

Managing dilemmas in “here and now” when care for people with heart failure translates into accounting figures (and back) – The DAGA case.

(Draft)

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Paper to be presented at the 18th Scandinavian Academy of Management Meeting, Aarhus 18th-20th August 2005

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Abstract

Health care organisation and professionals have been observed to face increasing ethical dilemmas during the 1990s (Llewellyn, 1998). The most common explanation to this development is associated with the growing significance given to the financial arguments. Another is related to the far reaching decentralisation of responsibility – guided by accounting models (Olson et al., 1998). In Sweden, county councils and local governments have tried to improve health care organisations by standardised activities with the introduction of several accounting models such as Diagnosis-Related Group-Prospective Payment System (DRG), Responsibility Accounting (RA) or Total Quality Management (TQM). Today, doctors and nurses are perceived as being more engaged in financial management than before, because of the increasing requirement to balance cost and levels of the care produced. However, the effect of the models where the actual care takes place is unclear and thus needs further investigation.

In an attempt to initially analyse effects of accounting practice integrated with medical practice a study at a close range has been carried out (in progress) and through conceptualising accounting as a chain of translation (Latour, 1987). This conception of accounting is a way to deconstruct the way health care is represented as accounting numbers. It focuses on how relations between people, things, movements and numbers are created in accounting documents. And finally, it focuses on how people in the health care become knowledgeable in their everyday work in new ways – meaning a way of valuing, defining and prioritising activities but also excluding other ways of seeing and knowing what is going on.

The discussion will highlight how the nurses, in the middle of arguments from both medicine and accounting, learn to use numbers, non-financial and financial, as a way to understand their own work but also to make arguments for their existence and eventually to expand the way of organising health care. The discussion highlights as well how their identities as nurses will at the same time change the way they manage “here and now” under the increasing pressure of decreasing time spent with patients. Some possible conclusions will be presented which will give insights and contribution to the processes of accountability and accounting in practice as a powerful knowledge device.

Keywords: Accounting practice, Medical practice, health care, translations, everyday work, dilemmas

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Introduction

Accounting driven innovations and new ideas in the health care, like Diagnose Related Groups (DRG), is today a common agenda. There is an increasing concern with the efficient and effective use of scarce resources, for instance, and governments have agendas of wanting to break old-style professional autonomy in the interests of the public good. People involved in using or producing accounting numbers are increasing. The decentralised ideas, at least in Sweden, have been a topic for the working organisation as a political and practical effort (Jönsson and Centrum för forskning om offentlig sektor, 1999). This has led to more people being engaged in using and producing accounting numbers in talk and in text. Even if some of these ideas about accounting models introduced under the heading of New Public Management¹, e.g., responsibility accounting based on profit centres, in hospitals can be regarded as less successful or the effects unclear they are not abandoned (Northcott, 2005; Chua, 1995; Llewellyn & Northcott, 2004; Llewellyn, 1998; 1993). Instead these innovations are further explored, modified and expanded such as in the “*Index*” introduced in England which Llewellyn and Northcott discuss in *The Average Hospital* (2004).

However, even with unclear effects due to which accounting models and control are set out by managers or politicians, studies show that the effects of putting this practice into use are many. For instance, the expanding accounting models and financial arguments in accounting practice are introduced at many levels and incorporate many people in health care organisations and other public sector organisations. It has also been noted that professionals have been observed to face increasing ethical dilemmas during the 1990s (Llewellyn, 1998; Olson et al., 1998; Jönsson & Tengblad, 1998). Preston et al. (1997) also point to how accounting affects life and death through new ways of defining health care and its practices. It has also been noted how nurses and doctors change their approach to their profession and medical knowledge by using financial and non-financial numbers, especially as the role of the medical profession also becomes the role of managers where accounting becomes an essential part of the managing devices (Frandsen, 2004; Kurunmäki, 2004, 1999; Nilsson, 1999; Nyland & Pettersen 2004, Stolt, 2003; Svedberg, 2000) This change of direction is not clear cut and in some cases creates delusion in the medical profession and polarisation between professionals and managers (Hunter 2002; Jacobs 2005).

As a parallel phenomenon to the increased accounting practice in health care, the research area of health care and accounting is today comprehensive. Many of these studies of accounting in this context are concerned with a “higher” level such as upper managers, whole hospitals, a region or even a whole nation (Aidemark, 1998; Llewellyn & Northcott, 2005; Llewellyn, 1998; Lowe, 2000; Chua, 1995) which all, no doubt, has importance. They are important because they provide the basis for asking other questions about accounting practice and for making further inquiries.

The purpose of this paper is to get deeper insights and knowledge about the effects on nurses in their *everyday work*, where ambiguity and complexity are present, and how the nurses handle ethical dilemmas that seem to occur where accounting practice integrates

¹ NPM is not all about new accounting models but as Olson et. al. (1998), claim that without financial management reforms, “New Public Management” reforms would be a far less significant and focused because of that on New Public Financial Management in their discussion of reforms in the public sector world wide.

into their everyday work as argued above. Or expressed in another way, what happens when two practices meet in everyday work? Furthermore, by carrying out studies at a close range it is also possible to complement the insights of how accounting practice works in detail and perhaps even provide elements to re-theorise accounting. However, this paper will take a more modest approach for the time being because it is a project still in progress. It has as its focus to analyse the effects of accounting practice in everyday work at a ward unit where nurses treat heart failures. Additionally, the paper will discuss how accounting practice in detail is integrated with medical everyday practice and its effects when doing so. Especially, the paper will focus on how nurses at a heart failure ward use different ways of handling dilemmas in their everyday work, dilemmas which are brought into the everyday work when financial arguments, connected with the medical practice, are increased.

Accounting in practice as a chain of translations

To be able to make a critical analysis of *how* accounting practice works and integrates with medical practices Studies of Science and Technology (SST), here represented by Latour (1998) and his "Circulating reference – sampling the soil in the Amazon forest", offers significant possibilities. First there is an analogy between how scientists construct facts and how accounting produces powerful pictures or, representation and facts of an organisation. This process has many similarities with the way accounting constructs facts and acts, since accounting also implicates people within a field of inscriptions, technology and machines, which, as in modern science, includes machines that both record and analyse what accounting technology and inscription constructs and thereby enables an intensification of accounting as technology and inscription device (Lowe A., 2000; 2004). Second, this "picture" of accounting gives an opportunity to broaden the picture of this practice and its effects and to ask questions which can specify *how* this practice works. Third, the elements for theorising are grounded in the local (local places connected together) where everyday work is carried out.

