

Managing the Health Care Practices by Relational Accountability: A Study of the Nutrition Care at a Swedish University Hospital

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Abstract

A current popular generalization is that accountability of health care practices is becoming transferred and “managerialized”. In recently published management studies this label is repeatedly applied to portray the transferability of the professional care skill, proliferation of standard accountability and spread of structural arrangement (Gray & Jenkins 1991, Humphrey et al 1993, Broadbent et al, 1996, Jones 1999). This paper focuses on the organization of the nutrition care and argues that the criterion of “managerial” accountability is less essential for understanding of the accountability of the health care practices. This paper argues that members of the nutritional care understand and use the accountability concept in terms of their “practical reasoning” i.e., the meaning of accountability is embedded in practical reasoning which is part of their practices. This will have implications for interpretation of how members of the nutrition care organisation practice accountability. By means of our study we could observe that members of the nutritional care organization construct their accountability in relation with mainly four bases. These are 1) patient, 2) colleagues, 3) knowledge and 4) personal engagement. The study concluded that organisational engagement for professional care services by means of networking is enduring.

Introduction

Health care professionals have been observed to face ethical dilemmas during the 1990s (Llewellyn, 1998b). The most common explanation to this development is associated with the growing significance given to financial arguments and requirement for practicing accountability in line with a language of finance. Others are related to the far reaching decentralisation of responsibility guided by accounting models as “Diagnosis-Related-Group-Prospective Payment System (DRG)”, Responsibility Accounting (RA)”, Balanced Scorecard (BSC), and Total Quality Management (TQM). However, the effects of the models are unclear and thus need further investigation, especially considering that the accounting profession are experiencing less ethical problems (Jönsson and Tengblad, 1994 and 1998).

Arguably, accountabilities for finance and accountability for healthcare practices involve in different vocabularies. Jönsson & Solli (1993: 304) have emphasized that, “Finances normally do not enter the professional discourse, other than as complaints about their inadequacy”. Thus, the formal language of accounting is a symbolic resource for management to practice accountability. In this paper we will provide some empirical evidences that can describe the accountability concept in action. We will argue that members of the nutritional care perform and use the accountability concept in terms of their “practical reasoning” i.e., the meaning of accountability is embedded in practical reasoning which is part of their practices. This will have implications for interpretation of how members of the nutrition care organisation practice accountability. Further, we will draw the attention to the notion of “vernacular accounting”. That is to say that it is quite possible that members of the healthcare organization use accounting vocabulary in their accountability practices, but such practices are “vernacular” meaning that they are qualified by members’ method of practical reasoning (Jönsson 1986).

The aim of this paper is to raise questions about the structural merit of management accounting in changing organisational accountability. In doing so, first, we present three different accountability frameworks, namely, managerial, political and professional and argue that these framework are involved to establish various line of relationships with accountability. Secondly, with the assistance of empirical materials characteristics of the accountability that are practiced at the operational level will be identified.

Managerial accountability

The concept of managerial accountability has attained a far greater importance following a period of “modernisation” initiatives in the public sectors. Introduction of “internal market” (Jones 1997), “customer” (Ying Hill 2001) and principal – agent or contracting (Broadbent et al. 1996) are examples of modernisation initiatives. In structural story telling, centrality of management accounting in changing the public accountability is strongly emphasized. According to Power (1994), accountability has become more complex as a result of the emphasis on accounting and ritual of verification (Power 1994). The applications of DRG, BS, RA and TQM in public sectors are examples that are used by researchers to emphasis the influence of accounting.

Basically, economic recession and the increasing difficulties in the 1980s to finance the resources needed in the public sector, can be seen as a background to the restructuring of public administration in the 1990s. As argued by a number of researchers, politicians and central salaried workers exposed to the influence of new management systems and outlook for restructuring the public organisations (Clarke & Newman 1997; Schwarz 1994).

Managerialisation hypothesis was initially introduced by Hood (1991) and repeatedly debated and applied by writers that believed in the idea that structure governs and determines behaviours and routines. In Sweden there are not many studies that tested the Hood’s hypotheses.

