Coordinating objects of care
Exploring the role of case managers as brokers in cancer patient pathways
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TITLE: Coordinating objects of care: Exploring the role of case managers as brokers in cancer patient pathways

SHORT RUNNING TITLE: Exploring the role of case managers

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CONFLICT OF INTEREST

None of the authors have any conflict of interest to declare.

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Title
Coordinating objects of care: Exploring the role of case managers as brokers in cancer patient pathways

Abstract
Objective
Health care systems increasingly make use of case managers to handle organisational complexity. In Danish cancer patient pathways, case managers handle the complexities of cancer diagnostics and treatment while adhering to pathway guidelines. This article explores how case managers handle their various responsibilities and focuses on the micro-politics of case management.

Methods
An ethnographic study was carried out in three Danish cancer patient pathways. Interactions between patients and health care professionals were observed, including professionals with case management tasks. We interviewed 13 cancer diagnostic patients in their homes and 26 health care professionals during work hours, among other things about case management.

Results
We found that the work of case managers differs between cancer patient pathways and settings but overall emphasises coordination of patient trajectories and being contact person. We argue that case managers, embodying the figure of the broker, handle their responsibilities by coordinating the following co-existing objects of care, each with different goals: the diseased body, the person, the organisation and the cancer patient pathway.
Conclusion

We conclude that case managers, in addition to being a response to the complexity of health care services, impact the implementation of cancer patient pathways and influence cancer diagnostic activities.

KEYWORDS: Broker, cancer diagnostics, cancer patient pathways, case manager, case management, coordination
INTRODUCTION

Increased specialisation and standardisation of services, efficiency requirements and growing medical and technological improvements reflect how contemporary health care systems are organised (Strathern, 2000; Nettleton, Burrows, & Watt, 2008). The changes that have taken place have had positive impact on, for example the quality of care, unwarranted variations and patient satisfaction but have also made health care systems increasingly fragmented and complex to navigate (Plsek & Greenhalgh, 2001; Nettleton et al., 2008). As argued by Day and others (Day, Coombes, McGrath-Lone, Schoenborn, & Ward, 2017, Andersen & Aarhus, 2017), the escalating complexity of health care impinges on service delivery, engendering fragmented care trajectories and patient transition issues.

In Denmark case management of chronic conditions (Norris et al., 2002; Buch, 2012), for instance, inspired the introduction of case management to cancer patient pathways as a political response to the increased complexity of cancer diagnostics (Danish Health Authority et al, 2011; Axelsen, Nafei, Jakobsen, Gandrup, & Knudsen, 2015). Pathways were introduced to guarantee a timely and efficient progression of evidence-based standardised diagnostics and treatment, but cancer care nevertheless remains complex, as shown in recent Danish surveys on the experiences of cancer patients (Danish Cancer Society, 2013; Danish Cancer Society, 2017). The surveys stated that one third of all patients engage with two or more hospitals when undergoing diagnostics and treatment with potential patient transition issues as a result (Ibid.). Furthermore, the surveys showed that while 80% of patients had a trajectory plan, nearly half of them still experienced unclear distribution of responsibilities, engendering uncertainty as to who was in charge (Ibid.).

The responsibilities of case managers (CMs) in Danish cancer patient pathways include coordination of trajectories to avert undue waiting, coordination of multidisciplinary team meetings, guaranteeing of continuity of care within a single patient trajectory and traversing departments, hospitals and sectors, registration and monitoring of set timeframes and being a contact person (Axelsen et al., 2015; Sundhedsstyrelsen, 2016). Even though overall patient satisfaction with case management has been shown (Jakobsen, Bjerrum, Grønberg, Thomsen, & Topp, 2014) and CMs responded in a survey that case management had improved quality of care (Axelsen et al., 2015), the use of CMs still varies vastly and only sparse knowledge is available on how their responsibilities are enacted in practice (Wulff, Thygesen, Søndergaard, & Vedsted, 2008; Jakobsen et al., 2014; Gorin et al., 2017).
This article explores how CMs handle their various responsibilities and, hence, the micro-politics of case management within cancer diagnostics. It suggests that CMs, in addition to handling the specified tasks, become brokers of various, co-existing and often ambiguous objects of care (the diseased body, the person, the organisation, the pathway) (Wolf, 1956; Law, 2010). In anthropology, brokers have been defined as go-betweens with the capacity to mediate between distinct worlds and conduct in-between management (Wolf, 1956; Bierschenk, Chauveau, & de Sardan, 2002). We use the figure of the broker to illustrate how CMs simultaneously handle co-existing objects of care, thereby embodying the capacities of the broker. This allows us to explore how CMs manage and coordinate their differentiated tasks.

