The Temporal Organizing of Same-day Discharge

A Tempography of a Cardiac Day Unit

Scheller, Vibeke Kristine

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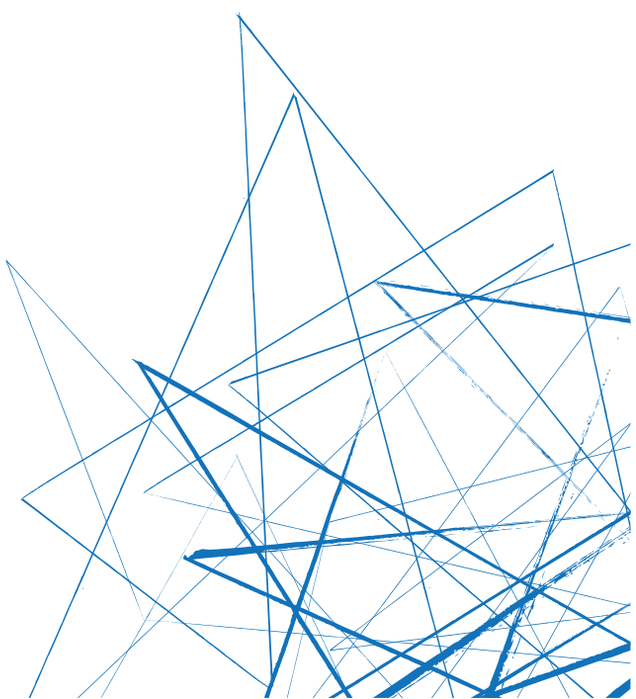

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Vibeke Kristine Scheller

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Doctoral School of Organisation and Management Studies | **PhD Series 29.2019**

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HANDELSHØJSKOLEN

The temporal organizing of same-day discharge

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Vibeke Kristine Scheller

Supervisors:

Professor MSO, Anne Reff Pedersen, Department of Organization,
Copenhagen Business School

Professor, Tor Hernes, Department of Organization,
Copenhagen Business School

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The Doctoral School of Organisation and Management Studies is an active national and international research environment at CBS for research degree students who deal with economics and management at business, industry and country level in a theoretical and empirical manner.

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SUMMARY

This dissertation investigates the intersection between time and organizing in a Cardiac Day Unit that introduced same-day discharge schemes for patients with ischemic and arrhythmic heart disease. Same-day discharge has been an influential mega-trend throughout health care sectors in several countries. Introducing same-day discharge schemes comes with the promise of providing both patient-centered care while simultaneously saving expenses for the hospitals and utilizing technological and pharmaceutical innovations. Researchers in various medical fields report that 'quicker is better' for patients, due to the fact that studies show that recovery is faster for patients who were discharged early after surgery. However, the introduction of same-day discharge also introduces organizational challenges, for how is it possible to create a smooth and efficient 'production' line of patients in an uncertain context where changes can happen continuously? What kinds of patient trajectories are produced in the compressed context of same-day discharge? How has an organization such as the Cardiac Day Unit challenged and affected the everyday organizing of patient care by professionals?

This dissertation adapts a practice based and processual perspective on organizing to explain the time-related tensions that arise from the introduction of same-day discharge in a Cardiac Day Unit. It presents a modern 'tempography' – ethnography with thick empirical descriptions of how the temporal organizing in the Day Unit was affected by the compression of admission schemes, i.e. the planning of patient treatment and ability to make decisions on treatment strategies. The tempography comprised more than 300 hours of observations that produced 150 pages of field notes, 17 interviews, documents, materials, and audio recordings of 8 strategy

meetings over a period of 1.5 years. It resulted in the creation of a PhD dissertation with three analytical papers.

The first paper explores what it means to care for patients' trajectories in accelerated discharge schemes. The paper adds to the literature on management of patient trajectories, by arguing for a perspective that includes 'the patient in time', e.g. their stories, their illness, their prospects and therefore their expectations towards their admission in the Cardiac Day Unit. The paper combines different theories on trajectories to explain how they are more than formal organizations and how they emerge from everyday conversations between professionals and patients. The concept 'patient trajectories' (or illness trajectories) was adapted by several researchers as an important concept to explain the formal organization of medical work around the patient. However, the trajectory literature mainly treats the patient as a body that is moved along a timeline by professional work. There are only a few studies concerning the experience of coherence in patient trajectories and even fewer on how professionals and patients continuously construct and re-construct this coherence, and therefore how they become 'temporal trajectories'.

The second paper describes the professional concerns regarding the speed of decision-making in same-day discharge and the need for rethinking what information is necessary at a given point in time to secure the best possible treatment. The paper presents the micro-strategical practices in the Day Unit and analyzes how they were affected by the introduction of a limited timeframe. These practices were evidently important for everyday organizing, and they were supported by the use of material objects, i.e. patient records, procedure plans and patient overviews. In the paper, we show how micro-strategic practices can be understood as 'temporal object work' because professionals continuously engage in object-mediated discussions in the

present that involve past concerns in order to make plans for the future. We offer a contribution to the literature by showing how objects represent certain temporalities and that a hegemonic relationship between different objects exists, which is essential for the professionals' use of the objects when conducting temporal object work in same-day discharge.

The third paper discusses the methodological implications of doing an ethnography that focuses on time and temporality in organizing. The paper contributes to the literature on ethnography and temporality, by arguing that researchers need to engage with 'the problem of time' in several layers of the ethnography. Firstly, in methodological temporal awareness, i.e. reflecting on how researchers can see time documented in different kinds of qualitative data. Secondly, that researchers need to accomplish analytical temporal practices, i.e. considering how time is understood through various conceptualizations, e.g. temporal work, time objects and patient trajectories. Thirdly, the paper argues for a broader perspective on temporal merging in ethnography, which means not just representing subjective/objective or processual/linear perspectives, but also delineating time as social structure/temporality perspectives of organizational life, i.e. multi-temporal merging.

Jointly, these papers offer theoretical contributions that explain how the coexistence of different time perspectives organizes health care. Time arranges practices and processes through plans, objects and conversations in the Cardiac Day Unit. Organizing is time, but in many different ways - as processes, practices, planning, conversations, stories and the use of materials - and organizing arises in the ongoing relationship between practice and temporality. It becomes an integral part of organizing over time and tensions arise when this organization is confronted with new demands on how time is spent etc. Accordingly, this dissertation shows how the

introduction of same-day discharge disrupts the order, but at the same time how it gets reestablished by the professionals engaging in practices that (in different ways) create order and meaning for themselves and for the patients. They engage in continuous articulation of temporal patient trajectories and they constantly make and remake plans by doing temporal work aided by temporal boundary objects.

DANSK RESUMÉ

Denne afhandling undersøger sammenhængen mellem tid og organisering på et Hjertemedicinsk Daghospital, der introducerede sammedagsforløb for patienter med iskæmiske hjertesygdomme og rytmeforstyrrelser. Udbredelsen af sammedagsforløb har været en betydningsfuld udvikling i sundhedssektorer i mange lande. Introduktionen af sammedagsforløb kommer med et løfte om både at sikre patient-centreret behandling samt at garantere besparelser ved at udnytte teknologiske og farmaceutiske innovationer. Forskere fra forskellige medicinske specialer fremhæver at 'hurtigere er bedre' for patienterne, fordi forskningen understøtter at patienter kommer sig hurtigere, når de bliver udskrevet hurtigt efter operation. Imidlertid skaber introduktionen af sammedagsforløb også organisatoriske udfordringer, for hvordan er det muligt at skabe gnidningsløse og effektive 'samlebånd' af patienter i en kontekst som er præget af uvished og hvor ændringer kan opstå kontinuerligt? Hvilke typer af patientforløb bliver skabt i den komprimerede kontekst i sammedagsforløb? Og hvordan har etableringen af en organisation som det Hjertemedicinske Daghospital påvirket den daglige organisering af patientbehandling som varetages af professionelle?

Afhandlingen anvender et praksisbaseret og processuelt perspektiv på organisering for at forklare de tids-relaterede spændinger som opstår ved introduktionen af sammedagsforløb på det Hjertemedicinske Daghospital. Den præsenterer en moderne 'tempografi' – en etnografi med dybdegående empiriske beskrivelser af hvordan den temporale organisering i Daghospitalet bliver påvirket af komprimeringen af indlæggelsestiden, det vil sige planlægningen af patientbehandling og mulighederne for at træffe beslutninger vedrørende behandlingsstrategier. Tempografien består af

mere end 300 timers observationer som producerede 150 siders feltnoter, 17 interviews, dokumenter, materialer og lydoptagelser af 8 strategimøder over en periode på 1 ½ år. Den beskrevne tempografi har resulteret i følgende Ph.d.-afhandling, der består af tre analytiske artikler.

Den første artikel udforsker hvad det vil sige at varetage patientforløb i accelererede indlæggelsesforløb. Artiklen bidrager til litteraturen om håndtering af patientforløb ved at argumentere for et perspektiv som inkluderer 'patienten i tid', for eksempel deres forhistorie, sygdomsudvikling, deres fremtidsudsigter og derfor deres forventninger til indlæggelsen på det Hjertemedicinske Daghospital. Artiklen kombinerer forskellige teorier om forløb for at forklare hvordan patientforløb er mere end formelle organiseringer og hvordan de optræder i dagligdags samtaler mellem professionelle og patienter. Begrebet 'patientforløb' (eller 'illness trajectories') er anvendt af mange forskere som et vigtigt begreb til at beskrive den formelle organisering af medicinsk arbejde omkring patienten. Imidlertid behandler forløbs-litteraturen først og fremmest patienten som en krop der flyttes på en tidslinje af professionelle der udfører deres arbejde. Der er kun få studier der omhandler oplevelsen af sammenhæng i patientforløb og endnu færre omhandler hvordan professionelle og patienter kontinuerligt konstruerer og rekonstruerer denne sammenhæng, og derfor hvordan de bliver 'temporale patient forløb' (eller temporal patient trajectories).

Afhandlingens anden artikel tager udgangspunkt i de professionelles bekymringer for hastigheden i beslutningstagning i patientforløbet hvilket afføder behovet for at nytænke hvilke informationer der er nødvendige på et specifikt tidspunkt for at sikre den bedst mulige behandlingsstrategi. Artiklen præsenterer de mikro-strategiske praksisser på det Hjertemedicinske Daghospital og analyserer hvordan disse

praksisser bliver påvirket ved introduktionen af en begrænset tidsramme. De mikro-strategiske praksisser er åbenlyst vigtige for den daglige organisering, hvilket understøttes ved brugen af materielle objekter, såsom patientjournaler, procedureplaner og patientoversigter. I denne artikel viser vi hvordan mikro-strategiske praksisser kan forstås som 'temporalt objektarbejde' (eller 'temporal object work'), fordi de professionelle kontinuerligt deltager i objekt-medierede diskussioner der involverer fortidige bekymringer for at træffe beslutninger i nutiden og lægge planer for behandling i fremtiden. Vi bidrager til litteraturen ved at vise hvordan objekter repræsenterer særlige tidsforståelser og hvordan der eksisterer en hegemonisk relation mellem forskellige objekter, som er afgørende for de professionelle når de udfører temporalt objektarbejde i sammedagsforløb.

Afhandlingens tredje og sidste artikel diskuterer de metodologiske implikationer ved at udføre etnografiske studier der fokuserer på tid og temporalitet i organisering. Artiklen bidrager til litteraturen om etnografi og temporalitet ved at argumentere for at forskere skal reflektere over 'tidsproblemet' i forskellige lag af etnografien. Først og fremmest ved at udvise en 'metodologisk temporal opmærksomhed' (methodological temporal awareness), hvilket vil sige at forskeren bør reflektere over hvordan 'tid ses' belyst gennem forskellige typer af kvalitativ data. Dernæst må forskeren mestre 'analytisk temporal praksis' (analytical temporal practices), hvilket vil sige at det er afgørende at overveje hvordan 'tid bliver forstået' gennem forskellige begreber, for eksempel temporalt arbejde, tidsobjekter (time objects) og patientforløb. For det tredje, argumenterer artiklen for et bredere perspektiv på 'temporal kombination' (temporal merging) i etnografiske tidsstudier, hvilket indebærer nødvendigheden af ikke kun at belyse kombinationer af tid forstået som opdelt mellem subjektive/objektive eller processuelle/lineære perspektiver men også

at udvikle en følsomhed overfor tid forstået som 'social struktur' og 'tid som temporal organisering' - hvilket resulterer i 'multi-temporal kombination' (multi-temporal merging).

Tilsammen udgør de tre artikler et teoretisk bidrag som forklarer hvordan sameksistensen af forskellige tidsperspektiver organiserer patientbehandling. Tid ordner praksisser og processer gennem planer, objekter og samtaler på det Hjertemedicinske Daghospital. Organisering *er* tid, men på mange forskellige måder – som processer, praksisser, planlægning, samtaler, fortællinger og brugen af materialer – og organisering opstår i det konstante forhold mellem praksis og temporalitet. Den temporale organisering bliver til en grundlæggende del af organisationen over tid og spændinger opstår når denne organisering konfronteres med nye krav til hvordan tiden bruges, udnyttes og opdeles osv. I overensstemmelse hermed viser afhandlingen hvordan introduktionen af sammedagsforløb forstyrrer organiseringen på afdelingen, men på samme tid illustrerer afhandlingen også hvordan orden bliver reetableret af de professionelle der deltager i praksisser der (på forskellige måder) skaber orden og mening for dem selv og deres patienter under de nye organisatoriske betingelser. De deltager i kontinuerligt i diskussioner af patientforløbenes organisering og de udarbejder og tilpasser konstant planer ved at udføre temporalt arbejde, der understøttes i deres brug af temporale objekter.

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CHAPTER 1: INTRODUCTION

1.1. ”Making time in a Cardiac Day Unit”

It was a dark and cold Tuesday morning in January 2015. Before me, Rigshospitalet[1] towered over the other adjacent buildings as I exited the bus. I took the elevator up to the 14th floor to meet with the clinical management team in the Department of Cardiology and discuss the possibilities of venturing into a joint research project under the heading ‘Health care innovation from an organizational everyday perspective’. I was directed to the right office door by a friendly secretary and sat down next to the Head of Department and the Head Nurse at a large white table. After some initial conversation, I asked, *"So, what is going on in the department?”* The Head of Department looked at me and said apologetically, "*we are currently very preoccupied with getting our newly established Cardiac Day Unit to function successfully. This is perhaps not very interesting to you, but we are trying to think about our patient trajectories in a new way and develop practices that support a shorter admission scheme*”. Having a research interest in everyday organizational practices as well as a growing fascination with the significance of time in organizing, this immediately sparked my interest. I wanted them to tell me more about this Day Unit. The Head Nurse talked about how it was new for the professionals to take care of a diverse group of patients with different diagnoses, where the main feature they had in common was the expectancy of a short and unproblematic trajectory within the

[1] Rigshospitalet is Denmark´s leading hospital for patients needing highly specialized treatment and is placed in the capital, Copenhagen.

Day Unit. Later, I asked the Head of Department to elaborate on the challenges in creating the Day Unit, and he explained:

"The biggest challenge has been that you have to be there when the patient is there, that is... to make a caricature one could say that if you have admission schemes that last two or three days, then it is less important if you get to talk to the patient now or in the afternoon about his lifestyle and about future planning, etc. So it has been a tendency that there was quite a lot of wasted time for the patients. In the Day Unit trajectory, one has to make sure to be there when the patient is there, and to, if I have to say so, make the right medical knowledge available at the right time, and that has been a challenge because it is an entirely new way of working. In the Day Unit, everything must happen at a relatively fixed time to avoid creating bottlenecks in the system".

The time-related tensions stared me in the face, when listening to his account. First of all, introducing a Day Unit meant shortening established timeframes, which created an increased need for professionals to 'be there at the right time' and to 'provide knowledge at the right time'. The latter especially ignited my curiosity - 'what is the right knowledge, for what, and how do you determine the right time?' Moreover, one of the objectives seemed to be providing patient-centered care by eliminating waiting time, which introduced a temporally fixed way of working for professionals and an elevated risk of creating temporal bottlenecks. So, even though the Head of Department initially downplayed the establishment of the Cardiac Day Unit as an interesting example for research purposes, it quickly became clear that there was something profoundly interesting at play. I therefore embarked on an ethnographic study of organizing in the Day Unit, the tensions that it creates for professionals and their relationship to time and temporality.

1.2. An ethnography of temporal tensions in a Cardiac Day Unit

The Day Unit was approached through an in-depth organizational ethnographic study, with different kinds of qualitative data: 300 hours of observations that produced 150 pages of field notes, 17 interviews, documents, materials, and audio recordings of 8 strategy meetings over a period of 1.5 years. The Cardiac Day Unit was established in 2015 at Rigshospitalet and received patients for planned or subacute procedures within two medical areas, arrhythmic and ischemic heart disease, who could be discharged to their homes or transferred to other hospitals on the same day as the procedure. The Day Unit was physically placed within the Department of Cardiology, which received patients with various illnesses and treatments, from lengthy antibiotic therapy for infections of the heart valves, to acute blood clots or cardiac arrests. The Department of Cardiology was highly specialized, and as such, they received some of the most complicated cardiac patients, not just from the local area but also from other parts of Denmark, Greenland and the Faroe Islands.

In late 2014, the clinical management team in the Department of Cardiology had become aware that the traditional structure of units, i.e. dependent on medical specialty, caused the critically ill and routine patients to be placed together. This meant that routine patients became unnecessarily nervous and critical patients had to share rooms with routine patients who arrived and were discharged continuously, creating unwarranted disturbances during their (sometimes lengthy) admissions. At the same time, the management team had to continuously develop new innovative solutions that could help the department to meet political requirements for cost

reductions in a way that simultaneously strengthened work organization. They agreed to take advantage of the possibility for organizing same-day discharge, while at the same time creating a unit where it was the expected length and complexity of the patient's trajectory that became the common denominator and not the specific type of heart disease.

The experiences from both cardiology and from other medical fields, was that same-day discharge benefited both the hospital and the patient. Same-day discharge in cardiology was a major focus due to innovative medical techniques making early discharge a safe alternative (Abdelaal et al., 2013; Antonsen, Jensen, & Thayssen, 2013). Many researchers in different medical fields argued that 'quicker is better' for patients, because studies showed that recovery is faster for patients who were discharged early after surgery (Hjort Jakobsen, Rud, Kehlet, & Egerod, 2014; Kehlet, 2011; Kehlet & Wilmore, 2008). However, the introduction of same-day discharge also introduced some organizational challenges, for how is it possible to create a smooth and efficient 'production' line of patients in an uncertain context where changes can happen continuously? What kinds of patient trajectories are produced in the compressed context of same-day discharge? How has the Cardiac Day Unit as a new organization challenged and affected the everyday organizing of professional work?

The establishment of the Cardiac Day Unit resulted in a rethinking of the role of patient trajectories, from a concern in the 'background' to a central assembling force in the 'foreground'. Organizing same-day discharge depended on collecting patients from different groups with the expectation of similar, short and uncomplicated trajectories. Organizing a unit like this was novel to both the management team and the nurses and doctors working in the Day Unit, and to the medical society in general.

Studies show that while same-day discharge after routine cardiac procedures was successful and preferred by most patients (Kim et al., 2013), same-day discharge also displaced a substantial part of the recovery process to outside of the hospital, where patients become 'patients in their own homes' and have to rely on help and care from family members or friends (Wagner & Carlslund, 2002). Thus, a pressing question became: how was the new organizing affecting the patient's experience of a coherent trajectory and the professionals' abilities to plan their trajectories? Decisions on how to manage patients' diseases had to occur within a shorter period of time. Much information had to be collected and many actions had to be performed while the patient was hospitalized, which meant a significantly shorter period than before (from 3 days to 1). As indicated in section 1.1. of this chapter, the clinical management's preoccupation with securing 'the right knowledge at the right time' resulted in many deliberations about what the right knowledge was in the context of same-day discharge. This question intrigued this researcher as well, and throughout the ethnographic study, it became clear that 'the right knowledge' was the knowledge that enabled professionals' successful interpretation of the past to move forward into the future with the optimal care for each patient. It was what they constantly did while participating in medical conferences, distributing beds and interpreting symptoms into a possible diagnosis in conversation with the patient. Based on the challenges experienced in the Cardiac Day Unit, this dissertation adds to these theories by researching how actors make small-scale decisions continuously in the organizing of same-day discharge and how professionals manage the relevant information for making these decisions. The professionals in the Day Unit utilized a number of material objects to contain and share information. Some of the objects were designed specifically for planning in time and rescheduling according to unplanned events. In same-day discharge, professionals were continuously balancing

different needs such as discharging patients as early as possible while still being attentive to each patient's specific needs. Accordingly, the discussions of this balance always occurred in relation to material objects. As such, the initial phases of the ethnographic study showed that the practices in the Day Unit were affected by the organizing of patient trajectories in same-day discharge. Furthermore, it revealed that this new way of organizing created tensions for the professionals that seemed to be related to time, because they dealt with processes in time, planning on time or objects that represented time. When studying practices in the Cardiac Day Unit these different representations of time arose in intertwined patterns and because of this ethnographic 'practice approach' it became imperative to investigate the implications of studying the relationship between organizing and time.

By studying seminal studies on the relationship between organizing and time, especially within health care organizations, I (naturally) came across Zerubavel's 'tempography' *Patterns of time in hospital life* (1979a). For Zerubavel, tempography describes an organizational ethnography representing the socio-temporal structures in an organization, i.e. a 'temporal geography' (Zerubavel, 1979a). I became inspired by the idea of conducting a modern tempography in the Cardiac Day Unit. The Day Unit, as well as hospitals in general, have changed dramatically since Zerubavel's studies were conducted, with the introduction of same-day discharge with accompanying at-home treatment (Cotton et al., 2000) and rehabilitation outside of the hospital (Ades et al., 2011). The relationship between time and ethnography has been discussed by researchers before, but not by many, and mostly concerning how researchers present time in ethnographic writing (Dawson, 2014b; Fabian, 1983; Willis, 2010). I found it necessary to develop my own framework for undertaking a temporal ethnography (tempography). These organizational tensions - creating

smooth patient trajectories in same-day discharge, decision-making within a limited timeframe supported by the use of objects, and organizing tempography -pointed to the coexistence of multiple time perspectives. This was the initial interest that brought me on the research journey, explained in depth in the next section on the thought process towards a research question.

1.3. Towards a research question

As the two prior sections revealed, there were several questions worth exploring when researching the Cardiac Day Unit. I wondered how tensions arose from the introduction of same-day discharge and how they could be understood theoretically. From my initial study of the Cardiac Day Unit, it became apparent that the organizational changes had something to do with time, but I was intrigued to explore how they were connected to different theories explaining the relationship between time and organizing. It made me formulate this research question that guided the dissertation:

RQ: *How does new organizing of patient trajectories create time-related tensions in a Cardiac Day Unit?*

To answer this question, I began exploring literature in order to find out how different perspectives could help me explain the tensions that professionals and patients faced when introducing same-day discharge in the Cardiac Day Unit. However, to answer this question in detail, the establishment of three specific sub questions was needed. First, I had an interest in exploring what it meant to care for patients' trajectories in accelerated discharge schemes. A lot was written about the management of patient trajectories (Strauss, Fagerhaugh, Suczek, & Wiener, 1997),

but what about the patient in time, e.g. their stories, their illness, their prospects and therefore their expectations towards their admission in the Cardiac Day Unit? I therefore formulated this research question:

RQ 1: *How are 'temporal patient trajectories' continuously reconstructed in a Cardiac Day Unit, and what are the challenges for professional work?*

I answer this question in the paper *Temporal patient trajectories: Long stories in short admissions* (Chapter 5). The paper combines different theories on trajectories to explain how they are more than formal organizations and how they emerge from everyday organizing and conversations between professionals and patients. The concept 'patient trajectories' (or illness trajectories) was adapted by several researchers (Pescosolido, 2014; Strauss et al., 1997) as an important concept to explain the formal organization of medical work around the patient. However, the trajectory literature mainly treated the patient as a body that was moved along a timeline by professional work. There are only a few studies concerning the experience of coherence in patient trajectories and even fewer on how professionals and patients continuously construct and re-construct this coherence, and therefore how they become 'temporal trajectories' (Hernes, 2017).

When I studied how patients were cared for in the Day Unit, other than through their trajectories, I came across the clinical management's concerns regarding the speed of decision-making in same-day discharge and the need for rethinking what information is necessary at a given point in time. Thus, my concern was the micro-strategical practices in the Day Unit that were affected by the introduction of a limited timeframe. These practices were evidently important for everyday organizing, and

they were supported by the use of material objects, i.e. representations of procedure plans and patient overviews. I therefore formulated this research question:

RQ2: *How is 'temporal object work' practiced in a Cardiac Day Unit, and what are the implications for strategy-as-practice research?*

I answer this question in the paper *Temporal object work in a cardiac Day Unit* (Chapter 6) by showing how micro-strategic practice could be understood as 'temporal work' because professionals continuously engage in object-mediated discussions in the present that involve past concerns in order to make plans for the future (Kaplan & Orlikowski, 2013; McGivern et al., 2018). The literature on temporal work was directed mainly towards larger strategy projects, and in the case of the Day Unit what mattered was how continuous practices supported the success of the Day Unit (or not). The significance of the objects for making decisions is studied through the examination of the (sparse) literature on temporal boundary objects. The literature describes the ability of objects to span different time perspectives in professional groups. In the paper, we challenge this notion by showing how the objects also represent certain temporalities and that a hegemonic relationship between different objects exists, which is important for the professionals' use of the objects when conducting temporal work in same-day discharge.

Finally, planning and executing the ethnographic study drew my attention to the difficulties with studying time in organizations through ethnographic fieldwork. The relevant literature was sparse and mainly concerned the temporal challenges of writing up ethnographies, e.g. choosing past or present tense for writing up and 'freezing cultures in the past' (Fabian, 1983). Even though Zerubavel, in his dissertation (1979a), established the idea of an organizational 'tempography' (i.e.

time-oriented ethnography), not a lot has been written to guide ethnographers on how to handle the many representations of time that they encounter when doing ethnography. I therefore formulated this sub question:

RQ3: *What are the 'organizational tempography' implications of researching the coexistence of multiple time perspectives in a Cardiac Day Unit?*

I answer the question in the paper *Seeing, understanding and representing time in tempography* (Chapter 7) by developing a framework for conducting tempography, inspired by 'temporal awareness', 'temporal practices' and 'temporal merging' (Dawson, 2014b), which primarily concerns the representations of time in writing ethnography. The paper brings these considerations into other aspects of doing ethnography, i.e. thinking about ethnographic methods and their suitability in capturing temporal details, and the significance of different conceptualizations of time and temporality for how we understand organizations.

The three analytical papers investigate different aspects of practices connected to the Cardiac Day Unit that create tensions in same-day discharge. These tensions are connected to time, but in very different ways. The objective of this dissertation is therefore to follow the tensions that arise from the introduction of same-day discharge and to trail these practices and their relationship to and through time. The idea, that these tensions are connected to a coexistence of multiple time perspectives in the Cardiac Day Unit, is followed through this dissertation. However, in order to trail tensions in the intersection between organizing and time, a small description of the literature on organizational time is needed, which is the point of the next section.

1.4. Time in organization studies

The body of time-related studies within organizational studies is vast. Time has been important to our understanding of how organizations are shaped by coordination and collaboration between organizational actors. Especially in the light of organizational changes to accommodate increased efficiency, new improved workflows, etc. time studies have been important. The discussions were many, e.g. between objective and subjective time and between structure and practice, all of them relevant and interesting lenses for explaining organizational phenomena. In studies of health care organizations, the discussions often focused on the tensions between the time experience of patients and the temporal organizing of professional work.

In **time in motion studies**, time is a resource that can be spent on activities, work or social interaction. The conceptualization of time is dominated by time as measured by a clock, e.g. timeframes, intervals and sequences (Taylor, 1911, 1970). For Taylor, the main objective was to break organizational tasks up into motions and find the optimal way (and time) to perform these tasks but, also on how to include breaks and provide shorter working hours for optimal production (Locke, 1982). This perspective prevails in perspectives such as Lean management that focus on how organizations can streamline activities in order to 'save time' (Al-Araidah, Momani, Khasawneh, & Momami, 2010; Fetter & Freeman, 1986; Locke, 1982; Taylor, 1911). For time in motion studies, time is clock time, and organizations are shaped by the way they utilize their time, e.g. more or less efficiently. Time as a resource that becomes scarcer because of societal developments has been pivotal to studies of **social acceleration** (Rosa, 2013; Ulferts, Korunka, & Kubicek, 2013)**.** These perspectives claim that modern societal structures nurture social acceleration at the

rate at which society is changing. Technology, knowledge, reforms and institutions are developing and changing at a faster and faster pace. Time in organizations is therefore characterized by frequent disturbances and interruptions. Rhythms in organizational life becomes increasingly fragmented and overruled by notions of 'instantaneous time' (Nowotny, 1994). Social acceleration scholars focus on the number of actions or experiences per unit of time, and regard organizations as shaped by the elevated speed of actions and level of fragmentation. The notion of organizations as landscapes of **socio-temporal structures** was suggested in the 1970s by Zerubavel (1979a). Zerubavel described socio-temporal structures as rhythms, temporal reference points/frameworks and the socio-temporal order. The common denominator of these concepts is that they reveal how practices are translated into temporal patterns by professionals making sense of their everyday practice. Many researchers have used Zerubavel's theorizing in studies of temporal practice in organizations (Georgiou, Westbrook, & Braithwaite, 2011; Heaton, 2001; Orlikowski & Yates, 2002; Reddy, Dourish, & Pratt, 2006; Waterworth, 2003). For these scholars time equals socially constructed temporal structures that create a sense of order for organizational members. Thus, organizations are defined by their socio-temporal structures that act as fundamental organizing principles (e.g. 'continuous coverage', Zerubavel, 1979b). Another important perspective is **time experiences**, which focuses on introspective experiences of time, e.g. as duration (Bergson, 1922). In an organizational context, many of these studies examine flow experiences to explain motivation and creativity in organizations – as a quest for 'timeless experiences' or meaningfulness (Bailey & Madden, 2017; Mainemelis, 2001). In health care, the subjective perspectives have been especially interesting in studies of how patients experience time when recovering from different illnesses (Andersen & Obling, 2014; Hauge, 2015; Klitzman, 2007). Time-as-experience focuses on the

experience of being in time – something very different from clock time. The experience of time is, however, still affected by and compared to clock time. From an organizational perspective the focus has been primarily on how different experiences clash, or how the patient experience is affected by imposing clock time or acceleration (Jones, 2010). **Process perspectives** draw on process philosophy (Mead, 1932; Whitehead, 1929). The processual view inherits a temporal perspective, just by being 'processual'. Process theories of organization shift focus from radical change versus enduring identity over time, to how organizational actors construct meaning in an ongoing present suspended between the past and the future (Dawson, 2014b; Hernes, 2014; Hernes, Simpson, & Söderlund, 2013; Langley, Smallman, Tsoukas, & Ven, 2013; Schultz & Hernes, 2012). For process theorists, 'temporality' points to the ongoing relationship between past, present and future e.g. in reconstruction of organizational identity. They focus on 'memory forms' (Schultz & Hernes, 2012) and 'articulatory modes' (Hernes, 2014). Process perspectives focus on temporality, i.e. the ongoing relationship between past, present and future. Organizations are not structures in themselves, rather they 'become organizations' by actors weaving together past, present and future. All of these studies are valuable contributions to understanding the significance of time for organizations. This section also highlights how they are connected to each other and often evolve from each other in search of new theoretical explanations, nurtured by the increasing complexity of modern life. An example is the emerging body of organizational studies that theorize the relationship between practice and time in order to explain what actors do 'with' and 'in' time. This dissertation is a contribution to these practice studies, by arguing for a perspective that explains the structural and processual simultaneity in temporal practices.

1.5. Temporal practice studies

Temporal practice studies comprise many perspectives from the other traditions, but make an important contribution by focusing on practices that bring actors, materials and organization together (Orlikowski & Scott, 2008; Orlikowski & Yates, 2002). Temporal practice scholars claim to bridge the objective/subjective time gap by focusing on what organizational members 'do' in relation to time and temporality (Orlikowski & Yates, 2002). 'The practice lens' implies a focus on everyday activity in organizations (Feldman & Orlikowski, 2011; Nicolini, 2010). Practice perspectives on time and temporality is an emerging research field, and include: Computer Supported Cooperative Work (Egger & Wagner, 2013; Reddy & Dourish, 2002; Reddy et al., 2006), Science and Technology Studies (Ancona, Okhuysen, & Perlow, 2001; Georgiou et al., 2011; Orlikowski & Yates, 2002; Perlow, 1999; Yakura, 2002), Communities of practice: (Fahy, Easterby-Smith, & Lervik, 2014; Nicolini, 2007), strategizing (Hydle, 2015; Kaplan & Orlikowski, 2013; Lee & Lee, 2008) and studies of narrative practice in organizations as 'chronotopes' (Pedersen, 2009). The practice perspective introduces concepts such as temporal structuring (Orlikowski & Yates, 2002), temporal brokering (Reinecke & Ansari, 2015), temporal boundary objects (Yakura, 2002), entrainment (Ancona & Waller, 2007) and temporal work (Kaplan & Orlikowski, 2013; McGivern et al., 2018) to understand organizational practice. In health care studies, the temporal organizing around patients and their trajectories has been theorized and discussed by many researchers (Pescosolido, 2014; Reddy et al., 2006; Strauss et al., 1997). The studies described in great detail how professional work moves the patient along the trajectory towards treatment.

This dissertation adds to this body of literature, by arguing for a practice-oriented perspective, which draws inspiration from the studies above, but combines them with insights from process studies on the significance of temporality, i.e. practice/process hybrids. Examples of these hybrids are temporal work and patient trajectories, where both temporal structures and temporality are of great importance. In this understanding, organizations are shaped by the plans that are made by organizational members while engaging in practices that span the temporal boundaries between past, present and future. My contribution to temporal practice studies is first and foremost to study (in great detail) how these practices unfold in the context of medical work.

Table 1 summarizes the central theoretical concepts in this dissertation and establishes the conceptual framework to which this dissertation offers theoretical contributions. Accordingly, this table will be presented in the conclusion (Chapter 8) including the contributions that are a result of the empirical papers. These concepts will be elaborated in the next chapter, which consists of the review of literature.

Table 1: Central theoretical concepts in the dissertation

Concept	**Definition**
Patient trajectories	Patient (or illness) trajectories describes the organization of work done to manage the physiological unfolding of a patient's disease, and the impact on those involved with that work (Pescosolido, 2014; Strauss et al., 1997)
Temporal work	Temporal work concerns the way organizational actors make interpretive links in time by discussing concerns of the past and present to shape future (strategic) action (Kaplan & Orlikowski, 2013; McGivern et al., 2018).
Tempography	Tempography is an organizational ethnography describing the socio-temporal structures in an

	organization (Zerubavel, 1979a). It is related to the research of urban development; 'temporal geography' (Auyero & Swistun, 2009).

The discussion of these theoretical concepts is repeated throughout this dissertation; their representations in the case study of the Cardiac Day Unit, their impact on the methodology and specifically my arguments for theoretical development of these concepts in the three papers. The patient trajectory is both a theoretical and empirical concept, i.e. the professionals in the Day Unit constantly talk about the organizing of patient trajectories (in Danish 'patientforløb') in interviews and in day to day conversations. Temporal work and tempography are theoretical 'translations' of observed micro-strategical practices conducted by professionals and methodological considerations for researchers who conduct time-related ethnography.

1.6. Chapters in the dissertation

This dissertation comprises eight chapters. Chapter 1 is this introduction and Chapter 2 describes a review of relevant literature on how the relationship between organizing and time has been theorized, from time as a measurable resource, over time as experience, and temporal structure perspectives to the practice- and process perspectives to which this dissertation offers contributions. Chapter 3 describes the case study of introducing same-day discharge in the Cardiac Day Unit - the new organizing, the challenges that it created for professionals and the relationship to a broader medical trend in the health care sector. Chapter 4 presents the methodological discussions and considerations that concerned me while doing the organizational ethnography of same-day discharge in the Cardiac Day Unit. Chapters

5 – 7 comprise the three analytical papers: Chapter 5) *Temporal patient trajectories: Long stories in short admissions*; Chapter 6) *Temporal object work in a Cardiac Day Unit*; and Chapter 7) *Seeing, understanding and representing time in tempography*. Chapter 8 establishes the discussion of this dissertation's contributions and ends with a conclusion.

CHAPTER 2: LITERATURE REVIEW

"Life holds one great but quite commonplace mystery. Though shared by each of us and known to all, seldom rates a second thought. That mystery, which most of us take for granted and never think twice about, is time. Calendars and clocks exist to measure time, but that signifies little because we all know that an hour can seem as eternity or pass in a flash, according to how we spend it. Time is life itself, and life resides in the human heart. "

- Michael Ende, *Momo*

2.1. Introduction

As this quote from Ende's popular children's book (1984) refers, time is a 'mystery' that has been approached by many researchers, authors, poets and musicians. We 'feel it' but it is hard to describe the effect of time in certain terms. This dissertation is also an attempt to describe the significance of time in an organizational context - in the everyday organizing of patient care and treatment of 'human hearts' in a Cardiac Day Unit.

This chapter describes the theoretical landscape to which this dissertation offers contributions. It begins with describing the research that regards time as a resource, e.g. Lean management and scientific management (Eriksson, Holden, Williamsson, & Dellve, 2016; Taylor, 1911). The next sections outline the bodies of literature that describe how time is experienced (Bergson, 1922; Csikszentmihalyi, 1990) and how time is socially constructed (Zerubavel, 1979a) by organizational actors. The following section presents the time-as-practice perspective to which this dissertation

offers specific theoretical contributions (Kaplan & Orlikowski, 2013; Orlikowski & Yates, 2002). The chapter ends with a section that describes the relationship between time and trajectories (Hernes, 2017; Strauss et al., 1997) in organizations, which is significant for understanding the relationship between patient care and discharge schemes.

Sections 2.2.-2.4., i.e. the resource, experience and structure perspectives, establish the foundation for understanding the theoretical discussions on time and organizing, especially in research on health care organizations. Sections 2.5. and 2.6. (which are lengthier than the previous sections) describe the specific analytical framework to which this dissertation offers contributions, i.e. time as practice and trajectories. I argue that both the practice- and the process perspective are relevant for understanding the Cardiac Day Unit, and that these different ways of thinking about time and temporality coexist in organizing same-day discharge.

2.2. Time as resource

Reducing time consumption has been an important focus in organizational studies and in managerial practices. 'Scientific management' and 'Lean management' focus on how organizations can streamline activities in order to 'save time' (Al-Araidah et al., 2010; Fetter & Freeman, 1986; Locke, 1982; Taylor, 1911). Hospitals specifically, have been subjected to many Lean-projects over the years (Dickson, Anguelov, Vetterick, Eller, & Singh, 2009). This perspective has been criticized for only focusing on time as measured by a clock and introducing an extensive workload in organizations at the expense of social work systems (Trist & Bamforth, 1951). As a counterweight to the Taylorist perspective, Roy proposes an example of employee resistance as 'banana time' (Roy, 1959). His analysis showed how social interaction

between employees occurred as interruptions in strictly organized production. The employees described these interruptions in terms of time, where banana time was a small period of time where 'fun' was the main focus. Banana time became a form of currency, an 'employee benefit' that was accepted by the management in exchange for employee acceptance of a high production speed. A similar perspective is proposed by Thompson (1967) who describes time discipline and time as currency. In this perspective, time is 'spent' and actors are valuated based on their ability to spend their time wisely. And Perlow (1999) describes how actors use their time at work, why they use it this way, and whether their way of using time is optimal. Similarly, Lee & Lee (2008) describe how the introduction of a new temporal scheme (working hours) in one of the largest conglomerates in Korea enhanced the awareness of time as a resource, i.e. employees became more aware of how they used their time within this new temporal scheme. For example, phone calls were often chosen over face-to-face meetings to save time. Time as a commodity between employees and employers has been researched from many perspectives, one of them being how employees can achieve motivation from working at self-selected times or from increasing their involvement in roster determination (Baker, Ferguson, & Dawson, 2003; Lee & Lee, 2008).

Even though this perspective is not the most relevant for the theoretical scope of this dissertation, it is still relevant when researching organizations. The realistic/resource perspective is the basis for understanding how time is treated as an important resource in many organizations. These classical understandings of time are deeply embedded in the way actors talk about time and organizing, e.g. as efficiency etc. However, time may be treated as a resource or even a commodity, but it is at the

same time deeply embedded in the human experience and specifically actors' experiences when working in organizations.

2.3. Time as experience

Subjective time has been an issue for studies of 'flow experiences' in organizations (Csikszentmihalyi, 1990; Mainemelis, 2001). Flow experiences have been used to explain both motivation and creativity in organizations – as a quest for 'timeless experiences' (Mainemelis, 2001). Some have also utilized time perspectives in studies of how employees experience task discretion and agency in organizations (Hirvonen & Husso, 2012). The subjective perspectives have been especially interesting in studies of how patients experience time when recovering from different illnesses (Andersen & Obling, 2014; Hauge, 2015; Klitzman, 2007). Accordingly, the subjective perspective has also been linked with narratives (Ricoeur, 2010) and specifically with illness narratives (Hydén, 2010; Riessman, 2015; Sakalys, 2000; Saris, 1995). In health care, patients' treatment satisfaction is directly linked to their experiences of time when recovering (Klingemann, 2001; Klitzman, 2007). Introspective experiences of time have been described as experiences of duration (durée) by Bergson (1922) to explain the relationship between time as a (quantitative) immobile time line, and the (qualitative) mobile experience of time, i.e. the paradox that for the individual, time can speed up or slow down, whereas, when measured by clock it would remain the same. Drawing on the concepts proposed by Bergson, researchers have studied how the inner experience of time is changed because of mental illness (Fuchs, 2005; Wittmann, 2009). Building on this, researchers have explained the relationship between the experience of accelerated time and the embodied 'outer' manifestation of this experience, e.g. using different technical

methods of perfecting the body to ‘stay young’ while time is slipping by (Gerisch, 2009). The notion of social acceleration (Eriksen, 2002; Nockolds, 2015; Rosa, 2010, 2013) is highly relevant for researchers concerned with experiences of time in modern life. These perspectives claim that modern society nurtures social acceleration at the rate at which society is changing. Technology, knowledge, reforms and institutions are developing and changing at a faster and faster pace. Experiences for organizational actors are therefore characterized by frequent disturbances and interruptions (Holt, Hvid, Kamp, & Lund, 2013; Kamp, Lund, & Hvid, 2011; Scheller, Pries-Heje, & Hvid, 2015). Organizational life becomes increasingly fragmented and overruled by notions of ‘instantaneous time’ (Nowotny, 1994).

Experience is important for both professionals and patients, and even though this dissertation does not offer a direct contribution to this literature, it is still important to consider the role of experiences in patient care. The subjective perspective on time is an inherent perspective when dealing with organizational actors’ as well as patients’ experiences. It is however a perspective that has been criticized for focusing purely on the subjective experience and ignoring the notion of objective time structures within the organization as well as the interplay between subjective and objective time. This relationship, and specifically the social structure of time, is important for understanding how organizing can be described in terms of time.

2.4. Time as social structure

Viewing temporal structures as social constructions is an attempt to bridge the objective/subjective time gap because it describes the relationship between how actors think and talk about time and how the socio-temporal order (Zerubavel, 1979a) establishes a framework for planning and coordinating in organizations. Time in

organizations has been theorized as socio-cognitive structures and frameworks to guide actions (Bluedorn & Denhardt, 1988; Cipriani, 2013; Waterworth, 2003; Waterworth, Gott, Raphael, & Barnes, 2011; Zerubavel, 1979a, 1979c, 1985). Time organization is described by Fine (1990) as the interplay of external and structural demands that sets the temporal dimensions of work, to which workers must adjust. The social structure perspective often includes a material dimension as well, as social constructions of time are often represented by objects such as clocks, schedules or calendars (Birth, 2012). As an example, timetables constitute the main institutions and processes that govern the temporal regulation of social life (Zerubavel, 1976). And following this, timelines in organizations are described as essential for cooperating and planning (Yakura, 2002). Yakura argues that timelines embody objectivist assumptions about time but simultaneously allow different professional groups in organizations with different understandings to negotiate and manage time prospectively and retrospectively. As such, timelines (and other objects) establish important social structures in organizations in general, and specifically in health care organizations, where coordination of patient treatment has to be structured in terms of time.

