Political and moralising moments: on visions of IT in Danish health care

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Abstract *In this paper, we discuss the production of visions for IT in Danish health care. Visions are not propagated "from above" but are produced through translation processes, in which contents change as they are inscribed in ministerial reports, leaflets or recommendations. This is illustrated by two cases: the electronic patient record at Hvidovre Hospital (HVEPS) and the Digital Doctor Project (DDP). Following STS-studies we propose to analyse such reports as material agents with distinctive capacities and features. Prominent among those is the ability of such reports to carry "contradictory" messages. We analyse this capacity as a strength as it enables reports to bind together various people in various contexts, rather than as a weakness. We propose the concept of political moment as a tool that can capture the material heterogeneity and the unexpectedness of translations. The concept of moralising moment is introduced to identify accounts in which such processes are glossed or covered.*

Introduction

> Modern information technologies are penetrating all parts of societal life, changing organisations and types of work at an accelerating pace. Skilled use of the new possibilities is becoming more and more decisive for the competitiveness of the companies, and for the ability of the public sector to provide good service of high quality for the citizens at manageable expenses. This development also affects the medical sector to a great extent. Data communication and electronic health care records are going to become increasingly important in daily work life (Danish Minister of Health, Sundhedsministeriet, 1996, preface).

In Denmark, like in many other Western European countries, information technology (IT) coupled with "new" administrative ideas are thus presented as the cure for "sick" health care sectors.

How should one understand such pronouncements? In the following we propose to analyse ministry leaflets and policy recommendations as a kind of "genre" with specific properties. Following STS-studies we view the paper trail of reports not as inert matter propagating visions from "above" but as material agents enrolled in the work of producing, negotiating and stabilising visions of health care (Berg and Timmermans, 2000; Clarke and Olesen, 1999; Latour 1992; Mol, 1998; Timmermans and Berg, 1997).

We are particularly interested in the moments when arguments seem to get "a life of their own". If arguments sometimes seem to "speak for themselves", we are interested in the materially heterogeneous work that makes this possible. We are interested in the production and stabilisation of argumentative agency, and how it manages to bind together various people in various contexts.

From this point of view, it is impertinent to keep up an analytical split between, for instance, new administrative ideas, such as NPM, new technological systems, such as the electronic patient record, and the local wards that are supposed to take over these ideas and technologies (Bentsen *et al.*, 1999). Instead, we view these entities as composed in a (more or less) seamless web, in which the social, the technical, the material, the symbolic, and the discursive are relationally defined and constituted (Hughes, 1983; Bijker, 1992; Callon and Law, 1995).

The question we deal with in this paper is how to conceptualise politics, if political efficacy is not solely a matter of human activity. How can politics be understood, if what is traditionally seen as the political proper, is only one part of an intertwining of humans, technologies and discourses? Below we develop notions of what we term political and moralising moments as some "tools" that can be used to articulate invisible political processes in the web of health care and ITs.

We exemplify the use of these concepts through two case studies. The first case is the HVEPS project (Hvidovre Hospital Elektronisk Patient Journal System), carried out from early 1994 to 1996, in order to expose so-called "necessary user needs" for an integrated electronic patient record at a major Danish hospital. Our second case is the digital doctor project (DDP), which took off in July 1999. This group, initiated by the Danish Board of Technology, had the explicit aim of imagining enhancements of the future of Danish general practitioners (GP) practices by means of IT. The group was to arrange a workshop and a conference, write a collection of visionary essays, and formulate an "action plan" for government use.

In conclusion, we discuss the possible purchase of adopting a vocabulary of political and moralising moments, in order to specify areas of invisible techno-politics (Star, 1991; Star and Strauss, 1999; Wagner, 1993) inscribed in official evaluations and recommendations.

Political and moralising moments
We deploy the notions of political and moralising moments as an attempt to displace the divides between discourse and practice, social and material or technical and symbolic. Instead, we view politics as criss-crossing these domains. Following Latour, we understand politics as having to do with the negotiation and translation of the goals or interests of networks (Latour, 1994).