METHODS

Study design and setting

This study was part of a PhD project on early diagnosis of cancer exploring how standardised cancer diagnostics configures clinical encounters and shapes agency and experiences of patients and health care professionals. The present article is based on ethnographic fieldwork carried out by the first author exploring the clinical and individual practices and experiences of cancer diagnostics in three Danish cancer patient pathways (lung cancer, colon cancer and non-specific symptoms). Fieldwork was carried out in general practice and hospital settings to cover the diagnostic phase of the three pathways. One small regional hospital and one large university hospital were chosen and in each of their catchment areas, a partnership general practice clinic was chosen. Overall, the fieldwork, which took place from 2013 to 2015, made it possible to explore how CMs, as brokers, coordinate co-existing objects of care within cancer diagnostics.

Data collection and analysis

We focused our observations on clinical interactions and on various diagnostic tests. Of special interest here is the observations focused on the job function of CMs, providing insight into how CMs struggled to make ends meet. Some of the practices CMs were observed doing included calling patients in, planning, interacting face-to-face with patients and colleagues, participating in multidisciplinary team meetings and following up on activities, always carried out in the immediate vicinity of a computer, a calendar, paper-based summaries and a phone.
The observation sites were also used to recruit people for semi-structured interviews. Thirteen patients (i.e. people with suspected cancer) were interviewed in their homes and 26 health care professionals during work hours. Ten of the health care professionals had case management tasks and a background in either nursing or as a medical secretary (see Table 1). In this article CMs are defined as professionals with coordinating responsibilities, allowing the inclusion of front-line workers, administrative staff, staff members formally designated as CMs and some whose work encompasses elements of case management. Interviews with patients and health care professionals touched on the topic of case management, though from different angles and with various levels of depth. Interviews therefore provided reflections on being case managed, doing case management and collaborating with CMs.

Interviews were recorded and transcribed verbatim. Data analysis involved a read-through of all data, a coding and categorisation process to make sense of data, and a dialectical move (Hammersley & Atkinson, 1995) between themes derived from theoretical concepts and the data.

**Ethics**

During observations participants received a short oral briefing on the aim of the observation and provided oral consent. Written and oral information formed the basis for the written consent of interview persons. The study was approved by the Danish Data Protection Agency (file no. 2013-41-2050) and was deemed ineligible for ethics approval by the Central Denmark Regional Committee on Health Research Ethics (file no. 103-2013).

**Theoretical perspectives**

Inscribed by praxiography, as outlined by Mol (2002) and Law (2010), we attend to four objects of care that are enacted in cancer diagnostics. Attending to care in this manner requires paying attention to the specific situation in which care is enacted (Mol, 2002). Mol (2002:66) proposes that, when focusing on the local specifics of a particular disease as they are enacted, e.g., in hospital practices, it becomes clear that the disease is a composite object aligned into a single object through coordination work. With inspiration from Mol (2002), Law (2010) explores the local specifics of veterinary interventions during the foot and mouth epidemic in the United Kingdom, outlining the improvised orchestration and coordination of the co-existing objects of care that are part of veterinary care. In a similar vein, we suggest that coordination holds similarities with the idea of the broker who carries out the coordination work of the co-existing objects of care that goes into case
management. Departing in how CMs as brokers coordinate (Mol, 2002:53) objects of care in cancer diagnostics, we therefore explore how, in carrying out their responsibilities, they share their attention between the various and sometimes ambiguous, objects of care. Caring for the patient, the broker must also provide care for the pathway as well.