One of the most detailed studies of socio-temporal structures in hospital work was completed in the 70s by Zerubavel (1979a). He explains how time is socially constructed by actors in the hospital as rhythms, temporal reference points/frameworks, and the socio-temporal order. The common denominator of these concepts is that they reveal how social life is translated into time patterns by professionals making sense of their everyday practice. ‘Temporal reference frameworks’ is an interesting concept as it describes background expectations adjusting individuals’ subjective references in accordance with a standard yardstick.

Zerubavel developed his concepts further in later works (Zerubavel, 1985, 1987). The studies focused on how time is socially constructed and represented in semiotic codes used to communicate social messages between actors (e.g. how we prioritize work activities etc.). Zerubavel's work touches upon discharge and 'patient careers', i.e. the time that the patient spends in the hospital, from admission to discharge. For Zerubavel, patient discharge is forced into a specific shape by the overall socio temporal structure of the organization (Zerubavel, 1979a). Zerubavel also describes how discharge acts as a patient's critical temporal reference point within the career (Zerubavel, 1979a) Also, the patient career inside the hospital is forced into a pattern mostly shaped by the structure of work shifts, where patients 'shift hands' between different professionals in a work organization promoting continuous coverage (Zerubavel, 1979a). Time is critical for the organization of hospital work on several levels. Zerubavel describes how the social structure of hospital work itself is organized with regard to time. For instance, *"... hospital staff often measure the passage of time in terms of number of patients, so that patients actually become units of time for them"* (Zerubavel, 1979a, p. 90).

Many researchers have used Zerubavel's concepts in later studies of time in health care organizations (Georgiou et al., 2011; Golander, 1995; Heaton, 2001; Jones, 2010; Reddy et al., 2006; Waterworth, 2003). Georgiou et al. (2011) investigate new technologies' effects on the organization of activities in a hospital ward. They advocate for a conception of time as a landscape that affects organizational functionality with regards to tempo (e.g. the pace and intensity of an activity), patterns (i.e. periodicity) and sequence and synchronization of events. A similar perspective is found in Adam's seminal research on time (2004) and 'timescapes' (1998). She addresses some of Zerubavel's concepts and extends the understanding of

the timescape to include several different perspectives. The timescape in an area such as a city or an organization can be described in terms of timeframe (life time, generation, historical/geological epoch), temporality (process world), timing (synchronization, co-ordination), tempo (speed, pace, intensity), duration (extent, temporal horizon), sequence (order, succession, priority) ; and temporal modalities (past, present and future). Adam's timescape is a (mostly) stable landscape described in terms of time but similar to Georgiou et al.'s (2011) description of the temporal landscape in hospitals.

Heaton (2001) also draws inspiration from Zerubavel in her study of temporal organization in hospital discharge processes. The paper investigates 'time gaps' between care in the hospital and the transition to home care:

"... discontinuities in the rhythms and routines of hospital and home-based care; second, the incompatibility of hospital and community care time frames; and third, the lack of synchronization of services with users' requirements" (Heaton, 2001, p. 101).

Without using the exact terminology, she describes the clash between different temporal landscapes. Another subset of studies is concerned with different understandings of time that guide the social organization of health care. Following this, Jones (2010) writes about clashes between different understandings of time in nursing work (objective, subjective and sociological). By referring to Zerubavel, she highlights the importance of sociological time for understanding how nurse work is organized, contrary to the common understanding that the objective understanding of time is dominant. Two studies by Waterworth (2003; 2011) use the concept 'temporal reference frameworks' to describe how nurses were affected by different social

conceptions of time in their work (i.e. patient time, listening time etc.). These different frameworks collide and make it difficult for nurses to orient their work effort. One of the studies (2011) concerns older patients with heart failure and their general practitioners' abilities to think about time in relation to their illness. Yet another study by Frankenberg (1988) focuses on the temporal contradictions of biomedical practice. The study shows how patients' and professionals' temporal reference frameworks differ, and how healthcare workers distance themselves from the 'patient's time' (Frankenberg, 1988) by taking the present-tense account of symptoms (the history) and translating it into a timeless, disembodied diagnosis.

All of the above studies deal with the social organization of time in (more or less fixed) structures and materials. But these studies have been criticized for their static way of understanding time. As an example, Adam's timescape concept (1998), even though it is multi-faceted and useful, lacks a dynamic capability to describe constant change in an organizational landscape. Therefore, other researchers have used time concepts offered by the social structure perspective, but in a more emergent context, focusing on how time is 'practiced' in organizations. The social structure perspective establishes a link between actors, structures and materials that represent time. It is these structures and materials that people 'use' when organizing time in practice, which is the point of departure for the next section.

2.5. Time as practice

Time-as-practice studies also claim to bridge the objective/subjective time gap (Orlikowski & Yates, 2002). The 'practice lens' implies a focus on everyday activity in organizations, practices regarded as routine by those who perform them, as well as improvisation (Feldman & Orlikowski, 2011; Nicolini, 2010). This dissertation

subscribes to the practice perspective by focusing empirically on how people act in organizational contexts, developing theories on the relationship between how they act and the structures (and processes) of organizational life, and building on the philosophical position that practices play a constitutive role in producing 'organizations' (Feldman & Orlikowski, 2011).

Time in organizational practice has been theorized by traditions such as Computer Supported Cooperative Work (Egger & Wagner, 2013; Reddy & Dourish, 2002; Reddy et al., 2006), Science and Technology Studies (Ancona, Okhuysen, et al., 2001; Georgiou et al., 2011; Orlikowski & Yates, 2002), Communities of practice (Fahy et al., 2014; Nicolini, 2007), strategizing (Hydle, 2015; Kaplan & Orlikowski, 2013; Lee & Lee, 2008) and even in studies of narrative practice in organizations (Pedersen, 2009; Vaara & Reff Pedersen, 2013). The practice perspective introduces concepts such as, temporal structuring (Orlikowski & Yates, 2002), temporal frames (Boden, 1997), negotiating temporal orders (Egger & Wagner, 2013) and entrainment (Ancona & Waller, 2007) to understand organizational practice. According to Orlikowski and Yates, organizational life can be understood as a process of temporal structuring in which employees and managers continually produce and reproduce time structures in order to orientate their ongoing activities (Orlikowski & Yates, 2002):

"The notion of temporal structuring focuses attention on what people actually do temporally in their practices, and how in such ongoing and situated activity they shape and are shaped by particular temporal structures." (Orlikowski & Yates, 2002, p. 696)

Following Orlikowski & Yates' argument, time is structured through practices that constrain and enable different actions e.g. using a project plan to coordinate and pace activities. Temporal structuring is conducted in different organizational practices such as scheduling and making plans. Temporal structures are both the medium and outcome of those provisional and ongoing organizational practices: *"They are always only "stabilized-for-now""* (Orlikowski & Yates, 2002, p. 687). Temporal structures can be more or less influential due to continuous reproduction and reinforcement in organizations. As an example, 'opening-hours' in a store tend to be more influential as a framework for working hours than the 'work day' for the average knowledge worker. Temporal structuring as a framework also comprises the idea of 'pluritemporalism' (Orlikowski & Yates, 2002). Actors practice multiple and often interdependent temporal structures, which suggests that actors have to balance contradictory expectations about (or frameworks on) how to act temporally. One of the most well-known examples is the balance between work and family life (see Hochschild, 1997).

The practice perspective entails that temporal structures are regarded as something that is 'done' by organizational members rather than something that is 'already there' (Orlikowski & Yates, 2002). Temporal structuring highlights the way in which employees and managers actually act in practice and how they shape and are shaped by temporal structures. Orlikowski & Yates' theory explains how temporal structures are renewed or changed completely. However, even though they are noted as being unstable and continuously changing through practice, the structures can be more or less rigid. This is probably the most important contribution of the practice perspective, as none of the previously reviewed literature on time and organizing is preoccupied with how time patterns are created and changed. Temporal structures

change when, for example, new technologies, tasks or schemes are introduced. Changing temporal structures is tightly connected to organizational change that aims to improve efficiency, timing, coordination or service quality. Orlikowski & Yates have introduced these concepts to assess the 'broadness scope' of temporal structures: 1) Size (the number of persons in a community); 2) Penetration (how many in the community use the structure); 3) Dispersion (geographical extent of persons using the structure); 4) Embeddedness (the extent to which the structure is implicated in daily lives); 5) Extent (number of communities using the structure (Orlikowski & Yates, 2002, p. 696). The use of these concepts would imply how easily a temporal structure can be altered. For instance, moving the 'summer holiday' to November for economic purposes would be changing a highly penetrable, dispersed, embedded and extended temporal structure. In change processes where new organizing has to exist within the old organization – with all its customs, institutionalized temporal structures and practices – the process itself becomes one of continuously translating, adapting and adjusting temporal practices. Temporal structuring in organizations seems to be an endless endeavor to reach 'entrainment': *"… the adjustment of tempo for one activity to synchronize with another activity."* (Halbesleben, Novicevic, Harvey, & Buckley, 2003, p. 440) This especially applies to health care organizations where different sections, operating rooms, laboratory technicians or hospital porters all have to be 'in sync' with each other. Entrainment has been an important focus in many practice studies (Ancona & Waller, 2007; Fahy et al., 2014; Halbesleben et al., 2003).

Orlikowski and Yates's perspective has been criticized by Hernes in his book about process perspectives in organizations (Hernes, 2014). He argues that,

"Rhythm and speed become socially defined labels that characterize organizational life, but they do not say much about its 'inner dynamic', which describes how the 'parts' of assemblages are 'on the way' to becoming more that they already are, due to what happens at certain events in time, and as events connect to other events" (Hernes, 2014, p. 35).

While the practice perspective illuminates several aspects of time in organizing, Hernes takes Orlikowski & Yates' perspective as his point of departure for developing a more emergent and micro- perspective on how temporal structures become structures through articulation in events. His theoretical ideas are discussed further in the next section on time as trajectory. But following his argument about the 'non-temporality' of temporal structuring, another perspective was developed, i.e. 'temporal work' as a theoretical framework for describing temporality-as-practice (Granqvist & Gustafsson, 2016; Kaplan & Orlikowski, 2013; McGivern et al., 2018; Reinecke & Ansari, 2015). Highlighting the role of temporality in organizational practices that establish interpretive links between past, present and future in practice, these studies provide explanations for why some links 'work' while others 'fail'. Kaplan and Orlikowski's study (2013) focuses on how changes in the surrounding market cause breakdowns in strategy which then foster temporal work in an organization to create new strategies. Temporal work concerns how actors discuss differences in their interpretations of the organization's past, present, and future to construct a story that provides a basis for strategic action. Another perspective that combines organizational (strategic) practices and temporality was proposed by Hydle (2015) as the 'temporal and spatial dimensions of strategizing'. She describes non-deliberate strategizing where strategy emerges through everyday activities and practices that are not necessarily performed at the same time or in the same space.

Her perspective proposes that doings and sayings in organizations form activities, which can be understood as intentional and voluntary events with temporal-spatial aspects, i.e. a 'timespace' (Schatzki, 2010). She describes two different ways of strategizing and connects the practices to building modes (strategy through purposeful planning) and dwelling modes (strategy through everyday practical coping).

The shift of focus from large-scale intended strategy to the strategical (and temporal) element in everyday practices, as proposed by Hydle (2015), is highly relevant for studying practices in the Cardiac Day Unit. As in strategizing in other kinds of organizations, professionals in hospitals constantly debate interpretations of specific patients and their symptoms in order to make decisions on medical plans and actions. They are continually undertaking small-scale 'strategy work' to balance bed-management, patients' needs, procedure plans and unexpected situations. This kind of work is in its nature very much about temporality, i.e. moving back and forth between past, present and future. This dissertation adds to the temporal work perspective through conceptual work in the paper, *Temporal object work in a Cardiac Day Unit* (Chapter 6). The paper introduces the concept 'temporal object work' to explain how temporal work in everyday practices are supported by objects that mediate between past, present and future, through material representations of these temporalities. In addition to temporal work, another perspective that combines practice-based and processual thinking about time, is 'time as trajectories', which is the point of departure for the next section.

2.6. Time as trajectory

The role of time and trajectories in organizations has been described by two lines of thought: 1) A linear, planned and staged perspective on trajectories and 2) an emergent, processual and temporal perspective. Both perspectives have something important to say about processes in organizations, how they act as orderly structures and how they emerge from conversations. The traditional perspective has been dominant in hospital studies describing illness trajectories for chronically ill patients (Strauss et al., 1997). The process perspective on organizational trajectories is new (Hernes, 2014) and has not previously been explored in a hospital context.

The 'illness trajectory' is a classical perspective coined by Strauss et al. (1997) to describe the total organization of work along the unfolding of a patient's illness through time. Additionally, later works by Zerubavel (2012) study 'time maps', which primarily refer to historical trajectories. Time maps, according to Zerubavel, are trajectories in which humans organize the past in their minds. Therefore this concept is more linked to narratives than the trajectory concept of Strauss et al. (Strauss et al., 1997). Golander (1995) also uses a combination of concepts from Zerubavel and Strauss to describe how institutionalized life and organizational interactions are utilized by elderly patients to construct a unique time perspective. More recently, Snyder (2016) uses time maps in his book about disrupted workplaces, to describe social schemes in organizations. His use of the concept establishes a link between time maps and trajectories by arguing that 'time maps' are maps of the possible and most likely trajectories of social time. The trajectory as a classic concept describes hospital practice and work from diagnosis to recovery, or possibly death, for the patient (Glaser & Strauss, 1965, 1968; Strauss et al., 1997).

The concept is used in many contexts, but most frequently with reference to the treatment of chronic diseases such as cancer, but also ischemic heart disease and heart failure. It describes the professional considerations of how the patient's disease will progress and how the work 'around' the patient's trajectory is to be organized. Working with patient trajectories concerns 'mapping the process' in what is called the trajectory scheme, which covers the possible course and mapping of interventions along the trajectory. The point of departure for Strauss et al. is the micro-social organization of work in hospitals (Strauss et al., 1997). 'Trajectory work' includes different types of work: Comfort, clinical safety, machine, composure, biographical and psychological work. The point is that these types of work together enact a patient trajectory, and the concept brings out the evolving character of the work along the trajectory. The ongoing trajectory work originates from organizational attempts to handle contingencies and to maintain 'the shape' of the patient trajectory. The concept also suggests a relationship to time: "*Since there is a division of labor, it must be organized in terms of time*" (Strauss et al., 1997, p. 277). According to Strauss et al. a patient trajectory is a process which is staged in trajectory phases (Strauss et al., 1997, p. 30). Also, earlier publications such as *Time for dying* (Glaser & Strauss, 1968) have treated temporality in relation to the patient trajectory. This publication concerns 'dying trajectories' and the temporal organization of these processes. Concepts such as 'temporal reference points' are used here to show the considerations that hospital staff (especially physicians) must make in meetings with the dying patient. Temporal reference points consist of: a comparison of this specific patient's progress in relation to the 'usual' trajectory for patients with the same disease; expectations of how long the patient should be hospitalized; and the hospital's temporal organization in terms of work schedules. The latter consideration deals with the safeguarding of patient needs across work shifts, etc.

Illness trajectories have been studied by many scholars since the 60's. An entry in *The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society* from 2014 picks up on the trajectory research under the heading 'patient trajectories' (Pescosolido, 2014). The article, which among other studies draws upon Strauss et al.'s work, describes the patient trajectory as a sequence of events and turning points in treatment processes. Patient trajectories have typically been described as a sequence of linear stages with a series of specific statuses that shift over time. Studies of patient trajectories have been preoccupied with many different themes such as timing of trajectories within different care settings (Andershed & Ternestedt, 1998). The point here was to show the different organizational layouts within surgical wards and hospice wards and their significance for patients' trajectories. Patient trajectories have also been utilized as a concept to highlight the importance of early diagnosis in medical journals (Armstrong et al. 2012). The importance stressed is that a wrong diagnosis would lead to extremely complicated trajectories. Also, the patient's own (and often invisible) 'trajectory work' has been treated in studies such as that by Dalsted et al. (2012). Scholars preoccupied with the organization of medical work have utilized the concept to analyze how decisions about rescue relate to categorization (Mackintosh & Sandall, 2016). The point here is the significance of trajectory schemes when deciding which 'track' the patient is following, and therefore to which ward he should be admitted.

Time is an integral part of trajectory research, but there are also a few specific attempts explicitly to grasp the trajectory/temporality theme. For example, take Murray et al.'s article (2005) concerning close-ended 'temporal reference frameworks' of palliative care. Here the trajectory concept is used to create an understanding of what good palliative care can be, if viewed as a trajectory that

extends beyond the organization of work at the hospital, relating to life in general. The issue of temporality has also been lightly touched upon by Strauss et al. (1997). They write about the 'temporal order' of the hospital, which refers to: *"The entire web of temporal interrelationships we shall refer to as the temporal order. It includes the continual readjustment and coordination of staff effort, which we term the organization of work"*. (Strauss et al., 1997, p. 279). When writing about the 'temporal order', Strauss et al. subscribe to 'the sociotemporal order', a concept put forward by Zerubavel (1979a). The temporal order in hospital life can break down, through not only; *"... accident and poor planning, but also through differential valuation of time by various echelons, personnel, and clientele"* (Zerubavel, 1979a, p. 280). Also Timmermans (1998) extends the framework of Strauss et al. by advocating for a more processual character of the trajectory by pointing out that the trajectory is an ever evolving phenomenon. Drawing on STS research, Timmermans describes how several different trajectories exist simultaneously and shape each other (e.g. the physician's trajectory and the patient's trajectory).

Despite it being a powerful time-related concept to explain the planning and coordination of medical work, the 'temporal' aspect, i.e. how past, present and future are connected through the articulation of trajectories is an (almost) unexplored territory in studies of health care organizing. Accordingly, the way in which the patients' lived past and possible future affects professional decision-making is one of the theoretical contributions of this dissertation. The temporal perspective on trajectories entails that the patient is not only a body being moved from A to B, but has a body and mind that have existed in time out of the hospital, and will (hopefully) continue to exist for a long time. In recent years, organizational scholars have been conducting studies on the relationship between temporality and organizational

processes (Hernes, 2014; Hernes et al., 2013; Langley et al., 2013; Schultz & Hernes, 2012). Even a special issue of *Scandinavian Journal of Management* had the combination of temporality and process in organization studies as the main topic (Hernes et al., 2013). Langley et al. (2013) argues for focus on temporality in process studies of organization that, *"… address questions about how and why things emerge, develop, grow, or terminate over time… "* (Langley et al., 2013, p. 1). Schultz and Hernes (2012) presented a temporal process perspective on organizational identity in their study on Danish toy company Lego. They introduce a process-oriented perspective on time and organizational identity as being articulated in events (Schultz & Hernes, 2012). Process philosophy implies that the present must be seen as an 'ongoing temporal present', where past and future are enacted simultaneously in events. The past and the future are therefore not seen as periods distinct from each other as, for example, they are in the studies by Zerubavel (2012). 'Events' is one of the most significant concepts presented in the book, which is closely related to temporality in this way: "*Acts are given meaning through reflection by turning a living present into an event, which takes place once the 'temporal diameter' (…) has been left behind by the flow of time"* (Hernes, 2014, p. 85). Events are, in this perspective, organizational presents that attained provisional closure, and they are causally connected to each other in 'event formations'. As in the study by Schultz and Hernes (2012), articulation is also significant, as it describes the process in which meaning structures are enacted in living presents. Hernes presents different articulatory modes in his book, namely intersubjective, practical, textual, material and tacit (2014). These modes can be utilized in studies of how provisional structures, entities or trajectories become organizing.

Similarly to ‘temporal work’ the research on temporal processes as focused on intended and larger strategy projects, and the relationship between temporality and everyday processes, has been explored by few researchers (Hydle, 2015). This dissertation offers a theoretical contribution that ‘brings work back in’ (Barley & Kunda, 2001) to the organizational process perspective, i.e. ‘organizing patient trajectories’ in a Cardiac Day Unit. Recently, the process perspective has been developed in terms of a new concept ‘temporal trajectories’ (Hernes, 2017). Hernes criticizes organization studies for focusing on events as, *“... mere happenings along a timeline that stretches from the past to the future”* (Hernes, 2017, p. 602). The studies reviewed as the ‘traditional linear processes’ would all belong to this group that Hernes criticizes. Instead, Hernes argues for an understanding of events as ‘performative of the trajectory’. This would imply that the focus shift from people to events: *“... it is the “eventness” of objects that makes for our sensation of time”* (Hernes, 2017, p. 602). Hernes suggests the ’temporal trajectory’ as the object of thinking of organization as becoming, i.e. a form of organizational entity, which actors are constantly reconstructing. Then the understanding of ‘work’ will be different modes of articulation performed at various moments and in various places. Organizational process perspectives draw inspiration from process philosophy (Mead, 1932; Whitehead, 1929). The processual view inherits a temporal perspective, just by being ‘processual’. Many of these researchers focus on organizational change and the role of temporality (Dawson, 2014b, 2014a; Langley et al., 2013; Lord, Dinh, & Hoffman, 2015; Purser, 2011; Tsoukas & Chia, 2002). Additionally, studies have been conducted on collective identity (Ybema, 2010) and shared narratives (Schultz & Hernes, 2012) in organizations. Process theories of organization shift focus from radical change versus enduring identity over time to how organizational actors construct identity in an ongoing present suspended between the past and the future

(Dawson, 2014b; Hernes, 2014; Hernes et al., 2013; Langley et al., 2013; Schultz & Hernes, 2012).

This dissertation argues that the two theoretical understandings of trajectories can inspire each other, by offering a way for researchers to explain how the trajectory establishes both a structure and an ongoing conversation that creates the structure. The conceptual work is described in the paper *Temporal patient trajectories: Long stories in short admissions* (Chapter 5). The paper introduces the concept 'temporal patient trajectories' to describe how these trajectories are reconstructed continuously by professionals and patients and establish the organizational direction in a reciprocal relationship between past experiences, present needs and future expectations when conducting same-day discharge.

2.7. Conclusion

This chapter described the theoretical landscape of the relationship between organizing and time. The classical understanding of time as a measurable resource is deeply rooted in the way actors talk about organizing as 'efficient' (or the contrary), which is embedded in the idea of establishing the Cardiac Day Unit. The experience of time is an integral perspective in organizing patient treatment, where professionals are constantly confronted with, and expected to act on, patients' experiences of waiting time etc. The socio-temporal structure perspective establishes a link between actors, structures and materials that represent time, which has been dominant for explaining the temporal pattern of hospital work. The practice perspective offers a relevant perspective for explaining organizing in terms of time, specifically with concepts such as temporal structuring and temporal work. A contribution to the practice perspective is developed in the paper *Temporal object work in a Cardiac*

Day Unit (Chapter 6), which introduces the concept 'temporal object work' to explain how temporal work in everyday practices are supported by objects that mediate between the past, present and future in patient treatment. The paper *Temporal patient trajectories: Long stories in short admissions* (Chapter 5) offers a contribution that combines practice and process theory and introduces the concept 'temporal patient trajectories' to describe how these trajectories are articulated continuously by professionals and patients. The last paper in this dissertation, *Seeing, understanding and representing time in tempography*, describes the methodological research process that produced these theoretical contributions.

The papers in this dissertation adapt concepts that emerged from different research traditions - temporal boundary objects (time as social structure), temporal work (time as practice) and patient trajectories (time as trajectory) - and develops them in two ways. First, by offering a conceptual specification, e.g. that temporal work is mediated by objects in 'temporal object work'. Secondly, by showing how the practice-based and processual ways of thinking about time and temporality coexist in the organizing of same-day discharge, e.g. the organization of patient trajectories included both practicing the timing of professional tasks and articulating trajectories as emergent and temporal processes. The next chapter describes the case of the Cardiac Day Unit, which establishes the empirical context of this research process and the theoretical contributions.

CHAPTER 3: THE CASE

"It became apparent that the patients actually didn't want to stay here longer than necessary, that we could save some expenses by changing the organization and that we could accomplish more treatments. So, given these three things, we chose to look at the Day Unit".

- Head nurse, the Cardiac Day Unit

3.1. Introduction

As the quote from the Head Nurse indicates, the Cardiac Day Unit began as an innovative idea in the Cardiology Department that arose from parallel organizational aspirations; to save expenses and provide patients with the service that they wanted. Accordingly, this chapter describes the case study of introducing same-day discharge in the Cardiac Day Unit. It comprises six sections. The first part describes the idea of establishing a Cardiac Day Unit with same-day discharge schemes as new organizing of treatment for cardiac patients. The second part presents the way that this new organizing met established practices at the Cardiology Department, and the third part presents the tensions that this meeting created, i.e. 'organizational arrhythmia'. The fourth section describes the policy level of promoting same-day discharge as a mega-trend across different medical fields. The fifth and final section of this chapter describes the adaptation of same-day discharge as a challenge for hospitals that leads to innovative and practical solutions, i.e. 'everyday innovation'. The chapter ends with a conclusion.

In this way, this chapter describes the process of 'zooming in' on concrete practices in the Day Unit and 'zooming out', to describe their relationships to policies and discussions about innovation in public organizations; the 'general' trend that this 'concrete' example is a picture of, i.e. how innovative capabilities develop from the work that professionals do to overcome the challenges that arise from the introduction of same-day discharge.

3.2. Same-day discharge as new organizing

The clinical management in the Cardiology Department at Rigshospitalet saw an opportunity to create an organization that responded to two needs: 1) the patients' wishes to spend the night in the comfort of their own homes and 2) the need for reducing costs. The latter became increasingly important because of politically initiated budget cuts in the Danish health care sector around the time of the Day Unit's establishment (2015). The reduction of costs stemmed from the reduced number of admission days, e.g. medicine, food etc. that the individual patient required, but also reductions in terms of payload expenditures because night and weekend shift coverage would no longer be needed in the Day Unit. The Day Unit was located on the same floor as other units, but as a new design choice the doors were closed between them; for instance between the acute section and the Day Unit that used to share a kitchen area. The point was to 'protect' the patients in the Day Unit from the severely ill patients in the acute section, to reduce their anxieties about being hospitalized. The division of patients based on the layout of their trajectories rather than their specific diagnosis created four different spatially divided sections in the department. Some were new (the Day Unit and the Complex section) and some were older (the Acute Section and the Intensive Care Unit). Admissions in each unit

had different timeframes: The Day Unit (1 day); the Acute Section (3 – 5 days); the Complex Section (3 days to 6 weeks); and the Intensive Care Unit (unknown timeframe). The 'Day Unit' received patients for planned or subacute procedures that could be discharged or transferred to other hospitals or to their own homes on the same day as the procedure. The characteristic for the patients admitted to the Day Unit was that their treatment trajectories were similar, i.e. short and relatively unproblematic. This meant that the doctors and nurses had to care for several types of patients, as they suffered from many different cardiac illnesses and needed various treatments while staying in the Day Unit. This placed increased competence demands on nurses who normally cared for patients belonging to one specific group (ischemic or arrhythmic). During the early phases in the implementation of the Day Unit, the nurses worked in transdisciplinary teams, learning from each other how to care for patients with diagnoses other than they were used to.

The aim was to close the Day Unit at weekends and at 22:00 on weekdays. By then all patients should have returned to their homes, to a local hospital or to a patient hotel[2] if they lived far away from the hospital. Some patients returned to their homes supported by a monitoring system that continued to send data to the hospital. This meant that both technical solutions (monitoring) and logistics (patient hotel, transports) had to support the organizing of the Day Unit. In some cases, it became necessary to move the patients to another section in the hospital that continued the

[2] Patient hotels are facilities placed near hospitals and accommodate patients who do not need acute medical attention, such as mothers staying overnight after birth or patients recovering from stroke. They are common in Scandinavia.

care and treatment, because of complications. The vast majority of patients in the Cardiac Day Unit followed a similar trajectory to the one presented in Figure 1.

Figure 1: The same-day trajectory

1-3 days before The patient is scheduled for an appointment in the ambulatory clinic (belonging to the Day Unit) before the procedure. Here he is seen by a doctor and a nurse and informed about the procedure, how he is supposed to prepare etc.
07:00 AM On the day of the procedure the patient arrives in the Day Unit early in the morning. He is greeted by a nurse at the reception in the middle of the corridor. She enters his data into the record system and informs the nurse responsible for the patient that he has arrived.
07:15 AM He is brought to a hospital bed. The nurse responsible for the patient talks him through the schedule of the day. She also checks if he is prepared for the procedure and gives him some muscle relaxant if necessary.
07:30 - 11:00 AM After this, the patient has to wait for his turn to go down to the operating room. Most of the patients are not required to fast and can go to the cafeteria and drink coffee etc. during the waiting time.
11.00 – 11.15 AM When it is time, the patient is sent to the operating room. Most of them can walk there themselves apart from patients who are monitored.
11:15 AM – 12:30 PM In the operating room the patient gets a local anesthetic and the doctor performs the procedure while the patient is awake. A nurse talks the patient through the procedure and calms him.

12:30 – 12:45 PM When the procedure is finished (after approximately half an hour), the doctor writes the discharge summary and the patient is transported back to the Day Unit. During a two hour period after the procedure, the nurse checks the bandages for excessive bleeding.
12:45 – 14:45 PM When the entry wound has healed enough for the patient to be mobilized, he is informed that he shall refrain from lifting heavy objects etc. in the coming days.
14:45 16:00 PM After this the patient is discharged. He goes home.

Because the Day Unit had to close at 22.00 pm, it meant significant changes for the cardiac nurses, both in relation to their working hours but also regarding their work tasks. Each nurse had to consider whether she could manage the pay cut associated with not working night shifts, or whether she wanted to work in another section in the Department of Cardiology. The establishment of the Cardiac Day Unit also resulted in deliberations about the distribution of doctors' work tasks, especially with regards to which doctor should be in charge of disseminating information to the patient. During the initial phases of creating the Day Unit, they established a task force of both nurses and doctors to discuss the organization of patient trajectories. This quote is from an interview with a doctor who participated in this task force:

"... we have been [...] trying to map out [...] the patient's trajectory through the system ... we did not really have an overview of what the patients are told when they arrive, what requirements, what they have discussed with the nurse, what they are

talking to the doctor [about]… so we spent a lot of time just mapping [this trajectory], and we quickly found out that we would try to change the process, so there was more focus on the medical part of the conversation upfront and less afterwards. The idea behind it was that we wanted the doctors who conducted the procedure [...] to be more involved, both in telling the patient what had happened [during the procedure], but also in the more formal things with writing the letter of discharge to their general practitioner and prescribing medicine, because it often happens that ... or what happened before was often that the patients came back from the procedure, and then it was up to a random … perhaps relatively new doctor who had a busy day and 'just' had to discharge the patient, and then it could be difficult to summarize all the actions that was planned.." (Interview, doctor)

In addition to discussing the organization of patient trajectories in the Day unit, other practices were affected by the introduction of same-day discharge. The next section is dedicated to describing these practices and the meeting between 'new' and 'old' practices.

3.3. New organizing meets established practices

The 'steps' in organizing same-day discharge are roughly the same as before, but as this chapter will show, it makes a significant difference when organizational actors have to perform the same tasks but faster, and therefore under very different circumstances.

As mentioned before, the Day Unit mainly treated patients with ischemic and arrhythmic heart disease. Patients with ischemic heart disease have a restriction of blood flow through the heart, possibly due to blood clots or narrowing of the arteries

in the heart. The most common procedure for treating ischemic heart disease in the Cardiac Day Unit was the coronary arteriography (CAG) which normally takes ½ to 1 ½ hours. During a CAG, contrast dye is injected into the arteries, which can be displayed by x-rays, therefore revealing obstructions to the blood flow. The other dominant patient group in the Day Unit suffered from arrhythmia, in which the heart rhythm is either too slow or too fast, which results in discomfort and breathlessness. Many of the patients underwent a catheter ablation where radiofrequency energy is utilized to burn away a small area of tissue in the heart muscle that causes the irregular heart rhythm. These procedures were unaffected by the introduction of same-day discharge. However, all the work that was conducted to bring the patient into the procedure and home again afterwards, was affected by the new timeframe.

In order to provide patients with correct treatment, professionals constantly needed to engage in meetings and other kinds of planning practices to ensure that the right plans and decisions were made. In the Day Unit (and in the Cardiology Department in general) there were several practices that supported this need: medical conferences, procedure planning and bed management. These practices are analyzed in detail in the paper *Temporal object work in a Cardiac Day Unit* (Chapter 6) in this dissertation. These practices included both planned, temporally fixed, and ad hoc meetings between professionals that enabled them to discuss patients' needs, receive advice from their peers and provided a direction for ongoing patient care. Similarly, documentation work in hospitals is important for safety reasons, to share information between different professionals, departments or even different institutions. For professionals in the Cardiology Department, patient records played a central role, and they spent considerable time creating records in preparatory conversations with the patient before admission and updating them along the way during their admission.

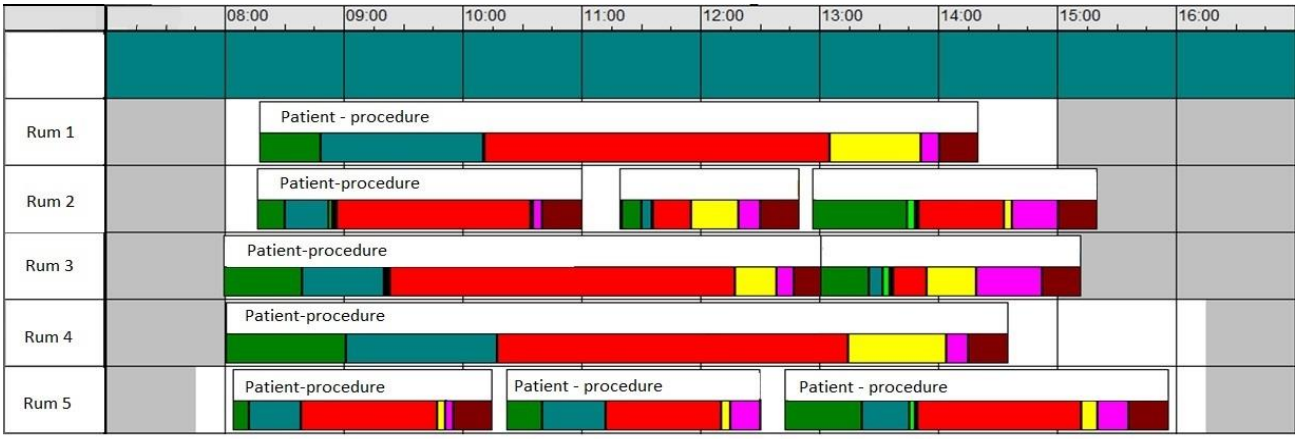
Documentation had a different role in the Day Unit, as writing summaries and updating patient records took up a substantial amount of time in proportion to the time that the patient was hospitalized. However, the quality of documentation also became important as it was difficult to maintain a coherent patient trajectory if the documentation was incomplete. The short admission period reduced the possibility to ask the patient one more time for necessary information. Therefore, the collection of relevant information needed to be done thoroughly by the professionals in the Day Unit, e.g. in a preparatory conversation a few days before admission. It was difficult for many professionals as there was only a short timeframe scheduled for the conversations that also included tests, talking about medication and answering the patients' questions.

In addition to increased documentation needs, the nurses had to care for a larger number of patients (4 – 6 patients during a day shift), compared to the acute section where a nurse normally cared for 2 (sometimes 3) patients during a shift. Even though the patients in the Day Unit were 'easier' and mostly self-supporting, there were still many different trajectories for the individual nurse to keep track of. Working in the Day Unit was regarded by some as a 'routinized' way of working with new demands for being 'just in time' that in some cases limited the professionals' abilities to "*control their own time*" (Interview, Head of Department). Accordingly, many nurses worried that it would become increasingly difficult for them to "*sense the individual patient's needs*" (interview, nurse) within the shorter timeframes.

Electronic patient records and other IT systems play an important role in hospitals in general, and no less so in same-day discharge. Monitors were significant for the everyday practice in the Day Unit. The nurses' office in the Day Unit displayed several monitors; some for monitoring the heart rhythm of the patients, one

displaying the processes in the procedure rooms, and one showing a patient overview with information on each patient's diagnosis, treatment and specific needs. The monitor displaying the processes in the procedure rooms (Figure 2) showed each patient how long the procedure was scheduled to last and how the procedure was progressing. The latter was shown by displaying different colors that shifted, e.g. purple for 'preparation', red for 'open surgery', yellow for 'completion'. The nurses in the Day Unit were able to predict whether their patients would return soon by looking at the color. However, sometimes the system failed or the employees in the operating room forgot to update the colors while the procedure was carried out.

Figure 2: Monitor displaying procedures



As the above sections illustrate, 'doing the best thing for the patient' is a frequent consideration when introducing same-day discharge. Nevertheless, some important pitfalls need to be considered as well. The delicate order of the practices in a hospital is incorporated over a long period of time and is easily disrupted by changes in the way that they are organized. New practices such as dividing patients based on the length of their expected trajectory within the Cardiology Department had to coexist

with older practices such as medical conference, which provided challenges for professionals. As an example, the professionals in the Day Unit had to be very careful to obtain the relevant information on patients for discussion at medical conferences. If they failed to secure the right information at the right time, decisions would be delayed and it could become difficult to discharge the patient. When practices (or timeframes) are changed, they affect other practices, eventually creating 'organizational arrhythmia', which is explained in the following section.

3.4. Creating 'organizational arrhythmia'

"The term "arrhythmia" refers to any change from the normal sequence of electrical impulses. The electrical impulses may happen too fast, too slowly, or erratically – causing the heart to beat too fast, too slowly, or erratically. When the heart doesn't beat properly, it can't pump blood effectively. When the heart doesn't pump blood effectively, the lungs, brain and all other organs can't work properly and may shut down or be damaged. " (www.heart.org)

A common term in cardiology is 'arrhythmia', which describes one of the illnesses that patients admitted to the Day Unit are treated for. It is also a strong metaphor for organizational challenges that professionals face when trying to make organizational changes that create 'impulses' that are different from the usual 'rhythms'. An important event in the change process, from several days' admission to same-day discharge, was a trial period in the fall of 2015, in which the clinical management team tested the implications of shutting the Day Unit overnight. One test was how it would work out when the Day Unit staff had to outplace patients with complications to other sections in the department, for example in the acute section. The conclusion regarding the trial period was that they managed to place all patients internally in the

Cardiology Department. However, some patients had chaotic processes when they had complications or if tests showed that they had to be transferred to another unit. Several discussions broke out between the Day Unit staff and the acute section staff during this period. The acute section sometimes objected to receiving patients from the Day Unit, as they were concerned they would occupy acute section beds, so that they would have nowhere to place incoming acute patients. Managers defended the 'Day Unit experiment' as a realistic trial period and the nurses advocated for the patient processes in this chaotic situation by, for example, refraining from moving patients in the evening. The professionals constantly engaged in discussions about the distribution of resources - beds, space, time etc. This was not specifically related to the Day Unit, but because planning in general was difficult due to interdepartmental dependencies and the many different patient types, unscheduled events and emergencies

Field note*: I am attending a medical conference at 12.30. The doctors who are present speak together worriedly. Right now, there is not a single bed available in the entire Cardiology Department, so what should they do if more patients arrive or if some of them need to stay - either acute patients or due to complications? The weekend is coming up, so there is a lot of pressure on the department, because the Day Unit closes before the weekend. It is a possibility that a few beds can be used in the acute section. They have four patients waiting to be transferred to other hospitals, but since they must be monitored with cardiac monitoring equipment and therefore can only be transported by ambulance, it can take a long time before their beds become vacant. There are no ambulances available at the moment, as they are also extremely busy with accommodating acute patients. One of the doctors exclaims: "It*

is interesting that the entire system always breaks down at the same time. It's like if one of the cogs gets stuck, and then the whole system just crumbles.

Like blood circulating through a heart, the patients circulated through the Cardiology Department, and any kind of 'obstruction' in one unit could affect the ability to organize patient care in other units. One of the significant challenges for the Cardiology Department was to make plans for scheduled activities while simultaneously making sure that they had the capacity to care for unscheduled acute patients. The very notion of performing acute and planned procedures in the same operating rooms posed a problem for the ability to plan. Planning in general was challenging because of emergencies, and the plans seemed to be very fragile. In order to succeed they had to plan with a buffer, both temporally and spatially. This buffering is important in relation to the creation of the Day Unit where the temporal buffer was now limited.

The need for buffering was materialized in a new space in the department called the 'buffer beds'. These beds were used by patients awaiting decisions on how to proceed with their specific cases, which were predominantly patients who were stable but where further treatment (and thereby also trajectory) was undecided. While the buffer beds were placed in the complex section, the patients were usually under the care of the emergency section and they were cared for by nurses working in the Day Unit, which established some difficulties and an elevated need for sharing information across different sections. The initial period also highlighted problems with transport (it came far too late in the evening), plans (documentation lacked and physicians showed up too late to discharge patients) and cancellations of operations because of emergencies (patients with acute conditions).

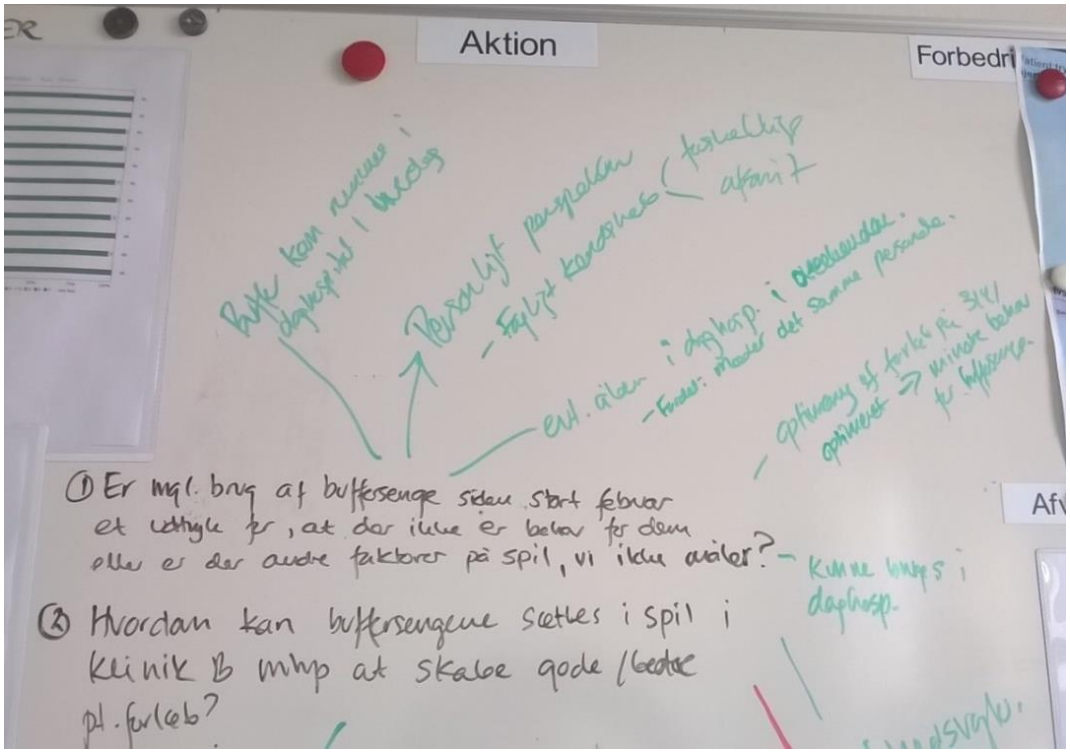
Despite the sometimes-chaotic processes, nurses found that many patients liked being discharged to their homes hours after the procedure. For the patients who fitted into the same-day scheme, there was great satisfaction and the professionals managed to create calm and patient-oriented trajectories with limited waiting time:

"You could say … that the biggest difference […] has been to consolidate the elective trajectories, which has created tranquility in a different way than in the emergency section, as well as calmness and room […] in the emergency section […]and you can say that from the patients' perspective, we have understood that there has been more ... what is it called ... tailored trajectories…". (Interview, Head nurse)

During the initial phases of establishing the Day Unit in May 2015, the nurses interviewed patients about their experiences. Most of the patients were highly satisfied with their treatment and complemented the 'fast, efficient and competent' care they received in the hospital. However, during this period there were many discussions between professionals about where to put 'difficult patients' who did not fit the new scheme. Planning was also complicated because of increased pressure on the different sections. This pressure travelled from section to section. For example, if spaces were occupied in the intensive care unit it resulted in very sick patients remaining hospitalized in the acute section; an organizational 'knock-on effect'. This made the implementation of the Day Unit difficult because patients who should be moved from the Day Unit in order to close it during the night put additional pressure on the other sections. Likewise, many interdependencies between the Day Unit and the other sections, but also between the hospital, the patient hotels and other hospitals proved difficult.