Negotiations do not take place between human actors only. Material agents displace the intentions of those that delegate actions to them (Latour, 1988, 1999). Thus, texts are misunderstood, doors jam or parachutes do not open. In

the political domain this problem often remains unthematised. The political work of negotiating with and through material actors often remains invisible.

It is this work we want to make explicit with the notion of political moments. Since political moments span categories technical, linguistic, scientific and political, they are part of what Latour (1993) has called the work of hybridisation. The hybrid character makes it impossible to capture with ready-made modern categories.

Political moments can be understood as events that allow work to go on through unexpected re-definitions or translations of situations. As events, political moments are always unexpected or, in a sense, untimely. They come, Steve Brown suggests (pers. comm), from "outside the existing system of thought". Our endeavour has to do with enabling us to theoretically match the complexity found in practice as events take place.

Often this complexity is glossed or reduced by means of common sense or theory. When this happens we talk of moralising moments. These are part of what Latour has called the work of purification (Latour, 1993), which cut the world (or the network) (Strathern, 1995) up in specific pre-defined ways, and attribute efficacy or agency of particular types according to this distribution.

Moralising moments are often highly visible, even explicitly on display, but are of little use when trying to affect change in real-time action. We claim they are also of little help when trying to theorise technologically mediated social activity. In a Nietzschean phrase they are the reactive counterparts to the proliferating, if invisible, activity of moments (Deleuze, 1983); if reactive, moralising moments are nevertheless practically effective. As the pragmatist's so-called Thomas theorem suggests: if something is believed in, then it is real in its consequences.

An example: distributed accountability

To flesh out these notions a bit more we turn to "History 2.0: performing the past in the context of electronic archives" (Brown and Lightfoot, 1999). They discuss the many organisational uses of e-mail. E-mails prove to be highly political devices, that can be "switched on" through such techniques as copying-in, blind-copying and keeping local archives of mails, in order to be able to "perform the past" in specific ways if accountability is challenged. The possibilities of e-mail redefine organisational accountability: through a specific sort of technical mediation, an un-thematised political moment has occurred.

Brown and Lightfoot's (1999) analysis does not stop there. Rather it goes on to show how this change of accountability is only functional up to a certain organisational level. Accountability has an exteriority:

> What emerges in the course of the extract is that very senior meetings, the places where big decisions are made, are rarely minuted. This is felt to be "absolutely unnecessary". The reasons for this as they are mobilised by the manager in question are interesting. At that level "you are basically colleagues together", which is to say that matters of routine accountability are on a very different footing. One is not expected to have to mobilise extensive evidence to defend one's position (Brown and Lightfoot, 1999).

In Brown and Lightfoot's (1999) story, a network has been built that is strong enough for the senior manager's room to seem to emanate power. The room works as a local blank spot, in which actors are temporarily unaffected by power mutations, since they are not held accountable. Along with the analysis of how e-mail reconstructs organisational politics goes an analysis of how a specific place is constituted where accountability is unnecessary. This is the recovery of another political moment. To capture political moments is to show how power and accountability becomes distributed (see also Casey, 1997, p. 311) throughout the organisation, by means of translations through material agents such as e-mail systems or meeting rooms. In contrast, moralising moments are constructed by any narrative viewing power and accountability as posited according to a specific organisational typology (powerless workers, powerful management), while ignoring the material conditions shaping and stabilising them.

Thus, political moments are determinable only through an analytical process of reconstructing translations taking place across diverse materialities. This is because these moments happen when modern categories are traversed, and therefore must be viewed as effects of entire networks, rather than as decisions made by intentional human subjects (see e.g. Haraway, 1995).

Dynamics of political and moralising moments
Following Brown and Lightfoot, it could be suggested that theoretical and practical recognition of political moments can take place only if it is acknowledged that discursive statements, propositions or visions are always translated as they are transferred. When this goes unrecognised we enter the domain of moralising moments. We use the term moralising moments became they reduce the actual heterogeneity of practice to simple explanatory schemes (such as the inevitable progress of technology), which ratify specific taken-for-granted courses of action.

