

Anticipating organizational change – A positioning theory perspective

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**ANTICIPATING ORGANIZATIONAL CHANGE – A POSITIONING
THEORY PERSPECTIVE**

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ABSTRACT

This study is reporting on the extended period prior to implementation of the largest ever Health IT implementation in Denmark – Sundhedsplatformen. Preliminary analysis of data points to the need to take into consideration what I call the *anticipatory phase*. The study argues that the anticipatory pre-adoption phase is where individuals prepare for pending changes through positioning. It is as such an early stage where sensemaking is based e.g. on vague strategic messages from management, hear-say-information and experiences from the past IT implementations, rather than on factual and up-to date information about specific changes or concrete experience.

Keywords: Positioning, Organization, Change, Anticipation, HealthIT

INTRODUCTION

It is well established in Organization Studies that IT-implementations affect relationships in organizations (Barley, 1986; Orlikowski, 1992; Perrow, 1967) and that in order for IT implementations to be successful, the receiving organization needs to adapt (e.g. Burton-jones & Grange, 2013; Orlikowski, 2000).

A common trait of these and other studies is however a focus on completed implementations or the actual implementation process. While this is obviously relevant this paper argues that by focusing isolated on the experiences of the past and present an important phase in the total sensemaking cycle associated with implementations of new technology is missed. What about the future? What can be learned from peoples anticipations and the antenarratives (Boje, 1991, 2001) of the people on the receiving end of Health IT? It is not just the experiences from the past and possibilities of the present that forms people and their relationships. Time matter and possible futures influence people in the now.

Preliminary analysis of data from largest Health IT implementation in Denmark – Sundhedsplatformen - points to the need to take into consideration what I call the *anticipatory phase*. This study argues that the anticipatory pre-adoption phase is where individuals prepare for pending changes. It is as such an early stage where sensemaking (Weick, 1995) is based e.g. on vague strategic messages from management, hear-say-information and experiences from the past IT implementations, rather than on factual and up-to date information about specific changes or concrete experience.

The anticipatory pre-adoption phase consists of three distinct elements; Sensemaking, Positioning and Scripting the future, of which this paper is focused

on Positioning. Data indicates that Doctors, Nurses and Secretaries engage in preemptive positioning in what appears to be an effort to bolster existing bases of identity and power in the organization.

BACKGROUND

In 2012 Region Sealand and the Capital Region of Denmark agreed to initiate a joint project to upgrade the Health IT-infrastructure in the two regions. Sundhedsplatformen was envisioned as a shared HIT-infrastructure that will replace a large number of outdated and scattered IT systems with a common IT platform. This update has the potential to transform the health sector for the 2.5 mio. people in eastern Denmark. The two regions employ 44.000 people in the health sector including doctors, nurses, secretaries other clinical and administrative staff and an additional 9000 people in other non-health related areas.

This paper is focused on three main groups of clinical staff members – doctors, nurses and medical secretaries. They are the main actors in the clinical work at hospitals and they are all being affected by the coming change in technology. The three groups of employees also makes up the majority of clinicians appointed to partake in the work on Sundhedsplatformen.

A governing principle in development of Sundhedsplatformen and a keyword in the strategic goals of Sundhedsplatformen is *standardization*. Standardization is seen as an important way to ensure quality of care and treatment.

“To ensure a persistent high quality of treatment for all patients, the patient course must be planned and completed based on standardized workflows and documentation. The solution must support health personnel in;

- *Choosing the right treatment course for each patient*
- *Supporting in optimizing the planning of the treatment course*
- *Supporting the correct documentation of the completed treatment”*

(Sundhedsplatformen, Bilag 0, p.7).

The standardization also extends to the decision-making of the clinical staff.

“With intelligent knowledge based functionality the solution must support the health professionals in making the right decisions at the right time and to ensure that health personnel are continually notified about the need for corrective actions based on incoming results” (Sundhedsplatformen, Bilag 0, p.7).

