

## **The Social and Political Significance of Technology-Driven Organisational Change** Discursive Battles to Frame, Define and Decide in 'a Space of Points of View'

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**The social and political significance of technology-driven organisational change:  
Discursive battles to frame, define and decide in ‘a space of points of view’**

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**Abstract**

Struggles over new organisational technology are, almost without exception, studied inside organisations. This paper aims to advance our understanding of how technology is embedded in social forces and relations of power that reach beyond individual organisations. It examines the ongoing discursive struggles in public media outlets between consultant doctors and regional actors concerning a controversial electronic health record system, called the Health Platform, which was implemented in 20 Danish hospitals. A theoretical framework inspired by Bourdieu's understanding of discursive activity in a field subsumed in a multi-level and cultural understanding of framing is used to examine the interests connected to platform design and its organisational future states. It is demonstrated that winning the support of the public is pivotal in the construction of frames by both groups of actors in their efforts to define problems and solutions and, ultimately, influence a political decision concerning the platform's future.

**Keywords:** Consultant doctors, discursive struggles, electronic health record (EHR), framing, ideology, politicians, public media, a space of points of view

A growing literature is concerned with the social, political, and conflicting aspects of organisational technology, seeing them as encompassing assumptions that are part of political and managerial agendas (Dawson & Buchanan, 2005; Plesner et al., 2018; Polykarpou et al., 2018). It is suggested that examining the structural and cultural forces involved in technology implementation and struggle in the public sector is pivotal for understanding the difficulties of technology-driven organisational change (Davidson, 2006; Plesner et al., 2018). However, an omission is that struggles over new organisational technology are, almost without exception, studied inside organisations (Davidson, 2006; Polykarpou et al., 2018). This paper sets out to demonstrate the importance of further advancing our understanding of how organisational technology is embedded in social forces that reach beyond individual organisations and, specifically, when technology and technology-driven change is constituted and contested in discursive struggles to stir public opinion (Contandriopoulos et al., 2004).

The paper examines the discursive struggles of groups of actors in the Danish hospital field who actively use national and regional public media outlets to state their points of view and position themselves in relation to a new electronic health record (EHR) system called the Health Platform (Sundhedsplatformen, HP in the following). The HP represents the single largest information technology investment in Danish healthcare to date (Statsrevisorerne & Rigsrevisionen, 2017). It aims to improve care integration within and across two Danish regions and involves substantial organisational change concerning work procedures, professional boundaries and roles (Brorholt, 2016; Region Sjælland, 2017a). A blizzard of media debate has followed its adoption, where groups of actors, with competing and conflicting interests in the platform, voice their opinion about the new system or have their points of view represented by the media. The debates convey the conflictual and difficult situation that has emerged following the platform's launch in 2016.

Research has shown that arguments and ideas about issues of public concern in public media outlets may mobilise public and political opinion on various subjects—including healthcare investments—and thereby legitimise political actions and decisions (Fredriksson & Edwards, 2019). Public media may thus be used to affect policy-making and policy changes (Fredheim, 2020; Fredriksson & Edwards, 2019). This can occur, for example, through the use of discursive tools and techniques such as frames that concern the selection and promotion of particular aspects of a phenomenon (Cornelissen & Werner, 2014; Entman, 1993; Koon et al., 2016; Shields & Harvey, 2010). It is thus important to pay attention to these discursive struggles and, specifically, to their political functions when they aim to mobilise the public (Contandriopoulos et al., 2004; Entman, 1993; Fredheim, 2020; Shields & Harvey, 2010).

The study is guided by the following research question: How can debates on the HP in public media outlets be understood as attempts to render the platform an issue of public concern and what is at stake in the battles?

To understand the structural and cultural forces involved in technology implementation, the article draws on a theorization inspired by Pierre Bourdieu's (1991) relational sociology, where the HP is seen as constructed in classificatory discursive activities, subsumed as framings (Entman, 1993) in "a space of points of view" (Bourdieu, 1999, p. 3), encompassing agents and forces that span the boundaries of hospital organisations. This conceptualisation of organisational technology responds to calls for rethinking and demonstrating "the muscularity of discourse" by placing it in a social context and paying attention to its effects (Alvesson & Kärreman, 2011, p. 1140).

The paper adds to the literatures concerned with the political and social aspects of organisational technology as well as organisational discourse and management by demonstrating that micro and macro "worlds" (Hardy, 2011) should be seen as interwoven in

relations of power. The literature on organisational discourse and management has, for example, focused on framing and leadership (Fairhurst, 2005) and the framing effects of discourse (Alvesson & Kärreman, 2011). Framing is seen to influence a variety of phenomena, including technology-driven organisational change (e.g. Barrett & Stephens, 2017; Grant et al., 2005). However, discursive battles and framing are predominantly explored at single levels of analysis only, and most often at the micro level of social construction (Cornelissen & Werner, 2014), having the consequence that the influence of macro level discourse on local change is overlooked.

Bourdieu's (1991, 1998) concepts of field, position, interest, and capital organise a multi-level framework that is used to analyse the discursive activities by groups of agents struggling to win the sympathy of the public for their point of view on the HP. I suggest that the conceptual link between Bourdieu's concepts and Robert M. Entman's (1993) concept of framing has the potential to provide novel conceptual insights and contributions to the field by approaching framing as a cultural practice embedded in a field. Through this framework, a deep understanding of the inherently political nature of discursive power struggles emerges when agents promote their interests and position themselves in the field in order to affect organisational future states of the platform.

The data demonstrate the various issues at stake for consultant doctors and regional politicians in charge of the platform as embedded in their framings. The analysis identifies two structuring forces that are principal for understanding the controversies that have plagued the new platform. The first force concerns regional and national political ambition towards digitalisation leadership and hospital services improvements and the second is the often overlooked symbolic constitution of the hospital field (Ernst & Jensen Schleiter, 2021).