Undoubtedly, aspects of the public health administration have exposed to the ideas of managerialism (SOU 2001:79). In the mean time, there are no reliable evidences that could show that managerialism had a practical impact. The point that we will argue here is that the dominance of managerialism over the work process and accountability may be exaggerated. The approach of the research is to discover the view of healthcare participants on accountability rather than impose any particular definition or framework. We focus on accountability by reference to the particular setting in which it is embedded, and in this we find out that to which extent the effect of managerialism can be empirically validated.

Accountability of budgeting austerity

The story of political budgeting austerity is an alternative view of defining accountability. Healthcare organisations in Sweden are established by law and are accountable through their local and regional tier to their respective local governments. This line of relationship is political and characterized by local autonomy and self-government. Local governments collect their own taxes and are responsible for budgeting balance and resource allocation.

A number of Swedish research reports have examined the current reform of the healthcare organizations by means of operational evidences. With the assistance of case studies they identified examples of public reform, for example, style of control, adaptation of organisational forms, notions of efficiency, budgeting interaction that are politically administrated in order to encourage housekeeping. According to these researches, the current public reform is not related to the discursive dominance of rational /structural ideas of management accounting. Instead, they argued, the rise of financial difficulties has motivated re-orientation of politicians and administrators towards budgeting austerity (see e.g., Jönsson & Solli 1995; Czarniawska-Joerges 1998). They examine various management accounting models, such as TQM, BS, DRG and BS with an expectation of keeping budgeting balance and cost reduction. In cases that these instruments showed non-beneficial result the application of them are seized.

Further, observation of 60 years of public reform indicates that the “Swedish story” of reform is different from the one which the major bulk of literatures point it out as “managerialisation”. According to Premfors (1996: p. 7), the Swedish reform experience can be understood by reference to “some basic features of her institutional and policy heritage” rather than behavioural pattern.

In spite of this long standing experience, suggestions have been made that applications of financial instruments may create an accounting-led vocabulary for manifestation of accountability. For example, Llewellyn and Northcott (2004) has shown that in UK applications of these instruments, which is a part of governmental modernization of the health care sector, has created a new framework for the practices of healthcare accountability. According to these writers, these instruments construct “evidence-based information” for central decision making (p. 8). This type of experience should be viewed as a new mode of theorizing the administrative reform. By focusing on the operational accountability of the dieticians, this study attempts to show the validity of this latter type of view.

Professional Accountability

Professional accountability arises from networking and a style of organizational form that raises the possibility of exercising less overt control over individuals. The difficulty of defining and measuring the health care outputs, coupled with the existence of a knowledge-intensive work and strong clinical clans meant that progress for managerial and budgeting model of accountability becomes both expensive and difficult (Jones, 1997). In Sweden, provision of institutional facilities for professionalisation of work within the public sector is one of the basic governmental values (see SoS, 2000:11). Through institutional support various occupations, within the healthcare organizations, engage in the processes of professionalisation. The governmental planning experiences indicate that a focus on learning, knowledge, decentralization and professionalisation decreases the need of hierarchic management. The organizing idea of professionalisation as a method of administration obscures the validity of the relevance of managerialism.

According to Wilensky (1964: 138) the main criteria of professionalisation are two: “(1) The job of the professional is technical – based on systematic knowledge or doctrine acquired only through long prescribed training. (2) The professional adheres to a set of professional norms”. These two criteria are highly relevant for understanding of the meaning of accountability in relation with professional discourse. In Sweden, it is a part of political policy making to facilitate the improvement of work by giving support to professional identity, e.g. in terms of educational training, jurisdiction to occupational standards and competence development.

Further, the health care organisation has undergone a type of knowledge-led changes that have to do with medical advancements and applications of new techniques. Technical advancement brings up a stronger relationship between the profession and clients on the one hand, and between colleagues on the other (Wilensky 1964). In some, the work characteristics of health care provide a strong motive for the application of professional style of accountability in that networking and the need for lateral communication

Theoretical view

This section provides a brief references to a few studies that apply social theories in order to define accountability. The objective is to present a widening framework that can be used for the analysis of the accountability from the practical view point.