The essence of the strategy can be summed up in saying that following the implementation of Sundhedsplatformen both decisions and actions will be supported/guided/dictated by standards in Sundhedsplatformen.

Sundhedsplatformen will prompt personnel to initiate certain actions and the subsequent documentation is also standardized and required to complete an activity. Treatment, care, planning and documentation, which constitutes the core of clinical work is essentially being standardized, which logically reduces the amount of autonomy afforded to the clinicians with regards to decision making and the practices of everyday work. The pending organizational change is in other words characterized by the tension between standardization and autonomy. Standardization of processes vs Autonomy of clinicians.

PROBLEM

This study is investigating how past experiences and anticipation of coming changes are forming and transforming perceptions and relationships amongst core clinical staff (doctors, nurses and medical secretaries). Particular focus is on how altering and standardization of decisions, actions, rights and responsibilities are affecting clinical staff members. The main question is;

- How does clinical staff interpret and react in anticipation of the new standardized Health IT?
 - How do the pending changes influence self-perception of individuals and perception of others amongst clinical staff members?

Behind the question is the fundamental premise, that in order to realize the potential of Sundhedsplatformen the long standing and institutionalized separation of duties and rights of doctors, nurses and secretaries must be redefined or renegotiated. In order to fit into the mold of the standardized Sundhedsplatformen both clinicians and their processes and procedures must change.

This paper is focused on the reactions to organizational development and change induced by pending implementations studied through the lens of Positioning Theory. It can as such be seen to answer the call made by Leonardi and Barley (2010) to investigate how “*various social construction processes come into play and entwine with the technology’s material properties, as well as with the existing social structure of the context in which it is used*” (Leonardi & Barley, 2010, pp. 5–6) .

THEORY

Leonardi and Barley (2010) has identified a pendulum-like tendency in organization studies, which has to do with the way focus shifts between IT studies and Organizations. This shift in focus has caused researchers to lose track of a main question – “*how is the shift to a computational infrastructure shaping the way people work and organize?*” (Leonardi & Barley, 2010, p. 3)

While this is closely related to the focus of this paper, it does however also point to an important difference. Leonardi and Barley asks about the specifics of work and organizing, whereas this study is about perceptions.

Leonardi and Barley (2010) identifies five distinct constructivist perspectives employed by authors in research of mutual influence of organization and IT. Perception, interpretation, appropriation, enactment, and alignment.

In the perception perspective *adoption* is described as the earliest phase of implementation. There is in other words nothing before 'adoption', which in light of the present study appears inadequate. By neglecting what I call the anticipatory phase, which is prior to adoption, the mental preparation that individuals inevitably engage in, even when change is merely lurking in the horizon, is missed. This study argues that the anticipatory pre-adoption phase is where individuals prepare for pending changes, by preemptively positioning themselves and others.

POSITIONING

Positioning Theory is defined as the “*study of local orders as ever-shifting patterns of mutual and contestable rights and obligations of speaking and acting*”(Harré & Langenhove, 1999, p. 1) which makes it an obvious analytical perspective of this study because the standardization of Sundhedsplatformen is exactly challenging the autonomy and institutionalized rights and obligations of clinical staff.

A position is defined as a “*cluster of generic personal attributes, structured in various ways, which imping's on the possibilities of interpersonal, intergroup and even intrapersonal action through some assignment of such rights, duties and obligations to an individual as are sustained by the cluster*” (Harré & Langenhove, 1999, p. 1).

A main concept in positioning theory is 'discourse' meaning the institutionalized use of language and language-like sign systems. Discursive practices in term are “*all the ways in which people actively produce social and psychological realities*” (Davies & Harré, 1990, p. 2) and as pointed out by Hollway, Davis and Harré also stresses the fact that discourses can compete with each other or they can create distinct and incompatible versions of reality. Discourse can be thought of as the language and the mental frame through which we make sense of the world we inhabit. Meaning cannot be created in a vacuum. Discourse cannot be escaped. Humans make sense through and with discourse.