The paper proceeds as follows. The next section examines the literature on the socio-political aspects of organisational technology on which the paper builds and aims to extend. The theoretical framework, case background, and methodology are then sketched. In the results section, the discursive battles and framings of regional agents and consultant doctors are analysed. Finally, in the discussion and conclusion section, the article draws out its main insights and contributions as well as suggestions for future research.

### **The socio-political aspects of organisational technology in the public sector**

It is argued that the public sector is a particular and difficult context for technology implementation due to the conditions and circumstances that characterise it, such as bureaucratic structures, complex decision-making processes, and the professionals who populate public sector organisations (Barrett & Stephens, 2017; Cho et al., 2008; Plesner et al., 2018).

Moreover, some commentators suggest that healthcare, in particular, is lagging in effectively exploiting new technological solutions despite receiving heavy investments (Barrett & Stephens, 2017; Cho et al., 2008; Mishra et al., 2012). In spite of apparent delayed action, the literature explains how organisational change may advance by embedding potentially disruptive features in technology to which professionals must adapt (Barrett, 2018; Cho et al., 2008; Davidson, 2006; Halford et al., 2010; Mishra et al., 2012; Plesner et al., 2018).

This is evidenced in studies focusing on new technology in hospitals, where disruption may refer to a break with health professionals' own conceptualisations of work and their profession (Halford et al., 2010; Håland, 2012). Several of these studies concern EHR or EPR (electronic patient record) systems where, in general, EHR systems are more comprehensive than EPR systems. EHR systems are seen as the cornerstone of modern healthcare due to their

ability to link patient data, which is seen to have the potential “to realise an unprecedented advancement in healthcare quality, efficiency and performance” (Oderkirk, 2017, p. 6). A general feature of these systems is that they reconfigure work in ways that challenge institutionalised professional boundaries and identities, attempting to create new divisions of labour as part of health policy agendas (Cho et al., 2008; Halford et al., 2010; Håland, 2012). Work reconfiguration thus concerns who should do what in practice (Cho et al., 2008; Halford et al., 2010; Håland, 2012). According to Barrett and Stephens (2017), high implementation failure rates of these systems are reported, and Hertzum and Ellingsen (2019) describe how the implementations of the EHR system, manufactured by American Epic, in the UK and Denmark have been “wrought with problems” (p. 315).

The research suggests that medical professionals, in their own experience, have been negatively affected by these changes and have laboured to circumvent them (Cho et al., 2008; Håland, 2012; Mishra et al., 2012). EPR and EHR systems have, for example, reconfigured medical work so that doctors must take on administrative tasks previously taken care of by medical secretaries (Cho et al., 2008; Håland, 2012), challenging both the doctors’ status in the health professional hierarchy and established boundaries in work.

The literature provides valuable insights into the day-to-day realities of technology in the public sector and in hospitals specifically. However, being limited to the contexts of individual organisations, these studies fail to connect their local analyses of organisational technology with factors outside the organisation that could be co-constitutive of how a technology is evaluated, perceived, justified, or problematised. In the context of public sector organisations, this includes interested activity when politicians and professionals position themselves in relation to new technology in public media with the aims of rendering it an issue of public concern. This could be “a step on the road to officialization and legitimation” in the



words of Bourdieu (1977b, p. 171) and a form of political pressure exerted to influence future decisions concerning a technology. This gap is of immense importance because it hinders an understanding of the political and ideological aspects of organisational technology.

This article extends the literature by suggesting an approach that does not take its outset in an organisation but in a technology embedded in a field as conceptualised by Bourdieu (1998). This framework spans multiple levels of relational analysis by connecting the symbolic level of framing with the immediate experiences of struggling groups and the forces structuring the field. In doing so, it takes an interest in “how such frames of reference emerge in the first place” (Cornelissen & Werner, 2014, p. 222), and how technology is interwoven in relations of power. The framework is explained in next section.

### **Theoretical framework: A Bourdieusian perspective on classificatory discursive activities**

#### ***Fields as social contexts for discourse***

Bourdieu (1991) is keenly focused on how discourse is performative as embedded in social contexts, providing the conditions for discourse production and employment (Blommaert, 2018; Hanks, 2005). He uses “field” to conceptualize the context of discursive practice and “interest” and “position” to explain social and political action. A field is a social space of differentiation, play, and competition, where interest refers to having stakes in what Bourdieu (1998, p. 25) often terms “the game,” which concerns the relational, antagonistic, political, and symbolic dimensions of fields (Robinson et al 2022).

The hospital field is structured by political and professional interests and envelopes all who have a stake in hospital services (Ernst, 2019). In the case studied, the geographical boundaries of the field are identical with the area of the two Danish regions that have invested in and implemented the HP, yet the political boundaries are national because the HP concerns the National Healthcare Digitalisation Strategy as well as national strategies concerning quality

improvements to hospital care. The hospital field thus depends on what Bourdieu (1998, p. 42) terms “the field of power,” mainly understood as the state as a meta field which has the power to impose its decisions and definitions on all other fields while also being influenced by these (Robinson et al 2022). As elaborated below, the medical professions have, managed to secure the hospital field great autonomy through history (Jespersen, 2013; Timmermans & Oh, 2010).

The hospital field and the field of power both relate to and depend on the media, which have a unique mandate to explore all spheres of life and share their findings with the public. In a Bourdieusian perspective, the media do not convey mere facts to the public, but should be seen as active co-constructors of “social facts” and public opinion (Champagne, 2005), where journalists, representing various media outlets, and groups that have the power to influence content and impact public sentiments about core issues engage in mutually beneficial relationships (Champagne, 2005; Fredheim, 2020; Shields & Harvey, 2010). The Danish media have historically been linked to the political parties. Blach-Ørsten and Burkal (2014, p. 68) describe the public media landscape as heterogenous and the products produced by the largest Danish newspapers as “by and large politically neutral.”