The clinical management team and the professionals continued to improve and streamline their activities in order to make the Day Unit a success. They began to conduct whiteboard meetings (see Figure 3) to single out, discuss and handle bottlenecks. The participants in these meetings were mostly nurses even though the initial idea was to have doctors present as well. By conducting these white board meetings, the professionals were 'diagnosing' organizational arrhythmia - just as they would do with their patients. This photo (Figure 3) is from a whiteboard meeting where staff discussed the use of the buffer beds: *How are they brought into play? How many patients are placed there? Which professionals should ideally care for them*? By the end of 2016, they had optimized the organization of the Day Unit to a point where the buffer beds were no longer required.

Figure 3: Photo of white board in the Day Unit



The whiteboard was used as a mediator for discussing professional preoccupations after the introduction of same-day discharge, as a way to illuminate possible obstructions in patient trajectories and to write down decisions that were made during these meetings.

Discussions about the physical layout of the Day Unit continued. The clinical management team investigated the possibility of creating a physical layout that supported the idea of the Day Unit. For instance, they wanted to create a spatial layout that reflected the idea of a 'conveyer belt' where the patient arrives in one part of the unit and is 'transported' through different rooms, where professionals perform discrete tasks in the same-day trajectory. In addition, they wanted more patients staying in specially-made recliner chairs than in traditional hospital beds. The patients in the Day Unit should (ideally) have the experience of being admitted into a highly specialized and service-minded organization, where they are not treated as 'sick' patients. These considerations (both on the positive and negative side) will be relevant for other professionals working in similar hospitals, as many will have to deal with the challenges of incorporating same-day discharge schemes into their regular practice. Same-day discharge is an important trend in health care, and as such, the establishment of the Cardiac Day Unit can be regarded as a case of a far bigger trend, i.e. a mega-trend.

3.5. Same-day discharge as a mega-trend

The Cardiac Day Unit can be seen a paradigmatic case (Flyvbjerg, 2004) as it operates as a reference point and will function as a focus for the founding of schools of thought connected to same-day discharge. All areas of the health care sector are creating similar organizing. Moreover, all will have to battle with issues of a related

kind. The introduction of same-day discharge is highlighted as one of the ways to 'save' the health care sector. Same-day discharge promises to provide both patient-centered organizing while simultaneously saving expenses for hospitals and utilizing technological developments.

On an international level, same-day discharge has been promoted in recent years in the spirit of the patient-centered and value-based care principles that guide health care policy. In the United States, same-day discharge began as small-scale trials but is moving into more and more medical fields (Mavromatis, 2013). In Australia, policies have been developed to promote clinically appropriate and consistent management of same-day surgery for patients in public hospitals across New South Wales (Ministry of Health NSW, 2012). In Denmark, the Danish Association for Day Surgery (my translation of 'Dansk Selskab for Dagkirurgi', www.dsdk.dk) has been established as a collective of different kinds of day surgery schemes in the health care sector. Especially within orthopedic surgery, same-day discharge has been celebrated as a beneficial solution for both patients and health care organizations.

A report issued by The Danish Prime Minister's office stated that: *"Accelerated patient trajectories is a treatment concept that shortens the time it takes to recover from an operation and reduces the need for hospitalization"* (my translation, Sekretariatet for ministerudvalget, 2007). The five Regions of Denmark also promote same-day discharge as a response to the elevated pressure on public hospitals as they have to keep budgets in check despite elevated drug prices (Jørgensen, 2015). They point to different 'paths' to effective hospital management: smarter (IT) systems and workflows; efficient use of buildings and equipment; minimization of waste (time); and accelerated patient trajectories. These are efforts that the five regions are promoting, and which require management and governance that supports

productivity, quality and well-being. The regions have also published a report on the quality and safety of same-day discharge (Danske Regioner, 2012). Even though they point to some challenges (which I will return to in the next section), they conclude that in the future, same-day surgery will be the norm and several-days-admission will be the exception. Therefore, it is important to develop knowledge of the implications it has for organizing in Danish hospitals. As one of the great 'answers' to the health care sector's challenges, the organization of patient-oriented same-day discharge can be regarded as an example of utilizing medical and technological innovation, such as the Angio-Seal[3] and tele monitoring of pacemaker patients, and linking it with process innovation, i.e. 'everyday innovation'. Policies always have to be operationalized by organizational actors that create new organizing and translate new ideas into everyday practices. This 'operational' level of innovation is just as important as the policy level.

3.6. Everyday innovation in same-day discharge

'Innovation' has been theorized in many ways - as user-driven, workplace-based, co-driven, learning-oriented, diffused, translated and many more (Brown & Duguid, 1991; Ferlie, Fitzgerald, Wood, & Hawkins, 2005; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Nicolini, 2010; Røtnes & Dybvik Staalesen, 2010; Van de Ven, Polley, Garud, & Venkataraman, 1999). Furthermore, innovation has often been comprehended as a 'characteristic' of the private sector, tied closely to product

[3] Before the collagen plug-based (Angio-Seal) closure device was invented, the patient had to lie horizontal in bed with heavy sandbags to apply pressure to the entry wound for 9 hours.

innovation for example. The public sector has even been criticized for lacking innovative capabilities (Mazzucato, 2011). However, research shows that it is rather the case that 'innovation' is sometimes named otherwise in the public sector - operations, quality work, patient-focus, participation, etc. (Pedersen, 2015). This would imply that innovation rather is something that evolves continuously within public organizations, sometimes intertwined with other practices, such as establishing same-day discharge. Public organizations are continuously finding new solutions - and this is also 'innovation'. 'Everyday innovation' therefore implies a focus on innovative solutions which spread throughout the organization in formal as well as informal processes (Pedersen, 2009, 2015; Pedersen & Johansen, 2012). This means, in other words, a focus on innovation as emerging from practice and embedded in practice.

The innovation perspective in this dissertation is everyday innovation (Pedersen, 2015). It is a micro-sociological perspective that focuses on small-scale innovation processes, in this case at the Cardiology Department. This calls for a perspective including different practice-oriented concepts. The process of researching everyday innovation in the Cardiac Day Unit opens the 'black box' of doing innovation in relation to same-day discharge. It combines practice, process and temporality by investigating the role of past, present and future in innovation processes. Practices and processes become inseparable when innovation is regarded as everyday organizing, where actors have to make sense of the new direction in which they are going. Both process and practice focuses on incremental change. Certainly, researchers investigating change processes in organizations have been preoccupied with ideas about 'ongoing change' in processes such as innovating (Tsoukas & Chia, 2002; Weick & Quinn, 1999). This perspective emerges from a critique of traditional

approaches to organizational change that have been focused on the interplay between episodic periods of stability versus periods of change – thereby privileging stability, routine, and order as organizational parameters (Tsoukas & Chia, 2002). Change has been treated by these theorists as *"the normal condition of organizational life*" (Tsoukas & Chia, 2002). In this perspective, innovation is an inherent part of new organizing and developed in response to emerging problems in organizations (Pedersen, 2015) such as overcoming the tensions that arise from the introduction of same-day discharge.

The introduction of same-day discharge entails a basic paradox: how can new organizing be both patient-oriented innovation at the same time as accelerated optimization of care? It gives rise to important discussions on safety, patient-oriented processes and the timing of relevant information for patients. In cardiology, research has established that same-day discharge after procedures such as the PCI[4] is completely safe, when patients are selected carefully (Abdelaal et al., 2013; Antonsen et al., 2013). They argue that hospitals need to establish a set of guidelines regarding which patients should be included in same-day trajectories. As an example, patients who can have the procedure with radial entry[5] are preferable because they do not have to lie horizontally in the hospital bed, and can be mobilized immediately after the procedure (Dominguez, Garcia-Rincon, Kiamco, Carrillo-Guevara, & Bautista, 2013). At the moment, the cardiology field is exploring the possibility of expanding same-day discharge to include other procedures such as heart valve replacement,

[4] Percutaneous Coronary Intervention (PCI) is a procedure where the blood flow in the heart is increased by inserting a small balloon into the artery via a catheter.

[5] Catheter entry via the radial artery in the arm.

which is a more complicated procedure than PCI (Genereux, Demers, & Poulin, 2015). Same-day discharge after PCI was associated with clinical outcomes similar to those of next-day discharge and was preferred by most patients (Kim et al., 2013). Within orthopedic surgery, the beneficial results of same-day discharge after hip surgery have been established (Hjort Jakobsen et al., 2014; Kehlet, 2011; Kehlet & Wilmore, 2008). Patients not only prefer it, but research also shows that they recover faster from the surgery compared to hospital admissions. In Australia, the success of same-day discharge as a transparent, patient-focused process is linked to well-informed patients and staff (clinical and non-clinical) who understand the process, their roles and responsibilities (Ministry of Health NSW, 2012). However, what does it mean to be well informed? The sections in the beginning of this chapter established that within limited timeframes, the timing of information is important. It is important for professionals not to leave too many questions hanging after discharge (Gilmartin, 2007; Wagner & Carlslund, 2002).

The ‘Day Unit’ is an example of everyday innovation, as it is an 'answer' to one of the hospital’s emerging challenges; being able to deliver high quality every day while keeping expenditure levels in check. The innovative capabilities develop from the work that professionals do in whiteboard meetings or in transdisciplinary teamwork to overcome the above-mentioned challenges. It is a wanted organizational innovation in the sense that it focuses on improving what the Cardiology Department is already excelling at i.e. delivering quality service to patients. It might be a new organization proposed by management, but professionals are continuously trying to make patient trajectories as smooth as possible. However, in the Day Unit it has to happen within a shorter and more synchronized timeframe. Innovations do not progress in isolation, however, but spread out through the organizational layers

through practice. It can be difficult to get innovation projects to succeed in practice. Typically, when the new practice meets organizational life, there are often barriers to sustain new innovative practices and procedures. Additionally, it is often difficult to fit new organizations in the regular operation - especially when there are also significant time pressures in the sector (Sehested, 2002). The same concern applies to the Cardiac Day Unit, where it is also a question of introducing new organizing into a hospital practice that is already 'occupied' by several kinds of (more or less flexible) organizing.

3.7. Conclusion

This chapter began by explaining new organizing in the Cardiac Day Unit, moving on to how this organizing created tensions in the Cardiology Department and how these were connected to a wider policy context that recommends same-day discharge. The establishment of the Cardiac Day Unit resulted in many deliberations about the distribution of work and the organizing of patient trajectories. It made a significant difference that professionals had to perform the same tasks but faster, and therefore under changed circumstances. Many nurses worried that it would become difficult for them to provide the level of care that they used to under an elevated time pressure. Practices such as interdisciplinary teamwork, patient interviews and whiteboard meetings were established to secure high levels of care during the transition process. However, when practices are changed, they affect other practices and sometimes create 'organizational arrhythmia', which is a strong metaphor for organizational change processes, which create 'impulses' that are different from the usual 'rhythms'. Like blood circulating through a heart, the patients circulated through the Cardiology Department, and any kind of 'obstruction' could affect the ability to organize patient

care. The considerations (both on the positive and negative side) will be relevant for other professionals, because many hospitals will have to incorporate same-day discharge schemes into their regular practices. Even on an international level, same-day discharge has been promoted as best case organizing, in the spirit of the patient-centered and value-based care principles that have guided healthcare policy in recent years.

Lastly, this chapter described how organizing same-day discharge in the Cardiac Day Unit establishes an example of everyday innovation, and what professionals do to cultivate innovative capabilities in everyday practices and processes. The innovative capabilities develop from the work that professionals do in whiteboard meetings or in transdisciplinary teamwork to overcome the challenges of introducing same-day discharge, such as ensuring that patients remain well-informed throughout the process. The Cardiac Day Unit as a paradigmatic case requires investigation of these outcomes organized in a systematic and methodical way. This is the focal point of the next chapter that describes my methodological considerations in connection with undertaking an ethnographic study of the Cardiac Day Unit.

CHAPTER 4: METHODOLOGY

"I would never claim nor believe that hospital life is reducible to its temporal structure. And yet time, the analytical focus and purpose of my study, provided my observations with both a direction and a sense of reference with regard to what is relevant. Though time is by no means an entity which one can directly observe, it was clearly my analytical concern with temporality that sensitized me to "see" temporal patterns which I would have probably missed without it, and that guided my decisions as to what to attend to and what to consider irrelevant for my purposes".

- Zerubavel, *Patterns of time in hospital life*

4.1. Introduction

The thoughts about observing hospital life through the 'lens of temporality' provided by Zerubavel (1979a, p. xvii) was a very insistent consideration when undertaking the ethnography of the Cardiac Day Unit. The methods that were applied, the data that they produced and the reflexivity of the researcher were all 'colored' by sensitivity to the temporality of organizing. Accordingly, this chapter describes the ethnographic methodology applied in this dissertation. It comprises: 1) my reflections on doing ethnography with focus on the temporal practices in medical work; 2) descriptions and discussions of the qualitative methods in the ethnography (Participant observation, shadowing, interviews and documents); 3) my considerations about engaged scholarship in the research project; 4) data protection and ethics; and 5) the thematic analysis process. As such, the chapter presents my ethnographic journey into the Cardiac Day Unit, which enabled me to explain how professionals actually

practiced same-day discharge by applying different qualitative methods to illuminate these practices from different perspectives, i.e. from observing them, talking about them in interviews and viewing their material representations in documents and objects.

4.2. Organizational ethnography

This dissertation is based on an ethnography carried out between 2015 and 2017, which comprised more than 400 hours spent in the hospital. Ethnography is a traditional approach to studying societies, communities or organizations (Atkinson & Hammersley, 1994; Pedersen & Humle, 2016; Ybema, Yanow, Wels, & Kamsteeg, 2009). Organizational ethnography (Pedersen & Humle, 2016) is a specific kind approach to ethnography that focuses on the researcher's ability to say something about organizations and not just phenomena within organizations (Bergman, 2003). Organizations can be 'opened up' by paying attention to the polyphony of voices and the tensions that arise from organizing endeavors. Another important contribution from organizational tempography as a specific method is that it brings theoretically informed concepts to the table ('bringing back theory' as suggested by Pedersen & Humle, 2016) which tends to be overlooked by ethnographers studying organizations, i.e. they mainly produce studies of time within an organizational context, rather than studying how different theoretical time concepts create organizing.

The ethnography in this dissertation therefore had an explicit, however theoretically open, focus of the intersection between time and organizing and therefore in continuation of classical studies that centered on the temporal organization of medical work in hospitals (Glaser & Strauss, 1968; Strauss et al., 1997; Zerubavel, 1979a). These ethnographic studies have been conducted with time as an important

research theme, usually emerging from a grounded theory approach. This dissertation does not represent a grounded theory approach, as it has an explicit focus on the role of time in medical work. However, the theoretical landscape of temporality in organizations is very different today from when these classical research studies were completed. There are many emerging research fields centered on time in organizations but from completely different perspectives, e.g. time as a resource (Al-Araidah et al., 2010), time as practice (Orlikowski & Yates, 2002), time as process (Hernes, 2017). The purpose of this dissertation was to uncover how these time perspectives coexisted as polyphonic ways of organizing. In this way, this dissertation is a 'tempography' of modern medical work, drawing inspiration from Zerubavel (1979a), who wished to map out the landscape of how medical work was planned, in terms of time. In a modern hospital context, doing tempography has the ability to bring forward the coexistence of different time perspectives, i.e. material representations, practices and processes.

Not a lot has been written about the relationship between ethnography and time, and the few publications that exist mainly concern temporal tensions when writing up, i.e. choosing past or present tense (Fabian, 1983; Willis, 2010). The paper *Seeing, understanding and representing time in tempography* (Chapter 7) in this dissertation contributes to the literature on ethnography and temporality, by developing a framework with inspiration from Dawson (2014b). The paper argues that ethnographers concerned with the temporal organization of work (i.e. 'tempographers') need to engage in 'methodological temporal awareness', i.e. reflecting on the ability to see time in different kinds of qualitative data. Tempographers also need to employ 'analytical temporal practices', i.e. considering how time is understood through various conceptualizations. Finally, the paper

discusses the need for a broad perspective on temporal merging (i.e. multi-temporal merging), which means not just representing subjective and objective perspectives, but also different time and temporality perspectives in organizational life. Despite the multi-temporal perspective, this dissertation zooms in on the same organizational phenomenon as the classical studies, i.e. the practice of medical work.

4.2.1. Zooming in on organizational practices

Research interest in practices has been increasing in the recent years (Feldman & Orlikowski, 2011; Gherardi, 2015; Nicolini, 2013). To explore the temporal organization of medical work, I became inspired by what Nicolini presents as his 'toolbox'; 'zooming in and out' in studies of organizational practice (Nicolini, 2011, 2013). Nicolini argues that researchers should 'zoom in on the accomplishments of practice' and 'zooming out to discern their relationships in space and time' by trailing practices and their connections to other practices. These tools are well-suited for producing elaborate descriptions of organizational practice. Nicolini even suggests that social researchers zoom in on temporality as a way to study accomplishments of practice. This implies a focus on temporality, timing and tempo:

- *"How are the sayings and actions temporally organized?*
- *How do the patterns of doing and saying flow in time?*
- *What temporal sequences do they conjure? With what effect?*
- *What temporality/rhythm is produced by the practice?*
- *What is the relationship between the different temporalities and rhythms brought to bear on the scene of action by different practices."* (Nicolini, 2013, p. 220)

By adopting these questions in my research framework, I was able to empirically 'zoom in on accomplishment of temporal practices' (i.e. the same-day trajectory) and explain how health care innovation unfolds as everyday practice at the Department of Cardiology. My analysis began by zooming in on temporal practices in the Day Unit, trailing them to other places; physically (e.g. other units) and temporally (e.g. past history, present needs and future concerns of the patient) to broader health care paradigms (same-day discharge). The lengthy ethnographic study of everyday practices in the Cardiac Day Unit enabled me to tap into their practical knowledge to produce theories of what is 'going on' when working with same-day patient trajectories. Zooming in on their practice as well as zooming out to explain how same-day discharge is supported and politicized at a societal level, brought out interesting tensions that were worth pursuing. However, being embedded in the everyday practice of professionals also resulted in feelings of awkwardness for this researcher. The emotional side of doing ethnography is unavoidable, especially in a hospital context, where the researcher is confronted with serious illness, bodies and sometimes life or death situations.

4.3. Qualitative methods

In-depth tempography requires different types of data: in-situ action, verbal accounts and reflections about their practice and depictions of material used by professionals in their work. Three methods provided these kinds of data - shadowing, interviews and recorded observations (see Table 2 and the Appendix 1 to this chapter for a detailed version). In sum, these methods comprised more than 400 hours of ethnographic fieldwork in the hospital.

Table 2: Overview of methods and data

Activity	**Details**	**Data**
Participant observation (meetings)	6 meetings	Notes
	8 meetings	Audio recordings
Participant observation (shadowing)	Shadowing nurses (114 hours)	Field notes
	Shadowing doctors (105 hours)	Field notes
	Shadowing patients (49,5 hours)	Field notes
	Processing field notes (103 hours)	Field notes
Interviews	Head of department	Audio recording and transcript
	Head nurse	Audio recording and transcript
	4 nurses	Audio recording and transcript
	4 doctors	Audio recording and transcript
	7 patients	Notes
Materials	2 patient satisfaction surveys	Documents
	65 patient information sheets	Documents
	3 professional guidelines	Documents
	35 photographs from meetings	Photographs
	3 depictions of objects in use	Depictions

Triangulation of methods is often promoted as beneficial, but it is also challenging because of an elevated risk of 'method slurring' (Annells, 2006). However, different research approaches can also be successfully applied if they 'fit' the research question and the research ontology in general. The research question for this dissertation is, "*How does new organizing of patient trajectories create time-related tensions in a Cardiac Day Unit?"*, and it points to 'organizing' as the central phenomenon. Studying organizing entails a practice ontology that views 'practice' as the site where organizations, actors, materials and work are entangled (Gherardi, 2015) in the effort to accomplish something, i.e. 'organizing'. This research project attempted to uncover every aspect of organizing, and as such, observations, interviews and materials were all beneficial as they focused on different parts of hospital practice. Table 2 - and the following chapters - demonstrate that a majority of time during the study was spent shadowing and undertaking observations, and this data was also best at illustrating how medical work was influenced by the introduction of same-day discharge. However, the interviews also provided interesting data on how actors reflected on their work. The PhD project entailed a constructionist perspective with a strong focus on work; people doing work, creating tools to support work, engaging in discussions and conversations with others and reflecting upon their work in interviews.

4.3.1. Participant observation

This dissertation focuses on studying practices in a Cardiac Day Unit from a temporal perspective, which makes space and time important parts of understanding, "… *practices as spatiotemporal accomplishments obtained by knowledgeable actors who use a variety of (ethno) methods, tools, techniques and procedures"*. (Nicolini, 2013,

p. 134). In order to understand changes in hospital practices, i.e. the introduction of same-day discharge, methods like participant observation (Have, 2004) are beneficial to capture temporal and spatial details:

"The participant observation methods generally seem to be important to be able to uncover the temporality of management and organizing — to unveil how organizing happens, in real time — the actuality of organizing and the actuality of temporality". (Hernes et al., 2013, p. 4)

Observations are popular in qualitative research projects that seek to understand and represent how organizational members act in practice. Especially amongst ethnomethodologists, observations are the preferred method for studying the ways in which organizational actors create and maintain a sense of order in their daily practice (Have, 2004). Even though this dissertation is not an example of an ethnomethodology study, the aim was still to study how professionals tried to maintain a sense of order while introducing same-day discharge, which can only be understood by looking at what they actually do in practice. The recordings of meetings between different professional groups helped me tap into the discussions on how to accomplish same-day trajectories, e.g. how to handle postponements and bottlenecks.

The researcher's level of participation is a prominent discussion in relation to observations. Some argue for a more distant approach to avoid 'going native' while others argue for total participation. What matters is of course that researchers participate enough to be able to describe the work in detail, e.g. the painfulness, the satisfaction, the smells, sounds and emotions connected to the work that participants in the field do (Delamont, 2004). In a hospital context, there are of course some

limitations to what kinds of work the researcher can do with regards to ethical and safety issues. I helped with performing small tasks like moving beds, changing bedding and fetching drinks for the patients etc. Those small tasks were completely safe, and they helped with forming relationships with the professionals that I observed. However, the researcher cannot actually spend the entire time in the hospital, because that would prevent the accomplishment of other important tasks, such as writing field notes, thinking about fieldwork, and testing the initial (theoretical) ideas against the empirical findings. Thus, being a participant in the field does not mean that you do the same as the professionals, but rather that you interact with them while they do it (Delamont, 2004). I found the idea of 'shadowing' professionals and patients a helpful way to think about how I could interact with them, i.e. a way of participating in the field.

4.3.2. Shadowing

Shadowing' (Czarniawska, 2007; McDonald, 2005) is a form of participant observation in which the researcher follows a member of an organization over a period of time in order to get access to the intimacy and simultaneity of experiences of work (Gill, 2011). In health care, shadowing has been utilized to access the actuality of medical practice, rather than what is intended and planned (Liberati et al., 2015). For example, in patient-centered care, it is relevant to scrutinize the effects of 'good intentions' on medical practice, e.g. what does it actually mean to put the patient in the center of organizing? Is it always possible to do so? Shadowing patients and their experiences provides insights into subjective care experiences, as well as the practicality of how professional work unfolds in time and space (Liberati, 2017). My further reflections on shadowing patient trajectories can be found in the paper

Temporal patient trajectories: Long stories in short admissions (Chapter 5 in this dissertation).

Another important consideration, when shadowing, is reflexivity. It is true for all researchers doing participant observations that they are, in some way, influencing the field that they are studying, however this is particularly true for shadowers. Shadowing actors does not allow a 'passive' role for the researcher, as this will be experienced as intrusive by the person being shadowed. For professionals in hospitals, the shadowing relationship easily mimics the relationship they have with nursing students, whom they supervise, and they are very skilled at explaining their work at the same time as performing it. Shadowing professionals helped me to feel at ease with respect to where to place my body and it also reduced awkward feelings, i.e. it offered a way of belonging in the field. Of course, these relationships were not always easy. They depended considerably on the person that I followed, and I had to use my emotions as an indication of when to engage in deep conversations about their work or when to back off. When encountering professionals who gave a positive, or exceptionally a negative, impression, I made sure to write down how the person came across to me in attempting to analyze why, by referring to my own emotions. Why did they appear to me as extremely competent or short-tempered? By way of example, the young physicians starting out in department often appeared under more strain than their more experienced counterparts, and I usually chose to leave them alone after a few hours. I sometimes also came across nurses who appeared to be stressed by their workload, and in these instances I also chose to back off. My impressions of the professionals were often strong and sometimes they provided a theoretical idea:

Field note: *During the doctor's round in the acute section, we enter a patient room where a patient is sitting. The patient came for an acute procedure yesterday, but says she is feeling much better today. She says, "Thank you for providing good treatment". For the next couple of days, the patient will be observed at a local hospital. The doctor asks if she has any questions before leaving. She asks about the procedure. She has been told that she had a PCI, but she is not quite sure if she has understood it correctly. What is a stent? The doctor grabs a pen from his uniform pocket and disassembles it. He pulls out the spring. He explains that a stent is a* tiny wire mesh tube *that in many ways resembles the spring and it is placed in the artery to ensure that it remains open. Then he explains that the patient must take a specific type of medication for the rest of her life to make sure that blood clots do not accumulate in the tube.*

I followed this doctor for an entire shift, and it struck me how happy the patients became after having a conversation with him. In this account, the relief of the patient was unmistakable in the patient room. I could feel it. Was this due to this doctor's ability to explain what had happened to the patient and what the prospects were for the future? Was it because he used a simple tool to explain a very complex procedure? These observations became the initial steps towards the paper *Temporal patient trajectories: Long stories in short admissions* (Chapter 5 in this dissertation). Following people around for entire days creates a special relationship. I could sometimes help nurses with remembering tasks that they struggled to remember, usually resulting in a joke that I was useful as a 'remembering shadow'. And I told the doctor in the account above that he seemed to be very skillful at putting his patients at ease. I could not stay silent when shadowing, even though I was very careful to not pose interruptions, even though this was challenging. As a researcher,

you are always interrupting in some way – and this is the way it should be. On the first day of field work, I put on the wrong uniform, i.e. the 'doctor's uniform', which was pointed out to me many times before I had the chance to change. Following this, I deliberately chose to wear a uniform that was different from both the nurses' and doctors' as this was a subtle sign that I was an outsider. While the entire time shadowing was characterized by my aspirations not to create unnecessary interruptions, it also became clear that some conversations needed a specific space allowing interruption, i.e. the interview.

4.3.3. Interviews

When doing semi structured interviews, I was inspired by Nicolini's idea regarding 'the interview to the double' (Nicolini, 2013, p. 225). I asked the interviewees to instruct 'a double' on how to do their job or how to perform a well-organized patient trajectory in the Cardiac Day Unit. The purpose was to get the interviewees to talk about how they experienced accomplishment in their hospital practice. I also followed up on specific themes while trying to allow the interviewee the space to talk at length (Rapley, 2004). I tried to restrain myself from taking over the conversation by primarily using 'nonverbal responses' and suppressing the need for 'filling out the awkward silences'. Towards the end of the interview, I sometimes asked the interviewee about specific events that I witnessed together with him or her when I was shadowing. My interviewing was unavoidably 'colored' by the large amount of time I spend with these professionals before interviewing them. Interviewing was then an active practice that I engaged in together with the interviewees:

"Regardless of how interviewers try to restrain their presence in the interview exchange, and no matter how forthright respondents are in offering their views, the

resulting narratives are interactional accomplishments, not communicatively neutral artifacts" (Holstein & Gubrium, 2016, p. 2).

In a way, I was even more 'active', because I took part in their everyday activity (though for shorter periods of time). Being a 'facilitator' of interviews was not possible as I experienced events together with the professionals and they tended to use examples from their practice that we experienced together. The same reflection applies to conversations during my shadowing. However, the active role that I had as an interviewer also made it easier to refrain from 'bad interviewer practice', where the interviewee is treated as a research 'object'. When I offered my own thoughts and experiences this encouraged the interviewee to disclose his or her reflections.

4.3.4. Documents, photographs and depictions

The materials in this study are documents, photographs and depictions (see Table 2 in this chapter and Appendix 1). Even though some of the materials are not directly represented in the dissertation, they still play an important role in my understanding of the practices in the Cardiac Day Unit. Two patient satisfaction surveys displayed responses from interviewed patients about their experience of treatment in the Day Unit, and these responses were used during whiteboard meetings in discussions of how to provide better service to future patients. I studied 65 patient information sheets that detailed the most common procedures in the Cardiac Day Unit (and in the adjoining sections). They provided information on both the specifics of each medical procedure and on what information the patients had access to prior to admission. Three professional guidelines on which actions professionals should perform during the patient's trajectory in the Day Unit were constantly handled and debated, especially amongst the group of nurses.

According to Prior, documents should be regarded as active agents in social interaction (Prior, 2004). They can be manipulated, ignored or hidden. Understanding how these documents are manufactured and used in an organizational setting are important questions in the research process (Prior, 2004). As an example, information sheets are utilized by professionals to manage patients' expectations, e.g. when they describe the expectancy of waiting time. Hospital managers at different organizational levels constantly produce documents to disseminate 'best-practice' solutions, to secure alignment and patient safety. However, 'capturing' the continuous changes in medical practice can be challenging, as this excerpt from a planning meeting in the Day Unit illustrates:

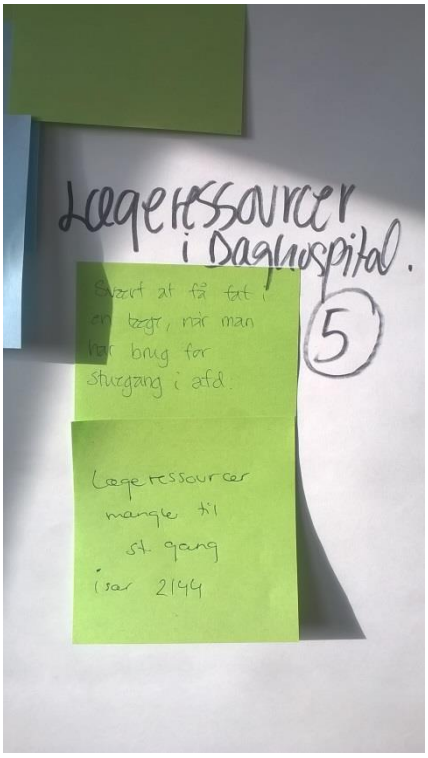
Field note: *A nurse mentions that the guidelines are outdated. For example, according to the guideline, they still need to ask patients whether they are planning to have relatives staying with them for the next few days as they are not allowed to be alone after the procedure. However, the agreed practice is that patients can be alone if they want to be. Research shows that this is safe. The changes in the guidelines always lag behind changes in 'reality'. But the descriptions are very important for aligning the patient trajectories so they cannot be ignored. And if they are not updated, then there is too much dependence on the individual nurse's interpretation.*

As this field note presents, documents quickly become obsolete for those engaged in hospital practice. Similarly, they become 'obsolete' in ethnographies as well. Documents, photographs and depictions are 'snap shots' of practice.

Taking photographs and making depictions of objects-in-use were not the methods that I used most, but they played a significant role for understanding medical work, especially in relation to the paper *Everyday temporal work in hospitals* (Chapter 6 in

this dissertation). Taking note of how whiteboards, IT systems and other technical solutions where used by professionals was important, e.g. how these objects became boundary objects (Schwartz, 1989). Photographing was limited due to confidentiality issues, i.e. that personal information, personal identification numbers etc. were displayed in many of the materials. So I mainly took photographs of whiteboard meetings such as this one, which is an example of how the professionals used whiteboards and post-its to discuss their work. In this case, the photo (Figure 4) is from a whiteboard meeting where they discussed organizational bottlenecks in same-day discharge. It says "*Point 5: Doctor resources in the Day Unit". "Difficult to get hold of a doctor when a ward round is needed". "Doctor resources are needed for ward rounds – especially in section 2144*".

Figure 4: Photo of post-it on white board in the Day Unit

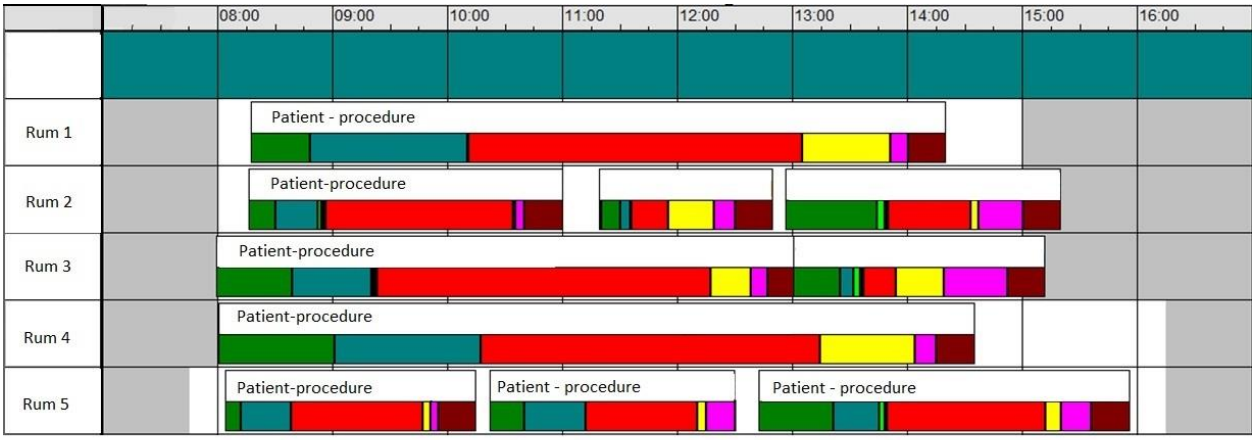


Whenever I came across important tools and materials that were impossible to photograph, I made depictions of them in my note book. This is an example of a patient overview board, which is central to the coordination of nurses' work in the Day Unit. It is stripped of confidential information but still provides an important context for how work is supported and how same-day discharge is organized. The depictions of objects-in-use in the Cardiac Day Unit included the patient overview board (Figure 5) and the procedure plan (Figure 6), which were displayed on large monitors at the wall in the nurses' office:

Figure 5: Depiction of patient overview board

Bed	Patient	Diagnosis	Plan	Procedure	OBS	Day shift	Evening shift	Discharge
2	Name	KAG/PCI	Conference	2	Nervous	Nurse 1	Nurse 3	18/9

Figure 6: Depiction of procedure plan



Viewing photographic and other imagery is important in order to describe medical work as a social activity shaped by social context, cultural conventions, and group

norms. As was the case with documents, objects too are active agents in social interaction. An example is the use of patient records as a work object (Table 3). They are both direct representations of medical work and an indirect representation of 'the patient' (Prior, 2004). Even though they appeared in almost every activity, I chose to make very few notes about them, and the few that I did were drastically altered for anonymization purposes, i.e. changing information on specific diagnosis, procedure, dates, gender, age etc.:

Table 3: Adapted excerpt from patient record

Preliminary assessment	The patient complains of chest pain. Pt has experienced this since 2000. Expresses dissatisfaction with not having been admitted before now. Pt experiences pain on a daily basis and considers his physical capabilities to be severely impacted. Pt has previously worked with asbestos and has impaired lung function.
Allergies, CAVE	None
Note	Angina pectoris. Pain following light physical exertion
Procedure	Coronary catheterization possibly PCI
Treatment plan	There are indications of possible occlusions because of stable angina. The patient is admitted in the Day Unit for catheterization on Nov. 15th.

Zerubavel's study (1979a) highlights the centrality of charts, graphs and records supporting the socio-temporal organization of hospital life. However, as researchers such as Birth (2012) argue, objects are never inert but spun into complicated hegemonic relationships of power. This is an important topic in the *Temporal object*

work in hospitals paper (Chapter 6), which explores how some temporal boundary objects become more powerful than others, e.g. procedure schedules over patient overview boards.

Access to materials such as documents and, in particular, observations of objects in use depends on a good relationship between the researcher and research field. It has been an important special focus area during the research project and in the following section I will describe the process with regards to conducting engaged scholarship, negotiating access and balancing conflicting agendas.

4.4. Engaged scholarship

This PhD project was co-financed by the Department of Cardiology (Hjertemedicinsk Klinik) at Rigshospitalet, which makes it a project with special circumstances, both in terms of access, but also in terms of dilemmas, e.g. how to balance the ongoing relationship between researcher, management and different professional groups. I found inspiration in 'Engaged Scholarship' as proposed by Van de Ven (2007) to guide my relationship with actors in the field. One of the ways to be inspired by engaged scholarship is to collaborate with practitioners on several aspects of the research project: 1) research design; 2) problem solving; 3) theory building ; and 4) problem formulation (Van de Ven, 2007, p. 1). The point is not to have the field making decisions for the researcher, but rather to be transparent, and make sure that there is a common understanding throughout the research process. My relationship with the actors in the field was smooth from the beginning. The research agenda was initially very open (as described in Chapter 1), and the output was never meant to be a specific 'consultant task' but rather the production of knowledge. We continuously held meetings and discussed the problem statement for the project, which is one of

the important aspects of the 'diamond model' (Van de Ven, 2007). Access to information and to study practices at the hospital was effortless because of this ongoing cooperation and involvement. What was interesting about the relationship in this research project was that the research field was involved in the project in an open-minded way, where the main objective was to be available for and support the creation of scientific knowledge while staying engaged throughout the project process. This implied engagement both ways, indicating a further development of the engaged scholarship framework, i.e. 'Engaged research relationship'. The following sections describe and discuss the different ways that researchers and the research field can negotiate and uphold an engaged relationship.

4.4.1. Negotiation of access as trajectory

In the case of this PhD, access to the field has been open. However, this does not mean that it is less important to reflect on how this access affected the creation of this dissertation. The negotiation of access can be very 'telling' about the actors and the field, and as such is an important observation in itself (Bruni, 2006). The interest in organizational research and trust has developed between the Department of Cardiology and the Center for Health Management at IOA in a number of previous small projects and collaborations, however none as comprehensive as this PhD project. In addition, the hospital's status as a university hospital becomes apparent in their interest in being part of the research community. The management team also had an interest in contributing to scientific knowledge, i.e. "*the scientification of our hospital practice*" (Head of Department). As a department at a research hospital, they were also very interested in supporting the dissemination of research in scientific journals and conferences. As this was also an important part of conducting a PhD

study, this common interest was fruitful. However, as proposed by Bruni (2006), access is not a stable entity, but rather a relationship that needs continuous negotiation to maintain:

"Accessing the field is thus framed as a trajectory, a never-ending process of engaging with multiple actors and organizational dynamics which can lead in different directions, depending on the ethnographer's ability to follow organizational processes and to demonstrate his/her ability to take part in them." (Bruni, 2006, p.137)

Upholding access to the organization and maintaining an engaged relationship between the researcher and actors in the field requires continuous occasions for informal and open discussions of the project. In the case of this PhD project, meetings were held along the way (as described in the previous section) as well as attendance in planning meetings in the team management group to support these negotiations. I also managed to 'keep track' of my own engagement by making reflective notes throughout about the reactions to my participation from actors, as well as my emotions. My trajectory began as a "newbie" where I did not try to hide that I was a newcomer with limited experience of hospitals to an "acceptable incompetent" who was not a part of the professional group but at the same time had a profound understanding of their practice from the many hours spent in the hospital. The latter was very helpful when interviewing professionals (especially physicians) whom I found to be much more open to my questions when I gave an impression of knowing their work in detail (which was in fact the case by the end of the study). The nurses in the Day Unit called me many different things. In the beginning I was mainly referred to as "the psychologist" or the "the sociologist", highlighting my 'exotic' role in their daily practice. By the end of my fieldwork period, I had

developed a relationship with the nurses, where we made jokes, e.g. that I was "almost a doctor" due to the many hours spent in the Day Unit. The trajectory was also visible in my field notes, where I initially made observations like *"the patient comes from another hospital because she is in acute pain"* to *"the patient is an ACS patient from Bispebjerg"*. Looking back through my notes, I saw them become more and more doctor-like as my understanding of medical work, the vocabulary etc. became deeper. In addition to reflections about the research process, the anticipation of 'giving something back' in exchange for access is an ongoing concern for ethnographers. The expectation is always there, not only from the management group, but also from the medical professionals that I encountered. They give their time. The next section presents my reflections on 'giving back' and dealing with different agendas when doing ethnographic fieldwork.

4.4.2. Conflicting agendas

Sympathetic feelings towards the actors in the field is an unavoidable part of doing ethnography, especially in a hospital context, where there are many different actors with often conflicting agendas. Based on his experiences from doing ethnography in a hospital setting, Nickelsen (2009) argues that patients and professionals are the most common allies as they have less power than managers and politicians. But they are all practitioners in the same space (Nickelsen, 2009). Thus, there are many tensions in the field - between managers/employees, different professional groups (e.g. nurses and physicians) and between different departments that fight for the same resources, i.e., time, space and labor. A preoccupation of mine was how to deal with these conflicting agendas in my data. Other researchers have reported that a reoccurring difficulty, when doing field work, is that actors often want to 'help' by

pointing to what they think researchers are interested in (Delamont, 2004). In my case, an example was the occurrence of serious disagreements during the implementation of the Day Unit, where the actors (although tacitly) wanted me to 'take sides' between different departments. This can be seen as an attempt to 'seduce' the researcher – but not necessarily on purpose (Nickelsen, 2009). Nickelsen argues that:

"[my translation] … a number of semiotic networks and not just the researcher versus the organization, tumbles into each other, whereby a considerable part of them tries to convince other networks and install their own ambitions in others, for example through good arguments and other tools". (Nickelsen, 2009, p. 62)

He proposes that researchers 'sort associations' as a tool for reflecting on their own research agenda. This implies that the researcher sorts and handles notes about their own sympathies in the same way as other field notes. Therefore, I chose to incorporate these types of notes into my 'reflexive notes'. This is an example:

Field note: *I am (in a way) seduced by some of the 'emergency section arguments'. The change has interfered with the organization of their section, because they have to care for patients that do not 'fit' the same-day admission scheme - in addition to 'their own patients'. The management group explains that they regard the perception of the patients admitted in each section as 'our patients' is old-fashioned. My sympathy relates almost naturally to the agenda of professionals in the emergency section, to whom the formation of the day unit feels like an 'attack' - both to their professionalism and their spatiotemporal organization.*

The point of recording these in field notes is to reflect on them and not just reproduce them. This also makes it easier for the researcher to remember that everyone in the

hospital has valid agendas, and to try to discover what they are. However, researchers are not ’blank slates’. With my background in working life research I am a proponent of professional work and organizational support for accomplishing work. However, I kept reminding myself that managerial work is just as valid and that their intentions are often not far from other professionals’, despite the way that they often brought my attention to the conflicts between professionals and management while I was at the hospital. The following section describes the specific qualitative methods that I used in the ethnography.