But moralising moments are themselves part of translation processes. For instance, in the HVEPS-report, the descriptions of "enormous possibilities" of IT in health care co-exist with the acknowledgement of the many contingent problems that must be solved for them to be actualised. This makes it impossible to posit political moments against moralising moments in a dichotomy. Rather than as a typology of good versus bad politics we view these sorts of moments as markers in continually ongoing processes of everyday practice.

Sites of articulation
In the following we examine two different interdisciplinary working groups within the Danish health care services with the aim of explicating political and moralising moments[1]. In both cases these were effected in part through the inscription in evaluative reports, although the consequences of the inscription varied.

The focus of the first group, HVEPS was on how to implement an information system at a major Danish hospital. The second group worked on a more theoretical and abstract level with the aim of generating ideas for an intensified use of IT among GPs.

The empirical backbone of our analysis consists of publicly accessible articles and reports, on the work, considerations and conclusions of the two work groups. Furthermore, Winthereik carried out participant observation at four out of a total of six meetings at the DDP, as well as at a workshop and a conference. This participation took place from summer 1999 to December 2000.

Planning the implementation of IT: the HVEPS project

Hvidovre Hospital, home of the HVEPS project, is a large and modern hospital. Situated in the Copenhagen area, it has around 1,000 beds, 4,000 employees and an annual budget approximating 1.3 billion Danish Crowns (DSI Rapport 96.05, 1996, p. 33). The hospital also prides itself on its advanced technology use in areas such as "diagnosis, patient care, registration, transport and communication" (DSI Rapport 96.05, 1996, p. 33).

The HVEPS project was carried out from early 1994 to early 1996, at Hvidovre Hospital in Copenhagen. The intent of the project, which resulted in a report (DSI Rapport 96.05, 1996, p. 9)[2], was expressed in the following way:

> . . . with the primary purpose of exposing necessary user needs for the electronic patient record, based on a practical pilot test.

The process of uncovering these needs are recalled in four steps in the report: an analytic phase, an accumulation of experience of "EPR-aspects", experiences with the pilot test, and recommendations for further EPR development.

In 1993, it was realised that a scattering of initiatives having to do with the EPR were taking place at various wards at Hvidovre Hospital. This acknowledgement led to the appointment of an interdisciplinary working group with the purpose of uncovering advantages and disadvantages with the introduction of an EPR at the hospital. The working group consisted of doctors, nurses, technicians, a secretary and a representative of the administration (DSI Rapport 96.05, 1996, pp. 33-4). The group went on to develop an "in principle" model of the EPR. In the model, the record itself was to function as a "gateway", integrating the various existing subsystems. Subsystems to be integrated included "intensive monitoring", "lab data", "X-rays" and "record data" (DSI Rapport 96.05, 1996, p. 34).

The development of this visionary model marked the end of the preliminary work of the group, and the next considerations had to do with the possibilities for actualising the "in-principle" model.

On this background, a co-operative effort started in the spring of 1994, between Hvidovre Hospital and the DSI Institute (Danish Institute for Health Services Research), economically supported by the Danish Ministry of Health. DSI is an independent non-profit research institute. One of its concerns has been the development of health informatics in Denmark:

In many ways, informatics is the prerequisite and the tool for the current adaptation of the organisation and quality development of the health sector to environmental changes. Health informatics is therefore closely linked to DSI's activities within the development of databases for clinical quality (from http://www.dsi.dk/frz_key.htm).

The Ministry of Health supported the project as a part of the national initiative HEP (Action Plan for Electronic Patient Record)[3]. The purpose was to create a basis for the development of the electronic health care record in Denmark. In early 1995, HVEPS was one of 14 such projects.

In the actual implementation process the "in-principle" model and its vision of a seamless work practice had to be compromised for at least two reasons. First, there was an economical compromise rendering it impossible to carry out the initiative at more than a single ward. Second, there was a technical compromise. It turned out that the structural model made "in-house" by the working group was based on technological assumptions that could not be fulfilled by any existing technology at the time. An agreement was made that the Belgian Health one system could be provided for free and used throughout the project, but should not be technically evaluated.