### ***Position and positioning through discourse***

Agents are positioned in a field depending on the capital they possess, where capital is that which is recognised by the field’s members as having differentiating and extraordinary value (Bourdieu, 1998). A position is a symbolic and material location in a field, referring to the connotative value of the capital associated with the position (Bourdieu, 1998) and reflected in, for example, the number of media appearances by an agent. Hence, capital yields power in a field, and power results from a relational game of capital accumulation and positioning activities attuned to the demands and logics of the field (Bourdieu, 1998).

Discursive production is part of positioning struggles as ways of protecting interests, where agents create classifications and representations of what occupies them to advance their interests and improve their position in the field (Blommaert, 2018; Bourdieu, 1991; Hanks, 2005; Robinson et al 2022). Classifications are sparsely explained by Bourdieu as “delimitations,” and representations as “performative statements which seek to bring about what they state” (Bourdieu, 1991, p. 225); thus, they aim to produce “social effects” with real and symbolic consequences (Bourdieu, 1991, p. 220). Understanding positions relationally thus begs an interest in the competitive and antagonistic aspects of the field—on the producers of discourse, the interests that move them, and the stances they adopt.

#### *Framing as cultural practices*

Discursive classifications and representations can be subsumed into framings (Cornelissen & Werner, 2014; Shields & Harvey, 2010), since framings rely on “linguistic artifacts” as “tools” to build their meaning and hint at the orientations and purpose of the communication with the purpose of building arguments with symbolic value (Cornelissen & Werner, 2014, p. 199; Entman, 1993; Koon et al., 2016, p. 808). This corresponds with a Bourdieusian perspective, where it seems fertile to understand framings as the organising of particular points of view in discursive struggles. According to Entman (1993): “To frame is to select some aspect of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described. Typically, frames diagnose, evaluate, and prescribe. (p. 52).” Framings are then performative in nature, constructed to make one’s point of view visible, legitimate, believed in and acted upon (Cornelissen & Werner, 2014; Entman, 1993).

While there are several approaches to framing, connecting Entman's framing with a Bourdieusian conceptualisation of classificatory discourse "brings ideas together" as advocated by Entman (1993, p. 51), and provides a critical sociological perspective for studying framing with solid theoretical backing in Bourdieu's multi-level relational theoretical architecture. Entman (1993) connects framing to culture and pays attention to power relations as does Bourdieu, but a Bourdieusian approach collapses binary distinctions such as senders and receivers (of frames), found in Entman, into relational cultural systems termed fields. Conversely, Entman's concept of framing adds analytically useful specificity to Bourdieusian treatment of language and discourse. As Hanks (2005) observes, Bourdieu seldom, if ever, approached the level of empirical specificity needed to pose concrete definitions of language and discourse because he was much less interested in the "opus operatum" of language than in its practical uses, the "modus operandi" (See also Bourdieu, 1991, pp. 107-112). Therefore, to understand Bourdieu's approach to discourse, we must focus on what he said about other aspects of social life and the epistemological foundation for his ideas (Blommaert, 2018; Hanks, 2005).

Coupled with the field concept, framing activities are conceptualised in a structural constructivist epistemology, that is, in a dialectic between everyday subjective experience of, for example, professionals using the HP, and objective structuring forces of the field, such as politics and policy. I suggest that we should understand these activities as cultural practices since their production and understanding presuppose an understanding of the conditions that apply to the context of their production, which in this case is the Danish hospital field.

Bourdieu (1977a, p. 650) explains that to understand discourse we must understand the social conditions of its production, including conditions that are not immediately visible in it—such as symbolic power relations within groups and in the entire field that decide who can

effortlessly command attention and who must win their audience—which amounts to understanding the hidden laws of discourse production. Discourse legitimizes social structural relations in the shape of hierarchies, setting the stage for social groups and for reproducing power relations (Bourdieu, 1991; Contandriopoulos et al., 2004; Hanks, 2005). A Bourdieusian approach, then, does not simply take the social world as it presents itself; rather, it deconstructs and reconstructs the field’s problems in a relational sociological perspective.

In summary, Bourdieu’s (1991, 1998) concepts of field, position, interest and capital organise a multi-level framework used to understand and explain how debates on the HP in public media outlets can be understood as attempts to render the platform an issue of public concern and what is at stake in the battles. This framework focuses on the relational struggles of consultant doctors and regional agents that materialise as framing activities, seen as cultural practices, that organise points of view on the HP.

### **Case setting: The two regions and a new EHR system**

The Danish healthcare system, commonly described as “public,” is tax-financed and provides universal coverage through a health security scheme. As the system’s major institutional pillar, the hospital sector is structured around the five Danish regions as hospital owners. In this role, the regions are often used to spearhead political ambitions to modernise the sector (Christiansen & Vrangbæk, 2018; Jespersen, 2013).

As part of a grand structural reform in 2007, the regions were introduced as a potentially temporary governance solution, financed through government grants (Christiansen & Vrangbæk, 2018). They operate through the regional councils that function as the region’s highest decision-making body and each consists of 41 democratically elected representatives and an elected chairman (Christiansen & Vrangbæk, 2018). The Capital and Zealand regions cover 20 hospitals and 45.5% of the Danish population (Region Sjælland, 2017a).

In 2012 the Capital Region faced a tender on their healthcare IT systems. Because disconnected EPR systems that were used to record, plan, and execute care had been a major challenge in relation to care integration across regions, the Capital Region and Region Zealand contracted with the US software developer EPIC and Danish NNIT to deliver a new common EHR system. Denmark has a tradition of consultative policymaking procedures (Jespersen, 2013), and more than 500 health professionals were involved in the development of the system prior to its implementation (Stenbæk, 2016). The system, which is described as “complex” and requiring “large changes,” was implemented in the hospitals of the two regions during 2016 and 2017 (Statsrevisorerne & Rigsrevisionen, 2017, p. 4). It replaces more than 30 larger and several smaller IT systems in the 20 regional hospitals and is seen as part of groundbreaking development in the hospital field to ensure a better integration of care (Danske Regioner, 2018).