In this paper the key concepts of translation, associations and black box have special importance. *Translation* means enabling us to understand how things become other things, such as heart failures treatment becoming accounting numbers, but also the other way around such as how numbers translated back into the everyday work of heart failure, and references circulate. SST has argued that translation, as a movement embracing both change and continuity, can be applied both to linguistic and physical objects. From translation, as an approach, it is apparent that in every translation something is lost while something is added, as the means to something being kept constant, an outcome achieved by using what is already known to create what would not be there without the translation process, via some technology. Latour (1998) points out that to make something durable and diffused it has to be materialised and simple, like numbers. The other side of this process is, however, that this simple construction gives rise to other translations and transformations, sometimes far from the original purpose. Translations can take many different paths and meanings in different situations. Translations cannot be controlled.

Translation creates *associations* between things, people and concepts. The associations thus established can then acquire a stable character if they are reproduced again and again, and here the appropriate use of technologies is a key way to reproduce and so to stabilise such associations. Translations continue and shift, they can take different paths, and at the same time they can have many interpretations in different situations. The very

attempt at stabilisation gives rise to destabilisation, but in the particular form of other translations and transformations, sometimes close to, sometimes far from, the original point of departure. *Blackbox* is a metaphor for those associations that are kept under cover, and are taken for granted. A blackbox is sealed under normal conditions. Lastly, this study has a performative focus in which, within the inevitable regularities that are running.

Still, it is important to consider that this is a study under progress. This means that some of the references are still missing in the chain of translation. However, in this paper in progress there are still some findings that can be discussed and reflected upon with this conception of accounting. Some difficulties have been due to the access to numbers and documents which would give a more comprehensive description of this translation. I have followed if and how translations of accounting come into play in the nurses' day-to-day work. It could be said that DAGA is a place where two practices meet, the accounting in practice and the medical practice.

The design of the field study – Mobile Ethnography

The study has been carried out with inspiration from anthropology (Wax, 1985) which also is of great advantage in the field of business administration (Czarniawska-Joerges, 1992; Watson, 1994; Jönsson & Macintosh, 1997) when looking at everyday work in focus and in getting to know how people in the field order and live their lives. The study attempts to conceptualising accounting as a chain of translation and focusing on how things are drawn together and facts are constructed. I will trace how places are related to each other, connected and how associations are materialised and in a certain sense stabilised such as watches, computers, diagnoses, walls or money. The idea is to follow “the object” under construction which is accounting practice and the facts relations it establishes between numbers and something else. In a sense it is a way of moving the laboratory of fact construction (Woolgar & Latour, 1986) out from the laboratories and focusing on accounting as phenomenon along a chain of translation where actions and things drawn are together instead of study accounting as an object (Czarniawska, 2004).

The empirical fieldwork presents a mobile ethnology² (Czarniawska, 2004). I have followed the nurses' day-to-day work since the fall of 2004. At each visit I have followed one nurse during the day. Even if there are 5 nurses working at the DAGA who move around between sections for open care, I have followed each of them as most of the visits at DAGA have been with the nurse who also acts as their supervisor and spokeswoman. I was present sitting in the corner of a very small room where nurses see their visitors. It is so small that some of the persons who visit here apologized when lying down because their feet were so close to my face. I attended meetings with nurses, and talked to them, ate with them, and drank coffee with them. The visits were carried out more frequently in the beginning from October 2004 and later on when the idea of how the work was organised, translated and carried out to a focus more on the changes that were decided at the start of 2005 which the nurses calls the “10-minutes patient.” I had my note book with me which I used during all visits. On some occasions I had my camera with me and took a lot of pictures. To date three interviews have been carried out, two

² As Czarniawska (2004) describes it “[...] facilitating study of the ways of life and work of people who move around a lot”. Here it is accounting practice in focus and how it's of claim facts of DAGA is constructed and stabilised.

with the doctors in charge and one with the supervisor nurse. Documents from DAGA and from other sources about DAGA have been available to me, and some have also been collected. Interviews have been carried out with two persons, the doctor who started DAGA, and who still has the medical responsibility for DAGA, and one of the nurses who also works as their leader. Of course, even if everyone has a name, every name in this paper is made up and patients with names are made up in the sense of putting several visits into one to avoid revealing identities.

The site – DAGA

The empirical site is called DAGA. Physically it is located at a big hospital in Gothenburg (organised within Sahlgrenska University Hospital where three hospitals are incorporated). They have 40 square meters located on the main building's 7th floor, side by side with wards for different heart diagnoses. DAGA was established on the 17th of November in 1997 as a project of a medical open care centre but also as a profit centre. The development of the project was a response to changing economic realities but also as a response to the requests for increased chronic heart failures (CHF) treatments that require complex and expensive hospital care. DAGA's history can be traced back to 1987³. At that time a huge survey of a new medication called Renitec was carried out. The medication was argued to have good effects on people with chronic heart failure (CHF). This was why they started to call the centre the Renitec but also due to a devoted doctor Marianne who still is in charge of DAGA. The hospital is financially controlled by an annual budget mostly related to order DRG points by the politicians each year. Open care treatments at hospital⁴ like DAGA is ordered to an amount based on experience on previous year and some basic simple calculation.

The medication was (is) given during a period where the dose was slightly increasing until right dose (target dose according to the survey) was achieved. But it could not be allowed to let all patients who needed the medication to stay at the hospital while taking the medication. Instead they could go home and visit the hospital when the increased dose was needed and have a check up. According to the drug specifications, the period of increased dose should be done during a couple of weeks. The start up was the critical part as the patient being treated stayed several hours during the check up for blood pressure every ½ hour, etc. Subsequent visits were usually shorter. It was later discovered that the medication had good effects on different types of chronic heart failure and more people needed adjusting medical care. Some other medications with similar effects were also introduced which is why they changed the name to chronic heart failure centre instead. While time passed, it was noted that a need for a different kind of care was needed, and thus the project became DAGA in 1997. In 2000 the project is no longer a project but has become a part of the ordinary activities.