In the previous sections three types of accountabilities, namely, managerial, political and professional were defined. The concept of managerial accountability stems from the focus on the use of accounting for hierarchization of organizational units, responsibility and communication. In managerial sense, accountability is defined as a set of techniques for obligatory passages of management accounting and diffusions of rationality. Drawing on Roberts (1991) we can say that the use of a cost centre for controlling of an organizational unit (Anthony & Govindarajan, 1995) is not a “neural” process of data transaction. Rather, it constructs impersonal image of hierarchy and self visibility. Self visibility draws our attention to the accounting situations in which “we are kept anxiously preoccupied with securing self in relation to the objective standards of expected utility that accounting advertises and imposes” Roberts, p. 362). More generally, the involvement of accounting-led model of accountabilities is often interpreted as suppression of personal moral values (Jones, 1999; Goddard, 2004; Gendron and Cooper, 2001).

In contrast to managerial accountability, the political accountability is often defined in terms of its “personalized” and social practices. According to Sinclair (1995), the political accountability stems from democratic traditions of vesting responsibility in the public servant. In this sense, it is not an impersonal process and requires, e.g., personal responsibility for the use of public resources and results. Practices of political accountability are not precise and in many aspects bear little resemblance with “managerial” in which centrality of accounting is emphasized. Political accountability requires various channels of communication, ranging from newspaper, budget, accounting, to hearings, meeting and face-to-face contact with community members. Political accountability is the subject of claims by competing ideologies.

Professional accountability is more difficult to be defined. Meaning of being “professionally accountable” varies from one group to another group (Sinclair, 1995). Dent (2002) compared the professionalisation projects of German and Italian nurses and concluded that due to

differences in work situations and institutional environments, these professional groups raise different issues for their projects. According to Lindkvist and Llewellyn (2003) professional accountability has a personal and a community dimension. The work of professionals is less regulated by the system, and, they rely on their own professional knowledge. According to Sinclair (1995, p. 229) professional accountability invokes the sense of duty that one has as a member of a professional group.

The theoretical view of this paper will encourage mutuality between the three styles of accountability by introducing the concept of network. According to Czarniawska-Joerges (1996) the Swedish tradition of public management is more responsive to networks than hierarchies. There is a value in using the idea of network on the accountability studies agenda to incorporate that which is trusted or truly shared and which is undesirable or should be avoided. Further, the framework of network draws our attention to the notion of culture, for example clinical culture, and ethic of care.

In terms of network, accountability can be fruitfully interpreted as a social and as an ethical concept immediately. According to Jönsson (1996), the ethical frame of “trust” and the social basis of “reputation” promote responses in terms of accountability”. The ethical - social view of accountability helps involving the life-worlds experiences of the individuals as the basis of communication. With the emphasis of network there is an opportunity for individuals to develop a sense of following their own reason. The ethical frame of trust denotes the members’ practical competences and reasoning “to manage a variety of contingencies within the area of entrustment” (Jönsson, p. 103).

This study aims to apply the framework of network for the analysis of healthcare accountability. The output of nutrition care is ambiguous, meaning that its accountability requires a symbolic skill beyond the notion of management accounting. We must understand how the individuals who work with care develop a sense of “practical reasoning” and find out how such a sense is agreed with dialogue partners. According to Czarniawska-Joerges (1992), in ambiguous or abnormal situations, there is a required congruence between “act, actor and scene”. The nutrition practices is a “scene” for a highly skilled joint service production, interdependent flow of resource allocation, flexibility of actions and boundary crossing actors. These situations can be categorised as the spectrum of situations which can be categorized as

“abnormal”. They require a collection of classifying accountabilities based on the repertoire of accounts that have shifting orientations.

Method of data collection

For understanding and presentation of accountability, we collected three types of data. These are interviews, actors own documentation and organizational documents. In this paper, the interviews are the major sources of our empirical materials. We present some segments of the interviews which perceived being representative of the whole. We analyse these segments in order to characterize the accountability. We attempt to understand the features of the dialogue applied for creation of agreement upon “practical reasoning”. According to Jönsson (1996) the focus on dialogue discloses members’ orientation of interactions as well as members’ competence in building up the in-group trust. This paper conducted 20 interviews with dieticians and 3 interviews with managers in the nutrition care department. The interviewed persons are working at the University Hospitals.

