting.*

Even if the members of the urology department seek to respect the deadlines to send every letters, the fact that this specific constraint is not respected is the result of a considered prioritization. The process that are prioritized are the hospitalizations and then the transmission of information for the consultations in the hospital. This is illustrated by tree elements: the delays of information transmission for hospitalizations are perfectly respected (referral letters included), the case where a patient come back to the hospital before his file have been totally processed prioritize this specific file and the MSec in charge of typing letters are also in charge of helping their colleagues working on hospitalizations and consultations. This last element mean that if there is a work overload for their colleagues, they will help them prepare hospitalizations and consultations even if it increase the delays for typing letters. We can also see this prioritization in the summary of the new process objectives made my the HDURo : "For [the new process] to work as expected, the typing backlog has to be recovered quickly. This is a priority issue for the department. The documents must be returned to the records before next consultations (and within the legally authorized deadlines)." *Field notes based on HDUro comments.*

The Archive Department

For the other main stakeholders involved in this project the objectives are perceived on a larger scale in terms of time and organization. The Head of the archives department (HArch) search to comply to archival norms, especially the probative value reference framework designed to guide the production of digital documents with legal probative value in healthcare sector. This body of documents is itself based on a set of norms and regulations specific to the fields of archives and health.

Another important crossing between archival practices and policies in the hospital is the destruction of records. The space available to store paper records is limited and already exceeded. However, the destruction of public records (already considered as archives in French law) require the authorization of the departmental archives (DepArch). An important task of the HArch is therefore to maintain or even reduce the quantity of records by collecting evidence that their legal preservation periods expired and requesting authorization for their destruction.

> "The 12 linear kilometers [of patient records] has been maintained for the last 10 years, but they have not achieved any reduction. They destroy about 100 meters a year [...] mostly records of deceased patients. They don't have the time to process all the files that need to be destroyed." *Field notes based on HArch comments.*

Consequently, one goal of the digitization project from the archives' perspective is to partially relieve them of paper records management for the same reason as the MSec (time-consuming management) and because of this storage problem. However, without the validation of the departmental archives, they will have to manage digital copies in addition to the original paper versions, which is a work overload rather than a relief. This constraint led to a preventive strategy from the HArch: "The aim of including [the departmental archives] at an early stage is to avoid them refusing to destroy the paper documents because a regulatory element was overlooked during the project." *Field notes based on HArch comments during the DepArch meeting.*

As for the urology department, the archives are prioritizing some constraints over others. They must keep the records for a certain amount of time but also eliminate them after this given time (because of the GDPR for example). The information needed to verify whether the conservation period has expired is sometimes difficult to find or unavailable. In this situation the choice of the archives is to keep the records : "Generally speaking, currently, we lack the information needed to apply deadlines and are not compliant with regulations, so we overkeep the documents for safety." *Field note based on HArch comments.* For them priorities are: obtaining authorization of the departmental archives to destroy documents, keeping information necessary to the hospital functioning (including medical practice but also legal disputes) and then comply to the storage environment norms for archives documents. The fact that the two first ones are considered more important explains why the last one is not totally respected. "The room used to store deceased patients' records is not suitable for archives. The HArch needs to find another place and can no longer move archives here. This poses real space problems, as there is currently no archives room that can store these files." *Field notes based on HArch comments.*

The Hospital Information Management Department

The last group includes the head of the medical information department (HMInfo) and the head of the IT department who have very similar policy compliance goals. They focus on increasing hospital's sovereignty on it's own data, and conformity to regulations on preservation for medical data. It is important to underline that the HMInfo is the direct hierarchical superior of the HArch and that he is responsible for ensuring the consistency of the hospital's strategy regarding medical data and for advising the different department on this issue. This position is recognized, as he has been called upon by the urology department to implement a digitization process. It also means that his opinions carry a particular weight in discussions.

> "With our electronic health records software, we don't own our data and must pay to get it back. The publisher refuses to delete the data [according to the legal duration], which also poses a problem regarding the GDPR. [...] Normally a specific authorization is required to host medical data, but the hospital does not have this. It just has an exception for hosting its own data." *Field note based on HMInfo comments.*

These varied policy frames highlight distinct perceptions and uses of patient records. For urology stakeholders, their main value lies in the medical information they contain, which helps to establish a diagnosis, regardless of their medium or form. For archives, on the other hand, the medium and form are important because they contribute to the probative value of the records, which is useful in the event of legal disputes. The importance of records as evidence of medical acts is shared by all stakeholders, but has different implications. They may focus on diagnosis and individual medical responsibilities, as is the case for urology professionals, or, as with HArch, they may be a record of the entire hospital's care processes. Most of the compliance objectives introduced during the project can be understood by the other stakeholders, but they may not be seen as important objectives to be pursued first and foremost during the project, even if they are linked to strict legal constraints.

Tensions in Cooperation under Multiple Policies

The differing positions lead to difficulties in cooperation between these groups. The case of the potential destruction of the digitized paper records can illustrate this element. For the urology actors this destruction is seen as trivial and easily reachable but they perceive the resistance of the other stakeholders : "We need information, to know what language to speak, so that we can digitize and destroy the documents." *Field notes based on HDUro comments.*

However from the archives perspective this is a end goal, quite difficult to fulfill in short terms as it requires the explicit validation of the departmental archives before destruction of the records. The authorization can be obtained for specific records or after the validation of the entire digitization process which require a sufficient compliance with archival norms.

This problem can be addressed through direct exchanges as it has been the case during the global meeting.

