THESIS PROPOSAL

Re-assembling transversal management in hospital service

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March 17th 2014
Re-assembling transversal management in hospital service – preliminary reflections (version nr. 11)

Outline
Through empirical observations and document analyses this thesis elucidate how transversal management matters in the context of hospital management. The purpose and contribution of the thesis is to show the how the idea of transversal management comes in many versions and how these versions constitute the managerial conditions and expectations to what hospital management is and can be. In this thesis I construe the idea of transversal management as an entangled, fractal non-coherent phenomena shrouded with an intriguing ambition to establish the opposite namely hospital coherence and continuity within health care processes.

Through “thick” empirical fieldwork conducted at Aalborg University Hospital (AAUH) and by interrogating documents such e.g. literature on health management, policy documents, legislations and building plans the thesis elucidate how they enact partially connected versions of transversal management and their concomitant expectations to hospital management. Thus the hospital service of northern Jutland, theories on hospital management and health care processes, political regulations and standards, architecture, technological artefacts and financial conditions partly and together mobilise series of expectations to what hospital management can and should be.

All of these are important entities in defining and pursuing the idea of transversal management including the hospitals general ambition of hospital coherency and continuity within health care processes. Hence the overall thesis I present here is that the very idea of transversal management as what is needed to establish hospital coherency and thus continuity within health care processes can be understood and described as fractal and multiple in the sense that it does not belong to any particular location or reality but comes in many versions.

Considering the formal backcloth of this paper described as a thesis proposal it does not propose a distinct thesis to be confirmed of falsified. What this paper proposes is one way to study hospital management namely through the vocabulary and methods of Actor-Network-Theory (Latour 2005, 1993) and science and technology studies (Mol 2002, Callon 1986). Thus, readers unfamiliar with ANT and the broader research field of science and technology studies (STS) that it is part of will have the opportunity to be introduced to key concepts, ontological and epistemological outsets.

Through the vocabulary and methodological stances of ANT which will be explained in details in section two, the very idea of transversal management is viewed as a multiple and partially connected dynamic network of heterogeneous socio-material relations comprised by entities such as policy documents, strategic plans, managerial practices, health technologies, architectural arrangements, theories on management and so forth.
Partly and together all of these entities and their entanglements mobilise various expectations to how management of hospitals and health care processes should be conducted.

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In **section one** I give a brief overview of some of the challenges and managerial voices that characterizes management in Danish hospital service and I also account for the recent managerial initiatives that the University Hospital of Aalborg has established in order to handle these challenges. On this basis I present the thesis’ main research question. In **section two** I unfold of the epistemological and ontological outsets of STS and ANT and I present some of the key concepts of ANT. The section concludes with a small analytical excerpt to illustrate how an ANT analyses can be conducted.

In **section three** I account for the empirical fieldwork I have conducted so far by describing how it were mobilised and by presenting a cartographic view on hospital management as it has emerged so far by following the idea of transversal management.

**Section four** accounts for the analytical strategy that has been develop so far as a four “knifed” apparatus to explore the expectations to and in hospital management and how they are translated into various versions of the idea of transversal management. This section also engages with methodological implications of drawing on ANT and how it has been further developed into a so-called post-plural attitude. **Section five** concludes the paper with an updated time and task schedule before handing in the dissertation.

**SECTION ONE: MANAGERIAL CHALLENGES IN HOSPITAL MANAGEMENT**

According to several observers the Danish welfare system, including health care and hospital service, is under massive pressure due to increasing structural and economic conditions such as an increase of the elderly burden, rising expenses of health care treatments, new treatments, a changing pathological picture and rising demands from patients (Indblik 2007, FOA 2010).

Scholars of public management have elucidated how the very conditions of welfare management are characterized by differentiation and steering complexity, management of self-management and a continuously restructuring of organizational boarders (Sløk & Villadsen, 2005). Hence, the welfare state has responded with new politics of modernization that “instead of aiming at the public sector as a whole gradually aim at each separate area of service- and administration, the particular organization and even the individual employee.” (Pedersen 2007:10, my translation). Unsurprisingly, fragmentation and lack of coherency in health care management has been a central topic in debates on hospital service (Seemann et al 2011).

Apparently, the hospital service of Northern Jutland responds to these challenges by launching an immense long term organizational change program with the overall goal of establishing more coherency within the continuity of health care processes and to address future managerial challenges where management ’has been [too] focused on
hierarchic and vertical management but should also prospectively engage with transversal and horizontal management, where functions and processes should interconnect crosswise” (Region Nordjylland 2012, my translation, underline in text)¹.

Two core elements constitute the change program: A discontinuing of the previous centre structure (figure 1 and 2) at the expense of a new team- and clinic organization (Ibid)². Among other things, this means that all head nurse positions are abolished and eight new managerial functions, entitled ‘vice clinic manager with responsibility for health care processes’ has been established. Hence, the management structure is completely revised on all hospitals in the region in order to satisfy expectations related to the overall improvement of health care processes.

Thus, the development of a new managerial structure comprised not by four centres but eight so-called clinics can be viewed as a curious attempt to translate the above mentioned structural and economical conditions of management. As it appears from figure 1 below, the previously managerial structure was organized around four centres and four heads of centres:

![Organisationsplan over Aalborg Universitetshospital pr. 19. dec. 2012](image)

Figure 1: Previous managerial structure of AAUH dated December 19th 2012, located at their website. A few months later the managerial structure was designed as illustrated below in figure 2.

1 However, I have come to notice an alluring twist to this vagueness related to the very invention of the change program. Thus none of the informants I have talked so far has been able to give any detailed account of the

2 Authors of the change program indicate that the organizing of hospitals in northern Jutland is basically unchanged since 1984 (Region Nordjylland 2012:2) which is surprising because I found that two financial employees were talking about how everyone were just started to get used to the new center structure implemented only four years earlier.
Figure 2: Excerpt from the change program illustrating the present managerial structure divided into eight clinics (Region Nordjylland 2012:17).

Each of the eight clinics are organized as illustrated below:

Figure 3: An illustration of how the new managerial structure is organized in the clinics that has been established as a consequence of the change program.

Thus, the core elements of the change program is the establishment of a new managerial structure along with a new management position dedicated to facilitate and enhance the continuity of health care processes across health care specialisms and other involved parties such as the municipality of Aalborg, local doctors and patient associations. By establishing this new function the importance of transversal management is highlighted as a key element in the coordination of relations through team organization: “Team
organization is one way to structure and systematize the relational coordination needed to achieve coherent health care processes” (Region Nordjylland 2012:12). Hence, the overall managerial expectations to hospital management are motored by the idea that a new management structure along with a new managerial position and team organization as one way to enhance relational coordination can contribute positively to the continuity of and coherency within health care processes.