DAGA is organised by specially trained nurses and some of their work is to contact patients at home after they have been discharged from the hospital. Still, most of their work is to meet and treat people with CHF at the hospital and make sure the dose of medicine is gradually increased until an effective dose is established under surveillance of medical

³ See Johansson, Dorriots and Frandsen (NFF 2005) Intentions and “*Effects of Arguments – Improving Health-Care practices*” for some background.

⁴ This kind of care is increasing for eg. SU had in year 2004 11.000 more visits than year 2003 (SU annual report 2004).

check ups, like blood pressure, blood samples, and other important medical measures. A lot of work is allocated to phone calls in order to give people instructions and advice about their illness. The nurses also educate the patients about their diagnoses and teach them to recognise important changes in their health status and urge them to contact DAGA when problems occur.

The centre is open Monday to Friday between 7.30 and 16.30. The centre is organised within a department where several day care centres for different illness are incorporated, like diabetes, hypertension, and intestinal illnesses. The five nurses and one practical nurse (undersköterska) from DAGA not only work at DAGA but circulate among other heart failure centres which are located on the ground floor. This circulation of personnel was organized for two reasons. First, the rooms where DAGA is situated are not the best since they are very small and the windows are high up so people can not look out and it is difficult for daylight to come in. Second, it takes a lot of energy to handle people with this illness, because of the illness involves much anxiety, so the nurses need a change in their work tasks. For the moment, there are five nurses working at DAGA who view their time spent as 2,85 persons full- time employment. The practical nurse works 25% part time at DAGA.

Nurses' everyday work

After an interview with Marianne in September 2004, the doctor and driving force behind DAGA, she introduced me to the nurses working there. Marianne has already informed them about me and the project I was doing so no one was surprised when we enter the room. We all said hello to each other and I felt welcome. Today it was Annelie, Karin and Emma working at DAGA. With Annelie I made an agreement of when to come next time in order to follow them around in their work. She revealed something that caught my attention – the week after I come they are going to do a time study of their work day. Clock time will be connected to different tasks to see if they can eliminate some tasks or change how they are performed with the purpose of increasing the flow of patients, a request from Marianne. Of course I have to follow them a day during this week that the time study is carried out. Until then I start my study the week before. This episode is then followed by when the time study is carried out, the creation of the 10 minutes patients and the evaluation later on which the nurses did.

The nurses start in the morning about 7.30 when they change clothes from civil clothes to white coats, signalling a change of status for the time ahead, at least to 16.30, which also is related to the space they are moving in, the hospital. Today at my first day I will follow Annelie in her work all day. When I open the door I can see Annelie and Emma working. This morning they have all been to a meeting which I have not attended. Annelie shows me where to hang my jacket and where to put my handbag. The space here is really small. Every inch is used and you always have body contact when you must pass each other. There is a space when entering the door where people with heart failure can sit down and wait if necessary. Then there are three rooms for consultation which are called DAGA 1-3, where DAGA 3 is slightly bigger than the other two. Annelie will use DAGA 1 today, a room with a desk and a chair along the right wall, and a computer on the desk. On the left side of the wall there is a bed for people to lie down on when their blood pressure is taken. On the walls there are also some shelves with files, books, documents and medical equipment. Annelie arranges a seat for me in the corner at the end of the bed, which she says will be “Ann-Christine’s corner”. Soon Annelie’s first visitor will come. It is a man

whom I call Olle. When he enters the room Annelie presents me to Olle and tells him why I am there and asks if it is alright for me to be present during his visit. It is. Olle starts to place himself on the chair just before the desk. The distance between Olle and Annelie is short. She gives him all her attention and she calls him by his first name, Olle.

Annelie has many standard questions to ask according to the document she fills in. Olle tries to answer the best he can.

He is informed that the ideas are to let the heart not to have a high heart beat frequency.

- Take a pause when it is necessary, Annelie tells him.
- How much can you do? Olle asks?
- Well, that is something you have to learn to feel but it is good if you can let the heart have an even charge. Plan your rest, try not to get many high peaks, is some of the advice Annelie answers him with.

Annelie brings out the blood pressure equipment and a stethoscope and asks Olle to lie down on the bed. The bed is on this side of the wall because then the right arm is available which is according to medical ideas is the preferred arm to take blood pressure. Usually the blood pressure is different in the left and right arms. When the blood pressure is taken, one when he is lying down and one when he is standing, she records what the instrument numbers said about the pressure on a document. Annelie also measures his pulse using her two fingers and counts each beat during a period of 30 -60 seconds using a watch. Meanwhile Olle asks a question

- Football matches make me excited sometimes, is that good for me?
- That is quality of life, Annelie answers him. But is only you who know the limit of when to stop.

Before Olle came into the room he took his weight which in this context is very important and is inscribed into the document, too. They have a discussion about the increase in weight Olle has had and his salt. The idea is to find so many relations to why Olle feels very tired. Tests are asked for and Annelie searches in the computer for Olle's latest results. The dialogues are now about how to learn to accept this illness and to learn how to live with it, which Olle now is doing.

- You are about to face the facts, Annelie comments.

A flu vaccine is brought up because all people with heart illness are offered a flu vaccine, of course after payment. But the reaction from Olle is:

- I have a heart illness?
- Yes, Annelie's confirms.

The visit has now come to an end and Olle is leaving. It is a visit which has taken about half an hour.

What can be noticed here is that this space of care is constantly reproduced and it can not be mistaken for other than a medical space. Here we find patients with a diagnosis, instruments, people with white clothes and signs showing they are nurses with names. Olle is reduced to many measures and texts via different technologies, the list of elements is long, which all are then put together and create "pictures" that nurses like Annelie and other medical personnel will know a lot of. They have learned to connect these numbers and text into for e.g. the confirmation of facts of a heart diagnosis (and still do each day). Small and sometimes invisible things and practices are connected together with huge effects, like expert knowledge and a diagnosis.

Still there are other related activities with this visit for Annelie. Everything that has been written down must also be typed into an e-journal. These are words and measures which later on can be available for relevant medical professionals to read, and make judgements about Olle.

- This takes time, Annelie says and continues, and I am not educated in the computer either. But I have taken a course in typing which makes me use all fingers which make this a lot simpler and faster, too.

She continues:

- We have to go to meetings to keep us updated but then the work will pile up. I have a lot of overtime here which they would like to be invisible. At the same time they want more patients to pass through here.