In anthropology, cultural brokers have traditionally been defined as go-betweens who mediate or translate culturally distinct realities (Wolf, 1956; Geertz, 1960). Cultural brokers, Wolf initially argued, act as buffers, standing “guard over the crucial junctures or synapses of relationships which connect the local system to the larger whole” (1956:1075). As described in Boissevain’s (1974) Mediterranean studies, the objective of brokers is to exchange their resources, i.e. strategic contacts and relationships, into resources that can help the people they work with obtain their goals. Consequently brokers juggle local rationalities and mediate a variety of normative worlds, serving the interests of various groups. In more recent research from the 1980s onwards, brokers were often depicted as initiators of change and as actors situated in positions that called for in-between management, or the bridging of perspectives, by creating new possible ways of doing things (Bierschenk et al., 2002). Brokers have thus been described as being able to bridge cultural divides in ethnically heterogenic care settings (Jezewski, 1990) or to organise and legitimise care through therapy management groups (Janzen, 1987). The present article, which uses the broker figure as an analytical heuristic to explore coordination between different objects of care (Mol, 2002; Law, 2010), suggests that work carried out by CMs embodies similar capacities of standing guard, mediating worlds and doing in-between management. In what follows, we discuss the four main objects of care separately, but in the everyday practices of cancer diagnostics, they interweave and overlap.

RESULTS: OBJECTS OF CARE

CM Linda observes the progress of her patients at the computer when the doctor, Carsten, rushes in to hand her a scrawled referral note for three extra examinations for their patient, Michael. Linda accesses the booking system, books the first examination, sends an online request for the second and, when realising that the booking slots reserved for her in the colonoscopy clinic are all taken, she calls the colonoscopy CM and has her do her magic. While on the computer, Linda checks Michael’s age and
driving distance to the hospital. She counts the days on the calendar at her desk and notes the upcoming national holiday. She then calls Michael in and asks, “Well Michael, Carsten has made a plan for you, how do you feel about it?” Michael appreciates his efforts and Linda hands him the scheduled appointments. Leaning back in his chair, Michael asks, “And these tests, do they have to be here and now or can they wait another week? I’ll have plenty of time then because I’m retiring.” Linda breaths in, “It’s probably best just to accept the plan, you know. We follow a fast pace here, with only 22 calendar days to finish”. Michael nods, “Okay, it’s fine”.

(Fieldnote excerpt)

Caring for the diseased body

Caring for the diseased body is an important object of care for CMs. Both secretary and nurse CMs were observed carrying out various clinical tasks, including measuring oxygen saturation, testing lung function and relieving pain and nausea. Caring for the body also involved managing side effects from examinations, such as fever or hydrothorax, often in close collaboration with staff at adjacent units. While Michael was apparently healthy, apart from the symptoms he was referred for, many suffer from other health problems when referred for cancer diagnostics. In a recent survey, 49% of Danish cancer patients reported this to be the case (Danish Cancer Society, 2017). According to CMs, other diseases had a bearing on the timing and sequence of diagnostic tests, as evidenced by the fact that CMs booked afternoon appointments, for example, for chronic obstructive pulmonary disease patients because they were aware that mornings are often difficult for them due to respiratory problems. Or when CMs booked an appointment to reduce the time spent fasting for all ing patients to avoid needlessly weakening them, or when they booked examinations requiring that blood thinners be put on hold until late in the diagnostics trajectory. When planning a trajectory, CMs also took into account that diagnostic tests could affect one another. Anna, a lung cancer CM, explained, “The positron-emission tomography scan should be made as soon as possible (…) it has to be made before biopsies, otherwise the spot of the biopsy also lightens up, confusing the interpretation”. One of her colleagues added, “If the lung collapses, it’ll affect the result of the lung function test, which is why it’s important to do it before the biopsy, even if the biopsy might deem it unnecessary”.