4.4.3. Awkwardness and emotions

Despite the researcher’s discomfort, awkwardness can also be an important source of information for the researcher, especially when studying medical work. Awkwardness can be a way to understand and represent communities when doing ethnographic research, because the feeling directs the researcher’s attention to something that is incomprehensible to her and thereby pointing towards an area that needs further exploration (Koning & Ooi, 2013). Whenever I felt awkward, it could be interpreted as a sign of me not accomplishing hospital work. Drawing on practice theory, as described in the previous section (Nicolini, 2013), accomplishment of medical practice is an important research focus, and feelings of awkwardness are helpful to unravel the many layers of practice within the hospital. As an example, the feeling of awkwardness arose whenever I stood still in the hospital corridor without having any visible task to perform, or when I attended meetings between professionals and patients where sensitive topics or bodily functions were discussed. This part of their work is very different from working at a university, and I took these

feelings of awkwardness as indications of what it actually means to accomplish hospital work.

Furthermore, being sensitive to the patient's bodily discomfort and feeling awkward on their behalf, told me something valuable, not only about what it means to conduct medical work, but also what it feels like to be a patient in the Cardiac Day Unit. Because ethnographic fieldwork is about participating in people's daily practice it is unavoidably relational and therefore emotional (Hammersley & Atkinson, 2007). Ethnographers such as Brannan (2011) and Koning & Ooi (2013) argue that emotions are often repressed in ethnographic writing, despite their potential for reflexivity thinking (Alvesson, Hardy, & Harley, 2008). Neglecting emotions in ethnography leaves out an important aspect of what it means to be part of the field, i.e. "*untold stories of the field*". (Koning & Ooi, 2013, p. 17). Awkwardness, emotions and the severity of heart disease are important aspects of organizing same-day discharge in a Cardiac Day Unit. When patients cry, bleed or die, this will unavoidably affect the ethnographer emotionally. This account is an example:

Field note: *Suddenly, the alarm that indicates cardiac arrest goes off. On the display above the door to the nurses' office, we can see that the cardiac arrest occurs inside procedure room number 2. It is a penetrating sound, a siren that sounds throughout the cardiac department. The relatives of another patient who is inside procedure room 1 are sitting right outside of the room. They start panicking and crying when the alarm sounds. Maybe it's their relative who went into cardiac arrest. A nurse hurries to them and calms them – "it's not in your room". The patient in room 2 does not survive and is later transported to patient room 2. It was the only one that was vacant.*

This excerpt is not directly linked to the research agenda in this dissertation, but I still recorded instances like this in my ethnographic field notes because they are important in order to understand what a hospital is. The Cardiac Day Unit does not exist in an orderly vacuum, but coexists with urgent and critical situations. This context can be overwhelming at times, for researchers, professionals and relatives. So how does the awkward researcher collaborate with competent actors in the field? The next section concerns the setup of the collaborative project and the research process as engaged scholarship.

4.4.4. Confidentiality and ethics

The classical codes and consent, confidentiality and trust principles were followed in this research project (Ferdinand, Pearson, Rowe, & Worthington, 2007). I made a contract with the hospital not to disclose patient names and to make sure that they were anonymized in the data. The data was stored in accordance with guidelines provided by Copenhagen Business School. My presence was announced to all involved, either directly and verbally or in writing in distributed flyers that described me and the research project. When I interviewed patients and professionals, the interviewees were informed about the use of the interview data, about anonymization and the right to withdraw from the research project, and were provided with written information about the project. I chose not to make audio recordings of the patient interviews for confidentiality reasons. However, consent is less straightforward when undertaking observations and shadowing. When I followed a professional, I was introduced to patients together with a broad description of the research project, but they rarely asked for further details. Only when I shadowed and interviewed them did I engage in further conservations about the project. Considering confidentiality,

researchers are obliged to protect the participants' identity. The management of the Cardiology Department, who co-financed the project, wished to be named, but I made sure to disguise other professionals and patients with very general descriptions, e.g. "nurse". The choice to name the department was made with regards to their wish to be part of a research community and therefore my responsibility as a researcher was to establish trust and not 'spoil' the field for others in the sense that they could become reluctant to participate in future research. Giving them credit was an important part of not spoiling the good relationship that developed between me as a representative of Copenhagen Business School and the Department of Cardiology. Researchers should always create their own code of ethics based on the principle of reciprocity, which in this case meant following the principles of engaged scholarship (as discussed earlier in this chapter).

4.5. From data to analysis

According to grounded theorists such as Strauss et al. (1997), the researcher should engage in the field without too many preconceptions (Charmaz, 2006; Dey, 2004). However, they also benefit from having some theoretical ideas before engaging with the field, even that *"... the more ideas the better*!" (Dey, 2004, p. 85). As explained earlier, this dissertation is not a product of a grounded theory approach, but I tried to stay open to emerging perspectives in my field. The intersection between 'time' and 'organizing' was the initial theoretical idea that provided direction when doing field work. Time for me is the 'research lens' that illuminates organizing (Ancona, Goodman, Lawrence, & Tushman, 2001). From a constructivist perspective, theory is regarded as a qualification of a viewpoint that is never neutral or unbiased (Justesen & Mik-Meyer, 2012). This then also supports the need for having a theoretical

interest early in the project as it provides a ground for discussing researcher subjectivity. However, despite the initial theoretical ideas, the framework developed during the fieldwork period and especially after the period ended. After completion, the recorded interviews were transcribed and coded in accordance with the principles of thematic analysis (Clarke, Braun, & Nikki Hayfield, 2015), which will be elaborated in section 4.5.2. First, I will present my reflections on the specific challenge of systematizing and analyzing ethnographic field notes.

4.5.1. Working with field notes

While performing a traditional thematic analysis of transcripts, field notes (Charmaz, 2006; Emerson, Fretz, & Shaw, 2014) require another level of consideration and methodology within the analysis. Field notes have the ability to record individual and collective actions in full and detailed descriptions with anecdotes and observations. They emphasize significant events and practices in the research setting and place actors and actions in vivid contexts. Done systematically, working with field notes can also clarify how the research project became progressively focused on key analytic ideas. When writing my field notes I divided them into four sections (as described in Justesen & Mik-Meyer, 2012, p. 102): 1) Brief notes in my notebook (that fit into the pocket of my hospital uniform), which reminded me of specific events during my stay in the hospital; 2) descriptive notes in which I reproduced the events in as much detail as possible; 3) analytical notes where I suggested how the descriptive notes related to each other; and 4) reflective notes where I documented my feelings towards the field, my preoccupation with specific themes or even my sympathies with particular professional agendas. The field notes comprised 150 A4 pages. Table 4 displays an example.

Table 4: Example of field note analysis

Brief notes	Descriptive notes	Analytical notes	Reflective notes
Note no. 28 Office in the emergency section: Attention to tele monitoring	A nurse sits in the office in the emergency section and updates the patient records. Occasionally, the alarms connected to the patients' tele monitors sound in the small room. They almost sound like an occupied phone line. I have heard this sound many times before in the other sections. The alarms are seldom urgent, as they are mostly a sign of a loose electrode. In the other sections, the sound is often ignored for a long time. Here, the nurse immediately rises to her feet and walks towards the patient ward to check it out. She returns to the office after a few moments and says, "it was just a loose electrode, now he's 'online' again".	Compare with notes about being aware of emergency situations (no. 11, 29 and 32). Compare to note about the patient alarm in the complex section (no. 16).	Attention to tele monitoring tells me something about the section differences. Some are more focused on emergencies than others. The way the professionals handle tele monitoring systems shows how different timeframes (when are you supposed to check-up on a patient) are practiced.

I analyzed the field notes as if they were 'texts', i.e. following thematic analysis principles (Justesen & Mik-Meyer, 2012, p. 103). The example in Table 4 highlights the differences between 'timeframes' (i.e. background expectations, as an openly

formulated but time-informed thematic concept) which emerged as practices in different hospital sections. Clashes between different timeframes can be a source of tension at the cardiac department, because shorter admission schemes require new forms of collaboration between different departments. Professionals with varying views on 'when to do things' (or timeframe flexibility in general) had to collaborate in order to succeed with same-day discharge. Limitations in working with field notes in this way (even though they are done systemically) are that it is difficult to move back and forth between 'brief notes' and 'descriptive notes'. But at least the systematic way enables the reader to see how the descriptive field notes are chosen and theoretically informed. Following this process, the field notes, interviews and materials were processed in a thematic analysis, which is the focus of the next section.

4.5.2. Thematic analysis

The thematic analysis followed six analytical steps: 1) Familiarization; 2) Coding; 3) Searching for themes; 4) Reviewing themes; 5) Defining and naming themes; and 6) Writing the report (Clarke et al., 2015). I familiarized (step 1) myself with the data, both during and after the fieldwork period ended, by reading and rereading transcripts and field notes while making basic analytical and reflective notes (as described earlier). Audio recordings were listened to. The coding process (step 2) took place as an open thematic coding related to the research question, i.e. how the intersection between organizing and temporality appeared in the data, e.g. as people talking explicitly about timeframes, to talking about the past or making plans. This coding resulted in many bundles of codes, e.g. initial themes (step 3) such as "working conditions and time pressure" or "bottlenecks". When reviewing these themes (step

4), I identified the most coherent and dense aspects of the data that told me something about the RQ. These coherent aspects of data became analytical themes (see Table 5 below) that described new organizing in the Cardiac Day Unit that instigated tensions for professionals. These tensions indicated important knowledge on how organizations, such as the Cardiac Day Unit, create meaning and establish order in time (Humle & Pedersen, 2014; Pedersen & Humle, 2016). The tensions in the data arose from the clash between same-day discharge and three different ways of organizing. The first aspect of data (1 in Table 5) displayed professional considerations about how patient trajectories should be organized in same-day discharge (i.e. what should be left out of the trajectory). The second coherent part of the data (2 in Table 5) showed how decisions by professionals in the Day Unit spanned past, present and future concerns and that these decisions were affected by the introduction of same-day discharge (i.e. a limited timeframe). The third dense aspect of the data (3 in Table 5) presented how organizing is supported by material objects that are crucial for the execution of same-day discharge. The last aspect of data (4 in Table 5) is different from the others because it concerns the temporal tensions that researchers face when organizing ethnography. These four dense aspects of data were named (step 5) as four analytical themes that eventually became the three empirical papers in this dissertation.

Based on insights from the literature review (Chapter 2 in this dissertation), I coupled the analytical themes with relevant theoretical concepts in search of sufficient explanations for how and why the tensions occurred, i.e. patient trajectories, temporal work, temporal boundary objects and tempography. Temporal work and temporal boundary objects were combined in the *Temporal object work in a Cardiac Day Unit* paper (Chapter 6) , as their analytical themes often overlapped in the data, i.e. that

medical decisions that spanned past, present and future concerns were often supported by the use of objects that represented time. As such, step 6 in the thematic analysis constituted the writing of this dissertation, which included all of the above steps.

Table 5 displays the main analytical themes and theoretical concepts in this dissertation. The table lays out the analytical process by presenting an empirical example, the analytical theme that comprised a bundle of these empirical accounts and the theoretical concept that was eventually linked to each analytical theme.

Table 5: Analytical themes and theoretical concepts in the dissertation

Empirical examples		**Analytical theme**	**Theoretical concept**
1	*"... we have had to go through a lot of things on the nursing side, but also on the physician side that is 'what is important for what we are doing now'. It may well be that there is other kinds of information or activities that are important for the patient's coping with a chronic disease, but it is just not the subject of the day."* Interview (Head of Department)	Organizing trajectories in same-day discharge	Patient trajectories
2	*"A physician presents a patient case while showing an ECG record on the large monitor on the wall. He explains that the patient has had a procedure done. Strangely enough, the results do not show anything. What should happen to this patient? Should he get a pacemaker, even though it may later prove unnecessary? Should he remain at the hospital while*	Decisions span past, present and future	Temporal work

	undergoing more tests or should he be transferred to another hospital? Another physician chimes in: "No, we have moved away from that (i.e. long admissions)" Field note (medical conference)		
3	*"The monitor displaying the overview of today's patients has stopped working in the Day Unit due to a technical update of the PCs. […] Now nothing of what they usually utilize to create an overview works. The nurses have pasted a printout of the patient board directly onto the monitor with scotch tape. They write handwritten notes on it, but it quickly becomes unmanageable".* Field note (the nurse office)	Material objects are central for organizing	Temporal boundary objects
4	*"Patients are talked about as time"* *"Professionals plan in time"* *"Objects convey time"* *"Time feels different in different sections"* Reflective field notes	Time appears in many ways when doing ethnography	Tempography

The empirical example in row 1 of Table 5 is a typical example of the analytical theme of 'organizing trajectories' as it presents the Head of Department's thoughts about what topics fitted into the patient's trajectory through the Day Unit, and also what subjects were excessive to the 'subject of the day'.

Each of the three papers in this dissertation present similar tables. They vary in design and in what information they contain, but all of them describe an element of the analytical and theoretical contributions. Table 6 displays the theoretical concepts that are specifically important to the study of patient trajectories in same-day discharge - 1) events, 2) articulation and 3) coherence. The table presents these concepts and describes their different implications in the two research traditions.

Table 6: Main theoretical concepts in paper 1

Concept	**Classical perspective**	**Processual perspective**
Events	Comparable to planned actions on a timeline. Critical junctures are unexpected events that call for action.	There is nothing 'outside' of the event. Events are 'ongoing presents' that simultaneously enact the past, present and future.
Articulation	Articulation work is work done to coordinate and direct collective professional efforts.	Articulatory modes describe different ways that meaning is enacted in events.
Coherence	Continuity of care and control of biographies that can be disrupted.	Coherence is the sense of time and allows the holding of things together over time.

These concepts are used in the analysis of the paper *Temporal patient trajectories: Long stories in short admissions* (Chapter 5), to explain how patient trajectories are both structured processes and temporal processes emerging from different kinds of articulation

Table 7 is inspired by Kaplan & Orlikowski (2013) and provides a simple representation of the temporal relationship in strategy, where actors think about the

organization's past, consider the most urgent concerns in the present and imagine the strategic future of the organization. In the paper *Temporal object work in a Cardiac Day Unit* (Chapter 6) the temporal relationship is presented in everyday practices, i.e. how professionals think about the past, consider present concerns and imagine the future in treating patients' illnesses. The table presents field notes that are divided into three sections according to the temporal 'cues' (presented in bold) that point to either the past, present or the future, while simultaneously naming the objects that are utilized in each of these practices.

Table 7: Main theoretical concepts in paper 2

Everyday practices	***Thinking about the past***	***Considering present concerns***	***Imagining the future***	***Temporal boundary object in use***
Medical conferences Occur twice every day (morning and afternoon). Attendees: physicians from different units within the cardiac department.	A physician presents records and observations about a patient in the near past to question a prior decision to perform a complicated procedure for curing arrhythmic heart disease.	The physicians engage in a discussion in the present on which procedure will be most suitable, when considering the records.	They decide on offering the patient a pacemaker in the near future instead of the previous scheduled procedure.	ECG and patient records

Planning of procedures Crafted in advance by the admissions office Need for continuous adjustments (but radical)	A nurse becomes concerned when she compares the procedure plan and a prior note in the patient record anticipating discussing the case at a medical conference.	The nurse tries to reschedule the patient's procedure by calling the operating room and visitation office in the present.	The nurse expects that in the near future, the patient will return bedridden from his procedure and unable to participate in the respiratory examination needed for the conference.	Procedure plan
Bed management Created a day in advance by the head nurse. Needs constant attention and reconfiguration according to changes	The physicians and nurses discuss the patients in nurses' office. They talk about a specific patient, where the nurses, during her previous admission, have had a hard time assessing her condition.	The nurses ask the physician who is present, if the patient can be attended to first on his round today, so that he can assess her provide some guidance for the nurses.	The physician promises to see the patient as the first one on his round later today. A nurse corrects the notes on the patient overview board.	Patient overview board

The empirical example in row 1 of Table 7 is a typical example of professionals conducting temporal object work in everyday practices, here in the context of medical conferences. The physicians use patient records to discuss the possibilities for medical treatment in the near future - in this case what the suggestions in the patient record indicate as the right kind of procedure (medication or surgical procedure) for this patient.

Table 8 presents the conclusion to the coding process in the paper *Seeing, understanding and representing time in tempography* (Chapter 7). The process took place as open thematic coding related to the research question, i.e. how did time (as a very broad concept) appear in the data, e.g. as people talking explicitly about time pressure, to talking about past times or planning for the future. When reviewing the themes, the most coherent and dense aspects of the data resulted in three analytical themes and later their theoretical representations.

Table 8: Main theoretical concepts in paper 3

Empirical example	**Analytical theme**	**Theoretical concept**
Field note (in the nurse office): "The nurses face the monitor displaying an overview of patients and consider what the status is. They are wondering why so few patients have been discharged. Has the staff in the procedure room been especially slow today? "	Material objects are central for scheduling	Objects of time
Field note (at a medical conference): "A doctor reviews the background for a randomized controlled trial, as well as	Decisions spans past, present and future	Temporal work

methods and conclusions. He then asks: "Based on this study, what should we do with our guidelines?" Then they discuss what the implications should be for their treatment of patients in the future."		
Interview (with a doctor): "... we have been trying to map out what the patient's trajectory through the Day Unit system was ... we did not really have a good overview of what the patients were told when they had the initial meeting [in the ambulatory clinic] ... so we used a lot time to map this process."	Trajectories are essential for organizing	Patient trajectories

The empirical example in row 1 of Table 8 is a typical example of how objects represent time in organizations such as the Cardiac Day Unit. The nurses use a monitor displaying an overview of patients in the Day Unit and use it for discussions and adjustment of plans.

4.6. Conclusion

Doing organizational ethnography concerns the researcher's ability to say something about organizations and not just phenomena within organizations. The methodological layout of this research project attempted to uncover every aspect of organizing same-day discharge and, as such, observations, interviews and materials were all beneficial as they focused on different parts of hospital practice. The aim was to study how professionals tried to maintain a sense of order while introducing same-day discharge, which can only be understood by looking at what they actually do in practice. This project did this by applying different qualitative methods.

Shadowing was utilized to access the actuality of organizing same-day discharge, rather than what is intended and planned. Conducting interviews had the purpose of getting the interviewees to talk about how they experienced accomplishment in their hospital practice, and studying documents focused on how these documents are manufactured and used in an organizational setting. I used the idea of engaged scholarship to continuously reflect on how I balanced the ongoing relationship between researcher, management and different professional groups. I maintained reflexivity on both sympathetic feelings towards the actors in the field and awkwardness as unavoidable parts of doing ethnography, by sorting and systematizing these feelings in my ethnographic data. The data was managed and coded in accordance with the principles of thematic analysis.

As Zerubavel described in the quote that opened this chapter (1979a, p. xvii), it is not my claim that organizing in hospitals is reducible to its relationship to time and temporality. However, if researchers are to be serious about conducting organizational ethnography (Pedersen & Humle, 2016) and thereby produce theories about organizations rather than theories about phenomena in an organizational context, a strong analytical focus is unavoidable. Accordingly, this chapter had the purpose of making visible the ways in which the ethnography was affected by the temporal 'lens', and to discuss the implications. What this dissertations 'says' about organizations is explained in the next three chapters that comprise the empirical papers: 1) *Temporal patient trajectories: Long stories in short admissions* (Chapter 5); 2) *Temporal object work in a Cardiac Day Unit* (Chapter 6); and 3) *Seeing, understanding and representing time in tempography* (Chapter 7).

Appendix 1: Detailed overview of methods and data

Activity	Details	Time spent	Data
Participant observation (meetings)	Meeting with clinical management team 25-06-2015	1 ½ hours	Notes
	Meeting with clinical management team 29-06-2015	1 hour	Notes
	Meeting with clinical management team 20-10-2015	1 ½ hours	Notes
	Meeting with clinical management team 24-1-2017	2 hours	Notes
	Meeting with clinical management team 12-09-2018	1 hour	Notes
	Meeting with Day Unit team managers 28-08-2015	1 hour	Notes
	Meeting with Day Unit team managers 06-09-2016	½ hour	Audio recording
	Meeting with Day Unit team managers 30-09-2016	1 hour	Audio recording
	Meeting with Day Unit team managers 03-10-2016	1 hour	Audio recording
	Whiteboard meeting 18-03-2016	½ hour	Audio recording
	Whiteboard meeting 01-04-2016	½ hour	Audio recording
	Whiteboard meeting 15-04-2016	½ hour	Audio recording
	Whiteboard meeting 10-06-2016	½ hour	Audio recording
	Whiteboard meeting 16-09-2016	½ hour	Audio recording
Participant observation (shadowing)	Shadowing nurse 18-05-2015	6 hours	Field notes
	Shadowing patient 19-05-2015	7 hours	Field notes
	Shadowing patient 20-05-2015	7 hours	Field notes
	Shadowing patient 22-05-2015	7 hours	Field notes
	Shadowing nurse 26-05-2015	7 hours	Field notes

	Shadowing nurse 27-05-2015	7 hours	Field notes
	Shadowing nurse 28-05-2015	7 hours	Field notes
	Shadowing nurse 29-05-2015	7 hours	Field notes
	Shadowing nurse 07-09-2015	5 ½ hours	Field notes
	Shadowing doctor 08-09-2015	7 hours	Field notes
	Shadowing doctor 09-09-2015	5 hours	Field notes
	Shadowing nurse 14-09-2015	5 ½ hours	Field notes
	Shadowing doctor 15-09-2015	7 hours	Field notes
	Shadowing nurse 16-09-2015	7 hours	Field notes
	Shadowing doctor 17-09-2015	7 hours	Field notes
	Shadowing patient 18-09-2015	8 ½ hours	Field notes
	Shadowing nurse 16-11-2015	7 hours	Field notes
	Shadowing patient 17-11-2015	7 hours	Field notes
	Shadowing nurse 18-11-2015	9 ½ hours	Field notes
	Shadowing nurse 20-11-2015	6 hours	Field notes
	Shadowing doctor 23-11-2015	7 ½ hours	Field notes
	Shadowing doctor 24-11-2015	6 ½ hours	Field notes
	Shadowing doctor 26-11-2015	6 hours	Field notes
	Shadowing doctor 27-11-2015	7 hours	Field notes
	Shadowing patient 05-09-2016	7 ½ hours	Field notes
	Shadowing nurse 06-09-2016	7 hours	Field notes
	Shadowing nurse 08-09-2016	5 ½ hours	Field notes
	Shadowing patient 09-09-2016	5 ½ hours	Field notes
	Shadowing doctor 12-09-2016	4 ½ hours	Field notes
	Shadowing doctor 13-09-2016	7 ½ hours	Field notes
	Shadowing doctor 15-09-2016	7 ½ hours	Field notes
	Shadowing doctor 16-09-2016	6 hours	Field notes
	Shadowing nurse 02-10-2016	7 ½ hours	Field notes
	Shadowing nurse 03-10-2016	6 ½ hours	Field notes
	Shadowing nurse 05-10-2016	7 hours	Field notes
	Shadowing nurse 06-10-2016	6 hours	Field notes
	Shadowing doctor 09-10-2016	8 ½ hours	Field notes
	Shadowing doctor 10-10-2016	6 hours	Field notes
	Shadowing doctor 12-10-2016	6 ½ hours	Field notes
	Shadowing doctor 13-10-2016	5 ½ hours	Field notes
	Processing field notes	103 hours	Field notes
Interviews	Head of department 12-01-2017	1 hour	Audio

			recording and transcript
	Head nurse 03-01-2017	1 hour	Audio recording and transcript
	Nurse 1 08-09-2015	1 hour	Audio recording and transcript
	Nurse 2 14-09-2015	1 hour	Audio recording and transcript
	Nurse 3 31-08-2016	1 hour	Audio recording and transcript
	Nurse 4 05-09-2016	1 hour	Audio recording and transcript
	Doctor 1 14-09-16	1 hour	Audio recording and transcript
	Doctor 2 20-12-16	1 hour	Audio recording and transcript
	Doctor 3 03-01-2017	1 hour	Audio recording and transcript
	Doctor 4 12-01-2017	1 hour	Audio recording and

			transcript
	Patient 1 19-05-2015	1 hour	Notes
	Patient 2 20-05-2015	1 hour	Notes
	Patient 3 22-05-2015	1 hour	Notes
	Patient 4 18-09-2015	1 hour	Notes
	Patient 5 17-11-2015	1 hour	Notes
	Patient 6 05-09-2016	1 hour	Notes
	Patient 7 09-09-2016	1 hour	Notes
Materials	2 patient satisfaction surveys	-	Documents
	65 patient information sheets	-	Documents
	3 professional guidelines (same-day procedures)	-	Documents
	13 photographs (team meetings)	-	Photographs
	22 photographs (white board meetings)	-	Photographs
	Depictions of procedure plan,	-	Depiction
	Depiction of patient overview board	-	Depiction
	Depiction of patient record (adapted)	-	Depiction
In sum		402 hours	

CHAPTER 5: PAPER 1

Title: Temporal patient trajectories: Long stories in short admissions

Author: *Vibeke Kristine Scheller* (Department of Organization, Copenhagen Business School)

This paper answers research question 1 (RQ 1) that was presented in the introductory chapter of this dissertation: *How are 'temporal patient trajectories' continuously reconstructed in a Cardiac Day Unit, and what are the challenges for professional work?* It will be submitted to *Organization Studies* in the fall of 2019.

Abstract

The patient trajectory is an important organizing principle in health care organizations, concerning the organizational work around each patient and their treatment through time. However, organizing patient trajectories at hospitals today is challenging with the introduction of accelerated same-day discharge schemes in many medical fields. This means that the patient trajectory is formed by several short treatment schemes within different health care organizations, which risks introducing fragmented experiences for both patients and the professionals caring for these patients. The patients, at the same time, often have complicated illness stories, and health care professionals meeting these patients in accelerated same-day discharge schemes see only a limited part of the patient's trajectory. This article is based on extensive ethnographic studies in a newly established Cardiac Day Unit introducing same-day discharge schemes for patients with ischemic and arrhythmic heart disease. The findings suggest that the patient trajectory becomes a 'temporal patient

trajectory', in which professionals and patients continuously reconstruct a trajectory in conversations i.e. a processual perspective on trajectories. In addition, the article's analysis highlights tensions between patient experiences and the accelerated discharge schemes and how professionals try to overcome these tensions by engaging in articulation work in which they bridge different time perspectives, i.e. the long illness narrative and the short trajectory within the cardiac Day Unit.

5.1. Introduction

The 'patient trajectory' is both an empirical and theoretical concept used to describe work processes concerning treatment and care for patients. In hospitals, professionals continuously discuss the organization of patient trajectories as a way of approaching efficiency at an organizational level, while simultaneously referring to the quality of care. As such, it was not a coincidence that the term originally developed from Strauss et al's (1997) grounded theory studies of the social organization of medical work, i.e. 'illness trajectories'. While 'patient pathways' has also been a common term in scientific discussions of medical treatment (Allen, Gillen, & Rixson, 2009; Probst, Hussain, & Andersen, 2012), the trajectory concept is closer to the discussion of daily practice and work organization. The definition of a 'pathway' is: *"... a complex intervention for the mutual decision making and organisation of care processes for a well-defined group of patients during a well-defined period."* (Vanhaecht, 2007, p. 137). Examples are (political) decisions on standardized 'packages' of activities for patients with specific types of cancer in Denmark (Obling, 2012). In comparison, the 'trajectory' covers the everyday organization of work tasks and the impact on patient experiences:

"… trajectory is a term coined by the authors to refer not only to the physiological unfolding of a patient's disease but to the total organization of work done over that course, plus the impact on those involved with that work and its organization." (Strauss et al., 1997, p. 8)

Strauss et al. (1997) explain that trajectories comprise the parceling out of tasks for different illnesses, i.e. 'trajectory work'. Trajectory work concerns the process of professionals bringing the patient from illness to recovery, through performing tasks along a long and staged trajectory determined by the diagnosis (Strauss et al., 1997). In recent years, the health care sector in many countries has changed dramatically, with the introduction of day surgery (Gilmartin, 2007), same-day discharge (Antonsen et al., 2013) and fast-track surgery (Hjort Jakobsen et al., 2014), with accompanying at-home treatment (Cotton et al., 2000) and rehabilitation outside of the hospital (Ades et al., 2011). New challenges arise from this changing landscape of shorter admissions, e.g. what is the patient's trajectory and who keeps track of it? These questions pose problems for the traditional and very ordered way of thinking about trajectories, as presented by Strauss et al. (1997).

Even though many medical researchers argue that recovery is faster for patients who are discharged early, e.g. from hip surgery (Hjort Jakobsen et al., 2014; Kehlet, 2011; Kehlet & Wilmore, 2008), this research also presents some organizational challenges. The need for timing of information becomes increasingly important with the introduced risk of leaving patients with unresolved questions after discharge (Gilmartin, 2007). Other studies highlight that accelerated discharge schemes tend to displace a substantial part of the recovery process outside of the hospital, where patients have to rely on help and care from family members or friends (Wagner & Carlslund, 2002). This new development in the organization of patient trajectories

calls for a new temporal perspective, that takes into account what happens when time become a limited resource. The classical understanding of patient trajectories is built on patients with chronic illnesses and lengthy hospital stays, e.g. Mrs. Price and her 112 days admission (Strauss et al., 1997, p. 16ff).

In a modern hospital context it is important to look at how patient trajectories encounter a short-term reality, where tensions arise between admission time and the entire patient trajectory, and professionals have a short timeframe to perform trajectory work (Strauss et al., 1997). At the same time, 'coherence' is much sought after as an organizational principle in health care (Munkvold & Ellingsen, 2007). Coherence is important for patients, and for their trajectories in particular, as it describes an experience of connectedness over time, i.e. how the symptoms and treatments are connected to the diagnosis. Coherence is therefore an important concept in studies of health care organizing. But what is coherence in a trajectory that winds in and out of different organizations? It is not determined by a specific diagnosis that is treated in one continuous hospitalization. It is easy to point to the risk of increased fragmentation, but it is more interesting to investigate how patients and professionals try to maintain coherence in practice, i.e. what is happening when professionals and patients meet and talk about the patient trajectory in same-day discharge? I pursued this interest by conducting an organizational ethnography of patient trajectories by focusing on the tensions and polyphony in organizing same-day discharge. Aiming to explain why tensions arise from organizing endeavors tells us something important about how meaning is created in organizations (Humle & Pedersen, 2014; Pedersen & Humle, 2016).

Based on the ethnography, I suggest a new perspective on trajectories - 'temporal patient trajectories' - which is an extension of Glaser and Strauss's classical concept

with a contingent and processual perspective that emphasizes how the trajectory is continuously reconstructed in events (Hernes, 2017). This enables researchers to explain how a patient trajectory becomes a trajectory in time. The two theoretical perspectives inspire each other, i.e. the classic in-depth micro-analysis of medical work, and the processual understanding of the becoming of organizing. On this basis, I will pursue this research question through the article:

How are temporal patient trajectories continuously reconstructed in a Cardiac Day Unit, and what are the challenges for professional work?

This article begins with a review of the literature that describes patient trajectories (Strauss et al., 1997) as well as the processual perspective on trajectories (Hernes, 2014). The review is followed by an introduction to the ethnographic case study of the Cardiac Day Unit and the methodology, e.g. shadowing of trajectories. The subsequent analysis demonstrates how patient trajectories are temporal, by pointing to temporal conflicts that occur in accelerated trajectory schemes in the Day Unit and how professionals try to overcome these conflicts by engaging in articulation work. The article ends with a discussion and conclusion section, which discusses the theoretical contributions to the reviewed literature.

5.2. The trajectory as an organizational principle

This section reviews the literature on trajectories by bringing together two different bodies of literature. The first is the micro-sociological work perspective, presented by Strauss et al. (1997) and adapted by many other scholars thereafter. The ‘illness trajectory’ (Strauss et al., 1997) describes a sequence of activities lined up between disease and cure, and professional work in this view concerns the mapping of events

determined by the diagnosis. The other perspective is the organizational process perspective, to which the use of the trajectory concept is quite new (Hernes, 2017) and does not concern medical work or work practices in general. However, it offers a very interesting perspective on trajectories. The temporal trajectory concerns events that are connected and constitutive of each other and includes a temporal perspective on organizing, i.e. the simultaneous enactment of past, present and future in events.

5.2.1. Classical perspectives on illness trajectories

The classical concept of 'illness trajectories', from which patient trajectories developed (Pescosolido, 2014), describes hospital work from diagnosis to recovery (or possibly death) for the patient (Strauss et al., 1997). In this understanding, the 'trajectory' covers both the physiological unfolding of an illness and the organization of work to manage this illness. The concept has also been prevalent in discussion of terminal care for the dying (Glaser & Strauss, 1968) and their status passage (Glaser & Strauss, 1965). These studies have in common that they concern micro-sociological studies of medical work 'around' the object of work - the patient. The patients, in Strauss et al.'s view are 'objects' that are worked on by professionals, and even though they are not inert and engage in 'work' of their own (e.g. self-managing medication), they are not center of attention in this conceptual framework. The trajectory framework has been utilized in recent medical studies (Armstrong et al., 2012), usually with respect to end of life trajectories (Andershed & Ternestedt, 1998; Dalsted et al., 2012; Murray et al., 2005), but sometimes also acute trajectories (Mackintosh & Sandall, 2016). The concept has been pivotal in studies of computer-supported work as well, where it is utilized to describe new technologies' ability to support trajectory work (Reddy et al., 2006, p. 37).

Strauss et al.'s (1997) reason for using the trajectory concept grew out of a research interest in the difficulties that chronically ill patients posed for professionals who regarded themselves as primarily managing acute patient cases. The chronically ill seemed to be 'out of place' and the trajectory concept was promoted as an explanatory concept for the organization of work to care for these patients in the long run. For instance, the notion of quick/lingering or expected/unexpected trajectories proved a powerful explanatory framework for professionals caring for the dying (Glaser & Strauss, 1968). As such, prospects and plans are core to the understanding of trajectory management in hospitals. The concept is used most frequently with reference to treatment of diseases such as cancer, ischemic heart disease and heart failure. It describes the professional considerations of how the patient's disease will progress and how the transdisciplinary work 'around' the patient's trajectory is to be organized across different organizations and institutions. Working with patient trajectories concerns 'mapping the process' (i.e. the trajectory scheme), which covers the possible series of events and actions along the trajectory. To Glaser & Strauss (1968) some events are especially important because something unexpected happens that calls for professional action. These events are called 'critical junctures' and are described in relation to dying trajectories (Glaser & Strauss, 1968), where the dying trajectory takes an unexpected 'turn', e.g. that it accelerates and the patient is expected to die sooner than anticipated.

The two theoretical understandings of trajectories offer different frameworks, i.e. 'mechanics' in how trajectories are organized. In the traditional perspective, the trajectory scheme is supported by the 'arc of work' (machine work, safety work, comfort work, sentimental work, and articulation work). The two latter types of professional work are especially important in the case of same-day discharge.

Articulation work is the creation of overviews and plans to support medical work that bring coordination and assures, "… *that the staff's collective efforts add up to more than discrete and conflicting bits of accomplished work*." (Strauss et al., 1997, p. 151). In the traditional understanding, articulation work comprises three levels: 1) the main physician in charge of the patient case makes a decision; 2) professionals organizing or monitoring to ensure the decision is carried out (e.g. a head nurse) ; and 3) the professional (or machine) actually doing the requested work. Strauss et al. (1997) argue that sometimes these levels are not as distinct in practice. However, articulation work in this understanding is first and foremost a description of a 'chain of command' and the collective work from decision to action.

'Biographical work', as a part of sentimental work, concerns work practices that enable the professional to understand and utilize information about their patient in their contact with him or her. Typical biographical work activities in patients' illness trajectories are: 1) diagnostic interviews; 2) discussions about patterns of living and the patient's will to live (in palliative care); and 3) informal conversations on the wards, where nurses usually engage in 'small-talk' with patients to make their relationships smoother. Biographical work also has a 'technical' side, e.g. when professionals enter information obtained in a diagnostic interview into a patient record (Iversen, Melby, Landmark, & Toussaint, 2013; Munkvold & Ellingsen, 2007). In other texts (Corbin & Strauss, 1985), biographical work is also used to describe a patient's 'identity work' in illness trajectories that can be disrupted by a crisis such as divorce, unemployment etc. Thus, the classical understanding of the trajectory describes a (more or less) fixed structure determined by a diagnosis, and biographical work is one element in trajectory management. But is there something more to the narrative quality of illness trajectories, such as that the trajectory itself is

constructed and continuously reconstructed by the way patient and professionals talk about it? Is biographical work more than doing sentimental work, but itself constitutive of the trajectory? Is there a trajectory outside of conversations about the trajectory? These are unresolved questions in need of further investigation.

In addition, Strauss et al. (1997) point to the challenges that new technologies pose for trajectory management, e.g. life support promotes lingering trajectories. They argue that increased technological specialization introduces fragmentation of care for chronic patients and the possibility that continuity of care is at risk of disintegrating (Strauss et al., 1997, p. 4). In the same way, new technologies that enable same-day discharge likely change the way that illness trajectories are managed, e.g. from lengthy hospital stays with the same professionals caring for the patient, to several short admissions in different hospitals. From studying the traditional literature, we know a lot about how trajectories are managed, but we lack knowledge about how they become trajectories in the first place, which is increasingly important because of changes in the context surrounding patient trajectories. I argue that this calls for a new understanding of trajectories; a contingent approach that explains the relationship between the trajectory and how the trajectory emerges from conversations between actors in events, i.e. a processual perspective on trajectories.

5.2.2. The temporal trajectory as organizational process

In recent years, scholars have been studying the relationship between temporality and processes in organizations (Hernes et al., 2013; Langley et al., 2013; Schultz & Hernes, 2012). This perspective views temporality in a different way from Strauss et al. (1997) who mainly describe the division of labor in terms of time. Process philosophy (Whitehead, 1929) implies that the present must be seen as an ongoing

temporal present, where past, present and future are enacted simultaneously in events. The process perspective requires thinking about actors as emerging from processes, i.e. that everything *becomes* something rather than *is* something. For organizations, this radical perspective means that they are always in the state of becoming something other than fixed structures. Hernes (2017) argues that even though organizations are never fixed as final structures, that does not mean that work by organizational members is without direction. As a way to describe this experience of direction in organizations, he proposes the 'temporal trajectory' as an explanatory frame (Hernes, 2017). However, even though both Strauss et al. (1997) and Hernes (2017) present a trajectory concept, the two perspectives are distinctly different from each other. Hernes criticizes organization studies for focusing on events as, *"... mere happenings along a timeline that stretches from the past to the future"* (Hernes, 2017, p. 602).

He criticizes, that for these scholars, events are simply seen as making up a linear progression over time, and not that what occurs in these events is the creation of the sense of a trajectory by drawing on prior experiences and expectations for the future. For process scholars, there is nothing that is 'outside' of the event. However, at the same time, events are not reducible to what goes on in the event. Rather, actors draw connections between different events that are important for creating a mutual understanding of the task at hand. While his research mainly refers to organizational change (Hernes, 2017) and organizational identity (Schultz & Hernes, 2012), it offers a novel and very interesting perspective for health care organizing, especially in relation patient trajectories. The 'static' view that he criticizes is exemplified by the studies of illness trajectories presented earlier in this article (Pescosolido, 2014;

Strauss et al., 1997). Hernes suggests the 'temporal trajectory' as a form of provisional organizational entity, which actors are constantly reconstructing:

"The object of thinking of organization as becoming, I suggest, is the temporal trajectory of the organization, which actors are constantly involved in reconstructing. A temporal trajectory is a pattern, or patterning, of events that stretches back into time and extends into the future. A temporal trajectory requires work, which consists of articulation performed at various moments and in various places". (Hernes, 2017, p. 603f)

The same suggestion, i.e. the trajectory as an object of thinking, can be found in Strauss et al.'s (1997) theorizing, but in a different way. In relation to the social organization of medical work, the expected illness trajectory determined by a specific diagnosis creates a temporal structure which professionals can orient their activities towards. In comparison, the temporal trajectory is formed by events as central building blocks, but they are not planned or fixed - rather they emerge from temporal processes, stretched out in a reciprocal relationship between the past, present and future. From a process perspective, the central point is not how the events are planned in time, but rather how they form our experience of coherence over time: *"Coherence is not the same as consistency. Coherence allows for holding things together so that the whole make up of things is recognizable from one point in time to the next".* (Hernes, 2007, p. 133). I argue that this perspective is relevant, not only in studies of how organizations become, but in relation to how patient trajectories become objects of coherent organizing. Every patient is something more than an inert object being moved through time. Patients, their stories and their trajectories are objects of thinking, which both the traditional approach and especially the processual approach

point to. However, we lack knowledge about how the patient trajectory becomes a trajectory in events and how it is connected to temporality.

Hernes offers an elaboration of how meaning is enacted in events by presenting a series of 'articulatory modes' (Hernes, 2014). Intersubjective articulation concerns social interaction (oral or gesticulatory) that supports transmission of past and future experiences. Practical articulation covers practice- or work-based articulation, often embedded in routines. Textual articulation describes the use of writings that are disconnected from actors, and often span the distant past, the present and the future. Material articulation covers the use of material objects to span both events and actors, i.e. what have been studied as boundary objects (Star & Griesemer, 1989). The last mode is tacit articulation, which concerns the translation of experience in a non-verbal way, e.g. improvised music. To medical work, the intersubjective, practical and material articulatory modes are most important as professional work is heavily engaged in interacting with patients (and colleagues) to access past and future experiences. Furthermore, the use of technology to support the sharing of information is central to medical practice, e.g. the patient record. A point of criticism to the processual perspective could be that the practical, intersubjective and material articulatory modes overlap in practice.

The two reviewed bodies of literature present many concepts, some of them very similar. However, some of them are specifically important to the study of patient trajectories in same-day discharge: 1) events; 2) articulation; and 3) coherence. Table 9 below presents these concepts and describes their different implications in the two research traditions.

Table 9: Central concepts in the trajectory literature

Concept	Classical perspective	Processual perspective
Events	Comparable to planned actions on a timeline. Critical junctures are unexpected events that call for action.	There is nothing 'outside' of the event. Events are 'ongoing presents' that simultaneously enact the past, present and future.
Articulation	Articulation work is work done to coordinate and direct collective professional efforts.	Articulatory modes describe different ways that meaning is enacted in events.
Coherence	Continuity of care and control of biographies that can be disrupted.	Coherence is the sense of time and allows the holding of things together over time.

The introduction of a process perspective on patient trajectories forms a contribution to the research field by extending the understanding of trajectories, not only beyond the borders of organization but, as a process that expands in time and space. By analyzing the eventness of patient trajectories it becomes possible to provide an explanation for conflicts occurring in the intersection between same-day discharge and the life of patients. The analysis in this paper shows how a combination of the two perspectives can explain the challenges in organizing same-day discharge, i.e. where planning meets emergence in the Cardiac Day Unit. The next section describes the methodology and the case study of same-day patient trajectories in the Cardiac Day Unit.

5.3. Shadowing patient trajectories in a Cardiac Day Unit

This article is based on an extensive ethnography of same-day discharge in a Cardiac Day Unit and the challenges for patient trajectories and professional work. This section describes methods, data sources and the methodological considerations of doing ethnography of trajectories and ends with a case description of the Cardiac Day Unit.

5.3.1. An ethnography of trajectories

This organizational ethnography (Pedersen & Humle, 2016; Ybema et al., 2009) was undertaken between 2015 and 2017 and concentrated on the establishment of a Cardiac Day Unit. The ethnography focused on how professionals working in the Cardiac Day Unit provided care for patients in accelerated same-day discharge. The ethnography consisted of qualitative methods such as observations (mainly shadowing) and semi structured interviews (see Table 10).