The “invisible” overtime is related to their activities which are all planned and therefore no overtime should be produced. The meeting she is referring to is a meeting which is called APT, a meeting which the nurses at the open care centre (which includes DAGA) must attend to according to their manager (a former nurse). It is a meeting where some standard points are always discussed, for e.g. news is given about the hospitals or the wards latest accounting numbers which are also sometimes discussed. With these ideas and pictures of their activities they go back to DAGA and in different ways try to handle by translate it back to DAGA.

Annelie transfer Olle’s answers to standard questions and measures into text and the computer. Then she walks to DAGA 3. Here is a man called Jens lying on the bed to adjust the dose. He will be here for a couple of hours while the first start up dose is given and blood pressure is taken. Annelie goes back to DAGA 1 to read his journal and file about the medicine. She then checks the answering machine because when sitting at DAGA 1 it includes being available for phone calls but also calling people who need to be talked to. No one has called. After that she continues with Olle’s file. The paper she has been writing the answers on is also saved at DAGA. They give a better overview for their care than the patient e- file in the computer (Melior). If she or the other nurses at DAGA have any questions or have changed the medicine for someone she puts documents into a plastic map for the doctor working that day to verify her decision or to answer her questions. It uses to be a small pile for the doctor each day⁵. A doctor will later log in to the computer and sign what Annelie has suggest about the medicine for Olle. Then the papers will come back to Annelie which then makes the last notes about Olle in his journal.

The nurses at DAGA do other things that “normal” nurses do not. Not only are the specialists in the area of heart insufficient but they also evaluate and recommend changes of medicine which will be verified by the doctors. Still there are many things going on at DAGA at the same time as the treatment of people with heart failures. Things that will be integrated into the nurses’ everyday work in different ways. For instance, there is a competence program where the nurses are involved in evaluating and grading competence in combination with career sin the health care called CAT. Further the documents that the nurses have to fill in are not all about journals. There are many documents (in computer or on paper) to fill in for different purposes – there is a memory document, a statistical document to fill in, a **Beskrivnings- och ErsättningsSystem I Sjukhusens öppenvård (BESIS)** document, PAX registration⁶, a document for next visit and tests, and letters to be written and sent to patients.

⁵ As the Pelle a doctor comment on this pile, one nurse can have 8 visits during one day and some phone calls, and it takes him as a doctor about 15 minutes to comment the very qualified judgement and questions from the nurse instead of him meeting all of patients during 30 minutes.

⁶ PAX is an administrative program to book health care visits and payments.

At first sight the accounting numbers are not very present. For instance, the accounting reports are no longer sent to them since the year 2000. Instead the reports are handed by Mia, the nurse's manager. The nurses tell me that they do not use accounting reports in their everyday work. So does the accounting practice turn back with Mia? Well, not exactly. Even if Mia does not send the report to DAGA, Mia translates the results and moves these interpretations to the nurses via meetings, e-mails and informal talking. Mia then has these APT meetings which all nurses have to attend. The next time I visit them, I arrive according to the time we have agreed to, the door is locked and no one is there. Later it turned out they had to go to an emergency APT meeting. Mia had done this because the budget for the hospital had been exceeded. The focus of the discussion was due to what they could do to make their work more efficient according to Karin who had to attend the meeting. To get an idea of these meetings and how accounting discourse takes place an episode will be described.

On the first Friday of each month there is an APT meeting. Participants all sit at the end of the corridor outside Mia's room. There is a sofa and some chairs but that is not enough so whatever chairs that can be found are brought forward. There is no order of where to sit. But there is an order of what to talk about and who is in charge of the meeting which includes the latest financial situation. Mia has started a group of nurses who work with what to bring up at the meeting. The position of who has the chair, works as a secretary, etc. circulates among the nurses. After some short information, Mia writes BSC on the white board. She tells them that the letters stand for *Balanced Score Card* and asks them

- What is this good for?

After giving the audience the basic ideas about BSC Mia wants them to divide themselves into small discussion groups. The themes for discussion are; what are our main ideas for the open medical ward? What is important? Who are our groups of interest? She then moves on to the SWOT analysis which, after some explanation, could help to get the ideas flowing. Some trends of the discussions from small groups can be identified. One is the dependence of the doctors and the other is about the economic situation – can it be changed? Arguments are brought forward of how they can make things more cheaply and more efficiently. Mia talks about an article in the morning paper which discusses private clinics' efficiency. One idea is that they have control over tests which then can increase the profit for them. Others ask if they get about the same fees as the public sector. Mia's idea with this is to make them look upon what they are doing with new eyes and also to better motivate their activities. When the time is close to 9.30 many participants leave because the patients are booked in from that time – or to put it another way, there is no patients' time when this meeting is carried out.

In this context they are all learning how to interpret financial and non financial numbers. With the support of Mia and structured meetings and colleagues, ideas about relating these numbers to their activities are worked out and learned. As a former nurse Mia is hard to dismiss. And she has been working hard to get everyone relaxed and to speak out at these meetings. It seems to work now. Of course there are other situations where Mia talks about the financial situation and one of them is due to a new program. The program BESIS is a program to support the construction definitions about open health care which they have no option other than to accept. Here it also becomes visible that relating their everyday work and moments to these numbers has been practiced for awhile. They have been working with the BESIS codes on paper documents which will be done until the program is installed and they are trained how to use the program. Then the codes on paper will be typed into the program. This practice will be changed and instead be typed directly into the program. The new program and its practices will help them to connect and make them knowable about their medical practices as clear definitions for open care, as events for money value, just like they have practiced to connect measures and numbers to heart failures. It is practices that will take a greater part of their movements in their everyday work and perhaps be taken for granted or black boxed (Latour 1998).

As their spokes-woman, Annelie arranges meetings for DAGA nurses on Tuesdays. Here the discussion about the more practical consequences for DAGA is brought up, for example, how to increase the flow of patients.

- Our visits have to go faster, she argues. Today it takes about 1 hour; we could reduce it twice as much as today. Perhaps it is that we need other perspectives on our work?