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Caring for the body thus influenced the coordination of a trajectory. To ensure that examinations were sequenced optimally, CMs drew on clinical and organisational insight and their access to various resources, such as doctors and hospital admissions. Embodying the figure of the broker, CMs acted as in-between managers, making diagnostics possible via new ways of doing things for unruly bodies (Boissevain, 1974; Bierschenk et al., 2002). As brokers they exchanged their various resources, attended to the health of patients so they would be able to undergo diagnostic tests and evaded waiting time by ensuring optimal use of technological and clinical resources. But caring for the diseased body was sometimes in conflict with other objects of care; for instance, appointments in the preferred sequence were not available, the CMs’ collaborators did not send information about medication sometimes and patients occasionally refused to accept the afternoon appointments suggested.

**Caring for the person**

Caring for the diseased body often coincided with caring for the person. Caring for the person centred on remedying inconveniences and easing distress. CM Mona explained, “It’s a safety net that you want to stretch out called hope and ‘I carry your burden with you’...”. While many patients received a pre-booked diagnostic trajectory, CMs made an effort to take age, driving distance and other health problems into account. They tried to reduce the discomfort of fasting by assembling various tests on a single day, or to meet individual needs by exploiting the department’s build-in temporal buffers. Moreover, CMs weighed their words (often avoiding the word cancer) when calling patients, “not to add to their anxiety”, as one CM noted. CMs advised on how to disclose the diagnosis to relatives, they listened to worries and hugs were commonly exchanged between CMs and patients. CMs also acted as an intermediary between the doctor and the patient, as the following exchange between CM Molly, doctor Beth and patient Karen illustrates:

Karen: “Molly called on Wednesday with an appointment, but Thursday was not an option. My husband had to go to the hospital and it was more important”.

Doctor Beth: “No, it wasn’t – you’re the most important, your health is what matters”.

Karen: “No! My husband is more important. With all he’s been through”.

CM Molly: “Yes, Karen, you’re right, he is”.

CM Molly stood by Karen, managed to find another appointment and reassured her not to worry about unsuitable future appointments.

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Caring for patients, however, was not an easy task. Some patients, like Michael, asked to postpone appointments. While CMs sometimes went to great lengths to meet people’s wishes, they often also tried to persuade patients to stick with the plan. CM Paula elucidated one of the reasons why in an interview, “Well, sometimes you feel sorry for the patients and then [laughing], I don’t know how to put it, try to persuade them. ‘I’ll help you; let’s book your transportation, then it’ll be easier for you to cope with’”. While this may appear to disregard the individual needs, it is also an act of caring and ensures that patients reach the goal of rapid diagnostics while honouring the logic of urgency framing Danish cancer diagnostics. This approach may also provide a possible explanation as to why the option of registering a postponement as due to the patient’s wish was used little, even though doing so would reduce pressure on performance monitoring. Whether it was an act of caring for the person or about handling competing organisational interests depended on the situation. Caring for the person, CMs embodied the capacities of a broker standing guard and making use of their various resources to meet the individual needs of patients while coordinating the competing objects of care.

Caring for the organisation

A third object of care, caring for the organisation, included attending to its ability to perform well. In doing so, CMs were observant of the temporal rhythm of hospitals, for example, that outpatient services were scheduled during weekdays and not in the evening or on holidays, that staff were only on duty certain hours and that some diagnostic tests and medical conferences were scheduled on specific weekdays only. This temporal orientation was at times in conflict with the cancer patient pathways, which disregarded holidays and weekends in its definition of allowed number of days. As a result, CMs focused on reducing the pressure on the organisation by pushing patients through or, as CM Linda did in Michael’s case, by pushing for an additional appointment to avoid a bottleneck after a holiday.