Disputes over the platform kicked into high gear upon its first implementation in May 2016, when the group of consultant doctors, in particular, began to voice their criticisms through a range of regional and national media outlets. While several modifications and adjustments were made to the system as responses to some of the critiques (Hertzum & Ellingsen, 2019; Kristensen, 2019), disapproval has persevered and an overwhelming number of news items on the HP have been published in public media outlets. This impression of medical discontent was confirmed in a recent working climate survey, performed by the Capital Region, with participation of 15,000 staff, where 61% of medical staff responded that they were dissatisfied with the system compared to ‘only’ 36% of care assistants and nursing staff (Kristensen, 2019). The number should be assessed in relation to the fact that of the 15,000 users of the HP, only 3,437 are doctors (Kristensen, 2019).

### **Methodology: Constructing “the space of points of view”**

### ***Methodology and research epistemology***

The research is nested in Bourdieu's "structural constructivist" epistemology, which sees theory as inseparable from empirical research (Bourdieu, 1991, pp. 164-168). Discourse should thus be analysed as interlaced with its context by questioning the particular field; that is, the individuals and groups involved, the positions they occupy, and the stakes of the game (Bourdieu, 1991). I suggest that the field can beneficially be analysed as "a space of points of view" (Bourdieu, 1991; 1999, p. 3) to identify the dominant actors interested in the platform and to understand what is at stake for them in the debates on the HP. In the construction and analysis of this space, the term debate is used to denote the discursive presence of competing or conflicting points of view by interested agents whereby it emphasises framing as relationally constituted.

### ***Data collection***

To gain an understanding of the constellation of the space of points of view concerning the HP, secondary research was performed in the public media. It seems fair to assume that all substantial aspects of the platform debates are covered here in terms of major interests, positions, and discursive constructions by the involved parties (i.e., no new major aspects would be found by including social media, for example). In this, it is worth mentioning that Twitter, which enjoys widespread popularity in other national contexts, has never really caught on among the Danish public (Rossi et al., 2016). All publicly accessible media platforms were included in the study, including all national newspapers, regional newspapers, professional journals, the websites of the two regions and professional organisations, TV stations, and web-based journals and news outlets (See Blach-Ørsten & Burkal, 2014 for a brief outline of the Danish media landscape).

News items were located via the Danish information service, Infomedia, which links to all Danish newspapers, professional journals, and news agencies. Moreover, electronic articles were located via Google, and inspiration catalogues and news releases were located through the webpages of the two regions. To construct the wider context of the HP, the sample also includes national policy papers outlining strategies for the development of the health sector, reports from Danish medical authorities, fact sheets, regional policy papers, and strategy outlines as well as research articles.

The search term “the Health Platform” (Sundhedsplatformen) retrieved around 700 documents that were scanned for relevance according to whether or not they could contribute to an understanding of the research question—that is, if they conveyed the views of interested positions in the field, or could inform an analysis of the context of the debates, including the forces that structure the space of points of view concerning the HP (Bourdieu, 1999). The final data set included around 350 documents/articles. Table one provides an overview of the data material used.

Table 1 Data Material.

<b>Sources</b>	<b>Data material approximate weight (numbers in percent)</b>
National newspapers	68
Regional newspapers	6
Professional journals	5
Websites of regions and professional organizations	5
TV stations and web based media outlets	10
Policy papers and strategy outlines	3
Reports, facts sheets and research articles	3



## *Data analysis*

The final data set included around 350 documents/articles, and the research proceeded in three main steps. First, to understand how the HP has become the centre of debates, the documents were read guided by the questions: Why was it decided to implement a new and more comprehensive patient recording system? In which ways are EHR systems seen to support political goals for the healthcare sector? Why this EHR system? Through this process, I learned of the political currents that led to the recognition of healthcare IT as a significant problem, which ultimately prompted the decision to invest in a comprehensive EHR system, the choice of EPIC as the supplier, and finally, the process of implementing the HP.

The second step focused on identifying the main interested agents and groups in the debates—the main players in the space of points of view (Bourdieu, 1999). A wide range of agents and groups—including doctors, administrative staff of the regions, journalists, IT experts, researchers, regional and national politicians, nurses, patients, patient organisations, and members of Parliament (MPs)—were identified as active debaters and constructors of the HP in terms of its virtues and drawbacks, from its inception to Spring 2019. Working from the premise that the scope of media appearances—such as the number of appearances (e.g., in articles or commentaries) and the space (i.e., article length) provided to a group in the media—evidences the stakes this group has in the game (Bourdieu, 1998), consultant doctors, and politicians of the two regions, and, to a somewhat lesser degree, nurses were identified as occupying the main interested positions in the field. In accordance with the theoretical framework, the scope of media appearances is too seen as evidencing the amount of power and, thus, capital possessed by the group, which is the power to be heard and taken seriously by other agents in the field (Contandriopoulos et al., 2004). Specifically, while doctors and nurses are the two largest healthcare professional groups, the combination of “the Health Platform”

(Sundhedsplatformen) with “nurses” (sygeplejersker) yielded 237 results on Infomedia, whereas combining “Sundhedsplatformen” with “doctors” (læger) yielded 532 results.

Hence, consultant doctors and politicians from the two regions were identified as the main players in the debates—that is, in the ongoing constructions of the platform in the media—when they were either publishing their views directly or their perspectives were taken up by the media.