Table 10: Qualitative methods and data

Observations	Shadowing nurses	114 hours	Field notes
	Shadowing patients	49,5 hours	Field notes
	Shadowing doctors	105 hours	Field notes
Interviews	Head of department	1 hour	Audio recording and transcript
	Head nurse	1 hour	Audio recording and transcript
	Nurses (4)	4 hours	Audio recording and transcript

	Doctors (4)	4 hours	Audio recording and transcript
	Patients (7)	7 hours	Notes

'Shadowing' (Czarniawska, 2007; McDonald, 2005) is a form of participant observation where the researcher follows a member of an organization over a period of time in order to get access to the intimacy and experiences of work (Gill, 2011). In health care, shadowing has been utilized to access what happens in medical practice, rather than what should ideally happen in practice (Liberati et al., 2015). For example, in patient-centered care, it is relevant to look 'under the surface' of good intentions, to explore events and how these are perceived by the person being shadowed, in this case the patient. Shadowing patients and their experiences allows collection of qualitative data that provides insight into subjective care experiences, as well as the practicality of how professional care unfolds in time and space (Liberati, 2017). In the study of same-day discharge, shadowing professionals provides comprehension of how medical work supports patient trajectories.

While shadowing professionals is easy - because they are used to be followed by trainees - shadowing patients is challenging and sometimes awkward for the researcher. The relationship between researcher and patient becomes intimate and the patient is sometimes nervous but too polite to ask the researcher to leave, so the researcher has to be very attentive to subtle signals from the patient. Shadowing the patient's trajectory from admission to discharge provides a privileged view into the patient experience that is normally inaccessible to the professional, which gives the researcher a specific role as a 'carrier of the trajectory'. In this paper, an entire patient trajectory is presented in addition to excerpts of several patient trajectories in the

Cardiac Day Unit. In this way, the analysis cuts in and out of different patient trajectories, which is similar to how they are experienced by medical professionals in the Day Unit. Another important consideration is reflexivity. It is true for all researchers doing participant observations that they are active co-creators of the field that they are studying. However, this is particularly true for shadowers, as they can never be non-participants as Czarniawska (2007) and McDonald (2005) explain. If a 'shadow' tries to be passive, this will inevitably be experienced as intrusive by the person being shadowed. In my experience, the shadowed person (both professionals and patients) often demand that the researcher explain the motivation behind the research project, and they seldom settle for high-flown theoretical explanations. In such circumstances, I explained that I was a researcher interested in the organization of same-day discharge, particularly how efficiency and patient care can coexist, how patient treatment can be both accelerated and patient-centered, and, what challenges this tension causes for medical work. This explanation indicated my curious and, to some degree, critical stance towards the phenomena.

Balancing proximity and distance, i.e. exercising 'norms of politeness' (Gill, 2011) is another important challenge that shadowers face in the field. It concerns what feels acceptable to the shadow. For my part, I often had to make an instantaneous and intuitive decision on what was appropriate or inappropriate. For example, I chose to stay away when patients were to receive personal care (such as intimate shaving) and I chose to stay away when the nurse I was shadowing was to participate in treating cardiac arrests. The latter was also based on a desire not to disturb serious incidents in any way. This means that I lack insight into some parts of their medical practice. It is a limitation, but at the same time a prerequisite for being able to be present in the field as an acceptable observer (Hammersley & Atkinson, 2007).

After the fieldwork period ended, the data was systematized and analyzed thematically, i.e. as temporal tensions in same-day discharge relating to trajectories (Clarke et al., 2015). The recorded interviews were transcribed and coded. They display the way that professionals talked about the Day Unit idea and the challenges they faced. The ethnographic field notes show medical work, discussions and meetings between professionals and patients. Taking ethnographic field notes provides the researcher with extensive empirical data, which also requires systematic coding. The field notes were divided into four sections (as described in Justesen & Mik-Meyer, 2012, p. 102): 1) Brief notes in a notebook (that fits into the pocket of a hospital uniform), for reminiscence of specific events during the stay in the hospital; 2) descriptive notes that were utilized to reproduce the events as detailed as possible; 3) analytical notes with suggestions on how the descriptive notes relate to each other; and 4) reflective notes on the researcher's feelings towards the field. This coding system makes it possible to go back and forth between different analytical steps.

The patient perspective in this paper is unusual in the sense that the analysis is not based on interviews about their life worlds, but first and foremost on observations of how the patient appears in meetings with professionals, and how patients and their trajectories become the objects of organizing. In addition, the analysis presents one complete patient trajectory in the Day Unit as well as fragments of different but very similar trajectories. The purpose is to show how polyphony and standardization coexist in practice, which is one of the purposes of organizational ethnography (Pedersen & Humle, 2016). The ethnography presented in this paper also focuses on temporality in the everyday practice of the hospital by shadowing work practices and the professional dilemmas that arise in same-day discharge. The next section is a

description of the ethnographic case study, i.e. the Cardiac Day Unit and the organizational challenges that professionals face, such as bottlenecks etc.

5.3.2. Case and context: Organizing a Cardiac Day Unit

The Cardiac Day Unit was established in 2015 as an attempt to meet politically determined budget cuts while simultaneously utilizing technical and medical innovations that support early discharge such as the Angio-Seal[6] and tele monitoring of pacemaker patients. The Day Unit receives patients for planned or subacute procedures within two medical areas - arrhythmic and ischemic heart disease - who can be discharged to their homes or transferred to other hospitals on the same day as the procedure.

Patients with ischemic heart disease have a restriction of blood flow through the heart, possibly due to blood clots or narrowing of the arteries. The condition causes chest pain and breathing difficulties and is often related to lifestyle diseases such as elevated cholesterol levels or COPD. The most common procedure for treating ischemic heart disease in the Cardiac Day Unit is the coronary arteriography (CAG) which normally takes ½ to 1 ½ hours. During the CAG, a very thin catheter is inserted in an artery from the groin or arm to the coronary arteries. A contrast dye is injected into the arteries, which can be displayed by x-rays, and therefore reveals obstructions of the blood flow. Sometimes, a Percutaneous Coronary Intervention (PCI) procedure is performed immediately, where the blood flow is increased by

[6] Before the collagen plug-based (Angio-Seal) closure device was invented, the patient had to lie horizontal in bed with heavy sandbags to apply pressure to the entry wound for 9 hours.

inserting a small balloon into the artery via a catheter. If there are several blockages in the arteries, an invasive surgery called coronary artery bypass grafting (commonly known as ‘bypass’, CABG) is needed and in this case the patient will be transferred to another department within the hospital.

The other patient group in the Day Unit presents with arrhythmia, where the heart rhythm is either too slow or too fast, resulting in discomfort and breathlessness. There are several treatments for the condition, i.e. defibrillation and medication, and catheter ablation in which radiofrequency energy is utilized to remove a small area of tissue in the heart muscle that causes the irregular heart rhythm. The catheter ablation is a comprehensive procedure that normally takes more than 3 hours. Most of the patients in the Day Unit follow an elective procedure scheme, which entails that it is planned in advance. However, the Day Unit also receives patients from other hospitals, e.g. those with acute coronary syndrome (ACS) where their chest pain is unpredictable and can lead to a heart attack at any time. These patients require electronic monitoring of their heart rhythm and therefore have to be transported to and from the hospital by ambulance.

The patients who enter the Cardiac Day Unit follow a formal trajectory (Figure 7), that is roughly the same for all patient groups, with four central events:

Figure 7: The central events in same-day discharge

However, the formal organization has a 'human side' that became visible when shadowing patients. The field note below describes one of the patient trajectories that I shadowed, and even though this is an example of an uncomplicated trajectory that comprised all of the above events, it provided an in-depth understanding of what happens to the patient during admission and also 'in between' events.

Field note: The same-day trajectory

The patient had an appointment in the ambulatory clinic for a preparatory conversation with a nurse and a doctor three days before admission.	Preparatory conversation
I meet the patient in his room and ask about how he came to be enrolled in the same-day discharge scheme. The patient explains that he underwent an acute Percutaneous Coronary Intervention (PCI) in July 2015. It went well and he was very impressed with how fast he could be treated. He says that for him, the biggest problem was that he lacked information immediately after the procedure; about dietary restrictions and secondary complications that he should be aware of. He got a follow-up appointment when he was discharged - but not before September. The patient has had stomach ulcers in the meantime, presumably because of the increased amount of medication. The patient was admitted to a local hospital on 15/9 because of a bleeding ulcer.	Medical history
At approx. 7 AM the patient arrived in the Day Unit. He is	Admission

about to have a new examination of the coronary arteries because he keeps having chest pains. He feels okay, but is a little nervous about the upcoming procedure: "They are tampering with the heart". The patient tells me that the procedure is an old method; at the local hospital there was another patient who underwent a CAG 13 years ago.

The nurse comes into the patient room at 9 AM with water and a consent form to be filled by the patient. He does this shortly after she leaves the patient room. The patient is scheduled for the procedure as number 4 according to the plan, which means that the procedure will take place at approx. 1 PM. He understands: "There must be waiting somewhere, so it is the patients that must wait".

Consent form

A doctor doing rounds arrives in the patient room at 9:45. He asks for a description of the patient's chest pain and the patient tries to describe that he does not really feel pain but a form of diffuse discomfort in the chest area. Afterwards he tells me that he feels uneasy because he cannot give a clearer description of what he is experiencing. He thinks that this is what the doctor wants.

Doctor round

The patient and his neighbor are chatting in the patient room from 9:45 – 10:20. I am present too. We talk about different places they have traveled to pass the time while waiting.

At 10.20 the patient falls asleep in his hospital bed. Maybe because of the anti-allergy medicine that he was given as a preventive measure. Or perhaps I was boring to talk to. I go back to the nurse room, and they joke that they should rather send me in to interview patients than providing them with sedatives.

Kl 12.14: I return to the patient room, but both of them have gone to the lunch buffet and sit in the eating area talking. I leave them alone. Lunch

At 14:15 the patient must be brought to the procedure room. A porter comes and fetches him in his hospital bed and wheels him down there with the elevator. I'm following them. Arriving at the procedure room, the patient and I wait for ten minutes outside the room while they read his record and prepare the equipment. Then an operation nurse comes out and greets the patient. The patient is brought to the bed and the procedure begins. Procedure

We finish at 16:20. It takes a long time because of many balloons and two stents and a period when we waited for a doctor who was to confer with the PCI operator.

At 16:30: The patient comes back to the Day Unit and has to lay horizontal in bed for two hours. Then he goes home. Discharge

From the description above, same-day discharge seems straightforward. The patient follows a trajectory of planned events and coherence is articulated in different ways along the trajectory, e.g. the patient is met by a nurse who explains the process and later interviewed by a doctor who asks about his symptoms. However in many cases, it has proved challenging for managers and staff in the Day Unit to successfully complete same-day trajectories. Sometimes the patient's trajectory evolves in unexpected (and unplanned) ways. Also, there is a need for rethinking how and when information will be disseminated to the patients, and there needs to be a careful selection of which patients are suitable for quick discharge. All other hospital services (such as translators) and transportation have to operate at an elevated speed as well, which is difficult, and often results in bottlenecks. The professionals try to overcome the challenges by constantly debating the service level they provide in terms of how they can create smooth trajectories for the patients. They wish to 'see the trajectory through the eyes of a patient'. But how can the professionals get insight into the patient experience, and how can this experience become the object of organizing? The next section concerns the empirical findings relating to the conditions of patient trajectories in same-day discharge.

5.4. Findings: Temporal patient trajectories in a Cardiac Day Unit

This section presents the empirical findings in two parts, which are both centered on the main events in the same-day trajectory. The first section (5.1.) concerns the formal organization of same-day trajectories in the Cardiac Day Unit, i.e. scheduled

activities and events and the overall sense of time in same-day discharge. In addition, this first part highlights how the patient trajectory is constructed and negotiated by professionals and patients. The second part (5.2.) focuses on the challenges that arise from the introduction of same-day discharge, i.e. break downs, tensions and waiting time. This part displays tensions that sometimes occur between the patients' expectations and the professionals' abilities to meet these expectations within a short timeframe.

5.4.1. Same-day discharge: The patient on a conveyer belt?

Professionals in the Cardiac Day Unit constantly debate the formal organization of patient trajectories and how they can provide the best possible service to their patients. The patient trajectories within the Day Unit are sometimes described as organized along a 'conveyor belt', as in this quote from an interview with the head of department:

"… imagine a conveyor belt, where the patient arrives in one end and is received by a nurse, gets dressed and prepared for surgery, and then travels down the conveyer belt to the operating room and finally ends up at the end of the belt, where you will be prepared for discharge and medication check and new scheduled meetings, etc." (Interview: Manager, the cardiac department)

The whole idea of the Day Unit is characterized by an aspiration to bring together patient types that resemble each other in a single unit, where the professionals can concentrate on creating smooth and coherent trajectories for patients who have (expected) uncomplicated illness progressions. The vast majority of patient trajectories in the Day Unit proceed as planned, with few unexpected events along the way and with a satisfied patient as a result. The patient enters the hospital and moves

through series of meetings with professionals, periods of waiting, a medical procedure, return to the ward and eventually discharge. The trajectory is described as a series of events along a timeline, but each event is at the same time decisive of other events; both future events and through new understandings of past events. As an example, gathering information about the patient at the preparatory conversation is important for the coherent organization of treatment in the Day Unit. The preparatory conversations in the ambulatory clinic (usually a few days before admission) are particularly important, as professionals and patients exchange information and articulate an agreement on the organization of tasks and management of expectations. This field note is from such a meeting between a patient and a doctor in the ambulatory clinic:

Field note: The preparatory conversation

At 13:45, the doctor receives a patient in the ambulatory clinic for a preliminary conversation and I am attending. The patient feels good, but needs to undergo a procedure in the following week, because another hospital has discovered an area in his heart with decreased blood flow. By doing this procedure [a CAG], the doctors will be able to see if they can do something about it, so that the patient can avoid shortness of breath and chest discomfort. The patient underwent bypass surgery less than a year ago. The doctor explains what will happen once the patient is admitted in the Day Unit, prescribes medication, performs an ECG and asks the patient if he has any questions regarding his hospitalization. The patient understands the plan but adds, "I am a little surprised that the effects of my bypass surgery did not last longer. They say it lasts 20 years". The patient hopes that he will only have to get a PCI as it would be tough having to go through an invasive operation again. He says, "I just thought I could put it behind me".

This preparatory conversation is the first ‘stop on the conveyer belt’. The purpose of the meeting is to lay out the admission scheme for the patient, while also listening to the patient’s articulation of his illness story. Decisions on how to move forward with this patient rely on the result of the procedure - can nothing be done, should a PCI be performed or does the patient need a new bypass? The account suggests that it is not just a meeting to agree on a timeline within the Day Unit. The patient’s prior surgery and possible future bypass surgery are significant for the coherent patient experience and calls for the professionals to manage his fear, or at least recognize it. The doctor encounters a patient about to enter into the same-day discharge scheme, but he has a ‘failed trajectory’ in the past, and the potential of having to go through another bypass scares him. The trajectory is orderly and disorderly at the same time, i.e. ”what we expect will happen” does not always happen, which is a feature of all medical work.

The patient record that is articulated on the basis of the preparatory meeting is important for nurses and doctors in order to prepare for meeting the patient on the day of admission. Apart from the medical information, the record also holds important information about the patient’s life situation, preoccupations and expectations. This excerpt is an example, where a nurse prepares for admission by reading the patient record:

Field note: Admission

A nurse is about to welcome a patient in the Day unit and read his record before he arrives. The summary in the record clearly shows that it is important for the patient to be discharged as soon as possible as he works as a self-employed person. The

journal says: "The patient is informed about same-day discharge and is very happy about this".

In this case, the nurse reacts to this information by doing anything in her power to ensure that the patient is discharged as early as possible, but she also has to manage his expectations by explaining that postponements are still a possibility due to acute patients coming in. Accordingly, other activities prior to the procedure serve as reassuring events, where the patient and professionals can talk casually to each other and discuss the agenda for the day. One of these activities is when the nurse enters the patient room with a consent form and engages in a conversation with the patient about the procedure, which the consent form gives occasion for. In the patient trajectory that was presented in the case description, a doctor also talks to the patient while doing his round. This is however not a fixed event in the same-day trajectory, but dependent on the specific patient and his needs. Many of the patients in the Day Unit are not seen by a doctor, as all the necessary examinations take place during the preparatory conversation and in the procedure room. While showing newly employed doctors around the Day Unit, a supervising doctor describes the organizing of work tasks thus:

Field note: Doctor round

One of the young doctors asks: "is the point that all those from yesterday should be discharged?" The doctor replies that "it is mostly autopilot, so it is more need-driven, is there a patient that should be looked at now? It is not a normal doctors round. It is very much the nurses who take care of the patient flow. It is important that you get a grip on how to do the patient record, and then the doctor's round". One of the younger doctors says "It sounds a bit like a machine?"

The supervising doctor describes a constant and unproblematic flow of similar patients coming into the Day Unit and leaving again without incident. The flow of patients traveling along similar trajectories constitutes a sense of time, and the role of the doctors is mainly to smooth out inconsistencies along the way, make sure that patient safety is secured, and all relevant information obtained. In the initial account of a patient trajectory, the doctor asks for a description of the patient's pain, which can provide guidance for the staff in the procedure room – possibly because of a lack of information in the patient record. While the visits from the doctor occur at random times (or not at all) during the patient's trajectory in the Day Unit, activities such as lunch organize fixed reference points for patients and professionals. Lunch for patients is served at 12 o'clock, and because the procedures only require a local anesthetic, the patients no longer have to abstain from food and drink. Also, the staff in the procedure room takes a lunch break except when treating acute patients. Therefore, lunch becomes a reference point for the nurses that they can convey to the patients: e.g. "your procedure will be after lunch". For the nurses and doctors in the Day Unit lunch breaks are organized ad hoc because of continuous coverage of patient needs, and often they do not have time for collective lunch breaks, but eat while attending meetings or sitting at the computer and updating patient records.

The procedure itself is the most important event of the day. The procedure is what the patient is scheduled for, and every other task is supporting the completion of procedures in some way. The procedure either 'cures' the patient or marks out what other future actions are needed. However, the procedure is disconnected from the professionals working in the Day Unit, in the sense that they 'send the patient off' to the procedure room, and then wait for them to return. As a researcher, I had the

unique opportunity to follow the patient into the procedure room. This excerpt is from an ablation:

Field note: The procedure

The patient inside the room undergoes a catheter ablation procedure for arrhythmic heart disease. Two nurses in the room talk to the patient, who is awake, and continuously ask for descriptions of his degree of pain. Out in the ante room, the doctor sits in deep concentration. With the help of large magnets that spin around the patient, he leads the catheter's tip around inside the patient's ventricle. He uses a joystick. It is a task that requires a lot of attention, and he does not say much to either me or the technician sitting next to him. The work he does results in a kind of "embroidery" of burning points inside the heart to help the patient with his arrhythmia that causes shortness of breath and discomfort. In front of the doctor, 14 monitors display different views of cardiac rhythm, a map of the heart and x-rays showing the veins and catheter placement inside the heart.

The procedure room has another sense of time compared to the bed-section in the Day Unit. There the focus is in a way much smaller and concentrated on the specific micro-tasks in conducting the procedure. The doctor in charge has to electronically type in medication corrections and a conclusion note in the patient record about the procedure. This enables the staff in the Day Unit to focus solely on caring for the patient's body before discharge, clearing away the possible bottleneck of having another doctor to formally complete discharge electronically while doing the round. If the procedure went as planned, the patient is formally ready for discharge. Discharge is treated as the second-most important event in the Day Unit. It is crucial for the success of same-day trajectories that they end in uncomplicated and early

discharge. For patients in the Day Unit there are two possible ways to be discharged - to their own homes or to a local hospital (for ACS patients). Discharge normally occurs without incident, but sometimes it is hindered by complications such as excessive bleeding or because the professionals discover underlying medical problems that need further treatment, e.g. bypass surgery. Sometimes, the complications are organizational as this account displays:

Field note: Discharge

The entry wound in the patient's groin is still bleeding, but not much, so the nurse and a doctor agree that they can order transportation, so she can return to the local hospital. Meanwhile, the hospital's IT systems break down with a technical error that affects the wait for transport as well. When asking about a time over the phone, the transport coordinator replies "possibly on Friday!" It is meant as a joke, but there is no doubt that the wait will be long. The nurse goes in to the patient room to explain to the patient that they have ordered transportation but does not know what time it will arrive.

Discharge is the 'last' event in the same-day trajectory, and as such highly important for the total organization in the Day Unit, i.e. when patients are hindered to leave, the beds remain occupied and it becomes challenging to receive new patients. A failed discharge represents the ultimate failure of the same-day trajectory, i.e. that it oversteps the temporal boundary of being 'same-day'. However, the postponement of discharge happens easily due to bodily or organizational difficulties, as in the account above where transportation difficulties create barriers to patient discharge. The formal organization of same-day patient trajectories in the Cardiac Day Unit lays out an expected and standardized scheme, which provides a sense of time, i.e. a coherent

sequence of events that need to happen in order for the patient to travel through the Day Unit. The Head of Department's statement that the Day Unit is 'like a conveyer belt' presents the formal organization of same-day trajectories as a matter of aligning in order to complete more trajectories within a shorter timeframe. The meetings along the trajectory (such as the preparatory meeting) are important because they support the coherence between events, because they enable professionals and patients to discuss the expected trajectory, and because it prepares the patient to be a 'body on the conveyer belt'. However the change from 3 day admissions to same-day trajectories is not easy. To make the trajectories shorter, something had to be changed in the way that they were organized. When deciding to create the Cardiac Day Unit, the management team found that something had to be cut out if everything was to be completed within a reduced timeframe. They discussed the role of information and activities which did not directly concern the patient's treatment in the Day Unit, and what role these should play in the future. The Head of Department presented it as a professional dilemma:

"... we have had to go through a lot of things on the nursing side, but also on the physician side that is 'what is important for what we are doing now'. It may well be that there is other kinds of information or activities that are important for the patient's coping with a chronic disease, but it is just not the subject of the day, and there may have been a tendency to be 'all inclusive', because one should also talk about everything between heaven and earth while the patient was hospitalized. And take into account a lot of things, including other illnesses and how the diabetes was regulated and ... etc., etc. We have cut it off so it has become more focused on what it is about [in the Day Unit]. It's a ... it's been ... I think, a mental barrier for all professionals." (Interview, Head of Department)

The focal point in the Head of Department's statement is that in order to succeed with same-day discharge, some activities become 'outside of the trajectory'. And it makes sense in relation to the professionals' ability to handle many similar patient trajectories within a short timeframe. But where do the 'outside of the trajectory' parts go? Some activities take place in other institutions, such as follow-up appointments with their general practitioner or at rehabilitation centers. The organization of same-day trajectories calls for deliberation on what is and what is not part of the formal organization and what challenges this dilemma holds for the professionals in the Day Unit. Also, the initial account of a standard patient trajectory displays that there is also activity 'between' events, i.e. 'waiting time' where the patient lies in bed and thinks about his medical situation and worries about his future. There is something more to the patient trajectory than planned events, both in terms of how the events become connected to each other, but also how they sometimes become disconnected from each other.

The procedure is the most important event during same-day discharge because it connects past, present and future, i.e. (hopefully) solving the patient's prior discomforts while providing him with a better future. Thus, the procedure as an event emerges from a temporal process and informs the patient's (and professionals') sense of coherence in same-day discharge. This example illuminates how patient trajectories emerge from events connected to each other. What matters when patients and professionals meet is not only what events are planned during their admission, but equally what happens in the events themselves, and how what goes on is temporally connected to other events. Sometimes, tensions even arise between the expected and planned trajectory and what happens while the patient is admitted in the Day Unit. The following section concerns breakdowns between the planned same-

day trajectory, and what is ‘outside’ of the trajectory but still important when providing coherent treatment for patients.

5.4.2. The patient in same-day discharge: Outside of the trajectory?

This findings section concerns events that seem to be ’outside’ the same-day trajectory, but at the same time are still a part of a coherent patient trajectory. The section describes how the sequence of planned activities sometimes breaks down due to disagreements etc., and how the professionals work to establish order through articulation. Working with patient trajectories can prove difficult, especially when introducing same-day discharge schemes with less time for coordinating tasks and sensing the patient's need for extra care. It creates new dilemmas in trajectory work, because nurses and doctors have to care for ‘whole’ patients as well as the short term plan of the same-day trajectory. Thus, managing patients’ anxiety and uncertainty while securing the quick succession of activities in same-day discharge is an important task. Even though in medicine a certain amount of uncertainty is expected, this does not mean that patients (and professionals) avoid frustration over ambiguity regarding the patient trajectory. In the following account, a patient clearly expresses frustration over ‘not knowing the trajectory’. It is another example of a preparatory conversation in the ambulatory clinic:

Field note: Tension at the preparatory conversation

It is ten minutes before a patient arrives in the ambulatory clinic. The doctor reads his record. She reads that the patient has had a blood clot in the leg. At the Day Unit, they should investigate whether the problem of blood clots stems from an undiagnosed heart condition. The patient is scheduled for a coronary angiography (CAG) three days later. We greet the patient and walk into study room number 2. He

has talked with a nurse immediately before. The doctor starts asking him for a description of his symptoms. The patient says: "Your questions are so vague - what is pain during activity? And the nurse asked if I was allergic to contrast fluid - I don't know if I am. How should I know?" The doctor responds: "We must assume that you are not". The patient then complains that the doctor asks the same questions as the nurse. After the doctor has asked about the patient's medication and performed an ECG, she says goodbye to the patient. Afterwards, she examines the forms that the patient has filled out. One of the questions is: "Do you have any of the following diagnoses ... 'blood clot in the heart'". The patient has ticked the box based on "do not know" and indicated a "?". How would you know - isn't it the reason why you should have the CAG? The doctor scrutinizes prior notes in his record. There are many. She says, "some stories are easier to comprehend than others".

The conversation is tense - the patient complains that the doctor asks 'vague' questions, and that he does not understand the relevance of some of the questions. The patient gives an impression of an incoherent trajectory, and the doctor tries to ask questions that can provide an orderly articulation of the necessary actions to bring the patient towards recovery. The orderly (schematic questions in the patient record) and the disorderly (uncertainty) clash in this discussion of the patient's trajectory, and the patient does not recognize the questions as meaningful. Rather, he sees it as a sign of the professionals lacking insight into or control over his trajectory. The articulation of the patient trajectory as a common understanding between the patient and the doctor breaks down, and the patient seems to distrust their ability to provide coherent care for him in the Day Unit.

Patient admission in the Day Unit centers on a very specific agenda, i.e. to prepare them, get them to the procedure room and discharge them by the end of the day. But

at the same time, the patients arrive in the Cardiac Day Unit, carrying with them their long stories, and often the professionals cannot avoid them, but are directly confronted with the patient's 'irrelevant' medical (or personal) history. Sometimes patients are even so immersed in their own life story that it conflicts with work practices in the Day Unit. Some patients are very eager to tell their stories to the professionals, which can cause conflicts when the organization of the same-day discharge scheme otherwise calls for quick completion of tasks. An example is this account of a meeting between a patient and a nurse during admission in the Day Unit. The patient has arrived just in time for her procedure due to transportation delays:

Field note: Admission and consent form in a hurry

Suddenly, the phone rings, and it is the staff in the operating room, who want the patient transferred to them in a few minutes. The nurse hands the patient a form about permission to share information with relatives, but the patient says that she cannot fill it out because of her poor eyesight. The patient begins to tell about the time when she had a stroke. The nurse tries to gently rush her and says "the porter comes in about two minutes." The patient grabs her arm and raises her voice; "Now, you just hear what I say. I cannot even write my own name today - I was always told that I had a beautiful signature ". The nurse decides to forget the form. It must wait until afterwards. Right now the most important task is to get the patient ready for the procedure. The porter comes into the room, but the patient's groin has not yet been razed. The nurse considers for a moment whether she should do it or let them do it in the operating room. She says, "We get in trouble if they are not prepared." The porter adds: "But you will get in trouble too, if they have to wait for the patient".

This field note presents a patient who lacks understanding of what is going to happen in the Day Unit, perhaps due to lack of mental capacity because of a previous stroke. However, this is not a unique case, as many patients entering same-day discharge are vulnerable because they are nervous, difficult to communicate with because of language barriers, or who are lonely and would simply like to talk to the nurses about their life situation. In any case, the patient in this account places the nurse in a professional dilemma, because she must both be present and understanding of the patient's needs, but at the same time must attend to the tight schedule in the Day Unit.

While waiting for their time to go to the procedure room, patients are usually trying hard not to be 'in the way' of the professionals, but they want to be understood at the same time. It is especially the case when the patient joins an ACS trajectory, which begins at another hospital, that they are very confused about meeting different hospital departments and many professionals within a few days. In the field note below, I spoke to an ACS patient who arrived at the Cardiac Day Unit after having been hospitalized over the weekend at a nearby hospital:

Field note*:* Waiting and telling the same story

The patient in room 10 is curious about my research project. She says that she in a way 'studies' communication between people while waiting: "It's interesting how people approach each other". Her husband mentions that she has told her medical history at least 15 times to different health care professionals; "Can't they do it smarter? What if it was written down somewhere and the nurse could just read it". The problem is just that when the nurse tried to read the patient record obtained in the local hospital there was virtually nothing written down. They must have been very busy over the weekend.

The patient (and her husband) expresses puzzlement of having told her story 15 times, which gives the impression that there is an incoherent connection between the events in her trajectory. Here, there is a problem due to time pressure, where the patient record, which is otherwise an important tool for articulating and sharing information across the patient's trajectory, has been neglected. The practice in the Day Unit is otherwise to read the record before encountering the patient, so one gives an impression of knowing the pre-history. Time shortage is an all-round issue in the Day Unit, and professionals constantly find themselves waiting for one task to be completed before they can move on to the next one. As such, waiting for interpreters to arrive to help them communicate with patients often block the flow. This account is a typical one where nurses have to improvise in order to allow the flow of patients to the procedure room to continue:

Field note: Procedure lost in translation?

A patient is about to go to the procedure room, but the interpreter has not arrived in the Day Unit yet. A nurse comes up from the procedure room and asks the nurse to make sure that the patient arrives as soon as possible. Five minutes later, the interpreter has still not shown up, so the nurse tries to guide the patient to the procedure room using gestures and body language. She informs the interpreter (who is on his way) by telephone to go straight to the procedure room instead. The nurse asks the patient if he needs to go to the bathroom before the procedure. The patient does not understand her question. She points to the toilet and the patient nods. He goes out to the toilet booth and stands and looks at the room - confused. The nurse asks while gesturing at her crotch area, "Do you need to pee?" The patient shakes his head and laughs. All three of us laugh. "Well you couldn't possibly know what I wanted you to do in there," says the nurse.

In this account, a nurse tries to prevent a bottleneck, i.e. that the staff in the procedure room has to wait for the patient, risking postponements throughout the day. Bringing the patient into the procedure room is sometimes a complicated puzzle to solve, especially when the patient requires special assistance, in this case an interpreter. The nurse uses humor to ease the tense situation while simultaneously ensuring that the interpreter is redirected to another place in order to support the needs of the patient.

Often, the professionals have to prioritize between very different needs, on the spot. This is a premise for all hospital work where acute illness and planned actions coexist in the same space – and time. For cardiac nurses and doctors, this means caring for both the dying and routine patients, and as such, professionals need to be aware of very different trajectories, and the needs of different patients at all times. The field note below describes a typical situation that nurses find themselves in when caring for their 'own' patients in the Day Unit while having to help the staff in other units with urgent situations:

Field note: From cardiac arrest to discharge

At 16:15 PM I am together with the nurse in a patient's room. It is time for the patient to be mobilized. The nurse investigates the entry wound. There is no bleeding, so everything seems to be fine. The patient gets up slowly in bed, swinging his legs over the side and comes up slowly to a halt. The nurse explains that he may feel dizzy, because of the many hours in bed. The patient comes to his feet and there is still no bleeding from the wound. The patient says the he feels fine. He just wants to go to the toilet. The nurse helps the patient to move slowly towards the toilet when a loud alarm suddenly sounds throughout the department. The alarm is a sign of cardiac arrest in a neighboring section. The nurse quickly apologizes to the patient

and explains that he should pull the cord in the wall, in case of problems, but that she unfortunately has to run over and help the other section. At 16:31 AM I am waiting in the nurses' office. The nurse is still helping with the cardiac arrest. At 16:40 PM the nurse returns and explains that the patient unfortunately did not make it despite the fact that they performed CPR for 18 minutes. The heart rhythm never returned. The nurse stands in the office for a few minutes taking deep breaths before returning to her other tasks. When we walk back to the patient room she tells me that, "It can be difficult to switch from having been in the midst of a cardiac arrest to worry about discharge procedures".

Tension arises between the schedule in same-day discharge and cardiac arrest, where the latter (naturally) overrules the other. Professionals constantly have to decipher which is most urgent and important – also in much more mundane situations than cardiac arrests. They often come across patients who require special attention, but they still have to secure the quick succession of tasks in order to perform same-day discharge. Exactly this tension between the schedule and the patient is the focal point of the following quote from an interview with a nurse. She describes the dilemma that the professionals encounter:

"Yes, we sometimes find that people say:" well, you are busy, you have to move on". And then you think: Was there something you wanted to ask me? Was there anything we didn't talk about? Because I probably also have a tendency to stay very rigorously to what I'm supposed to and maybe, it may well be that you see the human being behind, but you just don't get… but you just don't always have time to know them, that ehm, that ehm, "Hey, you're also human." There are also those soft values that one… [inter.] And THAT is what I personally think may be difficult sometimes. I

think it gets pushed aside because everything is made more efficient and there is reduction in relation to savings and with one and the other …" (Interview, Nurse)

The nurse problematizes that they do not have time to 'know the patients'. But what does that mean? It is not that they should become friends, but that the nurses would like to be able to sense the patients' needs, to make sure that they do not forget something that is important for their experience of coherence. The nurse expresses concern about the role of 'getting to know the patient' in the future and voices discomfort at having to be rigid in her approach. As the Head of Department also mentions, it represents a professional barrier to many nurses and doctors. They explain that an important part of their work is being able to sense the patient and his needs, as they do not always articulate these needs themselves.

So the question becomes how the professionals, together with the patients, can succeed in creating coherence between fragmented events in spite of the small window into their experience? Many professionals are good at articulating coherence in conversations with the patient. In the Cardiac Day Unit, one of these 'windows' is the preparatory conversation in the ambulatory clinic, where time has been set aside for the patient to ask questions. In many patient trajectories, which are either complicated or where the patient seizes the opportunity to talk to a professional, the conversation becomes increasingly important. Accordingly, these conversations sometime become lengthy to compensate for lack of time on the actual day of admission. The following note displays how the conversation can provide an opportunity for the patient and the professional to articulate a common understanding of the trajectory:

Field note: Understanding the patient's needs

A doctor receives a patient in the ambulatory clinic. The patient is scheduled for a PCI the following week. Previously he has been admitted to a local hospital, where they performed a CAG and discovered a blockage in one of the coronary arteries, which needs to be treated. The doctor reads the patient record while he talks to the patient. The patient asks if he can get a copy of the record from the local hospital, "Then I can keep up". The doctor replies that he will make sure to make a copy for the patient before he leaves. An ECG must be performed so the patient removes the clothes of his upper body and lies down on the bed. The doctor performs the ECG and chats with the patient about favorite holiday destinations. As it is done, the patient puts on the clothes again. The doctor asks if he knows when and where to go next week. The patient answers: "I got a note that I should be here in the Day Unit at 8 o'clock".

The patient asks the doctor whether he will explain what will happen during the procedure. The doctor finds an A4 print of a heart and begins to explain: "Your bypass is here (he points and draws a line on the paper). The local hospital has discovered a blockage here (he draws a cross). That is the one that needs treatment". The patient asks: "How do they get in there (he points to the paper). Do they do it from below? The doctor answers, "Yes they go in through the groin area and up (he draws a line on the paper). The patient says, "I hope it is a skillful [doctor] that does it. Do you know who will do it? The doctor answers, "I do not know who it is yet, but we only have skillful ones here". We all laugh. The patient asks if it will be done with sandbags as he experienced it in 2001 or whether it will be with a plug as the last time at the local hospital. "The sandbags were in the last millennium," says the doctor. Finally, the patient asks if he can take the drawing home. Of course he can.

We all go out to the copy machine, so the doctor can take the copy of the record as he promised. The patient turns to me and says: "I provide the body. So it's nice to know something - then you become less nervous". I say that I understand.

The doctor in this account takes (at the patient's request) time to explain in detail, what has happened to the patient's heart in previous admissions, what actions should be performed during his admission in the Day Unit and draws connections between them. This displays the significance of conversations between the patient and the professional. To this researcher, it was thought-provoking that a patient who underwent the same procedure several times still needed that extra explanation. This event provides both a mapping of future events but it is at the same time an occasion where the patient's expected trajectory in the Day Unit hospital is articulated in the relationship between the patient's previous experiences in other hospitals, his nervousness and the doctor's ability to accommodate this nervousness by being very concrete and assuring in his communication with the patient about his immediate future. He utilizes various material articulations (the A4 print and the patient record), but is primarily able to create a space where they can come to an understanding of where the patient has been and where he is going.

This account is in stark contrast to the first account in this findings section, where the patient and the doctor did not succeed in finding a common narrative and their conversation is filled with incoherence and awkwardness. How much a patient trajectory differs from the 'standard' has much to say with regards to how easy it is to construct a common entity, but it just as much depends on the work that professionals do to support the articulation of a provisional trajectory together with and for the benefit of the patient. The professional challenge becomes one of being present together with the patient, even though everything else in the Day Unit is performed at

an elevated speed. What it means to be 'present' in events is both to engage in conversations as ongoing temporal presents as well as mapping the patient's trajectory. The example above presents the importance of creating coherence in confusion, i.e. utilizing intersubjective and material articulatory modes in medical work.

The empirical findings present the many different ways that patient trajectories are organized. They are work objects to coordinate professional actions in a series of scheduled events to secure the continuity of care. At the same time, the patient trajectories are emerging in events through processes of articulation that span past, present and future. They are not stable entities, but rather they become rearticulated and reassembled continuously in conversations between different actors in the Day Unit. The experience of a coherent trajectory is challenging for both patients and professionals because of the limited time that they spend together in same-day discharge. The next section elaborates on the relationship between long and short stories in same-day discharge.

5.5. Analysis: The long story in the short trajectory

This section presents an analysis that combines key empirical findings from the previous sections and theoretical points from the literature review. It is divided into two sections, each of which is specifically linked to this article's research question:

How are temporal patient trajectories continuously reconstructed in a Cardiac Day Unit, and what are the challenges for professional work?

The first part concerns the 'how' of temporal patient trajectories, i.e. how they emerge as both formal organizations and continuous temporal connections between

events. The second part concerns the ‘what’ of professional work, i.e. how professionals deal with challenges brought about by the speed of same-day discharge, by articulating temporal links together with patients and thereby creating a sense of coherence.

5.5.1. The continuous reconstruction of temporal patient trajectories

How does a trajectory become a trajectory? The literature reviewed in this article agrees that trajectories provide connective links between the past, present and future, that they consist of events as ‘building blocks’ and that they provide a direction for organizing. However, they disagree on whether the trajectory is an organizational structure or a process, and whether to focus on how a series of events comprise a planned trajectory of treatment, or how the trajectory emerges from the events themselves. The empirical findings suggest that both perspectives are relevant for understanding the organization of patient trajectories in hospitals. The patient trajectory as a structured ‘timeline’ of activities can be seen in the formal organization of same-day discharge and how trajectories for patients with specific illnesses appear in standardized schemes and guidelines, i.e. the ‘conveyer belt’ and ‘patient flow’.

Yet, the trajectory is not carved in stone. Rather, what goes on in the event creates the patient trajectory. The procedure and the preparatory conversation are examples of these types of events that are performative of the patient trajectory in that they involve reviewing past information, assessing present needs and deciding for future medical treatment. The preparatory conversation between a doctor and a patient who has reoccurring symptoms despite having undergone bypass surgery, is an example of an event where the patient trajectory emerges. The procedure will decide which

treatment the patient will receive (medication or possibly a new bypass), but the type of procedure (CAG) is determined by the specific symptoms that the patient experienced in the past, which were picked up on by a general physician who referred the patient to the Cardiac Day Unit. The trajectory for this patient was supposed to be simple, i.e. undergoing bypass surgery should have cured him of his symptoms. Evidently, this shows us 'the other side' of standardized patient trajectories; that they emerge from a reciprocal temporal relationship between the past, present and future, and they are continuously changeable in relation to what goes on in each event. Is there then a trajectory outside of conversations about the trajectory? The empirical findings indicate a 'no', especially when it comes to the patient experience. What goes on in these events is creating the sense of a trajectory by drawing on prior experiences and expectations for the future. This is the case with the preparatory conversation, but also ad hoc conversations with the nurses during admission, e.g. when the patient can expect discharge when transport is delayed.

The trajectory appears every time patients and professionals meet and engage in conversations. This also implies that the patient is a co-creator of organization and not just the object of organizing. The patient trajectory is not just a story about disease development and plans for treatment. It is a complex narrative that moves continuously between past, present and future and there are also periods where nothing happens. These are periods that are 'between events' or activities that are characterized by 'passing time' but which are also important for the patient's experience of the trajectory within the Day Unit. Our 'model' patient in the case description views waiting as a necessary evil, because 'somebody has to wait' and tries to fill these spaces of emptiness with meaning. When talking to the researcher and the neighboring patient, the patient brings in experiences from other non-

hospital-related events such as holidays etc. The trajectory becomes a way for the patient to think about his illness in terms of important (and less important) events. What is significant is how these events get connected and disconnected to each other to form a trajectory in time. The present must be seen as an ongoing temporal present, where past and future are enacted simultaneously in events. Whenever a professional is present together with a patient, they are connected to the patient's past and future, and it is difficult to streamline this relationship, as it is attempted in same-day discharge. I suggest the 'temporal patient trajectory' as a concept to describe the provisional entity in medical work, that focuses our attention on how the patient trajectory emerges in events and thereby what actually goes on in these events, i.e. a focus on articulation work, which is the point of the next section.

5.5.2. Challenges for professional work: Articulation under time pressure

Considering the constant negotiation of the trajectory - while also working within short timeframes in same-day discharge what are the implications for professional work? Both bodies of literature recognize the importance of practice, however it is quite different depending on the level. The sociological studies focus on the micro-practice of medical work 'around' the object of work, i.e. the patient and her trajectory. What matters is how the trajectory is managed by professionals performing an 'arc of work' (machine work, safety work, comfort work, sentimental work, and articulation work), where 'articulation work' is most important in relation to same-day discharge in the Cardiac Day Unit. Articulation, in the traditional literature, focuses on creating overviews and plans to support medical work. The preparatory conversation is an example of an occasion where such work occurs.

These conversations are also important for biographical work, which (in the traditional literature) is a part of sentimental work. However, the empirics highlight that biographical work is not only a matter of controlling the patient's sentiments, but that biographical work is actually an important part of articulation work.

The findings show us that the preparatory conversation can be tense, for example when the patient is worried and expresses distrust in the doctor's treatment plan, because he regards the doctor's questions as irrelevant for his current medical situation. This indicates that articulation work can be difficult and prone to tensions between different experiences. Even though the process perspectives (mainly) describe organizational processes at a meso-level, their concepts can be used to explain what goes on in micro-events such as the preparatory conversation. They present articulatory modes, e.g. intersubjective, practical and material articulation that supports transmission of past and future experiences. What goes wrong in the tense preparatory conversation would appear to be a breakdown in the intersubjective articulatory relationship between patient and doctor, i.e. they fail to communicate about past experiences and possibilities for the future. And the material articulation embedded in the doctor's standardized questions fails to provide any meaning or direction. In comparison, the doctor who utilizes various tools in the preparatory conversation, i.e. the A4 print of a heart and the patient record, manages to create a space where they can come to a shared understanding of the trajectory. The empirical findings also show that the work-based articulation, which is embedded in organizational routines, is challenged by the introduction of same-day discharge. This is presented in the interview quotes from both the nurse and the head of department, who talk about how they "have to cut something out" and that they "do not have time to know the patient". In same-day discharge, material articulation often replaces

intersubjective articulation by way of design, e.g. the patient record that spans both events and actors. When the materials prove insufficient for transmitting the patient's past experiences, as in the case of the patient who has told the same story 15 times, it impacts the patient's trust in the professionals and in her trajectory within the Day Unit.