CMs also took into consideration the hours various staff were on duty. Complex patients were not given afternoon appointments to avoid staff overtime or extra work because other resources were not available. In other cases, CMs booked this type of patient when experienced consultants were on duty. Moreover, while the handling of referrals differed from clinic to clinic, CMs depended on the continuous handling of them. When doctors had the responsibility, CMs compensated for the mismatch between this and the doctors’ other duties. They sometimes arrived on duty ahead of time to prepare referrals because they knew doctors had time in the morning or
they coded referrals with a suspicion of cancer to ease the doctor’s workload. When planning a trajectory, CMs also took into account that multidisciplinary team meetings were scheduled on specific weekdays and that the availability of some tests was lacking, leading to the postponement of more easily available tests in the event of overlap.

Caring for the organisation, CMs also focused on not overloading it, for example when CMs, to protect the department from ineligible patients, noted down the personal identification number of patients whose general practitioner called about possibly changing their referral from an elective one to a cancer patient pathway. Avoiding overload also involved CMs gladly accepting patient cancellations. During an observation, even though CM Julia had just heard that a neighbouring hospital currently had long wait times, and while in doubt she accepted a patient’s request to be transferred to that hospital, because, as she told the first author, it would release an appointment for another patient on the day’s booking list.

Another way to care for the organisation was by paying attention to the collaboration agreements that each clinic had with relevant departments describing the timeframe for appointments, e.g. when certain scans should be offered. CMs depended on the collaborating departments adhering to these agreements and they continuously nursed the relationship. This was what happened when CM Julia was observed overruling the doctor’s decision not to assess a patient for a cancer patient pathway but for a later appointment, commenting: “That’s not going to work. The agreement with that clinic says before six days have passed; that’s just not good enough”. Julia booked the patient and choose one of the pre-reserved pathway appointments. Through brokering, CMs thus brought together, or coordinated, various social arenas: hospital departments, general practices and patients, but also used temporal orientations, e.g. duty hours, and their insight into organisational patterns to create new ways of getting things done.

Caring for the cancer patient pathway

Caring for cancer patient pathways primarily concerned living up to the timeframes described in the pathways, for instance that diagnostics must be completed within 22 days. To accomplish this, CMs overbooked programmes and disregarded patient requests, such as CM Linda did when Michael wanted to postpone his examinations due to his impending retirement. CMs sometimes overruled what was considered good clinical practice at the hospital to adhere to established timeframes. For example, they split up examinations otherwise carried out simultaneously to expedite appointments; booked examinations supported with anaesthesia even though it was unnecessary because they were
available; changed the sequence of examinations; and called patients in during Christmas, which was, according to one CM, “mindless waste of time”. CMs pre-booked examinations before the patient’s first consultation after referral to gain a couple of days and called patients in from day to day for diagnostic consultations to avoid wasting time. In addition, initiating pathways was sometimes postponed until the patient was reached by phone, even though this went against pathway guidelines, or pathways were called off to avoid adding extra days if errors had delayed it.

In each of the clinics observed, complex systems for follow-up on examinations had been devised to establish a safety net to avoid any patient transition issues and, in particular, to monitor the progress of the pathway to be able to adhere to the established timeframes. At one clinic, they monitored the progress at a weekly meeting, while other clinics made lists, either manually or using electronic patient records that the CM and a doctor in charge checked every fortnight. In addition, CMs closely monitored the individual patient trajectory to stay abreast of wasted time to be able to react immediately on new information. Doing so, CMs followed up on collaborating clinics, calling them if they were delayed in providing the requested bookings and assessing the reasonableness of the timing of the bookings. They made use of the electronic patient record to access results in real time, to communicate with collaborating partners or to make reminders for themselves or their colleagues to follow up on requests or examinations. In addition to using electronic reminders, CMs used lists with elaborate coding systems to maintain an overview of the individual trajectories and to easily be able to answer questions if, e.g. a general practitioner called. CM Ellen, for instance, kept several lists, one with today’s patients, an electronic list with current patients and a list stating the timeframes for each patient. Several times a day, like the other CMs, Ellen went through them and checked electronic patient records for updates to ensure rapid action and to stay updated.