Third, in my construction of the space of points of view on the HP, I coded the data to gain an understanding of how the platform is discursively constructed by the main interested players in order to invoke public opinion (Contandriopoulos et al., 2004) on the platform. The data were first coded news item by news item and group by group, beginning with an inductive identification of codes that focused on how the HP was constructed. In this process, I followed the recommendations of Saldaña (2016) on inductive coding. Simultaneously, my coding was informed by my construction of the wider context of the HP to examine what is at stake in these constructions and how the main players are positioned and position themselves in the debates (Bourdieu, 1977a; Grant et al., 2005). This process allowed for identifying the classifications and representations of the platform that were used most often, and the concept of framing emerged as a useful analytical construct for understanding the performativity of this discourse. Inspired by Entman (1993) and Matthes and Kohring (2008), I focused on the relations between the codes and how they could be clustered into frames by assessing how particular aspects of the platform were evaluated and represented as salient by the main players—or from their perspectives—with the purpose of explaining the platform’s effects, defining or evaluating a problem, and/or suggesting solutions. The frames used most often by either group were then identified as having the greatest influence in the space of points of view on the HP. Thus, through patterns of repetition and similarity (Saldaña, 2016), robustness

(Matthes & Kohring, 2008) of four frames in total was ensured—two by the consultant doctors and two by the regions. Table two illustrates how the initial coding led to the frames constructed.

Table 2: Coding.

	<b>Data excerpt examples</b>	<b>Inductive codes used most often</b>	<b>Achieving a theoretical understanding with Bourdieu</b>	<b>Frames Constructed (see also table 3)</b>
<b>The regions</b>	‘The Heath Platform involves a break with the traditional picture of an authoritative doctor, sitting behind his desk, removed from the real-life situation of the patient’ ‘The patient at the centre of an integrated healthcare system’	‘A break with the authoritative doctor’  ‘Removed from the patient’  ‘The patient at the centre’	Power struggles concerning the position, capital and power of doctors in the healthcare field  The patient is at stake	The platform puts ‘The patient at the centre of care’
	‘We still believe in the Health Platform as the solution to the healthcare system of the future’. ‘We work hard at future proofing our healthcare system’	‘The healthcare system of the future’	The future tied to electronic ambition and progress → Capital	The HP as ‘future proof’
<b>Consultant doctors</b>	‘It is catastrophic that we still, in January 2019, cannot trust that the medication module will ensure that patients get the right medicine’	‘Cannot be trusted’  ‘Patients security at risk’	Positioning in relation to patients  Protecting medical professionalism and identity → capital	The HP as ‘dangerous for patients’
	‘It is the large amount of standard documentation that follows from the Health Platform. It is the time that doctors now spend with the computer instead of the patient . . . which, among other things, has been blamed for a decrease in productivity	‘The time we now spend’  ‘The computer rather than the patient at the centre’	Medical capital loss  Targeting ‘the patient at the centre of care’, which is at stake for all agents in the field	‘Time waste’ as a consequence of the HP

	in Zealand's hospitals of around 10 per cent. It's a time-waster. Many find that they treat significantly fewer patients than before'	'Productivity decrease'	Targeting the efficiency improvements that are at stake for the regions	
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The frames by the consultant doctors emphasise problems caused by the platform while the regions' frames emphasise the platform's opportunities and thus, the frames thrive in a relation of competition and opposition. This is not to say that no consultant doctors construct the HP favourably, but rather that the identified framings represent the dominant points of view held by the most dominant actors in the field. For example, to a limited degree the data showed that some medical specialisations view the platform in a more affirmative light than others because domains of work are differently affected by the platform. Similarly, there were slight divisions in the representation of the platform by the groups of regional politicians and administrators. The frames and their associated problem definitions, salient aspects, and suggested solutions are summarised in table three.

Table 3. Framings

	<b>Problem definitions</b>	<b>Aspects of the HP given salience</b>	<b>Frames constructed</b>	<b>Solutions suggested</b>
<b>The regions</b>	Problems to be solved with the HP:	Professions-oriented versus patient-oriented care	The platform puts 'The patient at the centre of care'	Keep the platform. Making it work is a question of time and patience
	Outmoded and disintegrated IT systems and outmoded professional practices that dislocate patients from the centre of care	Leaving past and outmoded IT practices behind. Embarking on the potentials of the HP	The HP as 'future proof'	
<b>Cons</b>	Problems caused by the HP:	A faulty medication module	The HP as 'dangerous for patients'	Abolish the platform – it has

	Obstructs good, efficient and safe care. Dislocates patients from the centre of care	Efficiency deficiencies	‘Time waste’ as a consequence of the HP	too many inbuilt errors
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In the following, the discursive struggles that allow the space of points of view to emerge are analysed by first focusing on the frames constructed by the regional actors, followed by an analysis of those constructed by the consultant doctors. The relation between the two and the constitution of the field are then discussed in the paper’s final section.

## Results

### *The patient at the centre of a future proof EHR system: The discursive constructions of regional agents*

The regions’ position in the hospital field is administrative and political in nature; their mandate relatively unstable because they depend on government support for their continued existence (Christiansen & Vrangbæk, 2018). The work of the regional councils is thus structured by the national political field. The representatives of the councils and their chairperson possess the “delegated capital” of political formal authority (Bourdieu, 1991, p. 194), being positioned as political leaders and representatives of the public and ultimately of the state. Thus, their power is subject to continuous negotiation because it resides in the relation between politicians and the public (Bourdieu, 1991). A core interest connected to this position is thus to maintain good relations with the electorate.