One of the ideas is to just ask the most important questions in a short and precise way but also to give the visit the next appointment before leaving. Annelie informs them that the increase in flow of patients is an order coming from higher up in the organization and there is nothing they can do about that but then she adds:

- We have spoiled the patients and now we need to rethink and try other ways, Annelie says.
- I think we are really under huge pressure as it is now, Johanna replies.
- It is all about new ideas and trying new ways of doing things, Annelie answers and continues: We give so much information to our patients over and over again. The question is what we shall make the highest priority. Marianne says numbers of patients. We could, for instance, easily put most of the information into the first and the last visits.

The discussion goes back and forth and Annelie is pushing for new ideas to be tested. They relate to the time study of their work they did the week before and to some of the problems it revealed as a point of departure and also its solution. For example, the increased change of medicine to similar medicine. They might think about how these changes could have to do with asking questions about side effects. Do the changes happen because the nurses bring the alternatives up Annelie asks? She points to all the big medical surveys carried out that conclude shorter time spans for administering doses give better results for the patient. Some patients are more sensitive to the medication which must also be considered, but as Annelie argue and continues;

- For the others the time span to reach a target dose must decrease. Here we have assumed that everyone needs a slower increase of the dose. Now we have to reconsider and try other ways.
- When we succeed in shortening the huge queue to DAGA, we will receive gain later on, Johanna adds.

At the same time as they try to evaluate their work and get ideas of how to change things are done and questions are asked in a more efficient way, they also do things which they know fall outside their responsibilities and take time. An example is the woman who called and had no medicine left but is no longer a patient at DAGA. The procedure is to call the open care centre office and get a prescription from there and send it home. But Annelie knows that will take time and the woman will be out of vital medicine before the prescription arrives. So instead of 'let this be somebody else's problem at the centre' she solves it and the woman will not be without medicine.

The nurses at DAGA also provide Marianne with numbers which are related to each visit, such as diagnosis, age, new visit, telephone call (which is new category since September 2004), a document which then Marianne uses for her arguments of what is going on at DAGA in more specific details. The nurses fill the document in after each visit or when

they have the time to do so. Then the practical nurse types the numbers into the computer into an Excel file and sends it to Marianne, a file which then she uses in different contexts, but also which will come back as arguments for increased flow of patients.

One way for the nurses to handle this pressure is to carry out time studies of their activities. The ideas are to visualise what they are doing, for themselves but also for others who need to know, like Marianne and Mia. Annelie knows that numbers counts.

- It's taken some years to understand that but...It is about visualising what we are doing, learning from each other and eventually changing how we work.

To carry out the time study they set a period of when to do the study when everything seems to be as *normal* as possible, for instant no one is sick. Annelie designs two documents, one for activities around the patients and one for other activities. Activities for document one are defined, for example, as follows; Patient status, drug checking, documentation in Melior (journal) etc., or for document two, PAX work, telephone (prescriptions, change of drugs), e-mail (reading, answering), meetings, lunch, ladies' room, and administration. These documents together with a stopwatch will help them to define what there are doing and how long it will take.

Later I follow Karin while she is working and do the times study of her work at the same time. When I meet her she is placing her everyday work into the predefined categorisations on the paper.

- Meeting 1 hour, talk to Mia 5 minutes, a cup of coffee 10 minutes and ladies' room 2 minutes.

She starts with typing notes into the journal for a visit yesterday which she did not have the time do then. It was a visit that took a very long time. 1 and ½ hours and yet the information about the heart deficiency was not understood. As a professional nurse she is not very happy about this. This work is now done and translated into clock time as 12 minutes and written down in the document. Her next visit arrives and it is visit where the woman is anxious and experiences a heart that is not working and is in pain. The woman is sitting at the end of the desk and next to her is a printing machine on the desk which starts to print out papers. There is a soft knock on the door and the door opens. It is a colleague to Karin who has started the printer and has to get the printing. She reaches for the paper between Karin and the woman and then leaves the room again. When the visit is over Karin writes down 55 minutes. She uses her own watch to do the time study but the others have special watches. She starts to make notes in the journal again and looks at the clock which is 26 minutes to 11.

- Now the computer has stopped, she says with surprise and fear in her voice. Maybe the entire thing I have written down is gone?

Her fear lasts only for a few seconds.

- No it is still here, she says and smiles.

But the computer will continue to make fuss and she realises that this has to be recorded but the document does not have a heading for computer fussing. She adds one. Karin thinks the idea with the time study is good. It is some work with it but it is really good.

You can see where you spend your time. She registers the telephone calls which take a big part of their working time.

- It must be visible that we are needed, she adds.

The next appointment takes a long time and that is because the patient is new. Otherwise they try to make the other appointment shorter and more concise even if that is hard to do:

- Because they want to talk. To talk is a way of handling this illness. We can offer them a social worker who can help them if they do not have anybody to talk to.

I wonder if she has an idea of what will take most of their time.

- The documentation, without doubt, she says.

She has a phone call where she has to adjust the dosage. To give advice over the phone is one of the most difficult things you can do, she tells me. But when that is done she types it in to the PAX program which is good for our statistics but we then get money for it, too, she informs me. The day goes by and at the end of the day her everyday work is translated into a document, with categories and numbers related to objective time.

After the time study and an evaluation of the result it was decided to change the way they work. From January 2005 they started with something they call "Drop in" visits between 8-11 two days a week. The idea is to see people during this time who do not have a lot of problems, to do their check ups and let them leave. They can come whenever it suits them between 8-11 but have to wait if there are people before them (a number will tell them their place in the queue). The nurses think that if you do the necessary check ups, such as asking the questions, taking blood pressure, etc. It should not take longer than 10 minutes. With a 10 minutes' visit they could have 8 visits during this time and increase the flow of patients. They also send a letter to the people they want to attend these new visits-- people they think will fit in to this short visit – the 10 minutes patients. The letter will give information of how to act when coming during this time to make it a short visit. As Isabelle puts it

- The patient must be aware that it is short visit.

To see how these 10 minutes visits are carried out in practice I followed them in one day. It was the same day they have decided to do a new time study to evaluate this new way of working. One day in February I followed Emma.

When I arrive I meet Annelie and Emma. Annelie has a really big pile of plastic folders on her desk. These are notes she does have not the time to do because of a very busy day. There are 16 folders in her pile. But they have to wait a little bit more to be moved into the journal. Now it is time for a time study and visits. At 8.12 Emma's first drop in visit arrives, Anders. She asks him question with increased speed compared to my other visits. It is not in a stressful way but it is faster. Emma does all the things that are set out to do and it looks like an ideal 10 minutes' visit to me. Anders seems to appreciate the fast and systematic visit. The only thing that might slow the process down is that he needs a new prescription, and then he leaves at 8.28.