As a complement to interviews, we had access to the personal documents and notes of a responsible manager. Personal documents disclosed a number of episodes in which organizational improvement was attained and responsibility for problem-solving was communicatively informed.

The organizational documents were studied in order to interpret how dieticians, as members of a care organization, seek communication with their environments. Study of documents helps identifying that how routine of the work is accomplished and became “patterned” for the context of accountability for the outer environment (see Jönsson 1996).

The field site of research

In recent years, organization of nutrition has been a focus of administrative evaluation. As a result of reform, responsibility for nutrition services was divided between Hospitals and Local governments, and as a consequence of this, nutritionists faced a new challenge for building a boundary crossing network. In order to overcome this challenge, nutritionists realized that their “professional identify” should be further emphasized. The enforcement of this identity can help members to improve the field of nutrition and scope of service obligation. A professional

identity based on knowledge reduces the hierarchic accountability and reinforces responsibility improvement and socializing forms of accountability (Roberts 1996).

In Sweden, the responsibility for welfare of elderly is divided between three levels of government. At the national level, the Parliament and the Government set out policy aims and directives by means of legislation and economic steering measures. At regional level, the county councils (21 in all) are responsible for the provision of health care. At the local level, the (290) municipalities are legally obliged to meet the social service and housing needs of the elderly.

In a governmental report (Vård och omsorg om alder – Lägerapport 2003), a division of responsibility between Local Governments and Hospitals was questioned. This division created quality problems. The division of responsibility was economically motivated (Ädel reform), but was not practically successful. Municipalities lack human and financial capacities that they can adequately apply for the elderly care. Additionally, a problem of “boundary creation” emerged (see Czarniawska, 1997) and the provision of health and medical care of the elderly faced organizational hinder. In the governmental report, it was emphasized that “boundary creation” led to the lack of co-ordination between Hospital and organizations of Social Services to improve the nutrition care capability.

According to an expert debate (published in GP 12 may, 2001) as the quality of elderly care decreases the number of malnutrition disease increases. Malnutrition disease is directly related to the division of responsibility and the need for the involvement of dieticians’ services. According to a series of research, lack of knowledge, insufficient competence and problem of routines are among the key factors that effect the treatment of malnutrition disease of the elderly (Saletti and Cederholm 1999, Elmståhl 1987, Unosson 1993, Cederholm 1994). The officials within National Board of Health and Welfare (Socialstyrelsen) have recognised these problems (SoS 2000:11). They point out two shortcomings; insufficient competence and “organizational boundary” as sources of organizational ineffectiveness.

Dieticians as a boundary crossing actors

Considering the scientific improvement that continuously changes the field of nutrition, it can be agreed that dieticians can considerably improve the current situations within the nutrition care. The medical skill of dieticians, combined with their professional jurisdiction, is a vital organizational resource that can solve many problems related to the area of nutrition.

Dieticians can provide highly skilled nutrition services at the Hospitals. They can cross the “organisational boundaries” to deliver their services to the elderly patients.

The empirical data that we present here narrate sequences of the accountability situations related to the dieticians’ work process. The first part describes how dieticians search after professional identity in order to receive recognition and improve their boundary crossing services. The second part provides some cues for interpreting that how dieticians as “members” of nutritional care understand and interpret their accountability in relationship with administrators and other members of the healthcare organisations.

In the Swedish culture of Hospital recognition of dieticians as professionals is a new phenomenon. The concept of dietician has existed for a long period of time without any connotation to the concept of professional. Studies of University Hospital indicate that it was in the 1960’s that the field of dietician received a formal acceptance. In those days there was no formal education rather individuals who had another type of education, such as kitchen and food education was employed as dieticians. In practice, the Hospital employed the individuals who studied ”nutrition economy” and had knowledge of ”mass production of food”.

Dieticians’ way to “professional identity” has then started from “the kitchen” and passed through the economy of “mass food production” towards a more established profession within the healthcare organization. *“One may argue that a passage from kitchen to the field of healthcare has been both a physical and mental travel.”(A citation from an interview with the unit manager for the nutrition care at the hospital)*

After this laborious passage, the dieticians have begun to reorient their services within the Hospital. Today, their services are related to the final stage of the health care which is organized as a chain of practices coordinated by interdependent units. This passage was possible, because the healthcare organization has gradually turned towards the culture of nutrition and the medical methods that appreciate the significance of the nutrition care.