In light of the diminished scope of HVEPS and the problems it was marred by, it is noteworthy that the hopes invigorated by the project were not only virtually untainted, but scaled up, when conclusions were made in the report:

> The HVEPS project has fully shown that the challenges of introducing EPR can hardly be underestimated, but also that the perspectives in this technology are no less than enormous (DSI Rapport 96.05, 1996, p. 7).

Our short description shows a number of re-definitions or translations of the HVEPS project. If the first move was to gather all the EPR resources from many small groups to one centralised, then the second was to formulate a possible vision for the use of IT in the hospital at large. But since the visions did not sustain themselves, and neither money nor technological solutions were as forthcoming as expected, a third moment of translation took place. Here, the project was distributed back to a single ward again. This could have led to the question of how much it was possible to generalise from the pilot project to the overall hospital, or other specific wards but did not seem to do so.

Considering the complex story of iterative trials and errors in the pilot project as it is narrated in the report and the small gains in functionality and instrumentality that this work led to, the enthusiastic conclusion referred to above seems remarkable. It could seem as if extra work was needed to maintain the plausibility of the EPR in the face of continual difficulties.

We have characterised political moments by their relation to the unexpected. We also suggested that this characteristic unpredictability stems from the cross-over of modern categories, such as discourse and materiality. In the HVEPS project we find a central political moment in the translation of the project from large and "in-principle", to actual but limited to a single ward. The down-scaling of the actual implementation process allowed for the up-scaling

of expectation. But this was not solely a discursive phenomenon, since it had to do with economy, organisational issues:

> ... it is important to choose a ward which is stable concerning tasks and staff (DSI Rapport 96.05, 1996, p. 14) and technologies (such as Health one).

The specific events that constituted HVEPS were the net-result or effect of all the particular re-definitions these entities deployed. Undoubtedly a serious learning process took place at the chosen ward. But the point is that the particulars of this process could not have been planned beforehand: possibilities and hindrances were only visible in retrospect. Political moments can therefore only be "caught" in action, and it is unhelpful to rationalise this contingency away. To do so is to ignore the amount of work the construction of such a network would take. It is also to ignore the many negotiations between human actors as well as technologies that would continually work to re-define the system.

Historian of science, Geoff Bowker, analyses an analogous situation in the context of designing biodiversity systems:

> ... integration cannot in principle be smoothly accomplished ... [A]nd ... data cannot be collected without making politically charged decisions (Bowker, 2000).

When discourses refer to the necessity, need or inevitability of specific types of standardisation, and thus efface Bowker's politically charged decisions, we view them as moralising[4].

This can be illustrated with a formulation by a member of the sixth office of the National Board of Health, which was particularly relevant to the HVEPS project, because they were (and are) in charge of the development of semantic standards for the electronic health care record in Denmark (DSI Rapport 96.05, 1996, pp. 70-1; DS-Hæfte 4, 1995, p. 5).

Faced with the heterogeneity of discourses and notions of what such a standardisation might entail, he is led not to question the idea of creating a general consensual language, applicable throughout Danish primary health care, but rather to define the standardisation process as ever more inclusive: more words and definitions can be added at will: "nobody will be missing language" (Hagel, 1998).

IT in the primary sector: the DDP

The DDP was initiated by the Danish Board of Technology (DBT) in mid-1998. The main theme of investigation was decision-support systems, and the sector to be zoomed in on became primary health care, which was already "relatively IT-advanced" according to the project managers.

The project was defined by the project managers as an exploration of solutions to the needs of GPs that should promote the quality and continuity of care given in Danish GP clinics. Like in the HVEPS project, user needs were central as "elements" that should be identified in advance. The exploration was

to take place through an interdisciplinary group study, which was to conduct meetings and participate in a workshop and a conference.

Representatives from eight different institutions were invited to participate in a number of meetings. Among these were representatives from DSI (Institute for Hospital Research), The National Board of Health and the GP association (PLO). The specific focus on decision support did not last long. During one of the first meetings an American expert system was demonstrated, and it was agreed that since decision support would be only a tiny part of the use of IT in primary care, there was no reason to restrict the project focus to this technology. It was suggested that since technological possibilities for creating good experts systems already existed, such systems would be adopted in the practices sooner or later anyway. Thus the workgroups decided to widen the scope of exploration to encompass the use of codes and online booking from patients' homes.