As noted, transversal management comes in different versions and I take the change program to represent just one such version. Other versions of transversal management also exist such as e.g. political regulations, technological solutions and managerial theories. By following these versions and their entanglements which form the present “solution” to the problem of hospital coherency and continuity within health care processes the thesis elucidates past, present and future managerial expectations to the organization of hospitals.

Thus, this thesis explores the intricate entanglements of various versions of transversal management and their concomitant expectations to the management of hospitals in general and health care processes in particular by asking **how the idea of transversal management matters in managing hospitals and how this idea mobilizes various expectations to what management is and can be?**

In tune with ANT’s theoretical principles³ (Callon, 1986) and newer writings on methodology (Law 2004, Gad & Bruun Jensen 2009) (see section two) I deliberately formulate my research question in a broad open-ended way to recognize both its heterogeneous nature and to avoid any deterministic approaches interested in defining it. Thus, I let anyone else but me define what transversal management is and should be.

Yet, this stance immediately produces a dilemma. How can one study something without knowing what it is? The epistemological constructivist tradition suggested by e.g. Åkerstrøm Andersen (1999) the empirical does not call for any specific ways of being observed implying that the researcher should thoroughly consider how ones observations co-constitute the observer as well as the observed by developing a clear cut analytical strategy capable of precisely accounting for what it can and cannot observe.

On the other hand, however, the actors that constitute the empirical material of many studies within social science would of course be interested in “true” representations of their reality. Hence, one cannot presume that informants claim specific ways of being observed neither that informants do not want to be represented “properly”. I touch briefly upon this dilemma in section four by drawing on Anne Marie Mols notion of multiplicity (1999, 2002).

³ I account for these principles in section two
As a preliminary remark regarding the research question I want to make clear that studying an idea and its concomitant expectations never just reside on a particular isolated location. Expectations, visions, promises and hopes do not just occasionally crash into reality but depart from existing socio-material phenomena that opens and closes horizons of possibilities (Langstrup & Vikkelsø 2014:395). Hence, the thesis’ empirical “object” is transversal management as an idea that comes in many versions packed with expectations and distributed around the vast network of hospital management. Following this line of thought, the research object bot is and is not a well defined or easy to locate “thing” and I therefore find it necessary not to restrict my analytical scope to define transversal management or focus exclusively e.g. the health care manager, policy documents or technological entities.

The aim is to explore transversal management as an expectation-mobilizing idea entangled in a socio-material network of entities comprised by health care managers, policy documents, various theories of management, architectural and technological arrangements and much more.

SECTION TWO: ACTOR-NETWORK-THEORY – AND ITS “WHEREABOUTS”

Actor-network-theory arose from science and technology studies developed in the 1980’s by sociologists of science John Law, Bruno Latour and Michel Callon. These scholars developed an approach and a vocabulary for zooming in on the every day practical processes of construction as an alternative to traditional ideals of natural science claiming to have privileged access to ‘true’ knowledge. In the 1970’s sociologists became increasingly interested in natural science as a social phenomenon conveying cultural and collective understandings of what knowledge. This approach was described as social constructivism because knowledge and even nature was perceived as socially constructed – that is as a consequence of social processes. (Ratner 2013:37-41)

On the one hand ANT supported the idea of the constructed nature of reality but also broke with the concept of the social as a frame of explanation by problematizing the very distinction between nature and the social. Instead of exclusively focusing on social categories such as interests or culture Latour and his colleagues sought to interrogate how various actors, humans and non-humans collectively, participate in the construction of knowledge. In order to e.g. write a scientific article of a mouse it is necessary to draw on scientific equipment for measuring, experimental mice, diagrams and other articles. (Ibid)

Knowledge does not exist as a fact waiting to be discovered but emerges whenever connections between e.g. mice, equipment and other articles have be established and stabilised. Thus these connections form a network of actors in which knowledge is distributed and whenever another actor is added or removed it entails a change or rather a translation of the entire network as well as the individual actors. E.g. scientific equipment translate the mouse into a series of numbers and again they become
translated whenever they are copy pasted into scientific writings in which they obtain new meaning when associated with other texts that appears as references (Ibid).

Paramount to ANT and the mouse example above is the methodological principle of generalized symmetry\(^4\) requiring the researcher to draw on the same concepts regardless of the phenomena studied. This means that any sociological concept comprised by an asymmetrical focus on the social e.g. ‘habitus’ or ‘social interest’ becomes irrelevant because they are not able to account for non-human actors their role and their effects. The theoretical implications of engaging with ANT is that the researcher should follow any actor of interest across all types of connections such as financial, technical, political, linguistic, practical and so forth. (Ibid) Thus, ANT can be viewed as a response to social constructivism with its concomitant perspectivism more or less disregarding how technology and other non-human actors matters in organizing and stabilizing the social (Latour, 1991).

Instead of perspectivism or social constructivism Latour describes ANT as a realistic constructivism (Latour 2005:88-93.) Realistic constructivism regards any network building activity as a process of distinguishing between the conceptual and the empirical. Put differently, in building networks actors develop and are guided by a range of “home made theories”.

Even though the spectrum of constructivism is widely stretched (Andersen 1999), for some reason, these researchers privilege language, discourse and culture and nourish little interest in materiality, nature and technology. Thus, ANT holds a strong analytical potential because it continues the relation and language oriented perspective offered by constructivism while also including artefacts and materiality in understanding the social (Latour 1996, 2005, Jensen 2005).

This socio-material arrangement of various human and non-human entities are key in understanding ANT both as an analytical stance and as a theoretical critique of the “sociologists of the social” who continue to follow the Durkheimian perspective on society as a particular domain sui generis using it as an existing cause instead of a possible consequence (Borch & Madsen 2005, Latour 2004:230). Latour elucidates a core problem in the way that sociologists establish their critical gaze on the social by suggesting that in following their line of thought we “have to learn to become suspicious of everything people say because of course we all know that they live in the thralls of complete illusion of their real motives.”(Ibid: 229, italic in text). What Latour polemically is hinting at here is how sociologists have come to cherish “powerful agents” of explanation such as society, discourse, knowledge-slash-power, fields forces, empires and capitalism (Ibid).