Emma goes to the ladies' room and stops the watch. She realises she has now included her ladies' room time in the visit time. Then she looks through the document to fill in and she tries to find toilet visits but can not find it.

- There are no toilet visits anymore, she says.

She tries to fill in the form as best as she can consider she has not checked the documents heading before starting the time study. Then she continues with documentation from the visit and then she shows me the new document that has to be filled in – the BESIS note. All codes will later be typed into a computer program. It is a new program that will be a basis for payments (and control) to hospitals for their open care visits. Different codes represent different activities that must be filled in; otherwise no resources in terms of money will be given to them the following year. This will be the basis for politicians to make decisions of how much money will be given to the open care in the health sector. The choice to participate in the filling in of the form is limited. She stops her watch again and tries to find a correspondence between her movements and the categories on the paper.

- It is not obvious, she says as she talks out loud. There are things that could fit in several categories. It is ambiguous, she thinks.

At a coffee break she studies the document to learn how it is structured in order to make it easier to fill in later. At 9.27 no more visits have arrived and Emma is getting nervous about how to handle 7 visits since now there is less time for drop in care. She tries to check who she is going to meet and do some preparations work. Then she sees something;

- This one does not seem to be a 10 minutes patient.

When looking at the visit list she realises that 2 patients can not be done in 10 minutes. One of them has difficulty in moving and it will take 10 minutes just to check the weight and get the patient up on the bed. At 9.47 a visit at last comes in. But it is not for Emma. She makes some phone calls and smiles when she notices that the phone has a timer and now she can just read 8:57 minutes and translate it to 9 minutes on her document. At 9.55 Emma's next visit arrives. It is a woman who also wants something for her flu which is not possible. She has to visit another doctor for that. After the check up she leaves at 10.13. The next visit sits outside the door and waits. This visit will take a very long time. She is not a 10 minutes patient. She starts the visit at 10.14 and leaves at 11.30. And that includes assistance from me in helping the woman who has trouble walking down to the entrance to get a taxi.

Emma handled 5 of the 8 patients today and the rest were taken care of by Annelie. They discuss which persons are suitable for 10 minutes from today's experiences. Annelie took the easier ones and that was no problem. The first visit Emma had today she thinks is an ideal 10 minutes patient.

While following the nurses through 10 minutes visit it is very rare that they actually do the check up in just 10 minutes.

But later on when they are doing the next time study Annelie sees that they have increased their efficiency from 4.8 patients per day to 5.2 patients per day because of the 10 minutes visits. Even if they know it is hard to keep the ideal visit up of the 10 minutes patient they have actually speed the visits up and they all think it is a fun way to work – then you have accomplished something.

The nurses do not feel that their everyday work is connected to accounting practice. Especially when the reports disappeared in 2000 (and Annelie do not miss them). Perhaps this is so because some practices in their everyday work and movements is already taken for granted and

therefore hard to notice or is not regarded as accounting practice. For e.g. their work with PAX, which is a program they have to use when making an appointment for each visit but also to registering phone calls. When doing so they describing which kind of appointment it is and then they connect the visit with money value. A visit to DAGA is 60:- and specialist doctors 300:-, but all are hidden behind a number code in PAX. But it is codes the nurses are well aware what they stand for. They press a button to connect their appointment with patients to money value many times during just one day. A click and 0: s and 1: s will transport these connections to a computer server and sent it to a printer which will print black ink on a paper, some called the income statement. For instance in the last report in 2003 in could be read that fees from patients was 81.000 SEK compared to budget 110.000 SEK, salary 838.000 SEK compared to 857.000 SEK in budget, and hospital internal costs 222.000 SEK compared to budgets 206.000 SEK. The income statement will continue its journey to Mia which will interpret the numbers and relate them to what they are doing and in this sense *return* to the nurses. At meetings Mia and the nurses will then discuss what this means and how they can make their work more efficient or just be informed of what they longer can not do. Even if the income reports are not returned as numbers on paper these accounting discourses and practices can and do connects to the increased flow of patience so no or little overtime will be claimed. What is not in question here is the relation the numbers claim to have of their work. More detailed accounting practice into everyday work for nurses is on its way. According to the politicians the numbers representing the budget and its outcome is not good enough. Not good enough to control and govern the health care for open care. BESIS this will be a solution to this problem, a program which the nurses from now on have no choice other than use – a new way of coding and knowing their activities in their everyday work.

The nurses are invited to start the education of how to use BESIS. Some of the discussion is about how this will increase their amount of time spent on documentation, something that seems to be increasing according to Mia and the nurses. They did their own study and found out that nurse use 4 hours per day to documentation and 1, 5 hour to meet patients⁷. While trying to orient them in the BESIS program and know the new codes they talk about what to registrar, and what to do when categories does not fit. They also discuss if the different diagnoses have different money values and which diagnose to use when there are several to choose from. They are well aware of the connection between this coding and money value even not yet in specific terms meaning exact amount of payment. Mia who guides them informs them about that today there is no relation between costs and revenues like for DRG and hospital care. They get an amount of money based on last years doctor visit as revenues and it does not matter how much you do. But now this is going to change, without registries their activities there will be no money at all. After some discussion the question is they should registries everything? Of course not, says Mia but it is not easy to decide what to visuals, because they all know what is put forward in numbers will count. And as she also mention, they have to improve to visualise what they are doing and also to get feed back. “We must get a better and more efficient system” as Mia adds.

In line with these ideas of visualising and evaluating what they are doing and get feed back the DAGA nurses not only did constant time studies but they also evaluated the 10 minutes visits by asking what the patient thought of it and made them fill in a document. When 12 patients had filled in the form all 12 was positive.