Additionally, the individual dieticians found that their knowledge and their methods can be best applied at the final stage of the healthcare chain of practice. The conceptual “passage” of nutrition, as described here, became even a source of emerging culture that bounded the dieticians together. A dietician accounted this point in the following citation

“The nutrition care is a ‘health care-section’ and it is an institution that has its own culture; different from the health and medical care institution”. The emphasis of “own culture” in this citation addresses fundamental issues such as existence of “interdependency and “self-conduct” among the dieticians. Dieticians see themselves as a professional group. Their practices have a paramedical function which recognized within the University Hospital, in line with other professional categories, such as physiotherapist.

Dieticians interpret the key focus of their professional challenges in their *“struggle for achieving legitimacy as a professional group”*. They regard the use of scientific/technical and tacit/informal knowledge, in their daily work, and at different clinics, as a ground for legitimizing their profession. One dietician addressed this point by telling that *“We have a lot of informal aspects in our work process, as you know. However, it is the technical aspect of our capability which help to legitimate us as a profession... we can loose our legitimacy if we fail to fulfil the requirements. Beside this, we need an ethical code for the function of our professional activities.”*

An overall focus of the interview materials indicates that varieties of metaphors were applied to communicate the need of professionalization. The ethical code of conduct, exemplification of other professional groups within the hospital, qualification, and university education are a few examples.

One powerful metaphor used by a professor of nutrition is “hospital-family”. *“Doctors are the father who carry out the actions and represent the intellect. Doctors are wise man – let say grandfather - which exists in the background and is unapproachable. The nurses are mothers who carry out care. The nursing assistants - who help the nurses - are naughty little sister. In a similar way, physiotherapists are a cousin from the city, somebody who has relationship with the family, in the mean time they are not a core member of family”.*

Dieticians work closely with doctors. They are closest to the concept of “hospital-family” and that members of “hospital family” are all professionals. The metaphor of “hospital family”

creates a powerful sentiment for the processes of professionalization. One of the managers expressed her sentiment by giving a recommendation that ethical code of profession must be initiated and recognized at the level of national corpus; initiation at the level of local hospital should be avoided.

In the course of interviewing we realized that managers of nutrition care express these metaphors to facilitate understanding of both the *possibilities* and *constraints* that dieticians experience to attain professional identity. It also illustrates the dynamics that surrounds the dieticians who strive to establish a “new” relationship with “the family”. Establishment of a new relationship is problematic in several ways. Traditionally, food and nutrition is related to the woman’s role in “the family”. However, the dieticians are trying to convince the other professionals in the health care organization that “nutrition” and “medicine” is similar concepts. Physiotherapist and occupational-therapists can take patients from the health care organization and treat them on an autonomous basis. But services given by dieticians are basically structured on the basis of doctors’ recommendation. *“It may be interpreted as too extreme, but as a concept dieticians can be even translated as ‘doctor’s mistresses’.* *In this role, they feel that they are excluded from the hospital family. In some situation this has a potential to create conflict.”* (A citation from an interview with the unit manager for the nutrition care at the hospital)

The dieticians can be regarded as a group within the University Hospital who has a boundary crossing organizational form. In the beginning of the 1990’s the “purchase and sell” system was applied and as a consequence, dieticians began to “sell” their services to other departments or clinics at the Hospital. When this system was implemented, managers of the nutritional care realized that the department of nutrition should be expanded. *“At that time, I realized that ‘we are under-dimensioned’, our practices are in demand.”* (A citation from an interview with the unit manager for the nutrition care at the hospital)

In the beginning of 1990’s there emerged financial problems that required budgeting shrinkage and saving. Since that time, austerity has been constantly emphasized. The budgeting accountability has been intensified and the focus on the costs increased. In spite of this financial difficulty the dieticians have been able to develop the knowledge-base of their practices and size of organization.