This shift from viewing powerful agents as a privileged factor of explanation to a possible consequence of how various actors become assembled in socio-material

\(^4\) I account for all principles of ANT later in this section
networks constitute the theoretical footing of this thesis. Instead of analysing hospital management as a representation of discourse, power/knowledge relations or processes of socialization, fields of forces and so on this thesis unravelled the socio-material arrangement of hospital service “simply” by asking how the idea of transversal management matters in managing hospitals and how this idea mobilises various expectations to what management is and can be.

Thus, ANT can be viewed as a curious paying attention to classic dichotomies of social science such as subject/object, nature/society, technology/human, micro/macro performed by a broad range of actors that do not solely belong to the realms of science. These dichotomies and can be observed among managers, politicians, in families, in schools, workplaces and not least among scientists. Because researchers of social science continuously draw on these distinctions as a matter of course with little interest in their historical and socio-material constitution Latour argues that we have never been modern (Latour 1993:17). Hence, social scientists keen on explaining the social by means of these dichotomies become entrenched in a somewhat disappointing oscillation between micro and macro level observations: “Social scientists soon realize that the local situation is exactly as abstract as the so called ‘macro’ one from which they came and they now want to leave it again for what holds the situation together. And so on ad infinitum.” (Latour 1999:17)

Yet, the ambition of ANT is not to overcome or do away with these dichotomies but to curiously:

“...explore the very conditions that make these (...) disappointments possible. By topicalizing the social sciences’ own controversies ANT might have hit one of the very phenomena of the social order: may be the social possesses the bizarre property of not being made of agency and structure at all, but rather of being a circulating entity.” (Ibid. 17.)

Instead of recognizing how ‘the social’ or ‘society’ became an idea distributed and circulated through various actor-networks social scientists asymmetrically and endlessly shifts between local face-to-face interactions and macro structuring elements such as culture, structures, norms and values when searching for an explanation of the social. Thus when following the idea of transversal management through the network of hospital management it becomes curious to explore the processes by which actors create lasting asymmetries (Latour & Callon 1981). E.g. when professional health care managers engage deeply with theories of relational coordination (Gittell 2009) and LEAN thinking (Womack & Jones 2003) reproduce the idea that humans, their relations and abilities to minimize waste are pivotal to hospital coherency and efficiency.
Theoretical principles and key concepts of ANT in relation to transversal management

Three principles characterize the ANT way of doing research: ‘generalized agnosticism’ emphasizes that the researcher adopts strict analytical openness regarding all actors and do not sympathize in particular with anyone – humans and non-humans. So far this principle has made me aware of how hospital buildings, health equipment, economy and political standards are entangled entities that contribute to the shaping of the pre-conditions of management. This awareness dawned on me as I participated in a meeting concerning the buying of new specialized and highly expensive washing machines and drying cabinets for cleaning surgery tools used to do bronchoscopy. Also at this meeting a nurse repeatedly expressed anxiety and worries concerning some issues that I interpreted as related to the new managerial structure. Knowing that the change program had affected many employees I found it difficult to support the vice clinic managers critique of the nurse arguing that she would just have to do something instead of complaining.

The second principle is that of ‘generalized symmetry’ entailing that the researcher always use the same analytical concepts on all phenomena. This means that the researcher should engage with ANT’s so-called infra-language. The infra-language is deliberately depleted of meaning suggesting that the researcher allow for the concepts of the actors to be stronger than that of the analyst (Latour 2005:30). Moreover, this means that the researchers analytical concepts should not be replaced due to the phenomena encountered (Callon 1986:17). E.g. when a managerial theory of relational coordination (Gittell, 2009) become highly recognized within the hospital service of Northern Jutland the researcher should not embrace this theory but describe how it is connected to other actors and in hospital management and how it may add meaning to the idea of transversal management. Thus, I would analyse such a theory as a non-human actor that matters to health care management in the sense that it performs a particular version of transversal management highlighting the importance of human relations.

‘Free associations’, is the third principle, and calls for the researcher to abandon all a priori distinctions between natural and social events (Callon, 1986). Instead of imposing a pre-established grid of analyses one should explore the manner in which actors “define and associate different elements by which they build and explain their world, whether it be social or natural (...) without locking them into fixed roles” (Ibid:4, 17). To me this principle entails a fruitful analytical force of contingency, in the sense that e.g. actors might be entitled managers, consultants and secretaries but these entitlements and their accompanied expectations do not necessarily convey good accounts of the state of affairs. E.g. the CEO of hospital administration in Northern Jutland is may be interesting to interview not because of his hierarchical position but as an actor that other actors in the network of hospital management delegate agency and thus responsibility.
Through these principles ANT can be described as an ontological relativistic gaze offering an understanding of the social that include both humans and non-humans and a refusal to know in advance what constitutes the realities of the particular network of interest. The three principles are to ensure that researcher follow the actors and their descriptions of reality instead of imposing particular favourite explanations e.g. sociologist explaining everything through concepts of power or meaning while e.g. researchers of communication and knowledge explains everything through these very concepts (Langstrup & Vikkelsø 2014:389).

Because of these “how-to-study” principles actor network theory can both be understood as theory and a method for studying the social. Consequently I draw on ANT as a “theory-method” for unravelling the social-material arrangement that constitutes hospital management and the idea of the transversal management. Thus, the interest of any ANT inspired study is to view organizations as socio-material arrangements that constitute a network of humans, technologies, ambitions and controversies that have a history and entail compromises (Ibid:383).

Key concepts

NETWORK
Networks arise whenever various actans such as humans, language or things become associated and the network change whenever an actant is added, removed or translated. Hopefully the reader has noticed that the concept of network should not be understood as a theory of social or digital relations but rather as a dynamic and process oriented concept for studying how actants are and become associated (Ratner 2013:41). Following this understanding of a network enables the researcher to explore how e.g. an idea of innovation, a cord, a theory, an organization chart emerge as an actor-network (ibid.) which in this thesis concerns the idea of transversal management.

ACTANTS
In ANT the concepts of ‘actor’ and ‘actant’ are synonymous but the latter more precisely denote that both human and non-human actors can act. Actants emerge and transform as a consequence of the network they are entangled in and they only matter in so far as they are related to other actants in a network. This means that actants never exists outside the network because this very network delegates their size, interests, roles and competencies (Ratner 2013:44). An entity can only become an actant if it is capable of either affecting the network or if agency is ascribed. Thus ANT’s concept of agency can be described as minimalistic and distributed. Minimalistic because it discards notions of autonomy, power and individual intentions typically used to conceptualize an actor and distributed because agency is delegated by the network and not by the individual actors (Ibid. 45).