The empirical findings illustrate how patient trajectories are continuously reconstructed by actors in events, and how they sometimes fall apart – not only due to physical obstructions in the patient's body, but because of different opinions on what the trajectory is. In addition, the analysis shows how professional work becomes a matter of creating a connection between the past, present and future of the patient, i.e. paying attention to the temporality of patient trajectories. The patient experience depends on the work that professionals do to support the construction of a provisional trajectory together with the patient. What it means to be 'present' is both to engage in conversations as ongoing temporal presents as well as mapping the patient's trajectory, i.e. creating coherence in confusion. This can prove challenging under time pressure, as in the example with admission of the confused elderly woman. Also, professionals have to be 'present' in many patient trajectories at the same time, e.g. focusing on one patient's upcoming discharge, while rushing to help a patient in cardiac arrest. This is perhaps an extreme case, but it presents the problems that medical professionals deal with. In this understanding, professional work becomes a question of accommodating these temporal tensions, i.e. between short and long, far and near, urgent and stable. Based on this analysis section, I propose that articulation work is important to how we understand what professional work in same-day trajectories consists of. In this understanding it is not only work that brings the patient from one place to another, but it is work that also understands the importance

of being able to create coherence across the patient's past, present and future as well as navigating between many pasts, presents and futures in patient care. The main theoretical contributions of this paper will be discussed in the following section.

5.6. Implications for organizing trajectories

This article offers two theoretical contributions to the field of medical work and temporality of organizations. The first is the introduction of 'temporal patient trajectories' with implications for health care organizing studies. The notion of temporal patient trajectories implies that organizing for patients is something more than making treatment plans. It is something emergent and intersubjective, which is important to consider in the context of standardization and accelerated treatment - two widespread trends in health care. It is also an important concept because it brings together events and actors in organizing, which provides an explanatory frame for medical practice that is more elaborate than traditional approaches. The temporal patient trajectory, as an object of work, is not linear and orderly, but it becomes a central provisional entity that patients and professionals negotiate continuously and it provides the focus of attention and task direction. Focusing on the eventness of temporal patient trajectories entails a patient who is not a passive object but an active co-creator of organizing. This finding has implications for how we think about patients, both in theory and in practice.

Another contribution to the traditional literature is the emphasis on articulation work in patient trajectories. I suggest that the processual understanding of articulation holds better explanatory possibilities in professional work than the traditional 'chain of commands' articulation. While other types of trajectory work mainly concern mapping and decision-making, articulation work concerns making sense of the

patient's situation and supporting a common understanding of the temporal trajectory. Articulation work becomes a question of bridging the temporal gap between past, present and future, i.e. the long and the short story in the patient trajectory. The importance for professionals to be 'present' becomes an important part of their work, which is something that they already talk about as important cf. in the quote by the worried nurse. The notion of articulation illuminates what it actually is to be present in a continuous present. Materials such as drawings, or ideally the patient record, can be utilized to support temporal bridging when time become a limited resource in same-day discharge.

This study holds some methodological limitations. First of all it is a single case study of a single Cardiac Day Unit. But at the same time, it was established in the introductory section of this paper that the aspiration for introducing same-day discharge is not limited to this Day Unit. Rather it is a mega-trend in the health care sector in many countries. Several medical areas will introduce same-day surgery in the coming years, and many of the professionals dealing with patients entering these trajectories will face similar challenges. Another limitation of this study is the 'indirect' patient perspective. Because this researcher chose to focus the ethnographic study on the practice of medical professionals, the patient primarily 'appears' whenever they encounter professionals. Further studies of the introspective experience of time for the patients in accelerated patient trajectories could be an interesting research topic. Following this, it is also a limitation that the total organization of work done over the period from diagnosis to recovery is not uncovered in this study. However, as I argued in the methodology section, this can at the same time be regarded as a strength because this researcher experienced the same

constraints as the professionals, i.e. trying to comprehend a long and complicated trajectory through small glimpses.

Another point of debate arising from this article is why it is important to merge two theoretical perspectives on trajectories. I argue that it is highly relevant for organization scholars, because it provides useful theoretical explanations for the importance of medical work, both with regards to the treatment and managing of illnesses, but also on a more intimate level, i.e. the relationship between professionals and the patients that they care for. The latter is often tacit and lacks appreciation in the literature on health care organizing. An additional theoretical concern is that articulation exists in both research traditions. What is the difference? Both perspectives concern organizational endeavors to make something 'visible' and understandable - but what? Is it the structure, or is it the 'making visible' that is worth studying, i.e. the process whereby the provisional 'structure' becomes visible.

In the case of the Cardiac Day Unit, it provides important knowledge to look at the events, in order to explain some of the pitfalls, e.g. that the patient is at risk of becoming 'a thing on a conveyor belt'. Focusing on the process gives them back their humanity and story. This article questions the understanding of new technology that can change patient trajectories as described in traditional literature, which is linked to technical solutions such as IT systems etc. In this case, it is management technologies, i.e. the introduction of same-day discharge that changes the patient trajectory. Short admission schemes require rethinking of the trajectory with regards to how to accommodate the patients' needs. It is a demanding task for managers to consider these issues when they make decisions. However, 'being present' and making time for the patients is something that many professionals emphasize in their daily work, and they will always try to find a way to make sure that they succeed.

Therefore, it will be a joint organizational task to make sure that the organizational setting supports these important events, e.g. prioritizing the preparatory conversations.

The theoretical contributions inherit some well-known criticisms: What is not an event? And what is not articulation work? For this researcher, the key is whether the event presents a continuous present with bridging of past, present and future. But perhaps, this theoretical direction can be further developed by researchers in the future. The issues of introducing same-day discharge will presumably vary according to the medical area, e.g. substantial emotional work at cancer treatment or mobility challenges and coordination needs in orthopedic surgery. These could be interesting research topics for the future. In addition, it is relevant to uncover the importance of temporal trajectories on other organizational processes that have the same dynamic. For example, it could be interesting to study collaborative projects in which professionals engage in meetings with various clients, for example through legal advice or project planning. There is, of course, something exceptional about caring for patients, but I argue that the trajectory concept is relevant for other kinds of work where actors engage in events that span past, present and future.

5.7. Conclusion

This article concludes that temporal patient trajectories are continuously reconstructed by professionals and patients and establish the organizational direction in a reciprocal relationship between past experiences, present needs and future expectations. Temporal patient trajectories are processes that cross organizational boundaries and appear in events, i.e. short ‘windows’ into the patient’s experience that are important for the execution of same-day discharge. Articulation work covers

the professional ability to be present with the patient while simultaneously considering the significance of past experiences and future anxieties. This work is challenging for professionals because of time pressure in same-day discharge, where attention to detail is confronted by a constant requirement for executing tasks as fast as possible. Professionals can utilize tools and materials to support intersubjective articulation of the temporal patient trajectory to maintain the patient's sense of coherence.

CHAPTER 6: PAPER 2

Title: Temporal object work in a Cardiac Day Unit

Authors:

Vibeke Kristine Scheller, Department of Organization, Copenhagen Business School

Anne Reff Pedersen, Department of Organization, Copenhagen Business School

Ewan Ferlie, King's Business School, King's College London

This paper answers research question 2 (RQ 2) that was presented in the introductory chapter of this dissertation: *How is 'temporal object work' practiced in a Cardiac Day Unit, and what are the implications for strategy-as-practice research?* It will be submitted to the Special Issue of *Strategic Organization* **"**Temporal Work: The Strategic Organization of Time" by November 1st 2019.

Abstract

Previous studies of temporal work have given a low priority to everyday practices, instead focusing on intended strategy formulation processes. Drawing inspiration from the strategy-as-practice perspective, this paper explains how temporal work is conducted in everyday practices through the use of temporal boundary objects, i.e. 'temporal object work,' in a Cardiac Day Unit. Temporal object work is performed in everyday practices such as 1) medical conferences, 2) planning of procedures and 3) bed management where the actors interpret and re-interpret the past, present, and future in order to make strategies for medical treatments, where to place patients and

when to perform procedures. Temporal object work is supported by objects such as patient records, overview boards and procedure plans that enable actors to discuss these strategies. Where earlier studies of boundary objects in temporal work focused on project plans, Gantt charts and PowerPoints and their ability to bridge different perceptions of time, this paper contributes to the literature by explaining how several objects coexist in everyday practices and that they affect each other in hegemonic relationships brought out by the objects' abilities to convey certain temporalities while eviscerating others: 'recorded body past;, 'treatment decision present;, 'inflexible procedure planning future' and 'flexible patient overview present'.

6.1. Introduction

This paper contributes to the development of the strategy-as-practice perspective by introducing 'temporal object work' as a way to explain the inseparable relationship between objects and strategy in everyday practices. Temporal object work describes the practices in which actors engage in object-mediated discussions of past experiences and present concerns to make strategies for the future. Strategy, as a research field, has introduced different theoretical approaches, from design-oriented approaches, to positioning, to cultural and learning-oriented approaches (Andrews, 1971; Barney, 1991; Mintzberg & Waters, 1985; Porter, 2008).

However, when organization scholars conduct research studies of strategy processes, they often include a temporal perspective to explain the phenomena (Bansal & DesJardine, 2014; Kunisch, Bartunek, Mueller, & Huy, 2017; Schultz & Hernes, 2012), but in different ways that reflect their underlying paradigm. In design-oriented

approaches (Mintzberg, Ahlstrand, & Lampel, 2009), for instance, a key question concerns the ability to create a sustainable design that lasts for the future of the strategic landscape. For positioning scholars (Porter, 2008) it concerns the assessment of present threats to a company's strategy as well as choosing a strategy for the future. For Resource Based View scholars (Barney, 1991) strategy preferably builds on the company's competitive advantages that have been developed in the past. The learning perspective (Mintzberg & Waters, 1985) by contrast considers an emergent practice perspective on organizational strategy, by bringing transdisciplinary and feed-back practices to the forefront. This ambition has also helped to create a contemporary practice perspective including strategizing (Jarzabkowski, Balogun, & Seidl, 2007), strategy-as-practice (Jarzabkowski & Spee, 2009) and increasingly a focus on time-specific 'temporal work' (Granqvist & Gustafsson, 2016; Kaplan & Orlikowski, 2013; McGivern et al., 2018; Reinecke & Ansari, 2015) within organizational and work settings.

Temporal work, as a theoretical perspective within this strategy-as-practice tradition, has also highlighted the issue of the creation of future strategies in concrete settings, which can be seen as an important theme for strategy-as-practice researchers (Barley & Kunda, 2001; Phillips & Lawrence, 2012; Whittington, 2003). We argue that their emphasis on practices is important as it gives focus to the need for understanding everyday organizing, and not just 'exceptional and unusual' strategy processes, which have been the focus for some prior strategy researchers (Agarwal & Helfat, 2009; Grant, 2003). We call attention to the importance of everyday practices in a way that is different from the common understanding of grand strategy, so that they are not formally considered as 'strategic' by the organization but are nevertheless highly important for strategic outcomes desired by many organizational members.

One of the reasons for the complexity of such everyday practices is the role of time and temporality in accomplishing such forms of strategy. Temporal work is inspired at least in part by interpretations of 'historical time' (Koselleck, 2004; Ricoeur, 2010) and concerns the way organizational actors, while engaging in strategy processes, discuss their different interpretations of the past, present and future in order to create an organizational story that then provides a basis for strategy (Kaplan & Orlikowski, 2013; McGivern et al., 2018). In this way, temporality plays a pivotal role in shaping strategy, as, *"…actors make interpretive links in time, as this significantly shapes organizational choices and actions"* (Kaplan & Orlikowski, 2013, p. 990).

While this perspective on temporal work provides an alternative to structural or formalistic approaches as it focuses on day to day practices and processes, authors have critiqued studies (such as Kaplan and Orlikowski, 2013) for lacking attention to the more mundane everyday practices in organizations (Hydle, 2015; McGivern et al., 2018). Many organizational actors engage in everyday practices such as planning and scheduling, which have consequences for the strategic outcomes of organizations that are closely related to temporal work (Jarzabkowski et al., 2007; Jarzabkowski & Spee, 2009). The strategy-as-practice perspective includes a broader view on day to day strategy, including 'temporal object work', which is the theme that will be developed as the main theoretical contribution throughout this paper.

The aim of this paper is to demonstrate how everyday practices in a complex health care setting (a Cardiac Day Unit) are both strategic in the sense that they contribute to the realization of strategic goals for the organization, and temporal because they bring past concerns and future expectations into the present. An example is when a heath care professional assesses *previous* medical history in a patient record and examines *present* symptoms to make a strategy *for future* treatment. These

characteristics point to the temporal work linking past, present and future in everyday work practices.

However, as researchers (McGivern et al., 2018) argue, temporal work rarely exists in a vacuum, but is connected to material representations of practice. Recently, organizational researchers have included the role of objects in supporting temporal work by providing a basis for interpretation and negotiation of 'temporal settlements' by different groups (McGivern et al., 2018). These objects, usually timelines (Yakura, 2002) and PowerPoints (Kaplan, 2011; McGivern et al., 2018), have been characterized as 'boundary objects', because they bridge different professional perspectives (Star & Griesemer, 1989). The bridging of different professional perspectives can be of great importance in organizations because the boundaries between professional groups retard cooperation and the spread of innovation (Ferlie et al., 2005).

A specific 'temporal' take on boundary objects has been promoted by organizational scholars to explain the role of objects in mediating different timeframes and time conceptions in professional groups (Ancona, Okhuysen, et al., 2001; Tukiainen & Granqvist, 2016; Yakura, 2002). Especially in relation to strategy processes, the use of objects provides a base for visualizing the future strategic outcomes as well as supporting the present cooperation between different actors by providing a basis for discussing timeframes, goals etc. The concept of boundary object has been criticized by other researchers for being too perfunctory and lacking attention to power relations in organizations (Huvila, 2011). Thus we propose a further development of the temporal boundary object concept to highlight the hegemonic temporal relationship between objects, by drawing inspiration from anthropology on 'objects of time' (Birth, 2012). Birth's perspective offers a way to consider embedded

hierarchical relationships between different kinds of objects due to their abilities to convey a specific kind of temporality while eviscerating others. This enables researchers to explain how strategy occurs in everyday practices, as an interchangeable relationship between actors engaging in discussions that span past, present and future while utilizing objects that convey a specific temporality, e.g. patient records presenting the past or procedure plans laying out the expectations for the future. We name this practice 'temporal object work'.

The research project presented in this paper is of temporal object work in everyday practices in an organizational context, thus this paper presents an in-depth ethnographic case study of a health care setting, namely a Cardiac Day Unit in a Danish hospital. A health care setting is relevant for investigating temporal object work in everyday practices, as professionals continuously discuss strategies in relation to patient treatment, which can be regarded as 'small-scale strategy processes'. Accordingly, the research question explored in this paper is:

How is 'temporal object work' practiced in a Cardiac Day Unit, and what are the implications for strategy-as-practice research?

The clinical management team initiated the Cardiac Day Unit's establishment in late 2014. The main objective was to collect, within a single unit, patients with expected uncomplicated admissions in two medical areas - ischemic and arrhythmic heart disease. The Day Unit receives patients for planned or subacute procedures that can be discharged or transferred to other hospitals or to their own homes on the same day, i.e. same-day discharge. The establishment of the Day Unit meant that professionals had to care for more patient groups than before, calling for a broader set of competences and transdisciplinary teamwork e.g. between nurses specialized in

arrhythmia and nurses specialized in ischemia. The introduction of same-day discharge also meant that discussions (and the settlement) of treatment strategies had to occur within a shorter period of time, which was sometimes difficult to manage for professionals. These discussions took place in everyday activities such as medical conferences, planning of procedures and bed management. These practices are interesting as contexts for strategy-as-practice, because they take place continuously, result in many strategic discussions between professionals and are supported by the use of objects. The Day Unit was followed by the authors over 1.5 years, in an in-depth study of everyday practices in hospitals, that included shadowing (Czarniawska, 2007) professionals, practices and patients; observing meetings (Atkinson & Hammersley, 1994); and conducting 17 semi structured interviews with professionals and patients (Holstein & Gubrium, 2016). The material side of practice was approached as well through visual recordings of tables, boards and plans (Prior, 2004).

The paper begins with a theory section that reviews the literature on temporal work and brings it into an everyday context by bridging the perspective with research on strategy-as-practice. This literature broadens the area of practices that are considered to be strategic. In addition, the theory section of this paper describes the relationship between temporal boundary objects and strategy by presenting relevant literature, which serves as a frame of explanation for why some objects are treated as more powerful than others in an organizational context. Next is a section on organizational ethnography, everyday practices and challenges for professional work in the Cardiac Day Unit. The analysis shows how professionals conduct temporal object work in these practices by linking together the near past by considering present concerns and imagining the future through the use of objects. The analytical findings are then

discussed by highlighting the implications of bringing a theoretical framework suitable for strategy formulation processes into everyday organizational settings and practices. The article ends with a conclusion and summary of contributions.

6.2. Temporal work and the significance of temporal boundary objects

This section presents a review of literature on temporal work in organizations and the role of objects to support these activities by offering material representations of the past (e.g. reported difficulties) and the future (e.g. plans for project completion) that can be utilized by actors engaging in discussions in an organizational present. Key existing research on temporal work concerns longer-term strategy processes in organizations (Kaplan & Orlikowski, 2013; McGivern et al., 2018).

This paper presents an alternative take on temporal work by arguing for its usefulness in describing how everyday practices unfold in organizations. The literature on temporal work is thus combined with a strategy-as-practice approach, drawing inspiration from practice theory (Feldman & Orlikowski, 2011; Jarzabkowski et al., 2007; Nicolini, 2013; Vaara & Whittington, 2012). In addition, the section argues for introducing a temporal perspective on objects such as plans and calendars to support everyday practices, especially those directed towards (more or less specified) strategic goals. The literature review concludes with our argument for ‘temporal object work’ as a suitable framework for explaining strategy-as-practice in a Cardiac Day Unit.

6.2.1. Strategy-as-practice and temporal work

The importance of practices for the strategic outcomes of organizations has been debated by many scholars and especially in issues of Strategic Organization. Though many researchers agree on the importance of practices, their views vary from the practice-based view (Bromiley & Devaki, 2016) with its focus on best practices in strategic management, over strategizing (Whittington, 2003), to the strategy-as-practice perspective (Jarzabkowski & Spee, 2009). The discussions revolve around whether practices can be studied in isolation or as embedded in specific organizations (Bromiley & Devaki, 2016; Jarzabkowski, Kaplan, Seidl, & Whittington, 2016b, 2016a). Where earlier studies concern strategy processes that radically change overall company strategy, strategy-as-practice approaches describe micro-changes, even at times designed to maintain the status quo of the organization (Jarzabkowski et al., 2007; Jarzabkowski & Spee, 2009). Jarzabkowski et al. ask for strategy scholars to consider the more 'ordinary' aspects of organizational life such as meetings and administrative practices (Jarzabkowski et al., 2007, p. 21). They define their broadened perspective on strategy thus:

"… activity is considered strategic to the extent that it is consequential for the strategic outcomes, directions, survival and competitive advantage of the firm (Johnson et al., 2003), even where these consequences are not part of an intended and formally articulated strategy". (Jarzabkowski et al., 2007, p. 8).

As this quote displays, everyday activities can be regarded as strategical if they are consequential to desired organizational outcomes, even if they are not part of an intended and formally articulated strategy. Furthermore, Jarzabkowski, Balogun and Seidl (2007) suggest that strategic activity might be consequential for outcomes at

different organizational layers and in different organizational groups. A similar perspective can be found in recent studies of 'temporal work', describing practices in which actors make interpretive links between past, present and future to realize strategical outcomes. Temporal work is a relatively new perspective in organization studies (Kaplan & Orlikowski, 2013; McGivern et al., 2018) and is inspired by notions of historical time (Koselleck, 2004; Ricoeur, 2010) as well as process theory (Hernes, 2014; Langley, 2007). The perspective constitutes a temporal perspective on organizing which is different from classical studies on temporal structures (Zerubavel, 1979a) because it not only concerns how time is structured but how organizational processes make up the experience of time by connecting the past, present and future in events (Schultz & Hernes, 2012). Ricoeur (2010) argues for the concept of 'phenomenological time' to explain how we make sense of our lives as interchanging links between past, present and future. Temporal work draws on this tradition and seeks to unfold how organizational actors make interpretive links between past, present and future in practice, and in pivotal studies, provide explanations for why some links 'work' while others 'fail'.

Kaplan and Orlikowski's study (2013) on temporal work in strategy-making, focuses on managers' perspectives in parallel strategy projects within one large organization. Their study shows how changes in the surrounding market cause breakdowns in strategies, which then foster temporal work to create new strategies. Their object of analysis is strategic accounts from managers about provisional settlements in strategy processes, i.e. 'strategy making in practice':

"We refer to this activity as temporal work and found that it involved reimagining future possibilities, rethinking past routines, reconsidering present concerns, and

reconstructing strategic accounts that linked these interpretations together". (Kaplan & Orlikowski, 2013, p. 973)

We would here like to push Kaplan & Orlikowski's point further, to explain how everyday practices in organizations are strategical by focusing on micro-actions and their temporal embeddedness. Drawing on Emirbayer & Mische's (Emirbayer & Mische, 1998) work, Kaplan & Orlikowski argue for a perspective on agency as a temporally embedded form of practice informed by the past, oriented toward the future (as alternative forthcoming opportunities) as well as toward the present (as the ability to connect past habits with future prospects with the possibilities of the moment (Emirbayer & Mische, 1998). Agency is also a central concept in practice studies on organizing (Feldman & Orlikowski, 2011). One difference between the traditional approach to temporal work and the perspective informed by strategy-as-practice, is that focus shifts from the individual strategist towards the practice itself, e.g. from the accounts of managers to the work of organizational actors. The notion of everyday practices draws inspiration from the strategy-as-practice perspective (Hydle, 2015; Jarzabkowski et al., 2007; Whittington, 2003) in which strategy becomes something quite different from other studies of temporal work.

This paper aims to explain the 'what, who and how' of the strategy-as-practice perspective as suggested by Jarzabkowski et al. (2016a), but here defined as 'temporal object work', because we argue that temporal work inevitably must be supported by objects that enable actors to engage in these discussions of the organization's (or a patient's) past, present and future.

Following Orlikowski's argument, that practices cannot be separated from the material arrangements that surround and support them (Orlikowski, 2000), the notion

of temporal object work acknowledges the material side of practice. Materially represented practices in organizations, such as Gantt charts, PowerPoint, whiteboards and post-it notes are significant because they render work possible (Orlikowski & Scott, 2008). The material representation of practice has primarily been described through the use of 'boundary objects' in organizations (Star & Griesemer, 1989). However, this paper aims to challenge the use of a broad theoretical concept such as 'boundary object', arguing for a time-specific concept 'temporal boundary object' as presented by Yakura (2002) in combination with a perspective presented by Birth on 'objects of time' as constructed to convey certain temporalities (Birth, 2012).

6.2.2. The use of temporal boundary objects

The role of material objects as potentially significant for strategy-making has been a debated issue for organizational researchers. A special issue in Strategic Organization (Spee & Jarzabkowski, 2009) focused on the use of strategy tools as boundary objects. Strategy tools can be defined as techniques, tools, methods, models, frameworks and methodologies that support decision-making within strategic management, e.g. SWOT analysis and Porter's Five Forces (Spee & Jarzabkowski, 2009). Especially when engaging in strategy processes together with external partners, the ability to cooperate and bridge different perspectives is key. As first suggested by Star & Griesemer (1989) the concept, 'boundary object' was introduced to describe how material objects (or even immaterial concepts) could assist as bridges between intersecting social worlds. Recently, the concept has been developed to include a temporal feature, i.e. 'temporal boundary objects' (Ancona, Goodman, et al., 2001; Yakura, 2002). Temporal boundary objects span not only epistemological boundaries, but also different temporal conceptions e.g. in various professional

groups. They also create possibilities for engaging in everyday practices that unfold over several days, shifts etc. as is common in hospitals:

"Temporal boundary objects create linkages across temporal voids, like the patient chart that allows doctors and nurses in different temporal maps to relay information to one another and to continue patient care without interruption…" (Ancona, Okhuysen, et al., 2001, p. 526)

The role of temporal boundary objects has been explored in project work as well. Gantt charts in Yakura's study (2002) act as central objects that bridge the boundaries of different participating groups in a joint project. Gantt charts (or timelines) render the ultimate abstraction and have a narrative quality. They provide a tool for temporal coordination while at the same time demonstrating a series of events that constitutes the project as a process. Yakura argues for a temporal object concept that includes 'temporal' objects other than merely calendars and clocks to measure time, because organizational actors in practice need to allocate, schedule and synchronize activities, which calls for more 'sophisticated' temporal objects, i.e. temporal boundary objects (Yakura, 2002). A recent study by McGivern et al. (2018) links the use of boundary objects with temporal work in organizations participating in a management consultancy project to redesign public health care. The study highlights the silent politics connected to the use of boundary objects in temporal work, i.e. the non-transparency and also hegemonic ambitions of PowerPoints conveying timeframes. Their contribution to the very small literature on silent politics in boundary objects is very interesting, as they explain how politics are embedded in objects, leading to covert manipulation of some project participants. McGivern et al. ask for further studies on boundary objects: "*Further research examining how different kinds of boundary objects impose temporal orientations and related task and time frames in*

organizations, during projects and more generally, would be valuable". (McGivern et al., 2018, p. 18).

This paper answers this call by elaborating how the use of temporal boundary objects in everyday practices includes unequal relationships between different objects according to their representation of temporalities and the evisceration of other temporalities. For this, we draw on anthropological research by Birth on 'objects of time' (Birth, 2012). Boundary objects are, in organizational research, often used without taking into account their special 'temporality', i.e. which temporalities they convey and which ones are eviscerated by the materiality of the object. The concept of boundary objects is criticized for exactly this reductionist perspective on materiality (Huvila, 2011; Kimble, Grenier, & Goglio-Primard, 2010). They are too innocent and devoid of focus on hegemonic structures. Therefore, we argue for an extension of the 'temporal boundary object' concept, by drawing inspiration from the anthropological studies of Birth (2012).

Birth's main objective was to study how 'things' shape temporality. His study describes the historical power struggles between different temporalities, different calendars (Gregorian or Mayan) and clocks (common or decimal), and how they resulted in certain 'victorious' objects. Even though Birth is not an organization scholar, his conclusions seem especially relevant for organizational studies as contemporary organizations consist of many different objects that convey temporality, e.g. calendars, clocks, plans, schedules, rosters, etc. The main objective is then to study how different objects in organizations represent coexisting temporalities and compete with each other, in order to explain how some objects become more 'victorious' than others:

"It is not enough to demonstrate alternative temporalities – anthropology and history have done that with great skill. Instead, the coexistence of multiple temporalities with the time of clocks and calendars must be shown." (Birth, 2012, p. 32)

However, for Birth (2012) 'temporality' is limited to different representations of time in clocks and calendars. Drawing inspiration from research of 'temporal work' in the previous section, we propose that temporality embedded in objects is connected to different representations of the past, present and future, and that their abilities to promote and suppress these representations affects actors' abilities to make interpretive links in time. As an example, strategy presentations sometimes convey an 'open future' while company status reports convey a 'closed past' or a patient record that enumerates confusing symptoms conveys an 'uncertain present' where the ability of actors to make a strategy for the future is challenged.

This review of literature established that everyday activities are strategical when they contribute to widely desired organizational outcomes, and that temporal object work occurs in these practices, because actors make interpretive links between past, present and future with objects. These objects enable actors to engage in discussions of the past, present and future by representing these temporalities. Nowhere are there so many everyday practices supported by temporal boundary objects as in hospitals, e.g. where planning tools, schedules, rosters, alarms, patient records etc. are utilized continuously by professionals. The next section explains the ethnographic case study of a health care setting (a Cardiac Day Unit), where temporal object work in everyday practices unfolds.

6.3. Same-day discharge in a cardiac Day Unit

The cardiac ‘Day Unit’ was proposed in late 2014 and established in early 2015 as an 'answer' to one of the hospital’s emerging challenges; being able to deliver high quality care to patients while keeping expenditure levels in check. The introduction of same-day discharge was a new organization, but the professionals continuously tried to create strategies for making patient admission and care as smooth as possible. With the help of technical developments and medical innovations, same-day discharge has been an important trend in both cardiology (Mavromatis, 2013) and orthopedic surgery (Kehlet, 2011) as well as in other medical fields (Gilmartin, 2007). The establishment of the Cardiac Day Unit forms an example of ‘everyday innovation’ (Pedersen, 2015) as it allows for a focus on small-scale innovation processes, tied to the everyday practice of organizations. Typically, it proves difficult to fit new practices into the regular organization, especially when there is also a great time pressure in the sector (Sehested, 2002). The same concern applies to the Cardiac Day Unit, where it is also a question of introducing a new idea into a hospital that is already ‘occupied’ by other practices.

When introducing the Day Unit as a new organization, the clinical management team became preoccupied with securing ‘the right knowledge at the right time’, which resulted in many deliberations about what the right knowledge was in the context of same-day discharge. From the initial period of doing ethnography in the Day Unit, it became clear that ‘the right knowledge’ was the knowledge that enabled professionals’ interpretation of the past to move forward into the future with a care strategy for each patient. It was what they constantly practiced by participating in medical conferences, distributing beds and interpreting symptoms into a possible

diagnosis in conversations with the patient. There was a general experience of being pressed for time as these practices had to occur within a shorter period of time. This called for an investigation of the everyday practices that were most significant for strategy in the Cardiac Day Unit. The remainder of this section is dedicated to descriptions of these practices, starting with the medical conferences, which are central to the organization as they are scheduled occasions where strategies regarding the care of each patient are discussed. The following practices are procedure planning and bed management, which describe ad hoc practices that are also central to the organization of same-day discharge in the Day Unit, and they are strategical in the sense that they allow for discussions and allocation of resources, i.e. beds, time and procedure rooms.

Medical conferences are traditional everyday practices in hospitals. In the cardiac department, they take place several times a day and serve different purposes. Some revolve around specialist decisions on whether to proceed with procedures such as cardiac bypass operations, and others concern work schedules and coordination of tasks. Some are only for physicians, while others are for nurses, and others again for transdisciplinary staff. The most important conferences are those for doctors, where they can discuss different patient cases across the department and get expert opinions on how to treat the patients. The following excerpt is from one of these conferences:

Field note: *It is 8:15 in the morning in the large conference room. The room is an old-fashioned 'lecture room' with wooden paneling. Two large monitors hang on one of the walls. One of them is for displaying various documents via projector and one where papers can be displayed on a kind of overhead (ECGs etc.). There are 33 physicians present. They are wearing long white coats together with white clogs and are sitting at tables placed in a horseshoe pattern – professors and chief physicians*

on one side and junior staff on the other. Most of them are men. Yesterday's patient cases are reviewed on a large monitor to clear up unresolved issues in relation to medical decisions.

The doctors take the opportunity to share information and lay out collective strategies in these medical conferences, by presenting ECGs[7] (heart rhythm records), symptom descriptions from patient records or other results. These objects convey important information about the patients and provide the opportunity for physicians to interpret this information to decide on treatments or procedures.

Planning of procedures is central to all other activities throughout the Department of Cardiology, i.e. the 'backbone' and unifying principle of everyday practices. A procedure plan is prepared at the departmental visitation office for many months at a time, which must comply with standards for treatment guarantees and take into account the type of illness, severity, suspected outcome etc. The decisions are based on requisitions from other hospitals or medical specialists who book patients for examinations based on symptoms that indicate various coronary illnesses. The staff in the visitation office tries to prepare a manageable plan, which at the same time does not include too much downtime since the resources - the medical equipment and the trained specialist personnel in the operating room - must be utilized optimally. In this way, the preparation of the procedure plan remains hidden from nurses and

[7] "An electrocardiogram — abbreviated as EKG or ECG — is a test that measures the electrical activity of the heartbeat. With each beat, an electrical impulse (or "wave") travels through the heart. This wave causes the muscle to squeeze and pump blood from the heart. A normal heartbeat on ECG will show the timing of the top and lower chambers." (www.heart.org)

physicians in the Day Unit. Their task is first and foremost to provide compatibility between the procedure plan and other practices. The plan must be upheld in general and restructurings must be kept at a minimum (only those necessary due to acute patient cases). The procedure plan is displayed on a monitor at the nursing office's end wall, where the professionals can always keep up to date with the plan and carry out their work in relation to it. A nurse explains:

"Yes, we are very much focused on [red. the procedure plan], that it proceeds as it should. Because if it does not proceed, then it is us who must go in and explain to the patients: "there are delays". Personally, I can feel that it concerns me a lot, because I HATE to tell the patients that they [red. their procedures] are canceled or they are postponed, especially because they are nervous and they are… they are often impatient to get it over and done with and you can understand that". (Interview, Nurse)

Much of the nurses' work revolves around taking care of the patients' expectations by anticipating the possibility of cancellations and communicating these to the patients. They are focused on making sure that patients are well-informed and that their needs are met. Nevertheless, they are also practicing in a context of limited resources, and therefore engaging in ongoing discussions of these resources' distribution, i.e. personnel, space, time and beds.

Accordingly, another continuous everyday practice in the Cardiac Day Unit, which concerns strategy, is bed management. Professionals continuously debate how the beds should be distributed, i.e. are there any patients with special needs or are there patients who are unstable and therefore need to be placed in a bed near the nurses' office, so that they can respond quickly to them when they call for help? They also

try to distribute beds in shared rooms to patients who are ‘similar’, e.g. have the same gender, suffer from the same illnesses, are talkative or quiet etc. The distribution of beds and patients is displayed in the nurses’ office on a large monitor - ‘the patient overview board’ (see Figure 8).

Figure 8: Excerpt from patient overview board

Bed	Patient	Diagnosis	Plan	Procedure	OBS	Day shift	Evening shift	Discharge
2	Name	KAG/PCI	Conference	2	Nervous	Nurse 1	Nurse 3	18/9

The patient overview is created by the head nurse the day prior to admission to the Day Unit, based on information provided by patients during an initial conversation a few days earlier. The patient must fill out a health form beforehand, where they provide information about coexisting diseases, information about which medications they take, etc. In addition, they talk to a nurse, who asks for expectations, e.g. whether they have previous experiences, are nervous, etc. The information about the patient is combined with other kinds of information from the procedure plan, work schedules, etc. Patients must be allocated to beds in specific rooms, cared for by nurses during day and night shifts, checked by doctors, their care plans must be followed and procedure time slots and discharge timeframes must be respected by professionals. The patient overview board is continuously updated by professionals - when schedules change, when tests have been performed or when discharge is planned. The board is central to ongoing discussions between professionals and in information sharing at the end of each shift. They use the board to explain what has happened to each patient so far in their admission and what is planned for them in the near future.

These practices fall in two groups: reoccurring meetings and continuous ad hoc practices. They are strategical because they are crucial for the strategic outcome of the organization; in this case, the ability to provide excellent patient care within a short timeframe. These everyday practices are mediated by objects that are used to share information and convey scheduled events and decisions. This paper presents both types of practices as they hold important insights into everyday practices and they coexist and affect each other, as the analytic section of this paper will illustrate. However, the processes in which these practices were approached by the authors of this paper are important to lay out, which is the objective of the next section that describes the organizational ethnography of the Cardiac Day Unit.

6.4. Doing organizational ethnography

Organizational ethnography (Pedersen & Humle, 2016) is a specific approach that focuses on tensions that arise from organizing in practice and how organizational actors make sense of and overcome these tensions. Combined with the ethnographic ambition to 'zoom in' on the accomplishment of (strategic) practices (Nicolini, 2013), this establishes a framework that is ideal for revealing how temporal object work is practiced in a day to day organizational setting.

The ethnographic study of the Cardiac Day Unit consisted of more than 300 hours of on-site observation over a period of 1.5 years. In addition, 17 semi-structured interviews were conducted with professionals and patients. As such, this paper is based on small single case study, which nevertheless provides in-depth descriptions of everyday practices that the researchers encountered continuously over a long period of time. The study was theoretically informed from the beginning in the sense that the relationship between time and organizing was a fixed focus. The

ethnographic material was assembled and prepared for thematic coding (Clarke et al., 2015), where one reoccurring and substantial theme was everyday practices which included a temporal element, i.e. temporal object work.

Ethnographic field notes were the most viable data source in describing these practices, as they allowed for description of details such as how objects are used, how discussions take place between different professional groups etc. In comparison, the interviews played a supporting role in describing these practices. The interview guide was semi-structured and followed the idea of doing 'the interview to the double' (Nicolini, 2013, p. 225), where the interviewer asks the interviewees to instruct 'a double' on how to do their job. In that way, they tend to talk about practices that they regard as essential for a well-functioning organization, which usually correspond with the same kind of practices that enable actors to make strategies. Doing interviews with professionals whom the researchers have shadowed (Czarniawska, 2007), enables conversations about events and practices in which the researchers participated together with them, which is a form of interviewing in which the researchers plays a very active role (Holstein & Gubrium, 2016). This can be a limitation, as the researchers guide the interviewee's attention to experiences that are not necessarily interesting to the interviewee, and therefore the narrative becomes actively constructed by the researchers.

In addition, ethnographic field notes as a qualitative data source has been debated. Qualitative researchers have sometimes made a distinction between 'manufactured data' (e.g. interviews and focus groups) and 'found data' or 'naturally occurring data' (e.g. observations) (Silverman, 2013). Justesen & Mik-Meyer (2012) argue that participant observations can be utilized to gather 'unprocessed' knowledge about practice. However, other researchers argue that,

"Seemingly spontaneous conversations are not necessarily more authentic, bias-free, or unstructured. They simply take place in what have been conventionally recognized as non-interview settings. But these settings, too, play a definite role in the production of experiential knowledge—just like interview situations. " (Holstein & Gubrium, 2016, p. 10).

Researchers should therefore not distinguish between observational notes and interviews as one of them being more 'true' than the other. Researchers are actively present in both situations and both types of data are equally 'manufactured'. The construction of ethnographic field notes therefore calls for a detailed description similar to the thematic coding of interviews. The field notes were divided into four sections (as described in Justesen & Mik-Meyer, 2012, p. 102): 1) brief notes in a notebook that reminded the researcher of specific events during the stay in the hospital; 2) descriptive notes in which the events were reproduced as detailed as possible; 3) analytical notes with suggestions on how the descriptive notes relate to each other; and 4) reflective notes that documented the researcher's feelings towards the field and how they shifted over time. This makes the analytic steps visible, just as in thematic analysis of interview data (Clarke et al., 2015). However, it is still very much constructed by the researcher's ideas; here, that strategy is about time.

The everyday practices that this paper describes, were observed during the 300 hours of fieldwork in the Cardiac Day Unit as a pattern of reoccurring practices that were central for the basic strategic outcome desired by many professionals: bringing the care for each patient forward. The observation of these practices uncovered the basics of how strategic decisions were conducted by professionals in temporal processes. Table 11 below displays the connection between everyday practices and the relationship between past, present and future concerns as enacted in each of the three

practices: 1) Medical conferences; 2) planning of procedures; and 3) bed management. The table is inspired by Kaplan & Orlikowski (2013), which provides a simple representation of the temporal relationship in strategy, where actors think about the organization's past, consider the most urgent concerns in the present and imagine the strategic future of the organization. In this paper, the temporal relationship is presented on a micro-level in everyday practices, i.e. how professionals think about the past, consider present concerns and imagine the future in treating patients' illnesses. The table presents field notes that are divided into three sections according to the temporal 'cues' (presented in bold) that point to either the past, present or the future. As an addition to Kaplan & Orlikowski's table, our version also displays the temporal boundary object in use in each of the three everyday practices.

Table 11: Temporal object work in the Cardiac Day Unit (inspired by Kaplan & Orlikowski 2013)

Everyday practices	*Thinking about the past*	*Considering present concerns*	*Imagining the future*	*Temporal boundary object in use*
Medical conferences Occur twice every day (morning and afternoon).	A physician presents records and observations about a patient in the **near past** to **question a prior decision** to perform a complicated procedure for	The physicians engage in a **discussion in the present** on which procedure will be most suitable, when considering the records.	They decide on offering the patient a **pacemaker in the near future** instead of the previous scheduled procedure.	ECG and patient records

Attendees: physicians from different units within the cardiac department.	curing arrhythmic heart disease.			
Planning of procedures Crafted in advance by the admissions office Need for continuous adjustments (but radical)	A nurse becomes concerned when she compares the procedure plan and a **prior note in the patient record** anticipating discussing the case at a medical conference.	The nurse tries to reschedule the patient's procedure by calling the operating room and visitation office **in the present.**	The nurse expects that **in the near future,** the patient will return bedridden from his procedure and unable to participate in the respiratory examination needed for the conference.	Procedure plan
Bed management Created a day in advance by the head nurse.	The physicians and nurses discuss the patients in nurses' office. They talk about a specific patient, where the nurses, **during her previous**	The nurses ask the physician **who is present,** if the patient can be attended to first on his round today, so that he can assess her provide some guidance for the	The physician promises to see the patient as **the first one on his round later today**. A nurse corrects the	Patient overview board

Needs constant attention and reconfiguration according to changes	**admission**, have had a hard time assessing her condition.	nurses.	notes on the patient overview board.	

This section described the theoretically informed ethnographic study of the relationship between strategy, everyday practices, temporality and the use of objects. The ethnography was conducted through interviews and observations of practices that produced ethnographic field notes and interview transcripts. The data was processed in a thematic analysis that produced bundles of data describing everyday practices where temporal object work took place (Table 11). The following sections comprise the findings and the analysis of these every day practices and their relationship to strategy, the objects-in-use and the temporality that these objects convey in order to discuss the hegemonic relationship between different objects and the implications for professionals' abilities to conduct temporal object work.

6.5. Findings: Temporal object work in a Cardiac Day Unit

This analysis unpacks the everyday practices in three separate sections: 1) medical conferences; 2) procedure planning; and 3) bed management while explaining how they are examples of temporal object work. The analysis establishes the relationship between the objects in these practices and the challenges they pose for professionals, because they promote specific temporalities that are more or less useful for making strategic decisions in patient care. In addition, the analysis shows how battles

between different temporalities take place, either within the same object or between objects.