> "The HDURo wanted to give the patient certain documents to avoid having to process them. HMInfo replied that as long as the letter contained the information used to make a medical decision, it would be possible from a legal point of view. After discussion the HDUro changed his mind and decided that it would be preferable to keep a version of all the analyses in order to strengthen the justification for medical decisions." *Field note based on discussions during the global meeting.*

It is interesting to notice the argument that convinced the HDUro is the legal risk of unjustified medical action and not the policies stating that it is not possible to give original public archives documents to patients. This compromise required long discussions involving many actors. It led to a new work process in the urology department avoiding the difficulties of digitization. As we learned in 2025, this process does not exist anymore. We cannot conclude that this result is directly caused by a specific event that occurred during the project, but it still indicates that the first project phases were unable to solve the initial problem of the urology department.

Discussion

Our study provides a grounded perspective on how different actors mobilize and negotiate policy compliance in the context of an ongoing digital archiving project in a French general hospital. The empirical material illustrates that, far from being static or uniformly applied, regulatory frameworks are interpreted and enacted to reflect each stakeholder's material constraints, institutional priorities, and professional responsibilities.

First, our findings emphasize that compliance is not binary. Instead, it emerges as a negotiated and resilient practice. Healthcare professionals and medical secretaries work under conditions that make full and immediate compliance with legal delays (e.g., 48- to 72-hour requirements for transmitting referral letters) unrealistic. Nevertheless, they prioritize urgent cases and push them to the top of their transcription queue to ensure legal requirements are met where they matter most. This form of *selective compliance* reveals a pragmatic approach to regulation grounded in professional judgment and a nuanced understanding of patient care priorities.

By contrast, the head of the archives (HArch) adopts a more formalist interpretation of legal constraints. Yet even this position is not rigid. Constrained by a lack of human resources and limited storage capacity, she also engages in partial or *delayed compliance* and prioritizes tasks to meet minimum expectations. The case study demonstrates that compliance is often modulated by constraints and negotiated in practice, even among actors with regulatory responsibilities.

These differences in regulatory engagement underscore a central challenge for cooperative projects like this one: stakeholders operate with distinct regulatory frameworks and temporalities. While the archives staff works to align documentation with the standards of the French Heritage Code and departmental archival authorities, healthcare professionals focus on providing timely care and managing workloads. Their shared object – the patient record – is not shared in practice, as each group emphasizes different aspects of its use, value, and handling.

These diverging perspectives make compromise difficult unless mutual recognition of each other's policy frameworks and operational logic exists. The policy knot metaphor (Jackson et al., 2014) remains helpful in illuminating the interconnection of policy, practice, and design. However, our findings suggest that the policy knot alone does not sufficiently account for how policy negotiations unfold during ongoing transformation projects – especially when compliance is fluid and distributed across actors.

The congruence loop (Plegat & Lewkowicz, 2025) offers a partial response by emphasizing iterative feedback between coordination mechanisms and artifacts. The congruence loop introduce a way of tying the policy knot in new work configurations. For instance, the authors point out the importance of the stabilization of practices before applying strong policies on practices and the technologies supporting them. However, and maybe because of the novelty of the work configuration and linked policies, it does not explicitly address how different actors interpret regulatory priorities or negotiate their meaning in collective settings. The model captures alignment over time but lacks tools for mediating between heterogeneous compliance interpretations.

Our case study highlights that designing technologies to support cooperative work requires more than simply understanding existing practices. It also requires attention to how these practices emerge from ongoing negotiations between available resources and flexible interpretations of policy. In the case we examined, the relationship between policies and practices had already been established locally, shaping the way health professionals carried out their work. Technologies that fail to account for users' situated understanding of these policies—policies that have been selectively interpreted and integrated into practice—risk being rejected early. Whereas the introduction of technology in conflict with negotiated agreements has the potential to disrupt ingrained workflow and suppress appropriation, we can create technologies with greater potential for significant adoption and sustained use by considering the interplay of practice and compliance with policy.

These limitations invite a reflection on more operational representations supporting interprofessional dialogue and decision-making in policy-dense environments. Potential directions could be drawn from the institutional analysis and development (IAD) framework (Ostrom, 2011), which attends to the interplay of rules-in-use, actors, and shared arenas. IAD could help map how actors such as archivists, physicians, and secretaries refer to different normative frameworks while interacting with the same object. Another avenue is risk-based management techniques (Chiu & Chung, 2000), (Otway & Haastrup, 1988), which might help actors jointly prioritize areas of compliance based on context and constraints. This approach would be instrumental in distinguishing between documents or situations where legal compliance is critical and those where it is desirable but not urgent. Lastly, process modeling approaches (Dumas et al., 2018) could visualize not just workflows but also the regulatory thresholds, margins for negotiation, and the roles of each actor in ensuring traceability and accountability. These models can help clarify which parts of a process are flexible, which are mandatory, and where support or reconfiguration might be needed.

Such models could help project stakeholders visualize and compare the various compliance strategies, their degrees of rigidity or flexibility, and how they interact with material and human constraints. Rather than aspiring to perfect compliance, they could support collective reflection and incremental alignment (Tosi & Benel, 2016), helping to surface potential mismatches and guide the project towards legally sound yet practically feasible implementations.

In summary, compliance is an evolving and negotiated process shaped by infrastructure, workload, and professional culture. Supporting digital transformation in healthcare thus requires not only technical solutions and legal knowledge but also tools and practices for surfacing and negotiating policy interpretations across diverse stakeholders.

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