As part of the communication strategy, the regions’ communication specialists had constructed a “Core Narrative for the Health Platform” (Region Hovedstaden, 2017; Region Sjælland, 2017a), which was posted on the websites of both regions. The Core Narrative is

embedded in what can be seen as a grand narrative of healthcare progress, expressing current ideas and beliefs about the past and future of the sector and functioning as an umbrella for legitimate discourse on the political ambition of leading healthcare digitalization, among other goals (Sundheds- og Ældreministeriet, 2018). Grand future-oriented narratives are common means of promoting new digital technologies in the public sector (Plesner et al., 2018). In the Agreement on the Regions' Economy for 2019, digitalisation is emphasised as a progressive and competitive topic:

The Government and the Danish Regions agree that the financial agreements of recent years provide a solid foundation for further digitalisation of health services. [...].

Denmark is at the forefront of public sector digitalisation, and common public infrastructure solutions provide the basis for Denmark to continue digitalisation and provide good, secure and up-to-date digital services to citizens and businesses.

(Regeringen og Danske Regioner, 2018, p. 17).

This ambition is tied to a well-known aim of new public management-oriented reform to award the patient a more central role in hospital care (Jespersen, 2013; Nancarrow & Borthwick, 2005). This is described in policy papers issued by the National Board of Health (NBoH) and the Danish Regions, and is often coupled with the ambition of achieving integrated care, for instance, with “the patient at the centre of an integrated healthcare system” (Sundheds- og Ældreministeriet, 2011, p. 3).

As we will see, “the patient at the centre of care” is a classification adopted by the regions as a metaphoric framing, expressing the better perspective on care that breaks with professions-oriented care and the monopoly over areas of work achieved by the medical profession through history (Jespersen, 2013; Timmermans & Oh, 2010). Patient-centred care carries the attributes of legitimate political capital that safeguards the public's best interest.

This break with institutionalised ideas of work is embedded in the HP. For example, as part of its technical design or “DNA,” the platform imposes medical recording *during* patient consultations rather than *after* consultations have ended, as was done previously when doctors would dictate their observations to medical secretaries who recorded them (Statsrevisorerne & Rigsrevisionen, 2017; Stenbæk, 2016). The change represents a professional displacement of work and, importantly, it challenges the powerful position of consultant doctors and the common sense of work. The frame functions to justify the change when “the patient at the centre of care” is represented in opposition to traditional practice. This was explicitly addressed by one of the regional chairmen at the launch of the platform in 2016: “The Heath Platform involves a break with the traditional picture of an authoritative doctor, sitting behind his desk, removed from the real-life situation of the patient” (Stenbæk, 2016, p. 1).

Here, the chairman offers a scheme of classification (Bourdieu, 1991) in which traditional practice produces a gap between doctor and patient with the desk as a metaphoric frontier, and where the platform solves this problem by closing the gap. This framing of the platform is thus part of ongoing power struggles in the field concerning the relative strength of the positions of the state, politicians as the representatives of the state, and the medical professions.

The choice of the HP over alternatives can be linked to an ambition of performing a digital “quantum leap,” (Drachman & Davidson Nielsen, p. 4) but, to some extent, it can also be interpreted as a matter of rivalry with other regions that had recently invested in a less expensive and less comprehensive EHR system (Region Hovedstaden, 2015; Region Sjælland, 2017b). The choice of the HP is evidence of competition in the hospital field that relates to the national strategy of leading healthcare digitalisation. Another framing metaphor, “future proof,” contrasts the future with past and outmoded practices and technologies to construct a

representation of the HP as securing an ambitious state of future care. This construction of the HP is incorporated into the Core Narrative under the section, “future improvements with the Health Platform” (Region Sjælland, 2017a), where a before-and-after comparison of clinical practices and systems states that before (the HP) staff “wrote information on paper and typed into OPUS [a registration system] remotely from the patient” and “undertook initial assessments on paper sheets” (p.10).

The framing of “future proof” is used actively by the regions as exemplified in the following newspaper accounts, where the two chairmen of the councils stated that “We still believe in the Health Platform as the solution to the healthcare system of the future” (Hæstorp Andersen & Knudsen, 2018), and a leading member of the administration said “We work hard at future proofing our healthcare system” (Geday, 2017) in a response to the heavy criticism of the platform issued by the consultant doctors, in particular. This framing is thus focused simultaneously on beneficial prospects and the elimination of outmoded systems and practices such as the “analogous versus the digital” and “the bureaucratic versus the proximate,” where the latter explicitly aims to address the patient’s best interest.

The two regions have been charged with digital overambition in the debates. However, seen in a field perspective that highlights competition and struggle (Bourdieu, 1998), having to realise that the platform was the wrong choice would be a major drawback for the regional politicians and administrators and an envisaged and dreaded “IT scandal” (Vibjerg, 2016, p. 2) since so much political, administrative and economic capital has already been invested in the HP.

***Danger and a waste of time to the detriment of patients: The discursive constructions of consultant doctors***



Throughout history, the medical profession has occupied a privileged and powerful position in the hospital field. It is described as a “clan regime” that “builds on strong common values and traditions” (Mishra et al., 2012, p. 741). The profession is hierarchically organised with consultant doctors at the apex because, as specialists, they possess recognised expert knowledge (Mishra et al., 2012). This endows them with professional and symbolic capital in the field and formal as well as informal powers. The former resides in professional jurisdictions and thus in “the social contract with the state” (Timmermans & Oh, 2010, p. S95), while the latter inhabits the relation to the public as patients, supporting the special status of doctors. Moreover, the medical professions have a historical tradition for mobilisation through their associations (Jespersen, 2013; Nancarrow & Borthwick, 2005) which has provided them with considerable political capital in the field, implying a “natural” right to command attention in a manner that will leave an impression (Timmermans & Oh, 2010).

The consultant doctors participate in the debates from their organisationally-sanctioned positions as clinical leaders with concern for the welfare of their patients—a service ethic believed to be at the root of medical professionalism and identity (Mishra et al., 2012; Timmermans & Oh, 2010). The doctors’ discursive constructions of the platform predominantly begin with their experiences of its various effects in practice. Principally, they are constructed as competing or counter frames (Entman, 1993) to those of the two regions, as they define different problems and different solutions in accordance with the doctors’ interests in the platform.