In relation to this study and the focus on organizational implications of anticipation of new HIT it is interesting to note how discourse relates to the concept of identity. Frazer writes that “*'actors' understanding and experience of*

their social identity, the social world and their place in it, is discursively constructed. [...] their personal-social identity, can only be expressed and understood through the categories available to them in discourse.”(Frazier in Davies & Harré, 1990, p. 5). In essence, this means that one cannot be outside discourse, and since a dominant, institutionalized discourse is very hard to disrupt it becomes virtually impossible to ‘wipe the slate clean’ and establish new ways of thinking. No matter how desirable this may be, starting over in terms of organizational identities does not really seem to be an option.

Translated into the clinical setting one can say that the doctors, nurses and secretaries have no choice but to create their identities within the confines of the institutionalized discourse of the hospital. The dominant discourse makes it virtually impossible to ‘invent’ an identity associated with a position (and even more so with a role) that is too different from conventional positions. Attempts to do so would be considered improper, not acceptable or even unrealistic.

One of the main insights offered by positioning theory is that positions are relational. No matter what context an individual is in, an obtained position is always in relation to some other position. Harré and Langenhove comes with the example that in order for one to be positioned as ‘powerful’, someone else must be positioned as ‘powerless’. The position of powerful only exists in relation to the position of the opposite – powerless. This means that the position of self and other always implies the position of the opposite. Positions are relational. If an individual positions someone as old and expendable it implicitly positions him/herself or others as young and important.

An essential element of positioning and as such at the heart of the explanatory force in the positioning theory is the applicability in the description and analysis of social encounters through a repertoire of acts/actions that limit or constrain behavior in social situations. Harré and Moghaddan (2003, p. 4) distinguish between actions that are logically possible and those that are socially possible. An almost unlimited range of actions are logically possible, including a secretary taking a blood sample on a patient. For all practical purposes this is possible and would as such be considered logically possible. But taking the social context into consideration it is considered socially impossible.

A secretary taking a blood sample on a patient is not socially acceptable in the clinical context. The secretary does not have the right or duty to perform this act, as opposed to the nurse or the doctor whom both have the right and in certain situations the duty to perform the act. This example points to how “*a position implicitly limits how much of what is logically possible for a given person to say and do and is properly a part of that person’s repertoire of actions at a certain moment in a certain context, including other people*” (Harré & Moghaddan,

2003, p. 5). This implicitly means that the positioning of oneself or of someone else affects the repertoire of acts that are available.

In the same vein it is practically possible for a doctor to do the writing in electronic health record her/himself, but it may not be socially acceptable – to the doctor – because this traditionally is the responsibility of the secretary and as such not fitting or socially acceptable for the doctor.

METHOD

The data of the study can be split in two overall categories. The formal data primarily consists of interviews conducted with all three categories of clinical staff members. A total of 18 interview were conducted consisting of six interviews with doctors, six interviews with nurses and six interviews with secretaries. In addition to the interviews the second primary data source were ‘official’ documents e.g. about strategic direction and purpose of Sundhedsplatformen. The informal data is everything else, including conversations at lunch, atmosphere at events, remarks made at the coffee machine, or what Becker (1998) calls all the quick exchanges made while participating and observing ordinary activities. It is essentially all the stuff that makes up everyday life in the organization. The study is as such distinctly qualitative and data gathering and analysis is informed by grounded theory (Glaser & Strauss, 1967). The main data of the dissertation are the interviews conducted from the start of the project in September 2013 with additional interviews planned in connection with the first ‘go-live’ of Sundhedsplatformen in May 2016. In the following is an overview of the data of the study.