TRANSLATION
Translation means that an actant or a network are displaced in the sense that actants not previously associated now become so. E.g. when the hospital service of Northern
Jutland develops a change program it is a translation of other important in the context of hospitals such as e.g. financial conditions, political regulations and the idea of transversal management. To facilitate the analysis of translations four ‘moments of translation’ can be identified as ‘problematization’, interestment, ‘enrolment’ and ‘mobilization’ (Callon, 1986:196-223). These concepts are suitable in analysing power struggles where some actors attempt to persuade others to support their initiatives.

Problematization entails the moment in which actors redefine a problem so that other actors become associated. When the hospital service of northern Jutland develops a change program it suggests that existing practices are not good enough and everyone should agree on that as well as the proposed solution. Problematization is often followed by moments of interestments where some actors e.g. hospital service attempts to impose and stabilize other actors identity e.g. health care professionals.

Major changes of the organizing of public institutions involves hearing processes that traditionally allow for voicing all relevant actors and the change program is no exception since it affect thousands of hospital employees. Thus these hearing processes can be described as moments of interestment in the sense that power struggle emerge. Some actors might not be that interested in changing anything, other may have reservations and yet others support the initiative but all actors become interested because the logic of hearing processes is that everyone are obliged to have an opinion. Weather actors like it or not they can hardly avoid the expectation that they of course have an opinion.

Now everyone is enrolled in the problem of how to organize hospitals and also in the present solution. When actors being to discuss in details how the change program may affect the every day practice they have been enrolled with change programs ambitions on more coherency through transversal management.

When something become accepted as a truth or gain terrain the ANT analyst would take it as a consequence of a successful process of mobilization (Langstrup & Vikkelsø 2014:390). Mobilization is the moment when one actor becomes spokesperson on behalf of the entire network. One moment of mobilization could be when the hospital service of Northern Jutland officially ascertain that “a new managerial organization of hospitals has been implemented to support the continuity and efficiency of health care processes” (www.rn.dk, 14.03.2014). Now all actors within the network has been mobilized so that hospital service can speak on behalf of everyone else. Thus any process of mobilization can be viewed as a struggle between program and anti-program. The change program is mobilised and become forceful by conquering different anti-programs. However, overcoming resistance comes at prize in the sense that the original program continuously must revise its ambitions and compromise similar to how the meaning of one word become slightly altered when translated into another language. (Langstrup & Vikkelsø 2014:390)

The different moments of translation elucidates how the process of building a network is far from a tensionless and entails a transformation of the entire network and the way
actants are associated. E.g. the new managerial structure implies that previously entitled head nurses now entitled as vice clinic managers now rank above doctors which in principle cannot be allowed due to the Hippocratic oath. Thus, if a medical doctor does not agree with the vice clinic manager she could just ignore the suggestions.

In sum hard work and power struggles underlie the emergence of any network and translation is fragile because actants can never be fixed once and for all. The concept of translation provides the researcher with sensitivity towards the many changes that occur when actants become associated in a network. Therefore it is extremely important to give thorough empirical accounts in tracing and unravelling the network connection, in describing how translations happen and how they affect the network. If we are to understand how the change program became mobilized and how it became entangled with the idea of transversal management it is necessary to interrogate the networks they are associated with. How did the change program gain its strength through different alliances? How did the idea of transversal management become important and how has it been circulated in various contexts? What problem does it claim to solve? How many were persuaded and who does claim to help?

**Analytical excerpt**

It was the change program that initially caught my interest in studying hospital management due to ambitions of reorganizing the entire managerial structure at all hospitals in the region. I here present a preliminary analyses of the change program as a mobilization process initiated by the hospital service of Northern Jutland that involves a particular translation of the idea transversal management.

Following the analytical concepts of program and anti-program as presented above the change program can be viewed as a program that gradually has been mobilized in order to counterfeit the anti-program here constructed as everything that pressures the consistency of hospitals and continuity of health care processes seen from a *managerial* perspective.

Thus, the change program represented by the CEO and staff of the hospital service problematize status quo by writing a new plan for restructuring the managerial structure in order to meet the overall goal of creating more coherence and continuity within health care processes. A plan that all members of the organization (all employees at all hospitals in the region) are expected to support at some point. However the puzzling part of this analysis is that I have both notices some resistance and some support of the change program. The hearing processes were broadly positive towards the initiative but various professionals do also express some reservations as they reflect upon the consequences of this drafted initiative. Here the field of psychiatry voice their reservation:

[Our] dominating critique of this draft describing a new managerial structure is exactly that it does not demonstrate in any details how [it] becomes the necessary answer to the significant problems of coordination that psychiatry face
in relation to somatic hospitals as well as primary sector. (Region Nordjylland, 2012a, my translation)

And bio analytics states that:

Danish bio analytics are disturbed with the dispense of department managements. Unequivocal management is extremely important. The department managements with executive consultants and executive bio analytics worked very well and have contributed positively to the organization of laboratories. The distance from top to bottom will increase will unnecessarily in the draft on the clinics. (Ibid, my translation).

Even though the hearing process reveal a blurred picture consisting of both positive and more critical stances towards change program has succeeded in becoming an obligatory point of passage motored by the hearing process as a legislative arrangement. Typically hearing processes are called for when e.g. a municipality wants to have something changed. On the one hand the is of course a democratic precaution which is supposed to ensure that all involved parties can express their pros and cons but on the other hand such an arrangement may also function as a moment of interesting. When all public health professionals “suddenly” become associated with this legislative arrangement of hearing processes they become identified as legal entities with particular rights: they have to comment on what ever is presented by hospital administration. Thus, it also becomes possible to enrol them in the change programs vision of a new managerial structure notwithstanding that critique could change the change program but not change the very initiative.

By focusing this analytical excerpt on the hearing processes I attempt to show how this actually may strength the mobilization of the change program in the sense that all health care professional become enrolled in the program as a consequence of the hearing processes.

**SECTION THREE: EMPIRICAL CONTEXT AND FIELD OBSERVATIONS**

I started to construct data even before knew about my enrolment at the Ph.D. program at Aarhus University, department of Business Communication. One day in September 2012 I received a call from a high ranked manager at Aalborg University Hospital. He explained how an upcoming change program was about to be launched and how the program had created a lot of insecurity and distress among many employees because no one really knew what to expect. Not many liked the idea of changing the organizations managerial structure because as he said “why change something that already works very well? This organization actually works very well and really does not have any severe problems regarding health care processes”.