The interview materials show that a common objective for dieticians is to develop a professional status. They believe that professional identity is an important factor for the space of action and situations in which their contribution are questioned.” *We must further develop what we are doing; we must develop our ability to verbalize what we are doing. It is important to have a collective vocabulary for what we do and a collective identity for our professional practices.*” (A citation from an interview with a dietician at the hospital)

To achieve the professional status, they know that their practices should be further improved and become visible. They know that a part of their action plans and method of treatment, which is tacit in nature, should be documented and explicitly presented. The dieticians use the concept of “Nourishment Diagnosis” to demonstrate their communication capability. By this concept they inform others about their plans and actions. The concept of Nutrition Diagnosis helps the dieticians to show their knowledge of nutrition and competence in explanation. Through this concept they coordinate communication with the other professional groups in the Hospitals and with patients who are under the treatment. One of the interviewed dieticians is pointing out the connection between tacit and explicit knowledge in this way:

“Professionalisation means to use the tacit knowledge as a point of departure. The tacit knowledge is also behind the attainment of document-based knowledge; nutrition-knowledge is based on repeated and validated experiences.” (A citation from an interview with a dietician at the hospital)

One dietician emphasized that it is important for us to “*do a good job*” both in relation to the treatment of patients and in relation to the team of professionals that are surrounding the patient. “..... *Since our practice is based on a purchase/selling system it is very central to do a good job. Otherwise, they will not buy our service.*” (A citation from an interview with a dietician at the hospital)

The dieticians that we interviewed believe that their success should be related to a historical process stemming from the change that occurred in the management of Hospital. “*We are basically the biggest unit in the country within the surgery clinic. It is not by chance that we dared to take responsibility where colleagues in other parts of the country perhaps did not dare, improvement in medical treatment and existence of specialist physicians are the basic motives for our initiatives.*” (A citation from an interview with the unit manager for the nutrition care at the hospital).

The patient is a key concept when a dietician describes her everyday activities. The dieticians label their practice as “nutrition-treatment”. The goal of the treatment is to optimize energy (sustenance) through nourishment by consideration of the patient’s condition.

Dieticians emphasize that in working with patients the primary key activity is competence in dialogue. Through the dialogue a dietician finds out if her/his method works or other method should be tested. *“I talk to the patient first to get a picture of what he or she thinks and to define the problem. Then I summarize the situation and use it in the discussion about the treatment plan with the nurse and doctor. I am trying to define the problem, find a solution or present a solution in discussion with others.. If the patient gets a better nutrition status they are also responding better to the medical treatment. In that perspective, the nutrition treatment is also profitable from a financial view.”* (A citation from an interview with a dietician at the hospital)

Nutrition is based on lateral communication. Dieticians are depending on their *colleagues* when they work with a nutrition treatment. *“A success in nutrition depends on the interest of the doctors for nutrition issues. When the doctors are interested in the method of nutrition treatment the field of nutrition becomes important.... Our work depends on, not only the attitude of the doctors, but also on the attitude of the other staff”* (A citation from an interview with a dietician at the hospital)

The respondents point out the doctors, the nurses and the assistant nurses as the core professionals. Consultants, for example, dieticians, physiotherapists and occupational-therapists are defined as distinctive groups who surround these core professionals. The decision-making structure differs between departments or clinics but in the end the doctor has a great influence over the treatment of the patient by method of nutrition. The dietician can only recommend but not decide on the application of their method. The communication between colleagues is both orally and by means of the written computer-based journals.

In many situations dieticians and nurses work together, especially in situations in which nutrition has less to do with medical care. The dieticians decide for a nutrition treatment plan, but it is the nurse that is carrying out the treatment. The nurses together with dieticians are responsible for the clinical evaluation of the nutrition treatment in relation to patient.

Another organizational constellation is the relationship between managers of the department and managers of the unit. The head of the department is in charge of the strategic and operative plans of the department. This person decides about nutrition treatment in regards to the patients that are treated in the department. The head of the unit is responsible for the budget that includes the cost of dieticians. By controlling the budget this person has a great influence on the time and cost of the nutrition care that a unit “buys” each year.