This investigation turned out to be problematic since it could not be carried out without consideration of any number of factors "external" to the explorations, such as the relation between GPs and the National Health Service, or GPs and the National Board of Health. Thus, historically "ingrained" organisational and political issues set restraints that were not easily compatible with medical visions of the future with IT. These underlying issues made visible the fact that no unitary conceptualisation existed for the future of IT in GPs' practices, and that there were serious divergences between the GPs self-understanding and how they were understood by the rest of the participants.

At the first meeting, the two GPs in the group were asked to make an account of the ways in which IT would be able to support daily work in their clinics. The GPs emphasised that the communication between clinics and hospitals could be made better and more efficient, and presented suggestions as to how this could be done. It was, for example, stressed that all hospitals should start sending discharge letters electronically, and that there needed to be a higher degree of uniformity with regards to content. According to the GPs, IT could also be of use for communication between the various GP practices. The implication of this was that the GPs did not have to change their main tasks, but would basically still work as "gatekeepers" to other health care services.

During the following meetings, a number of issues were discussed but two main topics stood out. The first had to do with the demands made on GPs by the National Health Insurance, the second with the development of standards. The main arguments were that it would become more and more important to measure the performance of GPs in order to ensure the quality of care[5]. IT could be of central importance for such monitoring since coded patient data could form the backbone of comparing the performance in primary care. Second, it was argued that to ensure a higher degree of structuring of the information exchange between hospitals and GPs, the GPs would have to use codes as a part of their clinical work. According to the representative from the National Board of Health it was very important that the GPs themselves made

specifications for coding. Otherwise the GPs had to expect that "the rules of the game would be made centrally".

At this point, a number of GPs were invited to participate in a workshop to further the discussion on needs. Approximately 30 GPs took part in a computer-mediated discussion session, which focused on a number of topics in relation to the aforementioned themes. However, in the subsequent evaluation on the workshop by the study group, what was focused on was primarily the scepticism GPs showed toward the use of codes. In the understanding of GP's the use of codes would lower the level of service since the time spent on coding would be taken from the patient. Accordingly, the use of codes could have little purpose other than enabling actors outside the clinic (the association of counties and the National Board of Health) to be able to carry out a higher degree of surveillance.

From this perspective nothing was wrong with standardising work routines to ensure better communication between the primary and the secondary sector. But this should not pose a threat to the content of clinical work (understood as the personal interaction between the GP and an individual patient). The rest of the participants in the DDP group were opposed to this view and wanted the GPs to be interested in specifications. In their view, standardisation of concepts (and the use of codes) could very well be seen as independent of the standardisation of work routines. What was at stake was related to the self-image of GPs as referring – as fulfilling a gate-keeper function[6]. According to the GPs, intensification of the use of IT should not imply a change of that role. To other participants precisely such change was crucial.

To "non-GPs" the future image of the GP was not a gate-keeper, but a "spider in a web" – an information manager. The envisioned GP would collect the necessary information by means of his access to, for example, clinical databases. This envisioned GP would be able to treat the patient on the basis of knowledge made accessible by IT. Coding became crucial, since the GP could only take on the role of the information manager if he was willing to provide those who maintained the databases with complete information of his performances in the clinic. These conflicting images of the GP translated into a third image in the document that contained ten recommendations for the parliament that was produced at the end of the project.

How was this document constructed? Participants were to each write a "visionary essay" on the future use of IT in primary health care. A science journalist was hired to support the writing of the essays. In fact most ideas were transformed in the process, as the journalist made them more publicly "edible", and less "technical". The change in genre from the writing of GPs to journalistic writing thus carried its own translation process. This is indicated in particular by the most "praised" of these essays, which was "so visionary" that the journalist hardly needed to re-write it. This essay contained a description of the GP-patient relationship in 2005, in which the GP monitored the patient and her family from his computer, and used e-mail to deliver

information and send reminders. In this scenario, the visionary content was high while the focus on the practical problems of implementing IT system in the sector was downplayed.