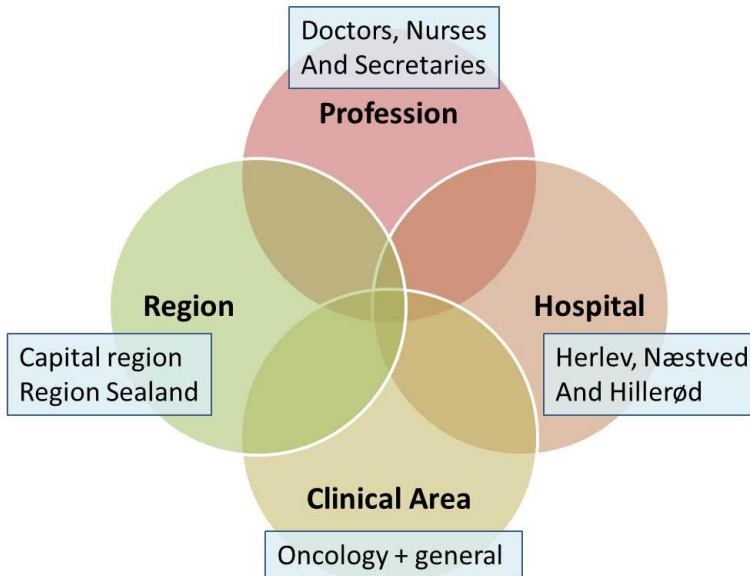
DATA

Selection of interviews for the research project was done taking into consideration four defining aspects of Sundhedsplatformen.

Sundhedsplatformen is implemented in two Regions. (1) Region Sealand and Capital Region. In the two regions are (2) 19 hospitals. The implementation will affect all employees to a greater or lesser degree, but have significant and direct effect on three major groups of employees at the hospitals; (3) Doctors, Nurses and Secretaries. And Sundhedsplatformen will affect (4) all clinical areas. These are the four dimensions taken into consideration in the research generally and specifically in relation to the selection of interviews.

Interviews are planned in order to ensure coverage across all dimensions. Sampling has been done in a way to ensure both coverage of one clinical area (Oncology) across hospitals and region and to ensure representation of several clinical areas in one hospital (Hillerød). Oncology was selected as a suitable and appropriate clinical area to focus on across hospitals/regions. One of the

characteristics of cancer treatment (Oncology) is the massive use of technology. Many aspects of the treatment course involve technology and the Oncology staff is used to using technology when dealing with patients and colleagues. The model below gives a visual representation of the sampling and the overlapping areas are where the variations are found;



The interviews of the study were conducted in four overall rounds. First round consisted of pilot interviews conducted in 2013. These interviews were open and explorative in nature and made possible through opportunity rather than deliberate planning. The main consideration was to ensure an interview with each of the three groups of clinicians. Three subsequent interview trips were completed offering more formalized data and to explore and refine the themes identified in the pilot interviews. Interviews were recorded as audio files and subsequently transcribed in Nvivo.

The interviews varied in length between 20 minutes and 1½ hour and were all conducted as open interviews consisting of two elements. First parts of the interview were focused on past experiences with HIT and technology implementations. Second part of the interview focused on expectations about the coming Sundhedsplatformen. As such the interviews were deliberately loosely structured allowing the interview to take the direction that manifested itself strongest in the situation. Interviews were initiated with an invitation tell about current job and the role of HealthIT. During the interviews interviewees were asked to elaborate on issues relating to past implementations of HIT and concerns about the pending implementation of Sundhedsplatformen. Another guiding principle in the interviews was to pursue relational aspects of technology

and technology implementations. During interviews the interviewees were encouraged to elaborate on relational aspects of technology use and implementations. This included questions about the involvement of other clinicians and causes of identified issues.

Of particular methodical importance and due to the terms of the PhD contract (working as part communication consultant and part PhD researcher) I came to enjoy the status as full organizational member and ordinary colleague at Sundhedsplatformen. I was in other words not an external observer but e.g. participated in department meeting representing communication and worked together with the other organizational members on equal terms.

As a researcher the status of *insider* is privileged. Rather than being an outsider trying to understand the inner workings of an organization I was part of the group. As such a significant source of knowledge about the health sector and Sundhedsplatformen stems from simply being part of the team and performing my duties on Sundhedsplatformen in collaboration with doctors, nurses and medical secretaries. Notes about events and observations have been made continuously, and in addition to this internal documents such as meeting minutes has served as valuable sources of insight.