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5 This informant asked for 100% anonymity.
Afterwards I went through the website of the Region of Northern Jutland and here I found an online brochure aimed at all employees in the region describing the purpose for the upcoming change program. Thus, I decided to contact the hospital service administration in Northern Jutland to ask if they would let me follow the change program hence engaging with a Ph.D. project on health care management. This way the data construction actually began quite early and was also entailed with some insecurity since I, at the time being did not know, if I would succeed with my Ph.D. application.

The field study so far has been focusing on the hospital administration of Northern Jutland with particular interest in their strategy for changing the managerial structure at the hospitals. Key employees have been interviewed at the hospital administration where I talked to both the project manager in charge of the change program and a special consultant who also played a key role in the development of the program.

Employees at AAUH were also interviewed regarding the change program and the continuity of health care processes. Here I talked to a consultant from the department of Strategy, Communication and HR, a vice clinic manager with HR responsibility, a member of hospital management and several interviews with the vice clinic manager with responsibility of health care processes who I also have been shadowing for eight full working days so far.

The vice clinic manager with responsibility for health care processes is sited at the ‘cerebral-orthopaedic clinic’ comprising orthopaedic surgical clinic at Aalborg, Hjørring, Frederikshavn, Farsø and Thy Mors. Additionally the clinic is also in charge of eye related issues, jaw surgery, ear-nose-throat issues, neurosurgery and neurology. The management of the clinic comprises one clinic manager, two vice clinic managers with responsibility for health care processes and one HR vice clinic manager. The staffs consist of two financial employees, one coordinator of quality, one PRI6 editor, one secretary, two medical social workers and one assistant. They are all located in a smaller three storage building next to one of the two main buildings of Aalborg University.

As mentioned above, the first person I talked to was a high ranked manager at the hospital. On the backcloth of this talk I decided to contact the project manager and personal assistant of the hospital administration at the region of Northern Jutland to whom I presented a description of my research interest and my wish to follow the new managerial function with responsibility for health care processes.

The project manager circulated my request and after some time she returned with a positive response from a vice clinic manager who was interested in letting me follow her at work. I now had access to the organization and started immediately by interviewing employees from the strategic HR and communication unit at AAUH about the change program and the management of health care processes. Meanwhile the project manager returned to me with a positive response from a vice clinic manager.

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6 Abbreviation for politics, guidelines and instructions (politiker, retningslinjer og instrukser)
interested in having me to follow her. At the time I grappled with questions of how far I would allow my self to go in order to balance my wish for maximum access to the organization and mutual confidence.

From my initial talk with the anonymous manager I knew that the change program had stirred the waters and created tensions in the organization so I hesitated and finally refrained from asking for more that could cause too much disturbance. To begin with I was a bit disappointed with my self because I really wanted to ask the project manager for more information more key persons to get in touch with such as the CEO but through our email correspondence I noticed some implicit aloof reluctance regarding my role as a friendly yet “intruding” researcher. Thus, I was from the very beginning of this project engaged in micro political negotiations where the project manager who became an obligatory passage point in the network which I would have to enter in order to gain access to the vice clinic manager7. Without diplomatic negotiations with her there would be no study at all. Consequently, I adopted a step-by-step approach deliberately postponing some of the other things I would like to ask for such as an interview with the CEO or gaining access to their intranet.

Reflections of scientific criteria for constructing data
So far I have not established specific criteria for constructing the empirical material other than those offered by ANT suggesting that the researcher should obtain a symmetric perspective on the social implying that both human and non-human actors can have importance and that the researcher should stick to the same analytical concepts regardless of the studied phenomenon. (Callon 1986). Hence, if I were to develop more specific criteria for constructing data it would jeopardize my wish for studying their matters of concern. This argument does not exclude a discussion on criteria in general. For now it functions as one way to deal with the complexity that studying hospital management entails.

Contrary to traditional concepts applied to asses the quality of a social scientific study such as validity, reliability and generalizability, criteria for gathering data is established on constructivist premises suggesting that the robustness, and hence its validity, of a study depends on its capability to give empirically descriptive accounts of social-material arrangements (Latour, 2005). A study will only be as strong or “valid” its empirical account allows it to be. Latour argues that the quality of an ANT study can be measured by asking if “the concepts of the actors [are] allowed to be stronger than that of the analysts, or is it the analyst who is doing the talking?” (Latour 2005:30). However, this argument hardly exempt or repel further reflections on my choices for constructing data which will be thoroughly discussed as I continue to work with the dissertation. E.g. Law introduces the concept of method assemblages “that do not produce or demand neat, definite, and well-tailored accounts (...) precisely because the realities they stand

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7 This topic, which will be discussed in a later stage of the dissertation, is of course intertwined with the question of how and to what extend I as a researcher may or may not influence on the data as they are being constructed continuously through out the field study.
for are excessive and in flux, not themselves neat, definite, and simply organized. But this does not mean that they are not good methods.” (Law 2004:14)

On the following pages I present some of the various activities, entities and events that I have encountered during the field study so. These encounters may very well envision what Law has described as method assemblages (ibid) to account for what I am doing as I attempt to re-assemble transversal management.

Entities of importance to transversal management

A so-called ‘Mussmann report’ from 2006 (Muusmann 2006, 2012) evaluating the organizational structure of the hospital service of Northern Jutland has apparently become the starting point of the change program. Thus, the report appears to matter in managing hospitals and health care processes because it was called for by the hospital service administration and because informants often refer to it when asked about the reason why the they think that the change program were developed.

During the process of developing the change program the hospital administration granted a funding from Knowledge Centre on Welfare Management to help further develop the hospital service of Northern Jutland. Meanwhile three working groups under the auspices of hospital service were established to contribute to the development of the change program. As I have come to understand the process many people had been working hard to create the change program and during this process a special consultant depicted the situation in a manner that helped the CEO to see the broader picture. By making a simple drawing of how he thought that the change program could be established the CEO suddenly saw the light.

Whenever a municipality or region wants to intervene in the existing practises of its employees hearing processes has to be initiated. Thus, two hearing statements from all employees in the hospital service of Northern Jutland were conducted. Even though the hearing process revealed a blurry picture of pros and cons the change program they did not had its basic idea changed. A new vice clinic manager with responsibility of health care processes and unambiguous management was still at the heart of the change program.