Discussion

While see accounting as a chain of translation and follow the object – the construction of “facts” about DAGA in money terms– the empirical descriptions above reports nurse’s

⁷ Internal report “Sjuksköterskans omvårdnadsdokumentation med och utan datorstöd – dess andel av arbetstiden”.

everyday work. Different tasks claimed space for time such as medical updates of people with heart failure, compulsory APT meetings where Balance Score Card is discussed and further learned, but also to get breaking news about exceed budgets, stop for new staff, meetings to discuss heart failure, administrative work especially text in patient files, learn new programs like BESIS and definition the get money next year and work to increase the flow of patience. In short it is a practice that is shown soon to be intertwined with accounting practice. In the middle of these tasks, they learn to use numbers, both financial and non financial, as a way to understand their own work but also to make arguments for their existence and eventually expanding way of organising health care.

The nurses like their jobs at DAGA which they find challenging and fun. They like to develop how things are done. They are open minded to new ideas but it is not always easy when the pressure from many directions wants their attention which must be handled. What to prioritise? What is important? But also where is the space for their own search for new things and experiences? The self evaluating time studies is seen here as a way to handle increased pressure from many direction. With self examining time studies, or specific time studies of already scheduled and budget money valued time, they interpret the possibilities to change how they work and increase the flow of patience.

They examining and evaluating their work and time and become self aware of what they are doing and where/how they can change things to increase output. Through these images it is also a way to show others that they are needed and when/where limits are reached. What to examine and visualize through predefined categories in the time study is therefore also an issue for debate and not always given. There is both as a discussion among themselves but also with the doctor, for instance if the visit to the ladies room should be included or not. Included or not, the time study seems to become a way to keep their initiative to shape what and how to do things, and with that some of the joy of working as a nurse at DAGA. But more things can be suggested to be happening here. Without numbers they have learned they are invisible. They account for their activities through numbers because they count. These number practices will give them experiences about the connection between movements at DAGA and its representation as numbers. And as such they become experts of defining and account for their movements down to minutes and seconds at DAGA. So what kind of meeting between two practices is this? How can it be understood?

To give some ideas about the relation between the two practices and some effects the use and relation to objective time is here central for both accounting and medical consideration. By relating the results from the time study of given scheduled time with no overtime and arguments of too much information to the patience is given, and the norm at DAGA to increase the dose of medication is to patience that needs slower period of increased dose, the queue is growing, and the priority of cutting the queue is a decision from higher authority which makes the change they have to make inevitable anyway, they create the 10 minutes visit. To argue for connection to the medical practise and its accountability is not so hard, and as Marianne says this is *the* argument. Still in this context it is shown that a lot of pressure and arguments do not only come from the medical sphere but also accounting practice which establishing references to produce facts about DAGA .

The intertwining of two practices can be seen when for e.g. when the nurses log in on the computer every morning. Then they counts as visible working hours and later on connected to value in money terms. The counting of hours and minutes will only stop when

they at the end of the day log off. It is not enough to just walk in and start working. There are computers placed at many spots at the hospital which contains a special program which they log in with personal identities for working hours counted. It is worth notice and may not be forgotten that to construct time as a distinct chronological event, to experience time as objective, it is necessary to see time as a numerical phenomenon (Crump 1990). The clock can be seen as a pedagogic device of how to keep the quantification of time as taken for granted. Ideas which has been taught and experienced since 13th century when the town clock began to emerge and taught citizens the invisible inaudible, seamless time was composed by quanta (Crosby 1997). A time connected to their working hours through a computer program that keeps tracks of their work hours produced. Hours that will be connect to money value but also to how many patients they can handle per day.

The flow of patient might rightly first be connected to medical arguments but the connection between objective time and money value will later on be visualised in DAGA's income statement translated by Mia is clearly present too. This is maybe not new, but first it is more integrated in detail than before due to more computer programs, and now self evaluating time studies. But it also have to be regarded in relation to several interrelated practices, like taking part of an accounting discourse and vocabulary, compulsory tasks of coding their movement for annual budget next year. There is a whole set of accounting practices which are connected to medical practices in their everyday work. Some already there some on its way. Accounting practice is well integrated with objective time in many ways as Frandsen (2004, 2002) discuss based on an anthropology study of a bus company. And with numbers claiming a relation to DAGA nurses also participate with their new knowledge in the accounting discourse and learn that (accounting) numbers also counts.

Account for time, is not then only a matter of medical accounts such as pulse per minute it is also an account for money valued time which here is connected together and effect what dilemmas will emerge in everyday work for the nurses. It happens because it is a way of knowing while and when establishing a relation between everyday work/life and numbers as facts and then translated back into everyday work. These establishing of associations to become facts and back, connect to our movements in life, (Frandsen 2004) have many similarities between medical practices of (re)creating facts about diseases, and accounting practices establishing relations between movements as events visualised in value in money. Objective time permits a reconstruction of space and spatial dynamics into revenue and cost-focussed time relations. These are practices which give grounds for experiences (Tuan 2001) and understanding.

Like for instance of how to establish definition of movements in small steps and link them to numbers, the use of technologies, sometimes fragile. The nurses use numbers and measures to make judgements about a person heart health and switch perspectives from a person sitting in front of them to numbers representing the same person just like turning a page. I suggest that small small practices will connect the medical practices with the accounting practice in the nurse everyday work with the help of education, documents, meetings, discourses, examination, evaluation and computer programs and mostly by using objective money valued time. It is a practice they will repeat doing many times, but perhaps more invisible, and which will add knowledge to the medical practices that will in some way be considered.

Even if some of the dilemmas could be said be related to accounting numbers in different forms it is like Power (2004, 1999) argues, numbers also give the ground for its own solution. The nurses reduce themselves to numbers of objective valued time and predefined definitions of their movements in everyday work, in a tiny space. These numbers will replace them as nurses in “here and now” in an face to face interaction with a person with heart failure, sitting close look into their eyes, talk with them, comfort them and call them by their names to quanta “there and then”. By this they increase their ability to account for their time in detail in numbers both to themselves and others. By evaluate and examine their own work constantly and come to learn how to create facts about their work and become experts.

By connecting their everyday medical work and movements with financial and non financial numbers to DAGA they learn over and over again that they belong together and that it can be viewed as such. This means that DAGA is not only a space for care and place for medical practice but also an accounting space (Frandsen 2004). They become knowledgeable about DAGA as both a space for care and accounting. This then could explain the tension the nurses feel between a long queue with most older people who need heart medicine⁸, and people who have the opportunity to get their medicine but who also needs time to talk and many times they have difficulties when the dose is right to leave DAGA because it feels safe and *scheduled* organised objective money valued time. Even if the argument for 10 minutes patience is based medical arguments the results of the change will fit into economic arguments, especially in relation to overtime and schedule. Time organised as schedules and calendar like Zerubavel (2001) argues is directly responsible for much of the rigidification (author's term) of our lives, but at the same time they can also be seen as the foremost liberators of the modern individual, as the nurses initiative of their time study could also be seen as.