In keeping with principles of grounded theory the study of Sundhedsplatformen has been a process of constant interaction between collection of data, coding in Nvivo and refinement of the theoretical apparatus. Gradually the main themes of the interviews has emerged out of the data and eventually crystalized into the themes below.

ANALYSIS

At first glance the list of thematic codes from the interviews may appear like a mixed bag of individual and organizational concerns. The interviews have been conducted with three different professions and the open interviews has explored past experience with technology and implementations and expectations about the future. A mixed bag is to be expected. On closer inspection however a pattern emerges. From an overall point of view the responses/themes can be split into four themes. Three themes are relating specifically to the pending implementations and a fourth category containing meta-themes relating to the hospital as an organizational setting and clinicians in broader terms. The four themes are;

1. Sensemaking (of change)
2. Positioning (as a way of coping)
3. Scripting the future
4. Meta-themes

Similarly to the sequential structure of sensemaking of Weick (1995) (Disruption, Bracketing, Resolution) and organizational change of Lewin (1947) (Unfreeze, Change, Refreeze) the themes above are sequentially structured, however without immediately presenting themselves as neatly structured narratives. In the interviews the elements more often emerge as fragments or clusters of arguments.

Sensemaking is happening when individuals are looking outward on what is transforming the organizational landscape. Individuals make sense of the pending changes by adjusting their inner organizational map taking into account the new features of the landscape. Positioning is happening when individuals are looking inwards in an effort to assess and renegotiate the ability of self and others to cope with and navigate the new organizational landscape.

If, in other words Sensemaking does not managed to protect the institutionalized rights and responsibilities of the group or individual adequately, positioning of self or others can help in securing these rights and responsibilities or alternatively identify a new / alternative position that offers equally attractive rights and responsibilities

By making sense and / or positioning self and others in desirable ways the ground is laid for scripting a future with a suitable position for one self. If on the other hand the individual has not managed to make sense of the changes in a way that leads to resolution or positioning self with desirable rights and responsibilities it can turn out to be virtually impossible to script a desirable future. Lack of future turns individuals into victims. In contrast a future based on a 'successful' sensemaking and on identification of a suitable position (either the same as now or a new one) leads to a brighter future with new possibilities.

This paper is reporting on the second theme - positioning which is identified as a way of coping with uncertainties caused by pending changes by positioning self and other favorably in relation to defining aspects. One such defining aspect is uniqueness. As is demonstrated below uniqueness is used position self and others amongst all three professions, but in very different ways. On the individual level, on department level and on profession level.

Uniqueness of profession

Uniqueness is being emphasized in different ways by the different professions.

A common way for doctors to position selves and thus implicitly others is to emphasize the uniqueness of the profession. They are well aware of the pending changes in technology and resulting consequences to work processes. The standardization will require them to enter notes directly into EHR's which has previously been done by secretaries. And while this may give rise to some

concern on a practical level, it does not pose a threat to the doctors self-perception.

The following sequence is an example of a doctor gradually becoming clearer about his own ideas as he talks (Weick, 1995). Various themes materialize in his reflections which appear as a case of thinking out loud in response to my question on possible future with Sundhedsplatformen.

(Interview, Doctor 1, [49])

Quote	Specific code / topic	Generalized theme
<i>' Well, if we are assuming that they are choosing the solution I hope for</i>	It is a technology project	Sensemaking
<i>' The essence of my job will not change, because there are still patients that needs to be healed or done less sick, but I think it will become a bit more fun'</i>	I am different/ unique and will not be affected. It is not going to make much difference to me because of the importance of my job. I heal patients, and no 'tool' is going to change that	Positioning
<i>'And I think it will change, or be significant in the introductory phase that it is young doctors who will be the experts, much more than the old doctors. It has never been like this before'</i>	Age matters - and unlike other colleagues I am not old	Positioning

Own translation of quotes

In one line of thought, the respondent use one premise and idea after the other as stepping stones in his own clarification of what he really thinks. He starts his thinking/clarification process with the importance of technology and moves through reflections about the importance/uniqueness of his own profession and his own personal position in the pending changes and ends up identifying age as one of the aspects that will play into the equation of implementation, adoption and organizational implications of the new technology.