Hence, the outcome of the hearing processes was, to my knowledge so far, nothing that problematized the backbone of the change program which. The change program still envisions the idea of a new managerial structure that is characterized by a distinct focus on coordination and management of health care process supported by the new managerial position.

As I have interviewed the vice clinic manager with responsibility for health care processes and participating in numerous of her meetings it dawns on me that hospital

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8 See also appendix 1 for an unfinished overview of the actor-network of hospital management.
management is concerned with various theories on management. On the one hand they are of course concerned with the idea of transversal management as a practical method for creating coherence and continuity within the hospitals as an organization and within health care as processes. This theory of how reality should be arranged at the hospitals are concomitantly associated with various literature on management in health care such as leadership pipe line theory, relational co-ordination theory, paradox management, LEAN management and so forth. Also the vice clinic manager that I have shadowed explains how she engage with a theoretical tool box that from which she can choose the proper tool for managing various situations.

Other points of interest that I have come across during field study was a decision to bye new equipment for cleaning surgical tools that failed because of politics on hygiene produced at the Danish Serum Institute set high standards for buying new equipment demanding that tools should be cleaned within very short time after usage and because of the physical and geographical conditions that this new equipment should be part of.

Thus, architectonical and technological arrangements e.g. the construction of the new super hospital, equipment for preventing dizziness, washing machines and floor plans all represent some interesting site of analysis, that could highlight how transversal management as an idea is far from a simple phenomena but turns out to be entangled with actants that are partially connected.

Other socio-material arrangements is about to be launched. As I write this paper it has been decided to implement a new digital infrastructure that entails a transition from partly to fully electronic patient charts and an online booking system for all patients.

I have also encountered reflections on the idea of putting the patient in centre by comparing this idea with wheel's physics and I have become aware that the relation between local politicians and hospital service is important. Apparently politicians have little to say in managing hospitals due to extreme organizational and economical complexity that politicians have little chance of dealing with. Hence, managers from within hospital service, hospital management included, may subtly guide politicians on what and how to make “good” decisions.

Finally I have come across the well-known tensions between doctors and nurses which are important because many of the vice clinic managers are nurses and not doctors. Thus the new managerial structure has

These accounts are far from meticulous but for now they can be viewed as a result of my fieldwork which has opened possibilities for further analysis. So far I have deliberately constructed this methodological assemblage in search for a sense of grasping the broader picture of hospital management as it evolves in northern Jutland. I plan to develop these accounts much more thoroughly and also to do some analytical close ups. Thus these broader and light weighted accounts of “the broader picture” will be
supplemented with close up analytical cuts of these encounters along with the cuts I present in the following section.

SECTION FOUR: ANALYTICAL CUTS AND METHODLOGICAL IMPLICATIONS

In this section I present the core analytical cuts that constitute the analytical strategy of this dissertation. Hereafter I show how actor-network-theory can be applied in an analysis of the mobilization of the change program.

I sketch out the analytical gaze to, concomitantly, cut open and construct an actor-network described as the idea that transversal management can do something good for managing health care processes. Thus the initial point of entrance to this network begins with a study of the hospital service of Northern Jutland.

On a foundation of empirical “thickness” generated by unravelling the history of traversal management, analysing different policy documents, and organizational strategic considerations and by engaging with ethnographical research methods such as interviews and shadowing (Czarniawska 2007, 2008) I follow the idea of transversal management not as a singular phenomenon but as different versions of transversal management. I follow the vice clinic manager in her everyday work as an important actor within the actor-network that constitutes the management of health care processes and I follow Hence, the dissertation explores both relations between structural and political conditions of hospital management as well as the very conditions of management that management and in particular the health care process mangers produce themselves through their ways of enacting the network.

Thus, the outset of the study of transversal management is not to use powerful agents to explain why it might fail or succeed but rather to explore and account for the heterogeneity and the indefinite displacement of the social and the mattering’s ascribed to transversal hospital management. The aim is to highlight a sense of the world “as an unformed but generative flux of forces and relations that work to produce particular realities” (Law, 2004:7)9 that cannot be reduced to e.g. a question of discourse or field of forces.

Following this methodological outset the dissertation does not hold a conventional thesis but poses a rather simple yet highly complex question of how transversal management matters in managing hospitals. Instead of deciding in advance what transversal management is based on the assumption that such a definition would frame my analysis better I set out to explore how the idea of transversal management may or may not play out in managing hospitals. While transversal management may evoke a somewhat romantic ideal of really creating coherency that transgresses everything I highlight how these “things of everything” contribute to (de)stabilize parts of the actor-network that hospital management.

9 This position is not to be seen as a dismissal of conventional research methods or a turn to idealism (See Law 2004:7-8.).
The overall analytical strategy of the dissertation is rather to construct the idea of transversal management in the context of hospital management as a vast actor-network with on-going processes of translations and mobilizations that contribute to change and (de)stabilize it. By focusing on transversal management in the context of hospital management instead of hospital management exclusively I construct hospital management as effects of how entities are and become entangled in the act of translating and mobilizing transversal management.

This means that the idea of transversal management is constructed as an idea that comes in many versions as a consequence of how it is translated. Thus, the change program, formal theories of management such as LEAN or relational coordination, digital arrangement such as an online booking system, building plans and buildings, official standards of hygiene, tensions between doctors and nurses and so forth as entangled entities that all have a history and enacts different versions of transversal management. Thus, these versions of transversal management each contribute to the construction of managerial conditions, possibilities, limitations and expectations as they become are enacted in the every day work of AAUH.

By exploring how this program was mobilized from the tiniest strategic considerations to a full blown on going and functioning program. This is done by investigating how the change program emerge as a consequence of entangled and historical dependent entities such as those I have briefly touched upon in the previous section. Beside the investigation of how the change program became mobilized, this study also entails a specific examination of how the new managerial position is constituted and enacted in managerial practice. Thus, the analyses of this mobilization process entail both a historical and present examination of expectations to and in strategic hospital management, health care politics and health care management practices.

In sum all entities within the context of hospital service and administration constitute a actor-network that can be unravelled in order to show its entanglements with the idea of transversal management. They way to study these entanglements is not through a priori theoretical clarifications but through empirical field studies and historical analyses in order to explore the concrete elements that matters in managing hospitals.