The 10 minutes patience and the increase flow of patience is one effect of the objective time (and medical practices) but now more intense connected to money value, integrated in everyday work. The flows of patience have to fit into the schedule and ordinary working time, which here means Monday to Friday 7.30-16.30. And no other time which means no over time. Time over normal working time has a different value, higher costs. The time is also connected to different tasks the nurse are doing and they are well aware of the administrative tasks takes more and more time from the time with people with heart failures. Which gives the ground for discussion and calculation of who to employ, a nurse or a secretary? With a budget which does not permit more personnel the numbers are well involved in dilemmas the nurses feels of what to prioritize and try to handle in everyday work. It also seems to be an ambiguity between the focus on an output and process accountability (Olson, Guthrie, & Humphrey 1998).

Through times study examination and evaluation the nurses at DAGA makes new categories like the 10 minutes patient. When translating this category into practice they do it by trial and error practice and the ideal as a frame of reference. Perhaps they will be able to find the ideal 10 minutes patient, a patient that will not only have less problems with their illness, more or less everything time they have an appointment, and a patient that will in a way help to create its own definition by for example measure their weight before entering the room and play along with fast answers to fast questions. More, they as nurses will also be a 10 minutes visit nurse who will talk faster, ask fewer and concise questions and

⁸ According to Marianne and several reports the proportion of the population with hear sufficient it will increase.

move faster, the flow of movements as a higher speed. They do parallel things while talking to the patient, like change the paper on the bed. Make notes while the automatic blood pressure machine is working. The effect is not only a 10 minute patient, and decrease the queue from 4,8 patients per day to 5,2, not only to make them experience in skills of using numbers but and change how they account for their time, it will change them nurses too.

Objective valued time and self evaluating practices, in the chain of translation from and to DAGA is of great of importance, for it will keep them connected to accounting practice and its increased importance and pressure of everyday work. It will also be a part of the discussion at informal and formal meetings reinforcing its importance. The 10 minutes patient visit in practice is also extremely sensitive for things that are not to be included, for instance requirements for prescriptions, or too much or too open questions asked. Both the nurses and the patients are learning to become the ideal 10 minutes patient and nurse. Still this new way of working have made Annelie say no to more than 2 days a week for this kind of care. This is the limit because when it does *not* work their work will be affected as a whole for several days. These two practices does not only give knowledge and skill about how to visualise, understand and change how they work and make it more efficient, it also set limits for what is possible to do, to argue towards others who claim something else.

Some concluding remarks

What happen when two practices meet? What I have pointed to in this discussion is the similarities of two practices seen as a chain of translation. It is small practices in everyday work with huge effect both in its own way. I tried to discuss the importance of objective time as a meeting point (of several) of these two practices. Together with a set of many accounting practices and technologies the time study the nurses do it is argued here to have several effects. The most important one is the experience these small practices in everyday work frame. It is experiences that make nurses skilled in the use of numbers; it makes them knowledgeable about the relation between financial and non financial numbers and their medical practices carried out. It is a framing for understanding of what is going on and to which accounts, focus output, can be referred to. But it is also a way of defining things which both makes some dilemmas emerge and hand its solutions too. Further it is also a way to create space for initiatives and set limits for what it is possible.

These interpretations of these finding needs of course further considerations but also related it to other issues. On of these issues is the importance of key actors. The knowledge that numbers counts is something the nurses have learned through the years when accounts for DAGA have been made with the doctor Marianne (see Johansson, Dorriots and Frandsen 2005). Today their manager Mia adds to the nurses its importance. She tries to motivate the nurses through discussions and meetings of how to use accounting numbers to understand their work. In that sense Mia could also be seen as a key actor for stabilize management accounting practices by impose and encourage the use and thereby expands participants of these practices. This has to be further explored.

Second accounting practices, process of accountability and change of identities. It is argued here and in earlier work (Frandsen 2004) the relation between practices, experiences, and expert knowledge. Hunter (2005) discuss the medical profession in England which he describes as having different core values as a main explanation to why they do

not adopt accounting driven management. The nurses are more in line to adopt new practices. Kurunmäki (2004, 1999) reports, the adoption of accounting practices in Finland at least for the doctors who emphasize practices of a general educational institutional setting as a way to understand differences in adoption. In contrast Jacobs (2005) try nuance these findings from three different countries and claim that there is no general adoption among doctors of accounting practice and ideas despite these education and social institutions. It is more related to organisational structure of each hospital which doctors was related too. Still no of these studies do not set small local practices (Foucault 1979, Hoskin 1993) in focus and do not follow the object. With different conceptualising of accounting practice it is worth making some comparison in this matter. "In the interplay between practices and ourselves, as self-examining selves many possible relations then obtain", as Hoskin (1996) argue talking about '*the awful idea of accountability*', it is highly important to explore these relations here.

Third, to deeper the discussion of framing and exclusion when two practices meet where different dilemmas can emerge is also of importance. In this analyse it could be worth to put attention to the medical practices and the problem this in its self seem to come up with. Stolt (2003) talks for instance about the influence of the natural science ideas and practices into the medicine sphere which will be problematic if the human being is systematic reduced to an object and never recognised as a whole person, this would both violate and insult the person as a patient. The relation then to accounting practice seems to encourage this view. It is notices in Frandsen (2004) and here for instance where elements of delimit movements connected to money value also seems to encourage more detailed and fragmented medical delimitations and responsibilities. For instance at DAGA it is heart failure in focus and the need to talk could be handed over to a social worker (and with their budget). Here the chronically heart failure is taken care of and nothing more. Other sickness must be rejected and passed on to another doctors and in another places. In a sense the human body becomes as parts of its functions and sickness spread all over the hospital and sometimes the city too. To become a whole person is then perhaps not easy.

These explored issues will then add something about accounting practices and its importance. This does not mean that in this case that the medical practices have become secondary to nurses, no not at all, but it is a practice that changes how medical practise are looked upon and are accounted for and in this sense accounting practice is a powerful knowledge device.

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