From a positioning perspective the emphasis on his own uniqueness and the age of others is particularly interesting. By positioning himself as part of a special group of professionals other groups are implicitly being positioned as less special or unique. He is bolstering his own position as important. By stressing the uniqueness of the profession of the Doctor he is also implicitly pointing to the rights and obligations of his profession, which are seen as indisputable and

institutionalized beyond argument. He is implicitly arguing that no technology can threaten him.

The question of age is also important from a positioning perspective. By positioning some as old, he is implicitly positioning himself as young, and there for better able to cope with the pending changes. The age theme is also picked up by medical secretary in the example below;

Individual uniqueness

Similarly to what was observed in interview with Doctor1, Secretary1 uses the interview situation as a gradual move from initial sensemaking, through positioning to describing a possible future.

In contrast to the interview with Doctor1, the interview with secretary 1 is an example of how an individual is establishing the individual a unique. She stressed that because of her position as ‘flying secretary’ (a term used for secretaries that are moved around to various hospitals depending on local needs), IT Super User and employed by the local hospital management in relation to Sundhedsplatformen. The combination of the three areas making her perceive herself as a bit out of the ordinary. “*We (flying secretaries) have become a kind of consultant, who are able to go out into departments and clean things up*” (Interview Secretary 1 [32]). The uniqueness expressed by the medical secretary is however different from the uniqueness alluded to by the doctor above. She is talking about her own particular position and not the profession.

(Interview, Secretary 1, [6])

Quote	Specific code / topic	Generalized theme
<i>' [...] It seems to me that there are many who does still not realize what is happening in this project, and that it will fundamentally influence everyday practice '</i>	Uncertainty caused by pending change	Sensemaking
<i>'for the better according to me, but it will change so many work tasks. Particularly for the medical secretaries, because we are not going to do the things we are today. Not at all. '</i>	Uniqueness. I am different/ I can cope with the change	Positioning
<i>'So we have to go out and seize the labor market to find new tasks and perhaps get trained in new areas '</i>	Secretaries are required to break with traditional roles, through a rebellion against tradition	Scripting the future

Secretary1 explains how secretaries will have to go out and steal (jobs) and reinvent their own tasks and perhaps change the education of the medical secretary. *“Our profession drowns if we do not find something else to do”* (Interview Secretary 1 [44]).

The future foreseen / scripted by secretary1 also entails new requirements to new hires, when older colleagues, whom are not able to cope with the changes, are being ‘phased out’. *“[...] it is no use to hire a little scared lamb, if that person thinks that it is about a desk and just sit there and write. It is over!* (Interview Secretary 1 [43], own translation). As was the case with Doctor1 and Nurse1, Secretary 1 points to age as factor, but also the inexperience of new hires, which is yet another example of the indirect positioning of self as experienced and thus better able to cope with changes. Not everybody understands the implications of the changes that are coming.

Unlike the others, she has seen it coming and particularly seen the change coming for the secretaries. She herself sees it as a change for the better, which is once again a way of underlining her personal uniqueness. I am different. *“[...] it is no longer Mrs. Hansen who is sitting at her desk and pusse nusse [slang for cute but irrelevant activities] and this and that and writing all day. It is over!”* (Interview Secretary 1 [42], own translation).

Uniqueness of the collective

Similarly to the Doctor and the Secretary above the nurse is positioning herself as unique. This is however in yet another way, as it is an example of positioning takes place on a departmental / group level.

According to Nurse 1 the first important consequence of the coming Sundhedsplatform is that work related activities will likely be more controlled or dictated by procedures embedded in the technology than what is the case today. Procedures will be standardized, which will spark reaction. *”[...] some will come to ‘stritte’ [slang for resistance]. Well I think that we are going to be enormously controlled by this. You can pull out data drill down to what each individual are doing”* (Interview Nurse 1, [2], own translation).