The ten recommendations were eventually presented to a committee under the Ministry of Health. In these the present situation was characterised by a general "lack of good quality service, and the best treatment possible", and it was argued that the right documents were often not available to the involved health care providers at the right time[7]. The health services were not seen as functioning to an extent where good service could be provided for all patients. The solution to this predicament was a coherent use of IT in the health care sector. Coherence and integration of various systems would ensure faster and more flexible access to the necessary information when it was needed. Furthermore it was argued that:

> ... if the health care sector does not succeed in jumping at these new opportunities, it would be increasingly difficult for the general practices to keep its position as the supplier of advice and knowledge to the Danish population.

As in HVEPS, a number of translations happened during the course of the DDP, however, the specific nature of the translations were different. The first translation transformed the subject matter which the group was expected to discuss, from decision support systems to a focus on how to develop standards and coding procedures. A political moment arose as questions of GP identity, the value of the present organisation of GP work, and autonomy and integration between sectors were discussed. The second translation changed the focus on the needs of the GP to a focus on the needs of patients. Like in the HVEPS project, user needs were central. However, the moment the gap between the professional became too wide, needs were translated from referring to GPs to referring to patients.

Within our frame, this translation work indicates that the DDP may be understood as a project carrying invisible political weight: political moments are decipherable by following the series of translations we have pointed at. These include not least the construction of visionary essays, the results of which could be re-translated in the end document in a definition of GPs as "suppliers of specialised knowledge". While it would have been difficult to agree that the "specialised GP" was the right definition of GPs, this became possible by means of a detour through the genre of "science journalism".

Translating visions

> The enjoyment of the thing itself is thus undermined in its act and in its essence, by frustration. One cannot therefore say that it has an essence or an act. Something promises itself as it escapes, gives itself as it moves away, and, strictly speaking, it cannot even be called presence (Derrida, 1976, p. 154).

We have illustrated our notion of political and moralising moments by the work of two working groups in the Danish health care system. In HVEPS the

size of the project diminished, but this allowed the pronouncements made on the background of it to enlarge. Throughout the official HVEPS report this fact emerges in the uneasy tension of various statements:

> User responses confirm that EHCR can drain personnel resources initially. It has not been easy to see where any time has been saved. However, over the long term, everyone can see the advantages of introducing an EHCR system. The project was subject to heavy time pressure. For example, it was difficult to incorporate the instruction needed – considered insufficient from the start – into daily work. Information was not what it could have been either, which again influenced motivation and commitment. In contrast, technical support was unimpeachable, and helped shore up enthusiasm for the project (DSI Rapport 96.05, 1996, pp. 21-2).

In this bit of analysis it is very hard for the authors to simultaneously emphasise the relevance of the project and acknowledge the problems it was marred by: "the enjoyment of the thing itself is thus undermined by frustration". The work of translation seems painful to articulate but, in spite of this, the authors of the report suggested that the prospective benefits of using more IT at hospitals were "no less than enormous".

HVEPS presented itself as a success but as we have indicated such an interpretation is not self-evident. Rather, it would seem that the specifics of the project was felt as annoying, lacking resources, time and information (technical support aside). Projection into a future in which these practical contingencies were solved, allowed optimism to endure. Thus, the HVEPS report constructed a specific vision of the future of hospital health care, backed by IT.

In the case of the digital doctor, the work of re-definition had to do with changing the image of the Danish GP from a gatekeeper into an information manager. This transformation did not happen solely by means of the imaginations of the members of the work-groups. Specific mediations were instrumental in allowing the work of translation to happen. Instead of detailed analysis of how to practically accomplish different sorts of IT development, implementation and integration, the focus turned to the construction of visionary accounts of the future of the Danish general practices. The established equivalence between information and knowledge, presupposed by the notion of the GP as primarily a manager of coded patient information came to be seen as natural, when the work of mediation conditional for the possibility of this particular translation was forgotten.