A framing constructed by the doctors with direct reference to the service ethic is “dangerous for patients” (e.g. Steenberger, 2018). This is powerful in its direct appeal to the public and thus the electorate, who are represented as being in danger of mistreatment, and to professionals who are in danger of mistreating patients. “Dangerous” is connected to risk and

addresses the platform's medication module that apparently cannot be trusted to give the correct medicine in the right doses (Kristensen, 2019; Steenberger, 2018). The head of the Consultant Doctor Association in Denmark explains how doctors have to employ protective measures when prescribing medicine:

It is catastrophic that we still, in January 2019, cannot trust that the medication module will ensure that patients get the right medicine (Kristensen, 2019, p. 6).

Some ask the nurses to check if the medicine prescribed corresponds with the medicine prepared. Others work out paper lists to ensure agreement so that what is prescribed is also what is registered in the system. (Steenberger, 2018, p. 1).

The “dangerous for patients” frame invokes moral evaluation (Entman, 1993) and a feeling of temporal urgency since time delay may mean “lost lives or suffering patients” (Bernsen, 2018, p. 2; Drachman, 2019); thus, it addresses the core of medical professionalism, responsibility, and identity and the symbolic aspects of their professional capital.

While in situ recordings during patient consultations are proclaimed by the regions as progress in relation to patient-centred care, the computer screen is constructed by the consultant doctors in opposite terms as a barrier, cancelling vital functional capital attached to the HP by the regions: “The health platform delegates the patient to the side-lines when the doctor's attention is fixed on a computer screen” (Siim et al., 2018, p. 3). So, while the regions construct the desk as hindering good patient contact, the consultant doctors attribute this to the computer screen and thereby to the HP. In this way, they challenge the legitimacy of the regions' capital construction in relation to the platform.

Moreover, the doctors construct the platform as a “time waster,” countering the regions’ promises of more efficient care. As explained by a doctor who participated in the aforementioned survey:

It is the large amount of standard documentation that follows from the Health Platform.

It is the time that doctors now spend with the computer instead of the patient, which, among other things, has been blamed for a decrease in productivity in Zealand's

hospitals of around 10 per cent. It's a time-waster. (Kristensen, 2019, p. 6).

In this excerpt, a causal relation between documentation and the potential number of patients treated is established, and in their articulation of “time waste” as a frame, the doctors draw on a narrative established in the field, where standard documentation is constructed as a form of bureaucratisation that hinders efficient work and, thus, challenge the promised economic capital attributed to the platform by the regions.

However, more is at stake in the consultant doctors’ framings because, as mentioned, the doctors must now record care in situ via the computer. In an article, this is expressed by a doctor in a metaphoric version of the time waste frame: ‘We will be doing the secretaries’ work with two fingers.’ (Mølsted, 2016, p. 1). Nancarrow and Borthwick (2005) explain “vertical role substitution” as task delegations from one professional group to another, usually in a hierarchically downward mode: the medical profession delegates tasks to nurses, who might delegate tasks to nursing assistants, and so on. However, the HP delegates tasks from medical secretaries, residing at the bottom of the health professional hierarchy, to consultant doctors, who are at the apex. The consultant doctors complain that this form of task re-distribution is irrational because they are not trained to perform secretarial work (Kristensen, 2019; Mølsted & Falsing, 2017), indicating that they are trained for something larger than that (Håland, 2012; Timmermans & Oh, 2010). This is expressed in the following excerpt by the

Head of the Consultant Doctor Association in Denmark, speaking through the Danish Medical Association, who refers to the doctors' specialisation as something that the patient now loses: "All too often we spend time on tasks that, for example, the medical secretaries are much better at. In this way, time is removed from the patients that we are specialised in treating" (Lægeforeningen, 2019, para 5). Hence, the time waste frame, used by the consultant doctors to articulate loss for patients and society, can also be seen as an articulation of professional loss of capital that materialises symbolically and practically when the consultant doctors must do the work of medical secretaries.

By virtue of their framings which display anger, urgency, and misfortune, the doctors cast themselves as victims of a faulty platform through their patients and thereby through the public and the electorate, who are all in potential danger of mistreatment. The blame is commonly attributed to the administrative layers of the regions often called "djøfere" after the name of their association. The term is thus used to represent bureaucrats who are seen as the enemy of good medical practice. As one doctor said, "The system is made by Djøfere and will be completely annihilated" (Bernsen, 2018, p. 3, Samfund).

This quote is also illustrative of a development whereby the doctors' proposed solutions increasingly move from pleas and suggestions for adjustments and corrections (Hertz, 2017; Kristensen, 2019) to pleas for abolishment of the platform, as when the spokesperson for the consultant doctors in Region Zealand refers to the time-waste frame. "Scrap the Health Platform," this spokesperson said. "The platform is hopeless and a time-waster that extends doctors' work time to late at night" (Mortensen & Würtz, 2018, para 1).

The yearlong controversies concerning the HP have attracted government attention. In spring 2019, there was discussion of whether the system should be scrapped altogether, as a majority of MPs supported abolishing the system in favour of using one EHR system across all

five Danish regions. Included in the discussions was the potential abolition of the regions in favour of a new healthcare governance structure (Wittorff, 2019).

## **Discussion and conclusion**

While it is well known that new organisational technologies may produce tension and resistance among staff (Cho et al., 2008; Håland, 2012; Mishra et al., 2012), this paper argues that it is necessary to move beyond the analytical level of the organisation to understand the scope of complexities involved in technology-induced organisational change, particularly in the public sector. The study makes a scholarly contribution by demonstrating the importance of understanding how such change is deeply embedded in structural, political and cultural forces and interwoven in relations of power across groups and organisations and analytical levels. This understanding is achieved analytically by focusing on the debate and struggle over the HP as embedded in a discursive “space of points of view” (Bourdieu, 1999, p. 3). While it makes sense to see framings as dynamic interpretive processes rather than stable symbolic manifestations (Cornelissen & Werner, 2014), the results demonstrate that framings are practical and cultural achievements anchored in the forces that structure a field.