When caring for pathways, CMs thus coordinated the bureaucratic demands of the pathway with clinical and organisational practices using institutional and relational resources. By referring to pathway timeframes, CMs legitimised care practices that would otherwise be considered inconvenient. This was the case when CM Linda explicitly referred to the pathway timeframe, for example, when she encouraged Michael to comply with the pathway standards stipulated.

DISCUSSION
The above shows that CMs were engaged in coordinating patient and institutional resources in space and time while also taking the diseased body and the pathway into consideration. The complexity of health care is mirrored in the cancer patient pathways, and by handling this complexity, we argue, CMs embody the capacities of the broker by coordinating the co-existing objects of care comprising cancer diagnostics (Law, 2010). This coordination is a situational and improvised act that negotiates potential tensions and discrepancies, which is why its outcomes may not always be to the benefit of all parties (Mol, 2002). We suggest that CMs, as brokers, thus make use of their diverse resources of clinical and organisational insights and personal competencies regarding empathy, persistence and improvisation, but also their contacts and relationships across departments, hospitals and sectors, in the effort to overcome complexity and fragmentation in the endeavour to actualise contemporary visions of seamless pathways and continuity of care.

The need for brokers to mediate the objects of care of cancer diagnostics reminds us of the multifaceted relationship between policy and practice. Rather than taking a linear model of implementation as our point of departure, we emphasise, in accordance with Law (2010), the need to include the improvisations and flexible responses that go into the coordination of the co-existing objects of care because they affect the implementation of a given policy. We argue that CMs hold an important position in the enactment of cancer patient pathways by performing in-between management and by bridging various goals and perspectives. While the seemingly immoral actions of accepting patients’ cancellations are recognised as potentially being the result of regulating practices and policies (Shore & Wright, 2015), we have illustrated that they may also be the result of juggling co-existing objects of care and coordinating their potential discrepancies (Law, 2010). This is not an attempt to excuse actions of this nature, but rather an insight to be considered when searching for solutions advocating a structural rather than an individual focus.

Finally, as we have discussed elsewhere (Andersen & Aarhus, 2017), the increased regulation of health care leads to leaking and blurred professional boundaries and hence to fragmented roles and tasks. This is reflected in the variety of tasks that CMs perform, where they have an area of responsibility containing both clinical and administrative tasks that sometimes supports doctors and that sometimes involves taking over the doctors’ tasks. Acknowledging the multifaceted nature of cancer care delivery, the present article sheds light on the contributions of a rather invisible group in the cancer care workforce (Manderson, 2015). CMs perform, as has been argued in the case of medical secretaries (e.g. Møller & Vikkelsø, 2012; Bossen, Jensen, & Udsen, 2014, Andersen & Aarhus, 2017), essential tasks that go beyond supporting doctors or being gatekeepers (Eisner &
Britten, 1999), which are the commonly described roles of secretaries. In keeping with Møller and Vikkelsø (2012), we suggested in recent work (Andersen & Aarhus, 2017) that secretaries contribute to diagnostic work. In a similar vein, this article shows that when CMs coordinate the various goals of the objects of care, they influence cancer diagnostics.
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LIST OF TABLES

TABLE 1: Overview of interviewed health care professionals with case managing work tasks

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<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

| Monitoring time standards                 |   | X | X | X | X | X | X | X | X |    |
| Participation in multidisciplinary team   |   |   | X | X | X | X |    |    |    |    |
## Contact with patient

<table>
<thead>
<tr>
<th>Meetings</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attend clinical encounter with doctor</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Individual encounters with patient</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>On the phone/by letters</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

## Administrative pathway tasks (registration, database)

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Apart from the 10 CMs listed here, ethnographic conversations took place during observations with other hospital-based CMs. Most of the CMs also had non-cancer related work tasks not listed here.*