I begin with a historically examination of how organizing has been conducted in hospital management and how this organizing is accompanied by shifting expectations to what management was, is and should be. I relate this historical analysis of expectations to a similar analysis of the hospital service of Northern Jutland along with an analysis of the change program understood as a mobilization process pursuing hospital coherency and continuity within health care processes through the idea of transversal management.

Thus the idea of transversal management is analysed through four cuts in the network of hospital management:
1) A genealogical analysis on the history of hospital management and the idea of transversal management. In this section I examine selected “chunks” of the history of health care management as it emerges in materiality (e.g. architectural layouts of hospitals) scientific theories of management and the political steering of health care and hospital service.
   o How does the current reorganization of hospital management emerge when analysed from a genealogical perspective?

2) An analysis of the change program construed as a historical process of mobilization. The aim is to explore how the idea of transversal management draws on both ancient and recent ideas of hospital management as they are translated into change program. Thus, this section is particularly interested in the ways that the change program mobilizes an assemblage of managerial expectations to what it means to establish hospital coherency and continuity within health care processes.
   o How can strategic considerations on transversal management, as they are presented in the change program be viewed as an assembling process that translate past, present and future managerial expectations?
   o How can these translations be viewed as a performative effect in the network of transversal management?

3) By following the mobilization of the change program along with past, present and future expectations to management this section focuses on the new management position. Thus, this section examines the very constitution of the health care process manager as a new organizational role and function by asking:
   o What are the expectations to this management function? How do strategic managerial considerations and ditto expectations assemble this new management function?

4) Finally, I present some analytical snap shots of the empirical material that was created through field work as I followed the process manager in her everyday work:
   o How does the process manager enact, translate and mobilize transversal management?
   o How does these enactments work in the network of transversal management?

Following the network metaphor these analytical cuts should not be viewed as a singular well polished method to reveal the full picture of transversal management. Strathern develops a notion of partial connections to describe how “[t]he relativizing effect of knowing other perspectives exist gives the observer a constant sense that any one approach is only ever partial, that phenomena could be infinitely multiplied” (Strathern 2004:xiv).

Law proposes a similar notion of fractionality (Law 2014:160) as a way to handle the problem of wholeness by suggesting that the hinterlands of objects, subject and realities partially intersect with on another in complex ways. Thus fractionality expresses the
idea that objects, subjects and realities “are more than one less than many” (Ibid). Anne-Marie Mol draws on the notion of multiplicity to handle the problem of wholeness. She suggests that one cannot presume that e.g. transversal management is a stable phenomenon that simply can be observed from multiple perspectives but rather that reality itself is multiple (Mol 1999:74-77). The overall methodological implication of these notions is that one can never expect to encompass a whole but also that the I as a researcher are seriously obligated to account for the choices I make when deciding what to write about.

By unravelling the socio-material entanglements of transversal management the thesis contributes with a weaving together of what is already in the process of being (re)woven. In short the ‘what’ is described through Anne-Marie Mol’s notion of multiplicity. The ‘weaving’ refers to Stratherns notion of partial connections which I use to account for my relation to hospital management and to describe how transversal management is comprised by partially connected entities that contributes to its (de-)stabilization and therefore do not add up to a whole. In short I as a researcher associate the network of social science with hospital management and both are partially connected to one another.

This strategy constructs hospital service as a vast network in which the idea of transversal management emerges in many versions. Thus, the thesis’ “empirical object” is both the very idea of transversal management and its entanglement within the socio-material arrangements of northern Jutland’s hospital service. By cutting open the actor-network of hospital service I unravel different versions of transversal management and elucidate how these matter to hospital coherency and continuity within health care processes.

**Methodological implications**

It is an open question whether ANT should be viewed as a theory, a method or rather as an attempt to dissolve these “genres” that we all have come to know so well (Gad & Bruun Jensen 2010:55). As the reader my have noticed ANT insists on problematizing well know and fixed categories and categorizations of social science. Gad and Bruun Jensen’s remind us that one key lecture of ANT is that: “... one can never isolate pure concepts from the socio-technical networks that shape them” (Ibid:56). This is also why ANT scholars often adopt a highly sensitive and critical stance towards any one claiming to improve society by means of thorough scientific methods.

Thus, one will find no clear answer to the question of how to deal with ANT as a way for studying the social. Following Ratner (2012) I “take ANT (and post-ANT) to be what is was from its outset: a set of highly interesting discussions that allows one to remain open and curious about how the world is continuously re-created and to participate in the making of this world through studying it.” (Ibid:86). I return to the implications of how the researcher may participate in making the world in section five. This does not mean that ANT offers no clue at all in how to study the social. It just means one cannot and perhaps should not expect to be nourished by a ready to use program of what to do.
Thus, section four which present the analytical strategy of this thesis can be viewed as a customized ANT program aimed at exploring how transversal management matters in managing hospitals and how it produces various expectations to what management is and can be.

The methodological implications of drawing on actor-network-theory is that conventional “rules and regulations” of social science and ideas of the unspoiled empirical material become unhelpful in describing the complex irregular entanglements of entities that constitute the “things” we call society (Law, 2004). Following this line of thought Law argues that the research methods of social science “tend to work on the assumption that the world is properly to be understood as a set of fairly specific, determinate, and more or less identifiable processes.” (ibid:5). Thus Law highlights the common assumption in social science that rules and procedures certainly may be problematized from time to time yet the very need of having these is rarely questioned.

As I interpret Law's critique of conventional research methods in social science that they tend to instil an authoritative sentiment obliging the researcher to wilfully master the rules of methods so that accounts of reality as it is per se can be taken seriously because they were developed properly. In other words: The very need for engaging with proper rules of methods has traditionally not been something to discuss and beginning to do so may guide our attention to questions of what kinds of social realities we want to create (Law, 2004) by “means” of social science.

This thesis acknowledges the premise that any research project always-already takes part in constructing particular versions of reality as do the reality-construction of human and non-human entities. I use Stratherns notion of partial connections (2004) and Anne-Marie Mols concept of multiplicity (Mol 1999, 2002) to account for how this thesis is both part of and not part of hospital management and how it both does and does not add something extra to the realities of hospital management. Mol uses the concept of multiplicity to describe how reality is not observed but rather done, performed and enacted (1999:77) and thus “various performances of reality (...) have all kinds of tensions between them, but to separate them out as if they were a plurality of options is to skip over the complex interconnections between them” (ibid:86).