In the DDP, a diversity of opinions on the possibilities of IT, rather than unequivocal enthusiasm, was encountered. In the "ten recommendations", however, heterogeneity was glossed. All that remained was a note at the beginning of the ten recommendations that "the members of the study group do not agree on all viewpoints presented in the document". Instead it was stressed that IT provided "new opportunities" which GPs had to "jump at", in order to maintain their "positions as suppliers of advice and knowledge to the Danish population".

Reports and recommendations as material agents

> We know that these exchanges only take place by way of the language and the text, in the infrastructural sense that we now give to this word. And what we call production is necessarily a text, the system of writing and of a reading which we know is ordered around its own blind spot (Derrida, 1976, p. 164).

Both of our sites of articulations constructed texts: evaluations, reports, recommendations, and information leaflets. Indeed, these texts form a large part of the background of the present analyses. In conclusion, we want to discuss the particularity of these actors and how they were instrumental in framing the understanding of such projects as HVEPS and the digital doctor. Viewing these reports and recommendations as a specific "genre" of material actors is consequential for our reading of the simultaneity of contradictory arguments.

The HVEPS report and the DDT recommendations were both characterised by tensions as they struggled to simultaneously contain heterogeneity and glossing it. We do not think this is a matter of "performative contradiction". Rather it points us towards the report/recommendation as an actor whose aim is to bind as many diverse practices and opinions as possible together. Thus, reports of this sort are negotiation devices that, through their own agency, allow otherwise incompatible viewpoints, and thus professional practices, to co-exist and even define themselves as aligned.

It could be suggested that the ability to carry contradictory meanings in this sense, is a specific feature of these types of reports. If this were the case, this sort of writing would be interesting precisely because it is able to flexibly negotiate the expectation of the new (improved use of IT) with the disappointing acknowledgement of the work that is needed to accomplish it. For instance, the ten recommendations that were the result of the DDP allowed for some degree of alignment between the Danish Board of Technology, the National Board of Health, the National Health Insurance, and some Danish GPs, through a visionary (if modest and compromised) account of the future of the work practices of Danish GPs.

If a primary function of such reports and recommendations is to work as negotiation and translation devices between seemingly incompatible definitions of what should take place, then their flexibility should be viewed as a strength, not as a problem. The negotiations of this writing process or the construction of political inscriptions taking place through the genre of ministerial leaflets is one (humble) way in which the relationship between Danish primary health care and the use of IT is stabilised. Through and by means of such documents as material actors, the "natural" cause of action in health care is shaped and re-defined.

Nevertheless, the need for a type of writing facilitative of such mediating work is only necessary because we are unable to capture the moments in which translations happen in practice. The intention with the notion of political and

moralising moments is to be able to capture some of this invisible work and articulate the importance of it.

Hence, we are not interested in opposing or criticising the work done in the groups discussed for being wrong-headed or unscientific. But we claim that it is necessary to place oneself in a position in which translations can be recognised and articulated in order to properly conceptualise the processes in which one partakes.

Thus, from our perspective, the relevant problem to point out is not that processes of envisioning and experimentation are a bad thing, but that they involve a fundamental political undecidability. This undecidability is rendered invisible, in theory and practice, through moralising moments. Being able to recognise invisible political moments could enable new sorts of accountable writing that would not rely on moralising tales of technology and progress.

Notes

1 The notion of sites of articulation follows Layne (1998). It highlights the negotiable character of the processes that take place in the groups.

2 Unless otherwise, notes page citations in this section refer to this report.

3 At http://www.hep.dk

4 In Bowker's case the politics were effaced by interpreting politically charged questions on how to standardise biodiversity data (according to the concerns of which disciplines?) as a matter of improving meta-data – data about data. This is an equivalent to the Danish conceptualisation of semantic standardisation of the electronic health care record: here, as we will see below, the claim, in the face of politically charged decisions, is that "no one will be missing language".

5 Project aims and development can be found at www.tekno.dk/projekter/index.htm

6 Which involves seeing the patients before they are sent further into the health care system.

7 This sort of argument is ubiquitous in contemporary Danish discussions on medical quality (Informatikafdelingen, OUH 1999; Kjærgaard *et al.*, 1999; Århus Amt, 1998; Sundhedsstyrelsen, 1999).

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