6.5.1. The battle between 'recorded body past' and 'treatment decision present' in medical conferences

Departmental medical conferences are essential for strategies on both work organization and patient treatment. Physicians attending conferences often stall other activities, such as rounds in the Day Unit etc. If a nurse needs to discuss something with the physician, she will have to wait until after the conference (or she can call the physician on duty by phone if the matter is urgent). Recently qualified physicians are especially attentive to the medical conferences in the cardiac department as they make for learning opportunities for those aiming for future career trajectories within cardiology. Also, the conferences bring together physicians who otherwise work alone in different sections of the department. The participants in the conferences discuss medical decisions by constantly moving between past, present and future concerns. The near past presents itself in their discussions of patients admitted to the department during the night or on the day before. When talking about impending procedures for patients in the coming days, the physicians look towards the near future, and when discussing the prospects for medical or technical developments they consider the possibilities in the distant future. This field note describes such a discussion:

Field note: *A doctor has brought a patient case to the conference. The patient has a pacemaker where one of the electrodes is broken and he is in for a new one. The doctor has chosen to present the case at the conference to discuss whether to go back to testing pacemakers immediately after they have been inserted in the procedure*

room. A few years ago they stopped testing because it gives the patient a false sense of security when tested under controlled conditions; "So we don't do that anymore". The other doctors, however, support his decision to test it this time since the patient has experienced that the previous electrode was broken

In this account, a physician uses a specific patient case to discuss a possible change in the strategy (whether to test pacemakers) with his peers. They settle on a decision not to change their current strategy and the doctor instead gets their approval for making an exception with his patient. In medical conferences, deliberations like this one take place in the present, while simultaneously engaging the organization's (or the patients') past and future, and is as such an occasion for practicing temporal object work. When physicians discuss patient cases, they display ECGs or patient records in order to decipher a possible diagnosis with associated future treatment possibilities. This field note excerpt shows a typical discussion, where a diagnosis is uncertain:

Field note: *A doctor presents a patient case where they cannot figure out what the correct diagnosis is. She reads aloud from the patient record and explains that the patient has experienced several episodes of breathlessness and heart palpitations. The doctor explains that they are considering whether it could be asthma. As she shows the ECG on the projector, several of the doctors exclaim, "It doesn't show anything?!". The doctor quickly removes the ECG from the screen. Then, the doctors who are present jump in with suggestions on possible examinations, tests and treatments for the patient: "Try this". The doctor rapidly collects her papers and leaves the board while she says, "thanks".*

This account displays how the ECG is utilized in discussions between physicians. Normally they provide important cues on how to move forward, but here the recorded

past of the patient's heart rhythm ('recorded body past') does not provide any cues of use for making decisions in the present ('treatment decision present'), which is surprising to the physicians. We attended many of these conferences, and in all of them ECG's were analyzed as a basis for making decisions about patient treatment. Unavailable to laypersons (such as the authors of this paper), these records contain important information for physicians. Patient records and ECG's outline the patient's past, e.g. cardiac events, procedures, tests etc. ECGs specifically display the changes to the patient's heartbeat, which need to be deciphered by professionals, providing them with a recorded body past to make treatment decisions for the patient in the present, corresponding to a 'bodily' Gantt chart that supports temporal object work.

Similarly, patient records are recorded accounts of the patient's body past (e.g. descriptions of pain, vital signs and psychosocial status) that are important to all medical decisions and care provided by nurses. ECG's and patient records are brought into the conferences to facilitate shared discussions on how to handle patient cases, bringing together the experiences and specialist knowledge from different physicians. The temporality that ECG's and patient records provide is recorded past information and accounts of the patients' bodies, usable for the physicians attending the conference in the present and crucial for making the right decisions for the future. However, as this analysis showed, the recorded body past embedded in these objects is sometimes hindering treatment decisions in the present. The ECG is a powerful object representing the past, but in order to translate this past into something that is comprehensible and useful in the present is demanding for the physicians, and sometimes not possible, prompting them to 'try something'. This uncertainty is a condition in all medical work. In this everyday practice, physicians engage in temporal object work when assessing the recorded body past embedded in patient

records and ECG's and trying to translate this past into viable treatment decisions in the present.

6.5.2. In the shadow of the 'inflexible procedure planning future'

Where the medical conferences establish fixed time slots for discussions, other ongoing ad hoc practices are equally important for strategy in the Cardiac Day Unit. They enable constant coordination, discussions, and micro-changes. One example is the ongoing planning of procedures, which is a central everyday practice in the Day Unit. Having a manageable strategy for completing procedures with a 'satisfying output' is crucial for departmental subsistence, enabling them to keep up with waiting lists. The everyday practices that support the procedure plan are regarded as very important and have high status. They layout of the procedure plan has been decided in a past that nurses do not have access to. So, they relate primarily to the plan as an inflexible future, which they must try to fit into the present, regarding how they prepare patients for the procedure and get them to the procedure room in time etc. They are constantly trying to think ahead, knowing that the future of the procedure plan can be changed by acute patient cases. The nurses often discover that the procedure plan collides with other practices in the department, such as the medical conferences. The plan can (in some cases) be changed, but it requires many deliberations, as in this account:

Field note: *A nurse has discovered that her patient is first on the procedure plan, but it appears from his patient record that the physicians expect having to discuss his case at a medical conference in the afternoon because they anticipate that he is a candidate for a future valve replacement procedure. It is problematic because how will they be able to perform a pulmonary function test before the procedure? There*

are two specific professionals who are doing the tests and they need to know ahead of time in order to be able to plan. And when the patient comes back from the procedure, he is probably bedridden and cannot do the test because the entry wound from the procedure will be at risk of rupturing. The nurse asks the staff in the operating room if they will be able to rearrange, so that his procedure will be performed later in the day [ed. leaving time for the pulmonary test]. The person at the other end of the phone promises to look at the possibilities. Some time goes by, and suddenly the nurse sees on the monitor that the patient has been moved to slot number four on the plan. She calls the operating room again. Number four also does not work, because then the physician cannot bring the results of the procedure with him to the medical conference [ed. because they will occur at approx. the same time]. A little later we see that the patient has been moved forward according to the plan so that he is now number three.

The field note displays how a nurse tries to change the layout of the procedure plan, so that it takes into account the doctors' expectations of the outcome of the patient's procedure, which is documented in the patient's record. In this way, the nurse draws connections between past, present and future by participating in the everyday practice of procedure planning and thereby conducting temporal object work. In this way, the procedure plan serves as a temporal boundary object, enabling discussions between different parts of the Department of Cardiology. Despite the fact that this object is often treated as an intermediary of a fixed timeframe, the excerpt shows how, in practice, it must be adapted by the professionals. However, when compared to other objects (such as the patient overview board in the next section), this is difficult, since changes affect other patients and practices across the department, involve many

different professional groups and take place in different locations, e.g. at the nursing office, the visitation office and in the procedure room itself.

The inflexibility of the procedure plan is not only due to it being crafted to control the outputs (completed procedures) into the future. It is also because of an embedded uncertainty; that the procedure plan can change at any time due to acute patients coming in. This makes the procedure plan a challenging object for professionals, as they have to treat it as both fixed and unfinished at the same time. This is especially demanding when trying to manage patient's expectations:

"... I often make much of telling them at the beginning… when they arrive, I say: "you are number two according to the plan", and ESPECIALLY, if I can see that they going to one of the rooms on THIS floor, because it is usually there where the acute patients arrive, then I usually say to them that they must be aware that the plan can be rescheduled. I usually refrain from saying more right then, because I also do not want to make them nervous about being postponed or something, but then in that way, they are a LITTLE prepared" (Interview, Nurse).

As a temporal boundary object it communicates an 'inflexible procedure planning future' very clearly with time slots that appear as fixed, but also contains temporal uncertainty related to acute patient cases, which is eviscerated from the object in the form it is given at the visitation office. It looks like a reliable and inflexible plan that must be realized at any cost, but it is often impossible to follow for reasons connected to the handling of other practices (such as providing sufficient information in time for medical conferences). Much work is done 'around the object' to balance prior medical knowledge, urgent needs and expectations for the near future etc. As an object, the procedure plan represents the inflexible future in two ways; both because

the plan is crafted somewhere else, but also because acuteness overrules everything. Acuteness is a hidden future inflexibility of the object because of an uncertainty that is eviscerated from the object, but that professionals still have to take into account when doing temporal object work.

6.5.3. Managing the 'flexible patient overview present' in bed management

While the main purpose of same-day discharge is to get the patient into the procedure room, their preparation and recovery after the procedure (even though short) is also important. For this purpose, beds are needed and have to be distributed to patients who are continuously entering and leaving the Day Unit throughout the day. The everyday practice of creating an overview of which patient is placed into which bed, what activities are planned for them etc., is bed management with temporal object work. Bed management is practiced by different professional groups, e.g. hospital porters, physicians, physiotherapists and nurses, when they have to get an overview of which patients are currently admitted to the Day Unit, what the most pressing tasks are and thus where to go first. The patient overview board is made for the purpose that all professionals working in the Day Unit can get an instant overview of what is happening across the entire unit in the present. In addition, the patient overview board serves as the focal point for interdisciplinary discussions of patients and their needs, as in this excerpt which is from a morning meeting in the nurses' office:

Field note: *The three nurses who are present go through the patients in the different rooms. Their eyes are all attached to the patient overview board. They talk about one of the patients who has been transferred from another hospital because he was unstable and had to be examined by the specialists. But when he arrived, they found*

him to be "not at all unstable". They talk about how this sometimes happens. Sometimes the patients look more unstable on paper than face to face. They talk about another patient where they find it very difficult to figure out what is wrong with her. "You can't use your clinical gaze on her". She must therefore be moved forward in the physician's round, so he can look at her and make an assessment of her medical condition. Usually, it is the patients who have to be discharged or transferred who are first on the round. The round order is listed on the patient overview board, where each patient receives a number depending on when they will be attended to by the physician. The nurses change the overview so that the patient with the unstable values is seen earlier in the round.

The account shows how the professionals use the patient overview board as a temporal boundary object to discuss the individual patients and make decisions about their care plans. In this example, the nurses, who have taken care of a patient in the near past, express concerns about how to address the patient's needs in the near future. In the present, they come to the conclusion that the patient must be attended to urgently by the physician so that he can make a clinical assessment of her illness and how it will possibly develop in the near future. In this way, temporal object work takes place in these ad hoc meetings, where the professionals jointly review the patients in relation to the patient overview board in order to formulate a short-term strategy.

As a boundary object that mediates timeframes, central appointments, plans and agreements, the patient overview board displayed on the monitor is central to organizing in the Day Unit. When the monitor breaks down, it is almost impossible for the professionals to practice care, make plans and decisions and maintain a sense of order, as in this example where it breaks down:

Field note: *The monitor displaying the overview of today's patients has stopped working in the Day Unit due to a technical update of the PCs. The update has resulted in an automatic log-off after 5 minutes, hindering the display of the patient overview to remain open. Now nothing of what they usually utilize to create an overview works. The nurses have pasted a printout of the patient board directly onto the monitor with scotch tape. They write handwritten notes on it, but it quickly becomes unmanageable. The monitor is still not working at eleven o' clock. The department nurse calls the technicians and speaks in no uncertain terms on the phone: "You must come and fix it urgently. We cannot work!"*

The patient overview monitor is used for discussions about what has happened in the very near past (the day before or earlier in the day), to assess the most urgent needs in the present and to plan a strategy for the rest of the day and how different resources should be utilized in the near future. As an object, the patient overview is sophisticated and conveys many different temporalities - the recorded body past (the diagnosis and symptoms), the inflexible procedure planning future (the scheduled time for the procedure) and a 'flexible patient overview present' - because the object can be changed easily in the present and is designed to be so continuously.

The patient overview board becomes second to more self-referential objects such as the procedure plan that represents an inflexible future. However, as an object, the patient overview board is closest to the core of practice, i.e. the patients, their treatment and current needs. The patients' bodies, their psychological status (e.g. 'nervousness'), their current needs, previous tests and their near future are represented on the board. The order of the patient overview board is constantly changed by imposing needs from the planning of procedures and conferences. At the same time, it is much more flexible than the other two temporal boundary objects -

ECG records and procedure. When compared to the other everyday practices, bed management comprises professional discussions on how to manage the present placement and care for each patient to accommodate the procedure plan and the medical conferences, making it temporal object work supported by the flexible present of the patient overview board.

The analysis of the three everyday practices shows how temporal object work in the Cardiac Day Unit consists of practices that bridge past, present and future concerns in different ways. In medical conferences, physicians engage in temporal object work when assessing the recorded body past embedded in ECG's and translating this past into strategic treatment decisions in the present. In procedure planning, professionals need to practice the inflexible procedure planning future by making sure to bring the patient to the procedure room on time. However, they also need to manage patients' expectations by taking into account the flexibility of the object due to future uncertainty. In discussions about bed management, professionals engage in temporal object work - supported by the flexible present of the patient overview board - that needs to fit the other practices in the Day Unit. The analysis reveals how practices collide and the tensions between these practices are visible through the temporality embedded in objects.

6.6. Discussion

Temporal work unmasks the practicality of strategy projects by showing how actors engage in collaborative practices and interpreting the past in order to make a strategic present and in a way that enables actions for the future (Kaplan & Orlikowski, 2013). In the same way, the few studies on temporal boundary objects display how these objects can facilitate the bridging of competing temporal perspectives in different

professional groups while at the same time representing time itself, e.g. through the production of timeframes and deadlines (Yakura, 2002). Neither body of literature has so far adequately discussed the combination of everyday practices and temporal boundary objects, despite them being important parts of ongoing strategic discussions in organizations. Further investigations are needed in order to bring everyday practices back in to strategic organization studies

The research question for this paper, *how is 'temporal object work' practiced in a Cardiac Day Unit, and what are the implications for strategy-as-practice research?*, was approached here through an in-depth ethnographic study of everyday practices, with different health care professionals collaborating and making decisions about patient care by interpreting patient records and consulting overview boards and procedure plans. The single case study approach entails some limitations, e.g. that the results are less externally generalizable. However, the in-depth ethnographic case study has the ability to develop contextually sensitive theories (Barley & Kunda, 2001) and also describe practices in such credible detail that they become recognizable to others, including to hospital management.

The practices and patterns described also become recognizable to scholars concerned with other kinds of continuous practices, such as the use of whiteboard meetings in different sectors. The case study design employed also had a theoretically informed approach, with a broad perspective on temporality in organizations. As such, it does not represent a strong inductive approach, but rather it inherits both deductive and inductive elements. Accordingly, temporal work was one amongst several relevant theoretical perspectives on time and organizing that came out of the thematic coding process of the data collected in the Cardiac Day Unit.

The core contribution of the study is to show how temporal boundary objects are utilized in everyday practices that span past, present and future concerns, e.g. in medical conferences, planning of procedures and bed management. These practices enable strategy on a micro-level and provide a basis for professionals to engage in discussions that resolve tensions and bridge different perspectives, such as the physicians' various perspectives on patient treatment when attending medical conferences. The analysis shows that the objects are enabling to the degree that everyday practices fall apart without their support. Treatment decisions in medical conferences are impossible without recordings of the patient's past, the inflexible future of procedure planning is represented by a crafted plan, and bed management without a flexible patient overview present proves almost impossible. Therefore, the authors of this paper argue for a new concept to describe this relationship: temporal object work.

Temporal objects have become embedded in practice and are supporters of practice, which is the common denominator for the use of boundary objects as strategy tools (Spee & Jarzabkowski, 2009). In the Cardiac Day Unit, some of the objects are treated as more powerful than others due to apparent inflexibility e.g. objects such as the procedure plan. The plan is constructed outside of the Day Unit and changes proposed by the staff involve discussions with many other departments and professionals. However, the procedure plan is also fragile and in a way 'unreliable' because of an essential need for incorporating unscheduled procedures on acute patients at a future point. As such, the procedure plan is an example of a temporal object that conveys a specific type of temporality, i.e. an inflexible planning future, while eviscerating a built-in uncertain temporality dominated by unscheduled events, i.e. acute patients arriving. This leaves the professionals to manage this tension by

engaging in everyday practices to adjust other objects, such as the flexible patient overview present. This shows that temporal boundary objects not only contribute to resolving temporal tensions, they also play a role in creating them.

This paper provides two important insights for the strategy-as-practice perspective - that everyday practices provide an interesting explanatory frame for what is going on strategically at the micro-level in organizations, and that these practices are related to material objects. Temporal object work in the Cardiac Day Unit presents examples of everyday practices, which, as opposed to isolated best practices, enable researchers to explain the 'what, who and how' of strategy (Jarzabkowski et al., 2016b). It is especially with regards to the 'how' of strategy that the practice perspective is important. It opens up the black box of strategy, by showing how strategic decisions are made in practice and how they are connected to temporality. The managers and professionals in the Cardiac Day Unit work towards a common strategic goal, namely to successfully accomplish same-day discharge schemes. Temporality connects the different levels of strategy, i.e. the managerial decision to establish a Day Unit and the everyday practices performed by professionals. Temporality in the managerial decision revolves around time as a resource, moving away from the lengthy hospital stays of the past and towards a 'same-day future'. Temporality amongst professionals concerns caring for patients at an accelerated pace by engaging in practices that enable them to access prior decisions and recordings of the past to decide on possible plans for the future. Both of these levels are temporal in the way that they span past, present and future concerns, and the managerial aspiration to establish the Cardiac Day Unit cannot be successful without the support of everyday practices. However, the temporal perspective on strategy also holds challenges for researchers, namely a difficult distinction of what defines a practice and whether a specific practice is

strategic. If practices are strategical when they are consequential for the strategic outcomes of the organization, then what is not strategy? Nonetheless, the temporality of a practice could be a new guideline for deciding if it is strategic or not, as the temporal element is in itself indicating that strategy emerges.

In addition, this paper develops the literature on the use of temporal boundary objects in organizations. They are not just bridging different temporal orientations, as earlier studies described (Yakura, 2002), but rather, they are crossing several temporal boundaries at the same time. They bring together different professional perspectives and provide a basis for transdisciplinary discussions on how to move forward, but they are also crossing the temporal boundaries between the past, present and future. As mentioned before, some of the objects eviscerate specific temporalities. However, this forms a challenge for researchers because the evisceration of certain temporalities is difficult to discover without seeing them clash with other objects, such as in the case of the procedure plan and patient overview board in the Cardiac Day Unit. Another difficulty is to establish what objects can be regarded as temporal boundary objects that are relevant for strategy researchers. In the Day Unit, alarms are also central objects that direct professional attention to an urgent need for action. However, the integration of temporal boundary objects and everyday practices poses a litmus test for the relevance of a temporal boundary object as a strategy tool, because it indicates strategy taking place.

6.7. Conclusion

This paper concludes that temporal object work is conducted in everyday practices and that these practices are supported by objects that enable the linkage of past and present concerns in order to make suitable decisions for the future. Therefore, the

paper makes a contribution to strategy-as-practice studies by explaining the mechanics of how strategy is temporal in the sense that professionals constantly engage in practices that link past, present and future concerns. The paper also makes a contribution to the literature on temporal boundary objects, by showing how these objects bridge several temporal boundaries, and that they are not just solving temporal tensions, but sometimes creating them. More research is needed on how temporal object work occurs in other types of organizations, e.g. IT-developers engaging in project work. Also, the analysis of other kinds of temporal boundary objects relevant for everyday practices could be an interesting agenda, for example the use of Lean-management whiteboards.

CHAPTER 7: PAPER 3

Title: Seeing, understanding and representing time in tempography

Author: *Vibeke Kristine Scheller*, Department of Organization, Copenhagen Business School

This paper answers research question 3 (RQ 3) that was presented in the introductory chapter of this dissertation: *What are the 'organizational tempography' implications of researching the coexistence of multiple time perspectives in a Cardiac Day Unit?* It was submitted, reviewed and resubmitted to the Special Issue *of Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* "Challenging Times - Qualitative Methods and Methodological Approaches to Research on Time" by July 18th 2019.

Abstract

Previous discussions on time in relation to ethnography mainly revolved around choosing an appropriate tense for writing up the text, whereas few studies have attempted to develop a framework for conducting time-oriented ethnography in organizations, i.e. 'tempography'. Doing tempography requires considerations regarding; how we see time (methods), how we understand time (theory) and how we represent time (writing). This article presents a tempography of a newly established Cardiac Day Unit. Health care organizations provide excellent arenas for studying the coexistence of different representations of time - such as scheduling and coordination, as well as illness and work-life trajectories. The empirical findings presented in this article illustrate different ways that time emerges in ethnography: in observational

accounts, through depictions and narratives that support different temporal conceptualizations, patients' stories of their trajectories and as ethnographic accounts of professional practices. The article concludes that ethnographers need to consider: 1) 'Methodological temporal awareness' as recognition of coexisting temporal modes in qualitative data, 2) 'temporal analytical practices' as understanding time and temporality through different theoretical concepts and 3) 'multi-temporal merging' as a matter of representing diverse perspectives in ethnographic writing.

7.1. Introduction

Ethnographers unavoidably have to choose between past and present tense when writing up; 'freezing' the descriptions in a specific time (Willis, 2010). This temporal perspective in ethnography has been explored by many ethnographers and debated in seminal texts such as 'Time and the other' by Johannes Fabian (1983). For Fabian, the freezing of studied cultures in the stasis of present tense leads to a problematic 'othering' of the studied subjects (Fabian, 1983). The present was experienced in the past by the researcher but either written up using past or present tense; both forming 'temporal' problems for the studied phenomenon. The use of past tense assumes that the culture (or organization) no longer functions this way and that their practice is a thing of the past, whereas the use of the present tense assumes that their practice is frozen in the past and unchanged.

Another important discussion related to time and ethnography has been the paradox of studying non-linear organizational processes, but writing them up in neat linear research accounts (Dawson, 2014b; Willis, 2010). Even though ethnographers cannot escape linearity completely, since it is an important part of the craftsmanship involved in creating convincing 'stories' of organizational change processes, it is at the same

time problematic, because the account loses some of the polyphonic detail. I argue that these discussions are insufficient in covering the challenges that researchers face. There are multiple temporal layers to doing ethnography in organizations. One is how researchers are able to see time in their ethnographic work, by applying different qualitative (or quantitative) methods. Another is how researchers are able to understand time through different theoretical conceptualizations of time in analysis. Lastly, ethnographers need to consider how they represent time in writing. Throughout this article, I will discuss the significance of these temporal layers and add to the sparse literature on time and ethnography. The growing interest of organizational scholars in time and temporality emphasises the need for more methodological discussions, rather than simply abandoning these in the black box of 'doing organizational studies'.

One of the few organization scholars writing about the relationship between time and ethnography was Patrick Dawson who wrote about temporality, ethnography and sense making in organizational change processes (Dawson, 2014a, 2014b). Dawson (2014b) proposes a framework for dealing with temporality in ethnography consisting of three concepts: 1) Temporal awareness, 2) temporal practices and 3) temporal merging. His suggestions focus on the ethnographer and his or her attitude towards the studied phenomenon:

"*Temporal merging in being able to accommodate the intertwining of objective and subjective time, temporal practices in being able to use different concepts of time without trying to resolve them during the collection and analyses of data, and temporal awareness in being able to accept the paradox of time in the use of a relational-temporal perspective, all open up opportunities for greater insight and understanding in engaging in ethnographic studies on changing organizations*". (Dawson 2014b, p.148)

Even though his framework mainly concerns the representational side of doing ethnography, his concepts hold potential for thinking about how to treat temporality in ethnographic studies. Temporal awareness means accepting the paradox of time, that processes are often presented in ethnographies as linear and staged, but experienced by the participants as emergent and chaotic. Temporal practice is a research objective to use different temporal concepts without resolving them, i.e. maintaining a variety of organizational time and temporality themes in the analysis. Temporal merging focuses on intertwining objective and subjective time perspectives in organizational ethnographies, i.e. primarily concerning the re-storying of change processes. The aim of this paper is to develop Dawson's framework, to bring it into other aspects of doing ethnography, i.e. thinking about ethnographic methods and their suitability in capturing temporal details, and the significance of different conceptualizations of time and temporality for how we understand organizations. In order to so, an ethnographic study of a newly established Cardiac Day Unit in a Danish hospital, undertaken by the author, is drawn upon.

Ethnographic studies of healthcare organizations (of which this article is an example) revolve around a specific type of organization that has been the subject of many classical studies (Glaser & Strauss, 1968; Zerubavel, 1979a). Dealing with illnesses and patients provides for some very specific temporal tensions that serve as illustrations for other kinds of organizations, e.g. the temporal space of illness (Moreira, 2007). However, discussions amongst organizational ethnographers have mainly revolved around the 'problem of time' as a matter of representing the ethnographic study in writing (Fabian, 1983; Willis, 2010), with few (but important) contributions to other methodological discussions (Dawson, 2014a, 2014b). This article contributes to these discussions by highlighting how organizational

ethnographers can engage with a multiplicity of time perspectives by methodological temporal awareness, analytical temporal practices and multi-temporal merging in tempography. Therefore, the research question that this article aspires to answer is this: *What are the 'organizational tempography' implications of researching the coexistence of multiple time perspectives in a Cardiac Day Unit?*

The article discusses the implications of how we see, understand and represent time as ethnographers by presenting a tempography of a newly established Cardiac Day Unit. *How we see time* in different kinds of qualitative ethnographic data is the pivotal point of the first section, describing the research methods, types of data and thematic analysis applied in tempography. Then, moving on to *how we understand time,* a mini-review of different theoretical perspectives on time and temporality in organizations. Next, a section unfolding the empirical case is presented: The Cardiac Day Unit, which was established in 2015 and followed by the researcher from 2015 to 2017. An analytical section follows, with examples of *how we represent time* using empirical illustrations from the tempography of the Cardiac Day Unit; as time objects, temporal work and patient trajectories. The article ends with a discussion of how ethnographers are supposed to think about time by considering methodological temporal awareness, analytical temporal practices and multi-temporal merging. At the very end, a conclusion lists the contributions of the article.

7.2. Tempographic methodology

This section concerns the how ethnographers 'see time' when doing tempography using qualitative methods. It is important to highlight that 'seeing' should not be understood as a realist objective, rather it is a concept describing how ethnographers are able to tap into different representations of time by using different methods. This

section begins with a description of ‘tempography’, moving on to an explanation of the qualitative methods used in the Cardiac Day Unit case study and their relationships to time and temporality, ending with a presentation of a theoretically informed thematic analysis process.

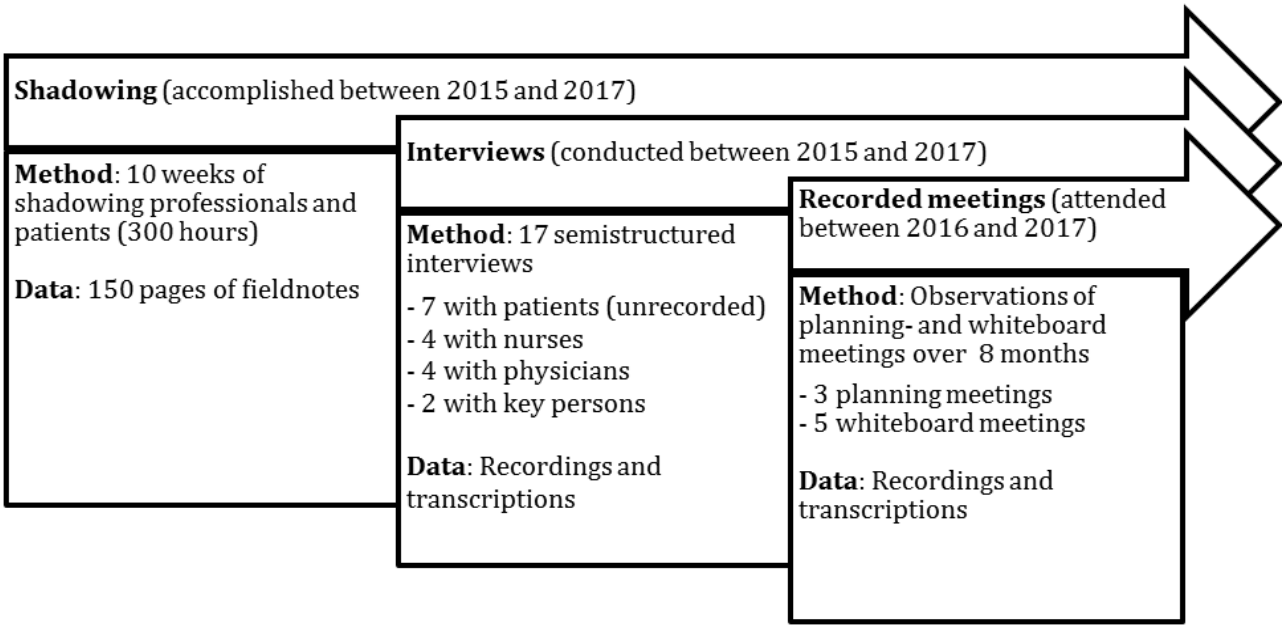
This article is based on an organizational ethnography with time and temporality as its pivotal point, i.e. a ‘tempography’, a term coined by Zerubavel in 1979: “…*time is among the major parameters of the social order, and that social life is structured and regulated in accordance with it. I shall try to accomplish this by presenting a detailed „tempography“ of hospital life*“. (Zerubavel, 1979a, p. xxi).Tempography for Zerubavel (1979a) means an organizational ethnography describing the socio-temporal structures in a Hospital. It is therefore related to the use of ‘tempography’ by researchers of urban development and neighborhoods, i.e. as ‘temporal geography’ (Auyero & Swistun, 2009; Harvey, 2015). For Zerubavel (1979a) as well as in this article, tempography is not just about laying out the geography of time, but describing the process of studying an organizational setting of time.

As classical ethnographies before, the case study of the Cardiac Day Unit focused on in-situ actions, conversations and accounts (Atkinson & Hammersley, 1994; Hammersley & Atkinson, 2007). More specifically, this study concerns organizational life in the Cardiac Day Unit, making it a subcategory of organizational ethnography (Pedersen & Humle, 2016), i.e. studying the role of time and temporality in an organizational context. Several classical ethnographic studies have been conducted with time as an important research theme, usually emerging from a grounded theory approach (Barley, 1988; Birth, 2012; Dawson, 2014b; Glaser & Strauss, 1968; Strauss et al., 1997; Willis, 2010). With this research project, I moved away from the grounded theory approach to ‘tempography’, advocating a more deliberate and theoretically

informed approach. It is important to note that this does not require settling for a specific theoretical time perspective, but rather having a research interest in time and temporality as broadly defined categories from the beginning, i.e. taking time as an (often tacit and implicit), but important organizational principle and bringing it to the forefront. For example, the Day Unit study initially focused on temporal practices, but the significance of patient trajectories and time objects developed as important research topics throughout the study.

Another parallel objective was to discuss how different kinds of qualitative data relate to time and temporality, highlighting attention points for researchers wishing to engage in tempography. The methods and data sources in the tempography (see Figure 9 for overview) were realized between January 2015 and May 2017 and consisted of interviews, recorded meetings and field notes produced while 'shadowing' (Czarniawska, 2007) professionals and patients at the Cardiac Day Unit. Shadowing, as an ethnographic method, concerns the researchers' choice to follow participants in their daily lives in order to understand their practices, and engage in informal conversations about their thoughts and actions. In this specific study, the objective in following the professionals was to understand how their work tasks were performed, specifically with regards to planning and engaging in professional discussions, whereas the objective in following patients was to participate in informal conversations about their experiences.

Figure 9: Overview of ethnography



The study produced different types of data (see Figure 9). Transcribed interviews and meetings as well as field notes gave different insights into how professionals and patients experience and handle the temporal tensions arising from the introduction of same-day discharge. Patient narratives (Pedersen, 2009; Pedersen & Johansen, 2012) form (more or less) linear stories connecting past, present and future, and in this way there is an inherent temporal aspect to collecting and studying narratives. In the Day Unit, the narratives appear in two ways; 1) in interviews and 2) in observed conversations between patients and professionals. Another data source is the observational accounts of practices (Atkinson & Hammersley, 1994; Czarniawska, 2007; Jarzabkowski, Bednarek, & Lê, 2014). These accounts form another kind of stories, explicitly constructed by the researcher that usually writes them up in linear micro-accounts. Organizational practices often take place at a certain time and place,

and some of them have a clear temporal quality, e.g. making decisions by bridging past, present and future concerns. Depictions of objects in use (Orlikowski, 2000; Orlikowski & Scott, 2008) provide for deep slices or snapshots, frozen in time, but important to show how objects represent time and temporality, and how they are utilized in practice. The different temporalities in ethnographic data are not easily separable because they coexist and affect each other continuously, as the analysis section of this article will show in more detail.

After the fieldwork period ended, I conducted a thematic analysis (TA) of interview transcripts and field notes (Clarke, Braun & Hayfield, 2015). The TA approach adopted in this article is a 'Big Q' approach, as defined by Clarke et al. (2015), i.e. an analytical attitude rejecting universal meaning but emphasizing contextual knowledge. The TA process moves through six analytical steps or phases: 1) Familiarization; 2) Coding; 3) Searching for themes; 4) Reviewing themes; 5) Defining and naming themes; and 6) Writing the report (Clarke et al., 2015, p. 230). Even though reproducing the entire analytical process in this paper is too comprehensive, I will highlight three of the most important steps. I familiarized (step 1) myself with the ethnographic data, both during and after the fieldwork period ended, by reading and rereading transcripts and field notes while making basic analytical and reflective notes. Audio recordings were listened to, both in the transcription process and outside of this process. The coding process (step 2) took place as an open thematic coding related to the research question, i.e. how did time (as a very broad concept) appear in the data, e.g. as people talking explicitly about time pressure, to talking about past times or planning for the future. When reviewing the themes (step 4), I identified the most coherent and dense aspects of the data that told me something about the RQ, resulting

in three analytical themes and later their theoretical representations, which are presented in Table 12.

Table 12: Analytical themes

Empirical example	**Analytical theme**	**Theoretical concept**
Field note (in the nurse office): *"The nurses face the monitor displaying an overview of patients and consider what the status is. They are wondering why there so few patients have been discharged. Has the staff in the procedure room been especially slow today? "*	Material objects are central for scheduling	Objects of time
Field note (at a medical conference): *"A doctor reviews the background for a randomized controlled trial, as well as methods and conclusions. He then asks: "Based on this study, what should we do with our guidelines?" Then they discuss what the implications should be for their treatment of patients in the future."*	Decisions spans past, present and future	Temporal work
Interview (with a doctor): *"... we have been trying to map out what the patient's trajectory through the Day Unit system was ... we did not really have a good overview of what the patients were told when they had the initial meeting [in the ambulatory clinic] ... so we used a lot time to map this process."*	Trajectories are essential for organizing	Patient trajectories

As with all TA's, not all themes could be included, e.g. ‚the relationship between time and space', either because of lack of data density, or a weaker relevance for the research question. The three analytical themes constitute different theoretical perspectives on same-day discharge schemes, highlighting a need for researching them as a coexisting multiplicity of organizational time perspectives, calling for new methodological implications and considerations for ethnographers.

An important contribution from organizational tempography as a specific method is that it brings theoretically informed concepts to the table ('bringing back theory' as suggested by Pedersen & Humle, 2016) which tends to overlooked by ethnographers studying organizations, i.e. they mainly produce studies of time within an organizational context, rather than studying how different theoretical time concepts create organizing (Bergman, 2003). The next section describes the implicit and explicit understandings of time in organization studies, focusing on three specific understandings that became salient through the thematic analysis: 1) Objects of time, 2) temporal work and 3) trajectories.

7.3. Theoretical perspectives on time and temporality in organization studies

This section's starting point is the relationship between temporality and organizational ethnography with suggestions for researchers to engage in analytical practices using different temporal concepts (Dawson, 2014b). Thus, it is a small literature review, describing how organization scholars understand time. The section ends with three short theoretical sections, describing the three perspectives on time that grew out of the thematic analysis.

Our understanding of ‘the organization’ is shaped by the time perspective we apply to understand it. When focusing on the relationship between organizational discourse and time (Jensen, 2007; Kozin, 2007; Wall, 2007), organizing becomes a matter of language evolving and representing time. When researching the socio-temporal structures (Zerubavel, 1979a) we tend to reduce organizations to collections of more or less solid orders and materials. The focus on practices (Kaplan & Orlikowski, 2013; Orlikowski & Yates, 2002) makes organizational life a matter of planning and strategizing. In addition, making temporal processes the central point of research provides an exaggerated focus on large-scale change processes (Schultz & Hernes, 2012). In this article, I argue for a perspective on coexisting time perspectives in organizations. Multi-temporality has been approached by researchers before (Adam, 1995; Nowotny, 1994; Waterworth, 2003, 2017), but rarely from a practice perspective. In order to grasp the significance of time and temporality in organizations, suitable research methods are required. This points in the direction of organizational ethnography. The role of ethnography in organizations has been debated throughout research communities, also in FQS, where Bergman (2003) appeals for a more explicit focus on ‘the organization’ in organizational ethnographies, i.e. what the study explains ‘about organizations’ and not just an ethnography ‘within an organization’. Accordingly, this article presents an ethnographic study of ‘the organization’ from a time and temporality perspective – not just a study of time ‘within an organization’ for which Zerubavel (1979a) has been criticized (Bobys, 1980).

The next short sections present three different theoretical perspectives on time and temporality that have been applied by organizational scholars. My objective is to show the perspectives that are the basis for engaging in temporal practices and temporal merging following a thematic analysis (as described in section 2 in this article).

7.3.1. Objects of time

The importance of objects in the way we think about time has attracted a great deal of attention from both organization scholars (Zerubavel, 1985) and within broader sociological research (Birth, 2012). The relationship between objects and the human experience of time has even been labelled as 'technological acceleration', where new information technologies elevate the speed at which human activity is performed (Rosa, 2013). Time objects as a concept belongs to the research tradition on time as social structure in organizations. They are used for a variety of purposes, including the coordination of actions, to facilitate collaboration and to bridge different professional attitudes towards time (Yakura, 2002). On a very basic level, time objects are necessary to even think about time; with clocks and calendars as the most classical examples (Birth, 2012). An important feature of time objects is that they convey specific ways of thinking about time, e.g. the clock conveying 'clock time' and the calendar conveying 'event time'. In a hospital context, clocks, schedules, plans and charts coexist in the ongoing care of patients and continuous coverage, which, according to Zerubavel, is the overall organizational principle (1979a). The patient record (which is also mentioned by Zerubavel) is an example of an object that conveys a different kind temporality, i.e. the patient's story, significant events, their preoccupations for future illness prospects etc., i.e. patient time.

7.3.2. Temporal work

When utilizing objects of time (such as schedules, project plans and calendars), organizational members engage in practices, which are crucial for the coordination, coherence and realization of organizational goals. 'Temporal work' has been an important subject in organization studies, especially in relation to the practice of strategy making (Kaplan & Orlikowski, 2013; McGivern et al., 2018; Reinecke &

Ansari, 2015). Temporal work concerns how actors discuss differences in their interpretations of the organization's past, present, and future to construct a story that provides a basis for strategic plans and action. The perspective has been popular in studies of strategy projects (Kaplan & Orlikowski, 2012), sometimes with the additional focus on the role of objects as facilitators of strategy processes (McGivern et al., 2018). As in strategy making, professionals in hospitals constantly debate interpretations of specific patients and their symptoms in order to make decisions on medical plans and actions. They are constantly doing small-scale 'strategy work' to balance bed-management, patients' needs, surgery plans and unexpected situations. This kind of practice is, in its nature, very much about temporality, moving back and forth between past, present and future.

7.3.3. Trajectories

A 'trajectory' is a specific processual practice unfolding over time. The concept has been used with regards to important organizational processes; professional careers (Schilling, 2015), discovery trajectories (Timmermans, 1999) and management of patient experiences (Strauss, Fagerhaugh, Suczek & Wiener, 1985). A trajectory describes a process, which constitutes a (personal or organizational) narrative, a series of events taking place over time (e.g. an organizational change process) or personal experiences that form a specific story (e.g. an illness story). All of these different trajectories coexist and affect each other within organizations (Timmermans, 1998). As an addition, process scholars have taken up the trajectory concept as well. Hernes (2017) suggests the 'temporal trajectory' as the object of thinking, i.e. a form of organizational entity or narrative, which actors constantly are contesting and reconstructing. In classical healthcare studies, the trajectory concept has mainly focused on 'illness trajectories' or 'patient trajectories' describing hospital work from

diagnosis to recovery or possible death of the patient (Strauss et al., 1997). The concept is frequently used with reference to treatment of chronic diseases such as cancer, ischemic heart disease and heart failure. It describes the professional considerations of how the patient's disease will evolve, how the patient experiences the process and how the transdisciplinary work 'around' the patient's trajectory is to be organized.

As the above sections show, organizational scholars have discussed time and temporality in many ways. Each of these time perspectives is important for understanding how organizations function and what they are, with a specific focus here on health care organizations. In this article, I therefore argue that there is a need for studying how different time perspectives coexist in organizational life, an approach which I adopted in my tempography of a Cardiac Day Unit. The next section describes the case of same-day discharge schemes in the Day Unit. The section begins with a context description of the overall preoccupation with same-day discharge in the medical field, hereafter moving from the general level to describing the particular aspirations, practices and difficulties observed when following attempts to realize the potential of same-day discharge in a specific organizational setting; the Cardiac Day Unit.

7.4. Introducing same-day discharge in a Cardiac Day Unit

The Cardiac ‘Day Unit’ in this research study was established in 2015 in a Danish hospital and received patients for planned or subacute procedures within two medical areas; arrhythmic and ischemic heart disease, that could be discharged to their own homes or transferred to other hospitals on the same day as the procedure. The common denominator for the patients admitted in the Day Unit was that their trajectories were similar, i.e. short and relatively uncomplicated, rather than a shared diagnosis. When

doing ethnographic fieldwork in the Day Unit, I quickly became familiar with the daily routines and discovered how a number of planning tools, patient records and protocols supported professional work in the Day Unit. Planning of medical procedures took place via an IT system that showed procedures (minor interventions) and operations that were scheduled for many weeks at a time. The procedures were booked by employees in the visitation office on the basis of references from specialist doctors or from departments at other hospitals. The wall in the nursing office in the Day Unit displayed a digital monitor on the wall, which showed an overview of planned procedures, i.e. 'the procedure plan'. Next to this was another monitor with a patient overview - a simple table list of patients distributed to beds and rooms. The patient overview played a supporting role in the work of the professionals as it reminded them of times, planned tests, attendance and important information about the patient's general health and specific illness. Patient records were used continuously by the staff to orient themselves in notes about the patient's previous history of illness etc. This patient record was made a few days before the procedure, where the patient would meet with a physician and a nurse in the ambulatory clinic.

During the initial phase of the study in May 2015, there were difficulties with accomplishing same-day discharge in the Day Unit, which brought attention to the tensions arising from the introduction of a shorter timeframe. At this time, the management team looked out for 'bottlenecks', chaotic processes and interviewed patients about their experiences. Most of the patients were really satisfied with their treatment and complemented the 'fast, efficient and competent' care they received in the Day Unit. However, during this period there were many discussions between professionals on where to put 'difficult patients' that did not fit the new discharge scheme. Planning was also complicated because of increased pressure on the different

sections. This pressure travelled from section to section e.g. if spaces were occupied in the intensive care unit it resulted in very sick patients remaining hospitalized in the emergency section, i.e. an organizational 'knock-on effect'. This made the implementation of the Day Unit difficult because patients that were to be moved from the Day Unit, in order to close it during the night, put additional pressure on the other sections. It became clear that the establishment of a Cardiac Day Unit with same-day discharge involved changes to deeply implicit and routinized work tasks, and not just 'performing tasks faster within a shorter timeframe'. However, it was apparent that many of the difficulties had to do with planning, managing competing systems and timing and synchronization between different departments, but also on how patients and their trajectories were perceived and handled by professionals.

The next section displays examples of time and temporality perspectives, as they emerged from the tempography in three ways; 1) as professionals utilizing 'objects of time, as 2) professionals engaging in 'temporal work' and 3) as patient 'trajectories' that are constructed and reconstructed by patients and professionals.

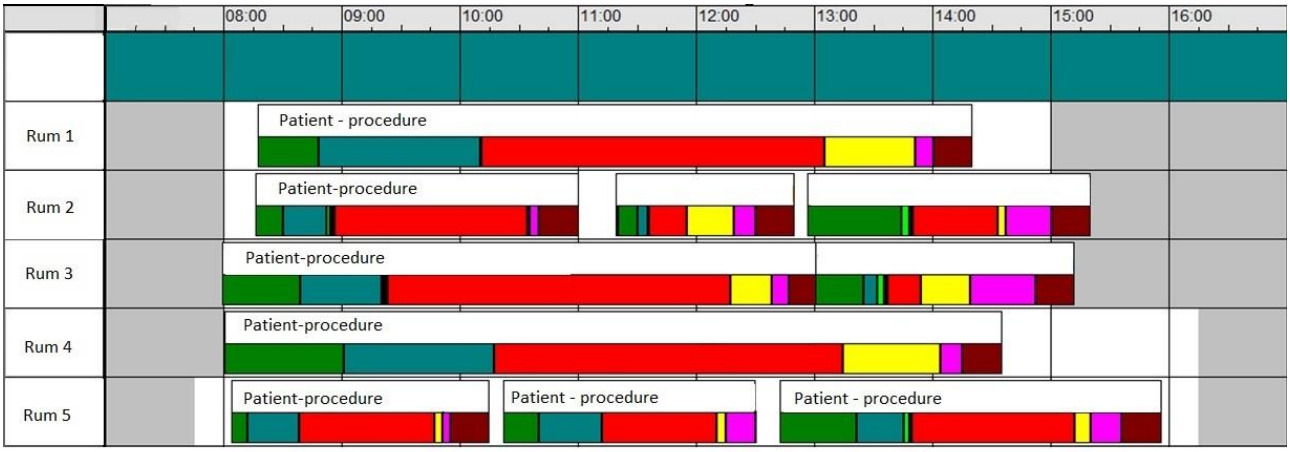
7.5. Empirical illustrations of time in a Cardiac Day Unit

This section shows excerpts from my ethnographic data that illustrate how time is represented in a tempography of a Cardiac Day Unit. The sections pose short empirical illustrations and are as such not fully developed analyses, since the main point of this article is to show how different multi-temporal organization perspectives are connected to ethnographic methods. The excerpts are both from field notes, documents and interviews and display three representations of time at the Day Unit: The use of time objects, temporal work and the handling of patient trajectories as temporal processes.