Beside, the communicative roles of patients, colleagues, budgeting department and management, knowledge and personal engagement are highly appreciated. The dieticians repeatedly emphasized the importance of developing the professional knowledge. *“You have to develop your knowledge about nutrition issues all the time, you have to be updated about the latest news in the field. But it is also important to understand more about medical treatments and their consequences. You need to be able to grasp the whole context and of course it is easier if you have knowledge about the medical side.”* (A citation from an interview with a dietician at the hospital). Dieticians relate their effort for knowledge attainment in regards with the context of professionalisation. As we saw before the dieticians identify themselves as an emerging group in the health care organization and for interaction with other groups they need to go through a professionalisation process.

The *personal engagement* of the dietician is embedded the stories given by them about the role of nutrition treatment in the healthcare. *“The managers of the nutrition care are very engaged in nutrition issues. They are working day and night. And they are updated about the latest results of research in the nutrition field, both in the national and the international field. They are pushing everybody else at the nutrition department to keep updated.”* (A citation from an interview with a dietician at the hospital).

During the course of interviews we heard a shifting stories that together point out the dieticians’ engagement in their work, stories that recounted the importance of professional identity as a basis of “doing a good job by means of nutrition knowledge” and stories that described obligation and responsibility for the consequences if a patient get a nutrition treatment. In the final section, we attempt to summarize our finding and develop some accountability concepts obtained from the interviews.

The observed accountability

The accounts presented above, illustrate the governance of “practical reasoning” with shifting focuses and proliferations. The dominant concepts that capture accountability have emerged from the engagement of the organizational participants for improving four practically reasoned key relationships, namely (1) patient, (2) colleagues, (3) knowledge and (4) engagement. These four accountability relationships are repeatedly conceptualized and emphasised in the course of interviews. By means of these key relationships dieticians have communicated that they are accountable primarily for contributing to the attainment of professional nutrition care which is also one of the strategic objective of the welfare society. Further, by emphasising on these relationships they have communicated that professional identity has a productive effect. It helps strengthening trust or expectations that their works, in a visible and routinized way, are skilfully conducted. Construction of vocabulary around the nutrition care, as stressed in the interviews, helps strengthening trust through manifestation of competence in inner and outer communication. We may say that a common vocabulary increase the capacity of the “members” in networking or establishment of lateral relationships. According to Jönsson (1996, p. 113), “Conversation between competent actors, who mutually recognize each other as competent, seems to be the crucial factor in the establishment of lateral responsibility relationships”.

Jönsson (1996) further argue that the inner and outer dialogue in the team generate successful problem solving capacity and help constitution of social identity or role. Professional identity provides an opportunity for each one of these individuals to improve the inner dialogue within the members. The inner dialogue help participants to develop a sense of following their own reason, or the reasons attained in dialogue with members.

The outer dialogue helps the dieticians to construct their social identity. They need to be recognized as a competent group. In terms of professional work they will declare that they are capable to be held accountable for the qualified nutrition services that society demand. It is a form of governance by networking, thus reducing the need for hierarchical control over behaviour (Jones, 1997). As emphasized by power (Powell, 1991), networking focuses on lateral patterns of exchange and reciprocal lines of communication. A search after professional qualification is in fact a networking response arisen from the need for flexibility, boundary crossing, reducing uncertainty, managing joint services and knowledge intensive organization (Jönsson, 1996; Powell, 1991; Jones, 1997).

In sum, our study shows that accountability of nutrition care is not a functional adaptation to the mega-trend of management accounting as it was hypothesized by Hood (1995). The micro focus of our study shows that the influential role of “New Public Management” in the reproduction and transformation of organizational life is exaggerated. The organisational attention is not on measurement of outputs and creation of performance indicators. Further, a temporary budgeting austerity imposed by central government should not be regarded as a sign or an incentive for the adaptation of businesslike control model. Instead it was showed that professional incentive for a networking model of organization is a dominant trend. Our data demonstrate that accountability is constituted by practical reasoning, networking and lateral responsibility linking. What is accountable is also negotiated through the stream of dialogue inside the members and by means of categories of accounts that have shifting orientations. Further, our data shows that in order to construct social identity, and attain trust and appreciation for their performances, dieticians have developed their communication capability through the knowledge intensification of their work and vocabulary construction. Professionalization of work through knowledge intensification and vocabulary construction are interpreted as attributes of networking aimed to work improvement. Professional identity - which is supportive of a network style functioning of organization - arises from the need for boundary crossing and reciprocal lines of communication between healthcare memberships.

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