Developing this further, the paper identifies two dominant forces that structure the hospital field and, thus, the discursive constructions of the platform. First, the HP struggles are embedded in a competitive context where the regions as hospital owners strive to appear ambitious through their technology investments (Christiansen & Vrangbæk, 2018; Drachman & Davidsen Nielsen, 2018; Plesner et al., 2018). This aspect of field-level competitive pressure in relation to organisational technology is neglected in the literature and emerges in this article through Bourdieu’s concept of field as a space of competition for capital and position. Hence, ideology and political goals of the wider field, driving competition, are forces that structure the space of points of view. These forces manifest in the regional politicians’ definition of the

problems that the HP is envisioned to solve, and in their construction of the platform as “future proof” and “putting the patient at the centre of care.” The consultant doctors, on the other hand, define the HP as *the problem* when they construct it as the enemy of good, safe, and efficient care. Hence, through the counter framings of “dangerous for patients” and “time waste,” the second and important structuring force emerges from the debates, which concerns the consultant doctors’ traditional powerful position at the apex of the healthcare professional hierarchy and as clinical leaders that attend to the best interest of the patient, as well as their interest in restoring the status quo of this position.

Thus, contrary to the suggestion by Barrett and Stephens (2017) that health professionals’ perceptions of use rather than intentions embedded in technology design are pivotal for the success of technology implementation, this article demonstrates problems that emerge when platform design is used to legitimise a break with institutionalised professional hierarchy and practice. This also is discussed by Håland (2012) in relation to an EHR system, where consultant doctors must take over secretarial work. However, failing to connect these problems to the political system and historical relations in the field, she overlooks an important reason for doctors’ resistance. The threat to the privileged position of consultant doctors, which the HP incorporates, ignores what Bourdieu (1977a) terms “the hidden conditions” of the group (p. 650), which include material and symbolic manifestations of tradition, including the professional hierarchy as it materialises in work, the medical knowledge base, and the medical service ethic (Ernst & Jensen Schleiter, 2021; Mishra et al., 2012).

I suggest that this aspect of the struggles is of utmost importance when attempting to understand the conflictual situation surrounding the HP. While other healthcare groups are affected by the platform, the stakes are higher for the consultant doctors who are responsible for care and who suffer severe capital loss. The doctors use their powerful position to mobilise

discourse that can be seen as “heretical” in a Bourdieusian perspective because it challenges the official discourse on technology as progress, produced in the field of power and used by regional politicians and administrators. It is also a demonstration of heretical power because the doctors’ discourse becomes authorised by the public as supporters of their point of view and delegators of political capital (Bourdieu, 1977b, 1991). This allows the doctors to challenge the formal power of the regions in their position as hospital owners and employers.

The regions and the consultant doctors are then deeply involved in symbolic struggles in the media concerning the imposition of specific understandings of the HP. Both parties co-opt the discourse of “the patient at the centre of care” from new public management-inspired policy (Jespersen, 2013) to further their particular interests. Throughout history, public opinion has been the stake of political struggles in fields—“constructed, appropriated and used” in the words of Contandriopoulos et al. (2004, p. 1576). These authors describe how political power in the Quebec healthcare system is linked to the capacity to speak in the name of the public. Likewise, the present study demonstrates that the route to legitimation of the points of view on the HP, that materialise in the frames of either party, passes through the idea that patients’ best interests are at stake. Mobilising public interest in the HP is thus pivotal for achieving the aims of either party: continuation of the platform or its abolishment. Public media, positioned as legitimate mediators between decision makers and those in power and the public (Champagne, 2005), are used in these struggles, but are also actively using and co-constructing the debates when their journalists agree to continuously engage in the conflict from the points of view of either party.

Building on evidence in the literature concerning the potential transformative effects of framing practices in public media (e.g. Fredheim, 2020; Koon et al., 2016), this article thus argues that the discursive battles in public media expectedly influence public sentiment about

the HP and its ongoing organisational materialisation in terms of platform modifications and a potential phase-out. Although no definite conclusions on the state and future fate of the HP can be made, it seems likely that the consultant doctors have achieved a slight lead in the arm-wrestling struggles with the regions because their framing activities have been forceful enough to render the platform a national political issue. The struggles have caught the attention of the prime minister and the government parties, and the platform as well as the regions' *raison d'être* have been questioned.

This study contributes to scholarship in organisational discourse and management by showing how discourse concerning technology-induced organisational change crosses the boundary of the organisation when it is formulated, articulated, and contested by actors who have “the power to control discourse” (Grant et al., 2005, p. 8) and who are based within and beyond organisations. Thus, while framing has been described as an art and skill in leadership that concerns relations of power and depends on the motivation, intelligence, and charisma of the leader (Fairhurst, 2005), the local management of technology-driven change cannot be evaluated in isolation from field level forces and power structures. While this is an omitted aspect in studies of public sector organisational change and discourse, the study may be relevant for other sectors employing strong professions, for example, investment banking and law firms (Mishra et al., 2012).

Future studies can also add valuable perspectives to our understandings of organisational technology, and specifically the HP, by embarking on an ethnographic methodological approach to examine how the platform influences practice as experienced in situ by different health professional groups. With reference to the working climate survey of 2019 performed by the Capital Region (Kristensen 2019), it is striking that in comparison with the doctors, a much smaller number of nurses and care assistants expressed dissatisfaction with



the system. Therefore, including the perspectives of professional groups who have received and demanded less media attention would provide us with a fuller picture of HP reception.

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