7.5.1. Procedure plans as objects of time

In the Cardiac Day Unit, a monitor hangs on the wall in the nursing office, which shows an overview of the procedure plan for the specific day. The overview displays patient names, a heading that describes the scheduled procedure and their allocation to a specific procedure room (‘rum’ in Figure 10). The overview displays the real-time unfolding of events in each room, where a vertical line marks the current time and the colors indicate the phases of the procedure, e.g. green for ‘preparation’, red for ‘knife-time’ (when surgery is performed) and brown for ‘completion’. The professionals utilize this plan to coordinate work activities in relation to each patient by reading the changes in colors. For example; When should the next patient be prepared for procedure, when will the patient return, are there any delays or have acute patients arrived? When the nurses look at the board, they can ‘decode’ where the patient is in his or hers trajectory by looking at the colors that change along the way.

Figure 10: Edited procedure plan (patient names and procedures omitted for anonymization purposes)



The procedure plan is a central work object in the nurse office. It is consulted constantly and closely observed for unforeseen changes. If acute patients arrive or

another demand for rearranging the patients arises, they appear as dark blue bars, indicating that they need to be ‘squeezed’ into the schedule. The following field note is an example of such a change and how it is handled by professionals:

Field note: *“It is 11 AM and a physician calls the nurse office and explains that the medical equipment in room no. 5 has broken down. Next, all the patients' names on the monitor become dark blue and the nurses know that this means that they will be moved to other rooms. It creates many problems for today's planning. The nurses discuss which patients can be canceled. They inform the waiting patients that ‘things are looking bleak’, but they are still waiting to see whether the procedures can occur during the day. We watch the development on the monitor during the day. The procedures are moved further and further into the afternoon, and suddenly two procedures have been moved to after 8 PM. A nurse explains that the operating staff would rather work over-time to complete a few more procedures than be behind with the plan for the rest of the week”.*

The situation displays how the overview board acts as an important time object for professionals, in the management of the overall planning, but also for the patients’ expectations that nurses need to reconcile. The monitor provides timeframes, which organize the expectations of the professionals for the forward-looking organization of the patient trajectories. In addition, the monitor can act as an object for ongoing negotiations and discussions of these expectations. The time objects in a hospital are many, some are particularly important for the organization of patient trajectories, and some objects have a more powerful status than others. In this account, the breakdown of equipment means a reduction of ‘clock time’ that is visible on the monitor. What professionals need to do in order for the schedule to “fit” again involves several types of rearrangements and disruptions of patient trajectories, i.e. ‚patient time‘. The time

objects play an important role in this rearrangement and reorganization of hospital work. The temporality of the professionals' workday is made into an object that tries to inherit two temporalities, but rather eviscerates the logic of the patient trajectory in favor of clock time. When researching the significance of time objects in organizations, the focus unavoidably becomes how socio-material objects and orders shape organizational life. However, the field note above also points to the importance of professional work in relation to these objects. Time is represented in two ways in this analysis, one is the 'frozen' depiction of the procedure plan, and the other is the observational account of this object in use. Together these two representations show that the plan conveys a specific type of time (here clock time), which has consequences for professional practices.

7.5.2. Dealing with postponements as temporal work

Sometimes patients cannot be discharged, due to complications (such as excessive bleeding), the postponement of procedures or other types of delays. At the end of each day shift, the head nurse makes a patient overview plan, which is central because it helps to plan work tasks distributed across the group of nurses in the Day Unit. However, when this plan 'falls apart', it is the task of the professionals to discuss and adjust the patient overview plan:

Field note: "*At 14:30, the head nurse prepares the patient overview plan for tomorrow. The overview board looks very messy. There are too many patients for the number of beds, because some of the patients have not been discharged as planned. She is also looking at the surgery plan, which looks completely packed. The head nurse makes some suggestions on how they can organize their way out of it, even though it looks quite hopeless. She says in an ironic tone: "you really can't squeeze the turnip any*

more"? A nurse answers: "No because no matter what we do, we lack beds for three patients." They proceed to discuss which patients can wait in the hallway if necessary; what are their psychological needs, were they displaying unusual nervousness in the initial meeting in the ambulatory clinic? They decide that it will be those patients coming in for some very short procedures".

This excerpt shows an example of how professionals engage in micro-strategical temporal work where they concentrate on making plans for the near future, while doing discussions in the present and interpreting how patients acted in the near past as a basis for making 'the right decisions' on how to move forward. What the patients told the professionals during a past meeting in the ambulatory clinic is suddenly brought into the present and used to make decisions on where to physically place them. An interesting point here is that temporal work often takes place in relation to time objects (as detailed in the first analytical section). In this example, time objects, i.e. overview boards, plans and patient records, support the temporal work of professionals. Temporal work and time objects are connected, but represent two very different time perspectives, i.e. temporal work concerns 'temporality' (micro-strategic practice in relation to past, present and future) while time objects concerns 'time' (structures used to map time). Time is represented here in observational data, constructed by the researcher as a small linear account of professionals engaging in micro-strategic practices that spans past, present and future concerns.

7.5.3. Professional dilemmas in patient trajectories

It is often important for patients in the Day Unit to convey their personal stories, in order to ensure that their previous experiences are passed on to a professional who can handle their trajectory within the Day Unit. Generally, the patient's personal stories are

of great importance to the way they meet the professionals in the Day Unit. The patient's previous trajectory may be characterized by problematic experiences (such as long waiting periods) which they consider necessary to communicate to the professionals, as they identify them as important events. The following example is from an initial meeting in the ambulatory clinic where the patient is frustrated not to have been called in for a procedure earlier:

Field note: *I've said since 2000 that something was wrong with the heart, but no one listened to me". The patient is generally tired of the health care sector as he has experienced many cancellations earlier. The doctor looks at me and says: "please note that patient names often do not appear in the IT systems – there are obviously follow-up conversations that have not been completed because of the system." The patient complains about the amount of waiting time: "Why should I wait so long to come here? I have called several times and complained". The patient is sad to experience that his health is deteriorating. He has many physical shortcomings and becomes exhausted quite easily. He tells us that he previously worked with harmful building materials in his youth and therefore has problems with his lungs today. The doctor listens to him, receives information about his medicine, informs him about the planned procedure and says goodbye. The doctor makes a note in the patient's record, which summarizes the situation and the illness history. She explains to me that is it specifically important to make these notes for patients in same-day schemes as the professionals encountering them have a short time to get an overview of the patient's situation.*

In this conversation, the doctor translates the patient's narrative into notes in the patient record so that the information can play a part in the patient's trajectory in the Day Unit. The doctor prepares a note in the patient record (Table 13) mapping the most important events in the patient's previous trajectory, which may be of major importance for the

same-day trajectory in the Day Unit. These explain both his irritation towards the hospital, his bodily discomfort and a description of prior illnesses that can (potentially) have consequences for his future treatment. The doctor also tries to direct the patient's dissatisfaction with the hospital towards a systematic error, thereby contesting the patient's experience of his trajectory so far. The preparation of patient records and the translation of the patient's information to notes is an important component of working with patient trajectories, because they provide information-sharing platforms that can be accessed by many different professionals in the future, i.e. "through time".

Table 13: Example of patient record (adapted by the author for anonymization purposes with a different diagnosis, type of procedure and scheduled dates)

Preliminary assessment	The patient complains of chest pain. Pt has experienced this since 2000. Expresses dissatisfaction with not having been admitted before now. Pt experiences pain on a daily basis and considers his physical capabilities to be severely impacted.
Allergies, CAVE	None
Note	Angina pectoris. Pain following light physical exertion
Procedure	Coronary catheterization possibly PCI
Treatment plan	There are indications of possible occlusions because of stable angina. The patient is admitted in the Day Unit for catheterization on Nov. 15th.

It is interesting that patient trajectories are also supported by time objects (the patient record) and temporal work, i.e. the work done by the physician to make sense of the patient's past to make strategies for future treatment. However, patient trajectories are something more than professional work supported by objects, even though this has been the dominating way that they have been described in organization studies. As the

above account shows, trajectories are not stable but are constantly contested and reconstructed by professionals and patients. The patient's near past and prospects for the future are of (if not greatest) great importance to how patient trajectories are formed, perceived and handled in hospital departments, such as the Cardiac Day Unit. Organizational processes as the central point of research provides an elaborate focus on change processes, while patient trajectories make for another kind of organizational process, one which has been discussed in health care journals for many years, but has not been given much attention by organizational scholars. Time is represented here by a linear patient narrative presented to the physician, who translates it into a plan for future medical treatment.

The three analysis sections showed that different time perspectives coexist in the Cardiac Day Unit. Objects represent time that support temporal work practices and trajectories intersect with both these objects and practices. Sometimes the time perspectives collide and create tensions, as in the relationship between patients' trajectories and the procedure plan, where the professionals have to decide on which trajectories to disrupt in order to rearrange the procedure plan. So where does this multiplicity of time and temporality perspectives leave the ethnographer? What questions will be specifically important for the ethnographer to explore when doing, finalizing and writing up an ethnography concerning temporality in health care organizations, or in other organizations? My contribution is the development of an approach capable of handling these problems, creating methodological temporal awareness through the introduction of a multiplicity of temporal modes in qualitative data, honoring analytical temporal practices by using different concepts and establishing multi-temporal merging by highlighting the coexistence of different temporalities in organizations. This framework will be discussed in the next section.

7.6. Temporal awareness, practices and merging in tempography

The existing body of literature on time and ethnography provide little guidance to researchers to determine the levels of temporal presence in organizational ethnographies. To make up for this lack of guidance, this article argues for several layers of temporal concerns that are important for ethnographers. This is important, especially with regards to recent developments in organization studies, particularly where researchers are not just studying temporal structures (as Zerubavel, 1979a did) but also intertwining practices and processes.

The problem of time in ethnography is particularly prevalent when studying temporal practices and processes (linking past, present, future), and one way to try and resolve this tension is be very specific on how different time perspectives are linked together in accounts. Another possibility to resolve the 'temporal paradox' when doing the ethnography is to videotape the work of health care professionals and replay it back to them when doing the interviews. Willis highlights this as enabling the interviewees to engage with the "Other" (Willis, 2010). Videotaping medical work can of course be ethically problematic, as the professionals constantly debate very sensitive issues related to the patients. The problem of 'freezing' accounts will continuously be a problem for ethnographers. Accordingly, researchers need to 'embrace the frozenness' of ethnographic studies as 'deep slices of practice at a particular moment in time'. I chose to write up my case description (section 7.4) in past tense while choosing to present the excerpts from field notes in the analysis in present tense. The purpose was to highlight exactly the temporal tension between what I experienced in my process as a researcher and how field notes represent deep slices of a particular moment in time.

Other than accepting that ethnographic accounts are ‘deep slices’ of organizational practice, it is important for ethnographers to think about how research projects are designed as linear processes – even if they are designed to study the temporal and processual nature of organizational life. The research process is planned, follows a linear trajectory and comes to an end, while the behavior of organizational members is ongoing and forever changing. Section 7.4 in this article (the case description) is constructed as a linear account of what happened in the Day Unit. Even though this is problematized by researchers such as Dawson (2014b, 2014a), researchers must ask themselves: How can a case description ever be written down as something other than a linear account, if it is to be understood by readers and reviewers? While organizational ethnographies could maybe benefit from more experimental approaches, we cannot escape linearity completely, nor should we, as that is also an important temporal perspective of doing ethnographic research. The objective is not to dispose of any linearity, but to make sure that other temporal representations are included in the ethnographic study.

In this regard, I find Dawson’s (2014b) framework useful, but my contribution is to push his points further, to explain even more about the significance of time and temporality in organizations and what implications the explicit temporal focus entails for ethnographers. As an example of temporal awareness, Dawson points out that the ethnographer spends long (chronological) amount of time in the field, which enables him or her to spot key events (event time). My contribution is to apply the need for awareness directly to the use of qualitative methods in ethnography, i.e. ‘methodological temporal awareness‘. Researchers need to be aware of the temporal embeddedness of qualitative methods, i.e. that interviews tend to produce linear narratives, that observations of micro-strategic practices are constructed accounts of

professionals engaging in temporal work, and that depictions of time objects are frozen in time. Accordingly, the methodological choices have fundamental implications for what kind of analysis it is possible for the ethnographer to undertake.

Temporal practices for Dawson (2014b) relate to the researcher's skills, specifically the demanding skill of holding on to (and presenting) different conceptions of time in the ethnography. However, the notion of doing temporal practices, as a researcher (i.e. using different concepts without resolving them) is a vague suggestion for ethnographers. I suggest 'analytical temporal practices' as a more adequate suggestion for tempographers. Engaging in analytical temporal practices means the ability to utilize different concepts to explain time and temporality in organizations, i.e. practices (temporal work), processes (patient trajectories) and structures (time objects). A way to perform analytical temporal practices is to consider how different conceptions of time lead to contradictions and difficulties, which I do in my analysis. By taking inspiration from the processual perspective (as I do with the trajectory concept), this enables me to illustrate how the past and the future are brought together in the present by organizational actors and in this way 'stay open' to different conceptions of time. It is important to point out, that the analytical choices (i.e. the breadth of concepts) form specific challenges for the representation of the ethnography and the ability to merge different perspectives.

When it comes to temporal merging, as the last part of Dawson's (2014b) framework, why should it be limited to the bridging of objective and subjective approaches in sense making? That seems like an inadequate approach to dealing with the wider variety of time perspectives taken up in recent organization studies. In my analysis I pursued 'multi-temporal merging' by explicitly laying out the different time representations in my ethnography. The objective was to represent tempography by

writing in a theoretically informed way that honors the coexistence of different temporal perspectives in an organization. Not only the merging of linear/processual perspectives, but also practice/structure/process. In the analysis section, I showed how organizations consist of structures and practices as well as processes. I argue that the explicit focus on bridging only objective and subjective time perspectives leads precisely to the pitfall of applying a single temporal perspective. In a way, researchers are subjected to the same pitfall described by Birth: the human need for making temporalities into objects and risking the evisceration of their logics (Birth, 2012). I have tried to avoid that by showing the connection between time objects, temporal work and trajectories but still keeping them as separate concepts with different temporal representations. I suggest that researchers engage with 'multi-temporal merging', making sure to integrate different time perspectives, i.e. time as social structure and temporality, in organization studies and in organizational tempography in particular.

A limitation of the tempographic approach, developed in this article, is that the temporal layers, i.e. how researchers see, understand and represent time, are all connected and sometimes difficult to separate. Objects are used in observational accounts of professional practices (e.g. the procedure plan) and patient narratives are translated into depictions of objects (e.g. the patient record). Separating them can be considered as a 'forced' exercise for ethnographers. However, in order to be comprehensive, I argue that it is important to do so. In addition, methodological, theoretical and representational choices by the researcher are rarely (if ever) made in a specific successional order, especially when doing ethnography, where inductive approaches are imperative. However, the establishment of a tempographic framework

will guide scholarly reflection on how to engage with time in organizational ethnography.

Lastly, I argue that temporal awareness, practices and merging need to be considered, not only in relation to carrying out tempography, but also in how we understand organizations, i.e. as collections of intertwining temporal structures, practices or processes. In my study, I create temporal awareness by showing how time as social structure and temporality coexist in the Cardiac Day Unit. Showing how different understandings of time coexist will make the field aware of multiple temporalities in same-day discharge and contribute to new explanations of why it sometimes proves difficult for hospitals (and organizations in general) to change work practices and establish new timeframes for completing them.

7.7. Conclusion

This article contributes to the literature on ethnography and temporality, by developing a framework for organizational ethnographers interested in the significance of time and temporality in organizations, i.e. tempographers. The article concludes that researchers need to engage 'the problem of time' in several layers of the ethnography. Firstly, in methodological temporal awareness, i.e. reflecting on how researchers can see time documented in different kinds of qualitative data. This awareness enables researchers to consider the appropriateness of a specific method to investigate time-related issues, e.g. choosing narrative interviews for detailed descriptions of time experience. Researchers also need to become accomplished in conducting analytical temporal practices, i.e. considering how we understand time through various conceptualizations, e.g. temporal work, time objects and patient trajectories. Conducting analytical temporal practices means making the implicit theories of time embedded in classical

organization studies explicit and elaborating on how these theories relate to the specific research project. Lastly, this article argues for a broader perspective on temporal merging (i.e. multi-temporal merging), which means not just representing subjective/objective or processual/linear perspectives, but also delineating time as social structure/temporality perspectives of organizational life.

CHAPTER 8: DISCUSSION AND CONCLUSION

"Everything's been out of order, Time, I mean. I thought for so long that time was like a line, that... that our moments were laid out like dominoes, and that they fell one into another, and on it went. Just days tipping, one into the next, into the next, in a long line between the beginning... and the end. But I was wrong. It's not like that at all. Our moments fall around us like rain, or... snow, or confetti."

- Nell Crane, *The Haunting of Hill House*

8.1. Introduction

As this quote from the popular Netflix series *The Haunting of Hill House* (Flanagan, 2018) demonstrates, different understandings of time can profoundly affect the way that we experience life in general or, as in this dissertation, organizational life. Despite the traditional understanding of time as a linear progression of 'dominoes', many researchers have contributed to expanding this understanding and have showed how time 'falls around' organizational actors as temporal 'confetti', embedded in structures, objects, practices and processes.

As described in the introduction (Chapter 1) of this dissertation, I initially embarked on an ethnographic study of organizing in the Day Unit, the tensions that new organizing created for professionals and the relationship to time and temporality. The research question that was approached in the dissertation was this: *How does new organizing of patient trajectories create time-related tensions in a Cardiac Day Unit?* The initial (and most obvious) tension that arose from the introduction of same-day discharge in the Day Unit was how it was possible to create a smooth and

efficient ‘production’ line of patients who had ‘unpredictable’ bodies and in an uncertain context where changes can happen continuously. However, the PhD project and the completion of the three analytical papers in particular revealed how different time perspectives collided in the context of same-day discharge and created time-related tensions in different ways. In the first paper (*Temporal patient trajectories: Long stories in short admissions*) different conceptualizations of trajectories collided - the trajectory as a manageable, reliable and planned structure and the trajectory as a continuously changing and provisional entity that emerges from conversations between professionals and patients. In the second paper (*Temporal object work in a Cardiac Day Unit*) time-related tensions occurred in two ways; the first one being that professional decisions for the patients’ treatment were affected by the condensed period of admission and the second being that collisions arose between different temporalities embedded in objects, e.g. the inflexible future in procedure plans and flexible present of the patient overview board. The last paper (*Seeing, understanding and representing time in tempography*) discussed time-related-tensions on a different level, i.e. the time-related tensions that ethnographers face between methodological, analytical and representational perspectives on time.

As discussed in the analytical papers, this dissertation entails some limitations, which have been elaborated throughout the previous seven chapters. It presents a single case study of a single Cardiac Day Unit. But at the same time, it was established in the case description of the dissertation (Chapter 3) that the introduction of same-day discharge is not limited to this particular Day Unit. Rather it is indicative of a mega-trend in the health care sector in many countries, where various medical areas will introduce same-day surgery in the coming years, and many of the professionals dealing with these patient trajectories will face similar challenges. The single case

study approach causes some limitations, e.g. that the results are less externally generalizable. However, I argue that this in-depth ethnographic case study has the ability to develop contextually sensitive theories (Barley & Kunda, 2001) and describe everyday practices in such credible detail that they become recognizable to others, including to hospital management teams. Accordingly, the theoretical generalization from the in-depth study of the Cardiac Day Unit is a contribution to how we theorize the relationship between time, temporality and organizing.

I argue that this dissertation shows that several time perspectives coexisted and that they were actualized and set in motion by the introduction of same-day discharge in the Cardiac Day Unit. This claim is the point of departure for the discussion in this chapter. The chapter presents the discussions in each of the three papers and discusses their contributions and their answers to the overall research question. After the presentations of the three papers and their contributions, the chapter introduces a discussion that crosses the chapters in the dissertation, on how the contributions offered are related to different understandings of time and temporality in organizations. The chapter ends with a conclusion with suggestions for future researchers who are interested in following this line of inquiry and for organizational actors that will encounter the organizing of same-day discharge.

8.2. The emergence of temporal patient trajectories

The introduction of this dissertation (Chapter 1) described my initial interest in exploring what it meant to care for patients' trajectories in accelerated discharge schemes. The establishment of the Cardiac Day Unit resulted in a rethinking of the role of patient trajectories, from a non-fixed period of several days, to a fixed same-day discharge scheme. This dissertation described and discussed the challenges that

this change posed for professionals i.e. that the time they spent together with the patient became shorter and professionals had to connect the parts of the patient's trajectory that took place both inside and the outside of the Day Unit.

The paper *Temporal patient trajectories: Long stories in short admissions* (Chapter 5) offered two theoretical contributions that combined theoretical perspectives on medical work and temporality in organizations. The first is the argument for viewing patient trajectories as 'temporal patient trajectories', which entails an emergent and intersubjective perspective on patient care which is relevant in the context of standardization and accelerated treatment schemes. The temporal patient trajectory, as a provisional organizational entity, explains how it is negotiated by professionals and provides attention and task direction, despite the fact that patient trajectories are rarely linear and orderly in practice. Focusing on the 'eventness' of temporal patient trajectories establishes a new role for patients as active co-creators of organizing. This new role for patients requires considerations for researchers on how they encounter them when researching organizations. I encountered them (mostly) in an 'indirect way', through my observations of professional practice, where they 'appeared' in encounters with professionals. Future studies that include a 'direct' patient perspective could entail other relevant insights to the eventness of temporal patient trajectories.

The second contribution from this paper is the emphasis on articulation work in patient trajectories, which has been underestimated by traditional trajectory research (Strauss et al., 1997) where it is one amongst several forms of work that bring the trajectory forward and not constitutive of the trajectory itself, i.e. that the trajectory emerges from articulation. Articulation work becomes a question of bridging the temporal gap between past, present and future, and therefore the long and the short

story in the patient trajectory as it appears in same-day discharge. The paper argues that materials such as drawings or patient records, can be utilized to support this temporal bridging and enabling of the professionals' ability to be 'present' together with the patient in a continuous present.

However, viewing patient trajectories as temporal trajectories establishes some challenges for researchers. Focusing on trajectories as they emerge from events entails that the 'object' of investigation becomes many 'brackets' or 'snap shots', which makes it difficult to craft 'neat' analyses of patient trajectories. In this regard, another possible limitation that needs to be addressed is whether it is sufficient to craft the analysis on the basis of these snap shots (as I do in the paper), or if it is necessary to uncover the total organization of work done over the period from diagnosis to recovery, which was a requirement in the classical studies of patient trajectories. I argued that the bracketed approach could be a methodological strength, especially in the context of same-day discharge, because the ethnographic constraint mirrors the constraints that professionals face in the Cardiac Day Unit. They are trying to comprehend a long and complicated trajectory through small glimpses.

Even though the paper provides an argument for the processual 'nature' of temporal patient trajectories, a traditional perspective on time is present in how professionals try to capture and anticipate the temporal 'confetti' and as such it cannot be ignored. They make plans and schemes to keep track of time and trajectories and these are important for understanding what role time plays in the organizing of their day-to-day practices, i.e. in an everyday context. I do not argue that trajectories can only be comprehended as emergent and processual, rather that we have to be aware of the coexistence of different time perspectives that pose a challenge for professionals; that they encounter both plans for trajectories and create the trajectories through

articulation work. In summary, both a structural perspective of time and a processual perspective of temporality exist in the organizing of patient trajectories. The coexistence is important, because it is this coexistence that creates tensions, i.e. that professionals constantly need to balance the trajectory as a plan-able structure and the trajectory as a continuously changing entity.

Accordingly, this paper answered the research questions presented in the introduction of this dissertation (Chapter 1) by explaining *how 'temporal patient trajectories' are continuously reconstructed in a Cardiac Day Unit, and what the challenges are for professional work* (RQ 1). At the same time, it offers a part-answer to the overall research question in this dissertation: *How does new organizing of patient trajectories create time-related tensions in a Cardiac Day Unit?* (RQ). It does this by explaining how the coexistence of different time perspectives in the organizing of same-day patient trajectories poses challenges for professionals, and that these challenges are related to representations of time, i.e. structured plans vs emergent articulation. As such, it follows up on the theoretical discussions that were presented in the literature review (Chapter 2). As a research field, health care organizing was dominated by 'time as experience' and 'time as structure' perspectives and the 'time as process/trajectories' perspective is novel to this research tradition. I argue that the contribution of temporal patient trajectories shows the relevance for a processual perspective – also in health care organizing. This does not mean that the other perspectives become obsolete, especially not the time-as-structure perspective that coexists in the research of patient trajectories that was presented in this paper. The second paper in this dissertation offers a similar combination of perspectives that will be unpacked in the following section.

8.3. The practice of temporal object work

My initial concern (which was described in Chapter 1) was the micro-strategical practices in the Day Unit that became affected by the introduction of a limited timeframe in same-day discharge. The preoccupation with securing 'the right knowledge at the right time' resulted in many deliberations about what the right knowledge was in order to provide patients with excellent treatment plans. Based on the challenges in the Cardiac Day Unit, this dissertation adds to organizational studies by showing how actors make decisions in the organizing of same-day discharge and manage the relevant information for making these decisions through the use of objects.

The paper *Temporal object work in a Cardiac Day Unit* (Chapter 6) provided two theoretical contributions. One was the contribution to temporal work which theorizes how actors engage in collaborative practices and interpreting the past, to make a strategic present and in a way that that enables actions for the future (Kaplan & Orlikowski, 2013). The paper focuses on everyday practices that enable strategy on a micro-level and provide a basis for professionals to engage in discussions that resolve tensions and bridge different perspectives, such as physicians' various perspectives on patient treatment when attending medical conferences. The paper argues that temporal work takes place in medical conferences, planning procedures and bed management, which provide empirical examples on both scheduled and ad hoc practices. We argue that this forms a relevant contribution to the strategy-as-practice perspective by exploring practices in the Cardiac Day Unit that, as opposed to isolated best practices, enables researchers to explain the 'what, who and how' of strategy (Jarzabkowski et al., 2016b). It opens up the black box of how strategy is

conducted in day-to-day situations, by showing how strategic decisions are made in practice and how they are connected to temporality.

This paper's second contribution was showing how temporal boundary objects were utilized in everyday practices that span past, present and future concerns, i.e. objects as important carriers and translators of the temporal 'confetti'. The paper showed that the objects were enabling for temporal work to the degree that everyday practices fell apart without their support. As an example, treatment decisions in medical conferences became impossible without recordings of the patient's past. Therefore, this paper proposed a concept that captured the materially embedded temporality of strategy - 'temporal object work'. The objects have become embedded in practice and are supporters of practice, which are the definitive characteristics of boundary objects when used as strategy tools (Spee & Jarzabkowski, 2009). In the cardiac Day Unit, some of the objects are treated as more powerful than others due to apparent inflexibility e.g. objects such as the procedure plan. The procedure plan is an example of a temporal object that conveys a specific type of temporality, i.e. an inflexible planning future, while eviscerating a built-in uncertain temporality dominated by unscheduled events, e.g. acute patients arriving. In this way, objects are crossing several temporal boundaries at the same time by bringing together different professional perspectives and simultaneously crossing the temporal boundaries between the past, present and future. And, as this paper shows, they are also sometimes assisting in creating conflicts between different temporalities.

However, the temporal perspective on strategy as everyday practice also holds challenges for researchers, namely a difficult distinction of what defines a practice and whether a specific practice is strategic. If practices are strategical when they are consequential for the strategic outcomes of the organization, then what is not

strategy? Additionally, the notion that objects eviscerate specific temporalities forms a challenge for researchers because the evisceration of certain temporalities is difficult to uncover without seeing them clash with other objects, such as in the case of the procedure plan and patient overview board in the Cardiac Day Unit.

As such, this paper offers a specific answer to the research questions that were presented in the introduction of this dissertation (Chapter 1). The paper shows *how 'temporal object work' is practiced in a cardiac Day Unit, and what the implications are for strategy-as-practice research* (RQ 2). And at the same time, the dive into the everyday practices that can be considered as strategical, shows us something important about *how new organizing of patient trajectories created time-related tensions in the Cardiac Day Unit* (RQ). The paper describes time-related tensions that arise from the introduction of same-day discharge in two ways. The first one is that professional decisions for the patients' treatment were affected by the condensed period of admission, which is visible in the professionals' efforts to 'time' the collection of information in relation the medical conferences. The second tension is that tensions arise between different temporalities embedded in objects such as the procedure plan. In this way, the paper contributes to the theoretical discussion framed in the literature review (Chapter 2) on the relationship between 'time as structure' and 'time as practice' perspectives. The acknowledgement of temporal object work as a theoretical perspective evidently shows that the material representations of time and the temporal practice of professionals coexist and are interconnected in everyday practices. This relationship between different representations of time is also relevant to explore in the context of ethnography, which is the point of the next section.

8.4. Accomplishing organizational tempography

Even though Zerubavel, in his pivotal study of time patterns in hospitals (1979a), established the idea of an organizational 'tempography', not a lot has been written to guide researchers on how to handle the many representations of time that they encounter when doing ethnography. It became an objective for this dissertation to expand the literature on time and ethnography, parallel to conducting the ethnography. The exploration of the cardiac Day Unit showed that new organizing created tensions for the professionals who dealt with processes in time, planning on time, or objects that represented time. Accordingly, I authored a paper that described and discussed the possibilities for researchers to engage with time and temporality on different levels in ethnographic studies.

The paper *Seeing, understanding and representing time in tempography* (Chapter 7) reviewed the existing body of literature on time and ethnography which provided little guidance to researchers considering the levels of temporal presence in organizational ethnographies. The paper adapted Dawson's (2014b) framework of 'temporal awareness, practices and merging' by pushing his points further on the implications that an explicit temporal focus entails for ethnographers. My contribution was to apply the need for awareness directly to the use of methods in ethnography, i.e. 'methodological temporal awareness'. I argued that researchers need to be aware of the temporal embeddedness of qualitative methods, i.e. that interviews often produce linear narratives, that observations of practices provide constructed accounts of professionals engaging in different kinds of work, and that depictions of time objects are frozen in time. Similarly, I suggested 'analytical temporal practices' as the researcher's ability to utilize different concepts to explain

time and temporality in organizations, i.e. practices (temporal work), processes (patient trajectories) and structures (time objects). A way to conduct analytical temporal practices is to consider how different conceptions of time lead to contradictions and difficulties and present them in the ethnography, which I did in this paper. I argue that temporal merging, which was the last part of Dawson's (2014b) framework, should not be limited to the bridging of objective and subjective time perspectives. Instead, I suggested that researchers engage with 'multi-temporal merging' and integrate different time perspectives, i.e. time as social structure and temporality, in organization studies and in the representational side of organizational tempography in particular.

The elaborated tempography approach holds some challenges for researchers, namely how to represent the temporal 'confetti' as a compelling story without reducing it to a linear account of organizing. How can a case description ever be crafted other than as a linear account, if it is to be understood by readers and reviewers? Similarly, the way that methodological descriptions are crafted provides the limitation of describing the research process as orderly and linear, despite if often being another case in reality. Accordingly, ethnographers need to consider how research projects are designed as linear processes, even if they are designed to study the temporal and processual nature of organizational life. Also, the problem of 'freezing' accounts will continuously be a problem for ethnographers. Accordingly, researchers need to 'embrace the ethnographic studies as 'deep slices of practice at a particular moment in time'. Consequently, I chose to write up my case description (Chapter 3) in past tense. A limitation of the tempographic approach, that was developed in the paper, is that the temporal layers, i.e. how researchers see, understand and represent time, are all connected and sometimes difficult to separate. Lastly, I argued that temporal

awareness, practices and merging need to be considered, not only in relation to carrying out tempography, but also in how we understand organizations, i.e. as collections of intertwining temporal structures, practices or processes that call for awareness, practices and merging.

As such, this paper offers a specific answer to the research questions that were presented in the introduction of this dissertation (Chapter 1). The paper took its point of departure from the lack of guidance that the literature provides for ethnographers and argues for several layers of temporal tensions in tempography that are important for researchers to address. The paper discusses *the 'organizational tempography' implications of researching the coexistence of multiple time perspectives in a Cardiac Day Unit* (RQ 3). It therefore (indirectly) provides an answer to the overall research question of this dissertation: *How does new organizing of patient trajectories create time-related tensions in a cardiac Day Unit?* (RQ). The paper discusses the time-related tensions that ethnographers face between methodological, analytical and representational perspectives on time when doing a tempography, as I did in the Cardiac Day Unit. In this way, the paper contributes to the theoretical discussion in the literature review (Chapter 2), because the methodological discussion is connected to theoretical representations of time. This is specifically relevant for researchers who engage with organizational ethnography (Pedersen & Humle, 2016) where one of the main objectives is the production of theories about organizations, which are described in the methodological chapter (Chapter 4) of this dissertation. Accordingly, the next section comprises a discussion of this dissertation's contribution to theories about organizing, i.e. the coexistence of time and temporality.

8.5. The coexistence of time and temporality in practices

The papers of this dissertation argued that time-related tensions are related to the different ways that time creates organizing that is affected by the introduction of same-day discharge. The literature review in this dissertation (Chapter 2) described the growing interest in organizational time and temporality. However, even though these studies subscribe to very different research traditions, they are often published under very similar headlines and with similar-sounding concepts. As an example, 'temporal structuring' and 'temporal work' sound similar, but the first describes the structuring of time through project plans and deadlines, while the latter concerns the temporal relationship between past, present and future in strategy-making. What is the difference between time and temporality, and why is it important to understand the distinction between them? I argue that the distinction is important because it provides very different conceptual understandings of 'the organization'. Even though many of the studies that were presented in the literature review (Chapter 2) draw connections between different perspectives (usually subjective experience vs structure), further conceptual clarification is needed despite the fact that representations of time and temporality are often intertwined – as is the case in the papers of this dissertation.

'Time' in organizations roughly concerns time as an entity that can be measured, spent and divided - an understanding which can be found in perspectives such as scientific management. The literature on experiences usually also frames research as being on 'time', as it often concerns the juxtaposition between objective and subjective time. The literature on socio-temporal structures is also related to 'time' as these studies (even though from a constructionist perspective) often regard time as an

organizational entity necessary for creating coherence and a sense of order. Even though these studies apply concepts such as ‘temporal reference frameworks’, they do not include a ‘temporal’ perspective per se. ‘Temporality’ in an organizational context relates to the relationship between past, present and future, usually with a focus on how the organizational past and future are brought into the present by organizational actors, e.g. in construction of narratives or in strategic discussions and decisions. This understanding can be found in process studies. The literature on experience is (even though in a different way) also connected to temporality, as these studies concern human experience, which is shaped by the individual’s past experiences, and their hopes for the future. Some of the practice-oriented studies concern both ‘time’ and ‘temporality’ as they describe organizational members engaging in temporal practices that structure time through the making of plans and objects to facilitate cooperation.

A way to view the distinction between time and temporality is the presence of ‘movement’. The patterns of ‘time’ as described by Zerubavel (1979a) mainly theorize the relationship between static temporal structures and the organization of hospital work. In contrast, the temporal process research as presented by Kaplan and Orlikowski (2013) and Hernes (2017) describe the movement in organizing, i.e. that the possibilities for making decisions brings organizing ‘forward’ by interpreting and discussing past and present concerns. Additionally, this dissertation shows that if we move away from basic material representations of time, i.e. clocks and calendars, the distinction between time and temporality in objects becomes blurred. The dissertation presented dynamic objects such as the patient overview board that represent both time and temporality by conveying timeframes and fixed points while simultaneously supporting temporal practices that move the organizing of patient treatment forward.

Drawing on these discussions, this dissertation presents three papers that also discuss the role of time and temporality in organizing. The paper 'Temporal patient trajectories: Long stories in short admissions' (Chapter 5) shows how time schedules and the temporality of patient trajectories coexist as two different ways of talking and thinking about patient care. The paper 'Temporal object work in a Cardiac Day Unit' (Chapter 6) describes the relationship between the timing of information and the temporal embeddedness of everyday practices and objects. Lastly, the paper 'Seeing, understanding and representing time in tempography' (Chapter 7) discusses the different ways that time appears in ethnography and argues for the multi-temporal merging of time and temporality perspectives in organizing. As such, the three papers show that both time and temporality coexist and are often part of the same practices in organizations.

The introduction of this dissertation (Chapter 1) pointed to a possible consequence of adapting a temporal practice-perspective in organizational ethnography, i.e. that these practices will unavoidably uncover an intertwined pattern of time and temporality perspectives. I argue that one of the strengths of this dissertation is that it subscribes to the practice perspective by focusing empirically on how people act (temporally) in organizational contexts that are formed by time structures and temporal processes, and builds on the theoretical position that temporal practices play a constitutive role in producing 'organizing'. As such, it describes an ethnographic practice view on time that honors the extensive literature on the social structure of time while simultaneously leveraging the dynamic and situational perspective offered by the process studies on temporality in organizations.

8.6. Time-related tensions in same-day discharge

As the introductory quote in this chapter established, time is like ’confetti’ that actors constantly attempt to collect, order and manage, and in the Cardiac Day Unit, they tried to do so in a changed context of same-day discharge. This is the essence of organizing. The purpose of this dissertation was to show how new organizing creates time-related tensions in a Cardiac Day Unit, and the short answer is that different understandings of time get actualized by the introduction of same-day discharge and create time-related tensions for professionals. The cardiology department changed with the introduction of same-day discharge and even though the changes were not fundamental, the organizing of patient trajectories had to be conducted within a shorter and fixed timeframe. As this dissertation established, ‘small’ changes can have ‘big’ consequences – in organizations such as in human bodies – and risk creating arrhythmias, as presented in the case description (Chapter 3). Moreover, the work that professionals do to reestablish order is an important component in public sector innovation as everyday innovation.

Table 14 displays the relationship between new practices in the Cardiac Day Unit, the tensions that this new organizing created and how these tensions are connected to the coexistence of different representations of time in practice.

Table 14: Time-related tensions

Practice	**Tension**	**Coexistence**
Organizing same-day patient trajectories	The trajectory as a structured care plan and the trajectory as emerging and continuously	Trajectory as time structure together with the temporal trajectory as process

	changing.	
Making decisions about patient treatment in the Day Unit	The condensed time structure in same-day discharge and engaging in ongoing object-mediated discussions of patient treatment.	Time in objects and condensed time structure together with the temporal process of making decisions
Doing ethnography of time in the Day Unit	The structure of ethnographic writing and the methodological/theoretical representations of time in organizations	Time structure in doing ethnography, temporal processes in organizations together with researcher practices to represent different understandings of time in writing

The table shows that professionals (including researchers) have to overcome several kinds of time-related tensions to reestablish order in practices. Professionals in the Cardiac Day Unit need to manage the tension between the trajectory as a reliable and planned structure and the trajectory as a continuously changing entity. The 'temporal patient trajectory' can explain this tension and present ways for professionals to overcome the discrepancy between the long and the short story by engaging in articulation work. Secondly, decisions for the patients' long (and short) future were affected by the condensed period of time, and collisions arose between different temporalities embedded in objects. 'Temporal object work' provides the possibility to explain how the use of objects contributes to the creation of temporal tensions and not only resolves them. Thirdly, ethnographers face several layers of time-related tensions between methodological, analytical and representational time when doing tempography. 'Methodological temporal awareness', 'analytical temporal practices'

and ‘multi-temporal merging’ provide the initial steps on the way to resolving these tensions for ethnographers by illuminating them in ethnographic writing.

8.7. Conclusion

This dissertation adds to the body of literature that describes the relationship between organizing and time, by arguing for a practice-oriented perspective in combination with insights from process studies on the significance of temporality, i.e. practice/process and structure/process hybrids. Table 15 sums up the central theoretical concepts in the dissertation, which were introduced in Chapter 1 and adds the theoretical contributions that the three papers provided.

Table 15: Central theoretical concepts and the contributions of the dissertation

Concept	Definition	Contribution
Patient trajectories	Patient (or illness) trajectories describes the organization of work done to manage the physiological unfolding of a patient’s disease, and the impact on those involved with that work (Pescosolido, 2014; Strauss et al., 1997)	‘Temporal patient trajectories’ are continuously reconstructed by professionals and patients and establish the organizational direction in a reciprocal relationship between articulation of past experiences, present needs and future expectations.
Temporal work	Temporal work concerns the way organizational actors make interpretive links in time by discussing concerns of the past and present to shape future (strategic) action (Kaplan & Orlikowski, 2013; McGivern et al., 2018).	’Temporal object work’ in everyday practices is supported by objects that enable the linkage of past and present concerns in order to make decisions for the future. These objects

		convey temporalities that create tensions for professionals by eviscerating other temporalities.
Tempography	Tempography is an organizational ethnography describing the socio-temporal structures in an organization (Zerubavel, 1979a). It is related to the research of urban development; 'temporal geography' (Auyero & Swistun, 2009).	Doing tempography by engaging with 1) 'methodological temporal awareness' (seeing time), 2) 'analytical temporal practices' (understanding time) and 3) 'multi-temporal merging' (representing time) in organizational ethnography.

Together, these contributions present how the coexistence of different time perspectives organizes health care. Even though it is not reducible to time, organizing cannot be separated from time. Time arranges practices and processes through plans, objects and conversations. Also, organizing takes place in time in patient trajectories that appear in events. If you take the above contributions seriously, we arrive at the overall conclusion that organizing *is* time, but in many different ways - as processes, practices, planning, conversations, stories and the use of materials. Organizing arises in the ongoing relationship between practice and temporality. It becomes an integral part of organizing over time and tensions arise when this organization is confronted with new demands on how time is spent etc. As Strauss et al. (1997) described, the delicate temporal order in hospitals can easily be disrupted by the introduction of new technology and forms of organizing. Accordingly, this dissertation shows how the introduction of same-day discharge disrupts the order, but at the same time how it gets reestablished by the professionals engaging in practices that (in different ways)

create order and meaning for themselves and for the patients. They engage in continuous articulation of temporal patient trajectories and they constantly make and remake plans by doing temporal work aided by temporal boundary objects. In this way, their efforts are the treatment for organizational arrhythmia that is introduced when making changes – an effort that deserves acknowledgement.

This dissertation presents implications for organizational studies and for practice in hospitals. For organizational studies, considering patient trajectories as processual and temporal means that researchers need to pay attention to emergence in practice. It establishes a new and demanding theoretical understanding of coherence, which is novel to the field of health care studies. The contribution could be relevant for other kinds of organizations that engage in trajectory work, e.g. trajectories in projects, innovation processes etc. For practitioners in health care organizations, a relevant insight could be how to create enabling contexts for articulation work in patient trajectories. Considering the role of objects in temporal work establishes a new direction for organization studies where objects that represent time are not 'innocent' bridges between diverging professional perspectives, but that they contribute to creation of temporal boundaries. This perspective could be relevant for other researchers who study organizations that use planning and scheduling tools, which means almost any kind of organization. For practitioners, reflecting on the representations of time in objects and the consequences for practice means recognizing the coexistence of different temporalities.

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