The same theme later in the interview;

”Specifically the older generation or those with a bit more experience, I think will have a problem being guided through the system that dictates the sequence of your activities and how to do things, and when to do them ” (Interview Nurse 1, [12] own translation).

First of all it is interesting to identify who the *some* referred to above are? It does not appear to be someone other than herself since in later sequences she is

referring to us, with reference to nurses in the department. It does in other words not appear to be an example of the uniqueness of the profession as observed in interview with Doctor 1 or the uniqueness of the individual as seen in the case of the secretary. It is an example of Uniqueness related to the collective of nurses in the department.

Another interesting detail of this passage has got to do with the specific wording of the consequence. Nurse1 is refereeing to it as 'stritte', meaning that it will cause peoples hackles to rise. She is presenting it as a natural reaction that one can do very little to fight. It is in other words not a matter of active resistance but almost an instinct like reaction, which one cannot be blamed for. Implicitly in this view of the order of the medical ward and the life of a nurse is an understanding of how things should be or even how they are at a quite fundamental level. It appears that the independence and individuality of the nurses in how the nurses go about doing their job is seen as essential. This cannot or should not be changed by procedures dictated by new technology, which becomes clear the following passage.

"I actually think that what will happen is that we will use the system as we can, and then we will go beyond it. We will not use the function that are offered – not initially anyway" (Interview Nurse 1, [22], own translation).

Nurse1 is not saying that they will not use the new system, only that it will be used in their own way. They will go beyond the system – turn in another direction. This is an example of how the uniqueness of the nurses is presented and how their special circumstances require or even forces them to find a way to deal with the change. By going their own way they cope with the change and get on with the job. Autonomy is maintained despite the inevitable standardization of Sundhedsplatformen.

SUMMARY OF UNIQUENESS AS POSITION

As the examples from the three professions above illustrate, positioning-as-unique is a pervasive coping strategy in the anticipation of organizational change. The uniqueness is different depending on the current position but is a uniform reaction in defense of rights and responsibilities or pursuit of new ones.

Doctors defend their position referring to the uniqueness of the tasks they perform. "The acts that I perform are so important that a new stage prop/technology does not really change anything"

Nurses find ways to circumvent the new technology and thus to evade the intrusive character of the new technology. "If it does not fit with how we do things, we will find ways around it."

Secretaries seem to know that their role is undergoing more fundamental changes and are searching for new positions or to redefine the performance of their current role to stay in the play. “Well, we might have to pick up some of the acts of the other players”. In the positioning terminology one can say that they are on the lookout for new rights and responsibilities to create a new and viable position around.

CONCLUSION - STANDARDIZATION VS. AUTONOMY

The efforts described above by clinical staff to position themselves in preparation of the pending HIT implementation are examples and symptoms of a more general organizational struggle. On the one hand it is a struggle between the demand for standardization driven by Sundhedsplatformen and deeply engrained desire to main autonomy amongst clinicians. On the other hand the struggle has to do with the relationship between the individual and the collective. Traditionally doctors have been individualistic experts curing the patients as opposed to nurses who have been part of a group of nurses caring for the patients. Both groups however have enjoyed a high degree of autonomy with regards to planning and execution of tasks.

With the introduction of Sundhedsplatformen the autonomy is under attack by standardization required by the technology in order to realize its potential.

New technologies standardize areas of work and organizational life that has previously been domains of autonomous professionals. Therefore new technology demands redefinition of selves and renegotiation of rights and responsibilities that has previously been taken for granted.

This study indicates that resistance to change may better be understood as a resistance to having to give up institutionalized rights and responsibilities, which in term means that the key to understanding the complexity involved in organizational change is to understand how the rights and responsibilities of individuals are affected. Coping strategies essentially has to do with maintaining a desired position that incorporates the reality of Sundhedsplatformen.

Further research should investigating patterns of rights and responsibilities in health organizations specifically and organizations generally. Better insights into how organizational members protect and renegotiate right and responsibilities through inter- and intrapersonal positioning can aid in IT implementations that take into account the individuals that are affected.

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