Thus the overall methodological concern in this proposal is to stress that taken for granted assumptions in social science produce a particular kind of methodological grudging that could fruitfully be replaced by another form of grudging; Instead of being concerned with questions of how to get hold of facts, how to manipulate data, how to confirm or deny the formalized thesis and how to create a method to validate conclusions this thesis draws on the principles and notions mentioned above. Thus the thesis engages in a discussion of how the ANT itself is an actor-network which has become a remarkable actor in the academic stage (Law & Hassard, 1999) translated through this thesis by re-assembling the idea of transversal management.
Hence, the question of what comes after ANT address an interesting discussion on how ANT can deal with it self as a network. The term “post-ANT” has be suggested (Gad & Bruun Jensen, 2010) to account for the problems that arises when ANT reflect on it self e.g. the paradox that it is difficult to describe ANT without contributing to its fixation while insisting that ANT is a heterogeneous position (Ibid.).

I have not engaged with these discussions so far and for now I have come to the awareness that writing a thesis is a mobilisation process that do not differ much from the network building of other actors within hospital management. Thus, this thesis poses a modest hope that the insights derived from analyses of transversal management can mobilise an actor that hopefully but far from surely will be added to and distributed in the network of hospital management.

By focusing on the reality as multiple and not multiple perspectives on a singular reality the this thesis does not engage with traditional old school questions of how to create valid accounts of reality by means of methods but rather seeks to discuss if and how the researcher may or may not contribute to shape hospital management in by adding another actant such this thesis.

The methodological consequence of viewing hospital management as an actor-network is that the viewing it self is construed as an actor-network. The criteria for applying ANT to hospital management is that the “applying” it self must be viewed as an actor-network and that the very idea of applying something to something else is problematic in the sense that ANT is a negative argument that does not say anything positive on any state of affairs. In a dialogue between a professor and a frustrated student confused about how to use ANT Latour explains: “The best thing it [ANT] can do for you is to say something like, ‘When your informants mix up organization hardware, psychology and politics in one sentence, don’t break it down first into neat little posts; try to follow the link they make among those elements that would have looked completely incommensurable if you had followed normal procedures’” (Latour 2005:141-142).

As noted the dissertations analytical cuts and the final “result” should not be viewed as an integrated singularized whole but rather as partial connected fragments that may or may not be added to and circulated in the network of hospital management by relevant actors. This means that the author of a Ph.D. should be perceived as a socio-material assemblage that may or may not be enrolled and enacted within the actor-network of hospital management and thus become part of the mobilization process(!).

Agnosticism has equipped me with an anticipatory stance. So far this analytical openness that agnosticism entails renders everything a possible material for analyses. In this sense the question of what to in- or exclude as an analytical resource changes and may rather be reformulated as a guiding question of what matters and how does this matter matters in the actor-network of hospital management. Thus, one could argue that the a fruitful way to take actors seriously and give through accounts of their realities is to blind one self through the principle of agnosticism similar to the hope Law is posing
namely that we learn to “live more in and through slow method, or vulnerable method, or quiet method. Multiple method. Modest method. Uncertain method. Diverse method” (Law 2004:11).

The overall implications of these theoretical concerns on “how-to-study” are that I as a researcher only partially decide what to in- or exclude in unravelling transversal management. Thus the thesis and thus they cannot constitute a single “whole” but should instead be seen as a consequence of my focus on transversal management and their interest, troubles, challenges or pleasures of participating in hospital management and health care processes.

By engaging with the vocabulary of actor-network-theory the overall research strategy I have devised at this point is constituted by a concretizing of the principle of agnosticism. Thus, the four analytical cuts entail a weaving together of what has already been woven and is the process of being re-woven. But one critique that could easily be aimed at blindness as analytical strategy is that it may produce so much blindness that it completely deadens any further discussion on methods and methodological challenges in studying transversal management.

Gad & Bruun Jensen draw on Anne-Marie Mol’s notion of multiplicity in their attempt to establish a methodological attitude described as ‘post-plural’ (Gad, 2005) suggesting that both pluralism and perspectivism fail to account for how reality itself is multiple. Thus the notion of multiplicity can be appropriated to account for the complexity of transversal management or how a disease such as arteriosclerosis: “One could say that the complexity of the disease is embedded in tension between its multiplicity (there may be several versions of arteriosclerosis) and its fractality (they may be related but not on all points or in all dimensions).” (Ibid: 66, see also Mol 1999:75).

Similar the analytical cuts of this dissertation attempt to account for the multiplicity of transversal management. Transversal management comes in many versions and no first version exists. Rather, transversal management is as an entity both fractal and partially connected: different versions of transversal management may partially interconnect but do not form a singular whole. Thus the various versions of transversal management constitute the empirical object of the thesis. How do they come about and how do the contribute to the “un-sewed fabric” of future expectations in hospital management are the questions that need to be answered in order show how the idea of transversal management matters in managing hospitals.
## SECTION FIVE: RESEARCH ACTIVITIES AND TIME SCHEDULE

<table>
<thead>
<tr>
<th>Year</th>
<th>1st semester (ECTS 15,5)</th>
<th>2nd semester</th>
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| 2014 | • Ph.D. course: New Ways of Doing Ethnography – using network strategies to understand the everyday life in the public sector. (ECTS 3)  
  • Unfolding the thesis proposal  
  • Participating in monthly network meetings with vice clinic managers.  
  • Conference at CBS: When Health Policy Meets Every Day Practices 9th International Organisational Behaviour in Healthcare Conference (without paper)  
  • DASTS Conference at RUC: Enacting futures (with paper)  
  • Readings on hospital management  
  • Writing  
  • Ph.D.- course: Socialising Big Data, ITU (2 ECTS) | • Ph.D. – course: Moderne sociologisk Teori, CBS (5 ECTS)  
  • Conference: What’s so critical about your critical management studies PhD? University of Leicester, UK. (with paper)  
  • Participating in monthly network meetings with vice clinic managers.  
  • Teaching ‘Kultur og samfundsteori’.  
  • Ph.D. Course: Forskningsmanøvrer: Undervejs med en afhandling, AU. (ECTS 3)  
  • Readings on hospital management  
  • Writing |
| 2015 | • Writing  
  • Ph.d. Course: No name (on mapping and visualising scientific controversy (ECTS?)  
  • Visiting scholar at CBS, Department of Organization  
  • Visiting scholar at foreign university | • Finishing the dissertation |
| 2016 | • Finishing the dissertation  
  • (February 1st) | |
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Appendix 1: preliminary cartography of hospital management