

Alone in the Team?

A Sociological Perspective on New Organisational Models within Health Care

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Discussions of the work environment used to focus on physical conditions in various professions, for instance on efforts to cope with heavy lifting, repetitive work tasks and hazardous or toxic substances. Problems such as exposure and vulnerability have been addressed, and explanations of ill health among employees have been looked for both in structural and individual conditions.¹ During recessions primarily the latter has been pointed to, whereas in times of prosperity the former. Research seems to be suited both to the available resources and the spirit of the times. Therefore it is no surprise that nowadays research on the work environment increasingly has come to focus on the social work environment. Following the structural changes in the labour market and the withering away of collective traditions, uncertainty is spreading. Utility maximising increasingly appears as an individual, often forced, principle of action. The employees have to face new demands due to the more flexible employment conditions, lean work teams, customer-oriented services, just-in-time delivery and rising expectations regarding social skills and lifelong learning. New studies on how the organisational environment and the work organisation affect the employees' health more and more point to the significance of stress and social conditions. Burn out caused by excessive demands is an example of a work environment problem typical of the times. Increasing work intensity combined with a lack of influence, responsibility, control and social support lead to sick leave.

A research tradition that stems from the beginning of the 20th century has hereby again become topical. I am referring mainly to the social-psychological, often experimental research on social groups that first saw the light of day in the Hawthorne experiments.² Up till now these research results have mainly been incorporated in various management models. This is rather odd, since the much debated Hawthorne experiments primarily point to the employees' exposed position and need of protection against increasingly smart managerial models.³ The experiments show, among other things, that there are basically no limits to the

¹ Härenstam & Wiklund (1999).

² Roethlisberger & Dickson (1939).

³ Asplund (1987), Mills & Tancred (1992).

extent to which the socially responsive individual can be manipulated.⁴ With this perspective it becomes interesting to study how new organisational models relate to, or can be derived from, the findings in Hawthorne.

From the many Hawthorne experiments a way of thinking developed that nowadays rather obviously invades new organisation models. The Hawthorne results gave rise to a series of research approaches within management on “human relations”. The results have for instance been interpreted as pointing to the necessity to create the right “atmosphere”, “unity” and “climate”. That is to say, constellations of groups or teams that guarantee high productivity and commitment to the work. After Hawthorne, group composition became a vital cog in the bigger wheel. My approach therefore is that gaining ascendancy over groups of employees at various levels in the organisation is a vital power struggle in change processes. Group composition is also decisive for the employee’s well being and health. A positive response from core groups of employees is finally decisive for management’s capability to improve the production results.

We can therefore assume that the struggle concerns who will get priority to the group’s loyalty and who will thereby set the norms for the group’s sensitivity and responsiveness.

Here I wish to discuss the difference between two common groups, on the one hand groups which form spontaneously among the employees – such as collectives – and on the other groups which are formed by management to enhance productivity, in my example labelled “teams”. I ask three questions: How do these two groups influence the social relations among the employees? How can we understand the employees’ reactions to these two types of groups within a sociological frame of reference? And how can we relate the current health problems among the employees to the basic social relations in the organisation?

Data

Two studies of health care employees constitute my background material. The fieldwork of the first study was carried out in 1989-90 and the second in 1996-97.⁵ Both these studies use qualitative interviews with personnel employed in the public sector.⁶ In both cases surgical work was performed at the workplace. In the first case a workplace at a large regional university hospital was chosen and in the second a workplace at a smaller local city hospital.

In the years that have passed between the two investigations public health care in Sweden has experienced extensive rationalisations. At the time of the first study the changes were yet a mere threat on the horizon. At the time of the second

⁴ Asplund (1987).

⁵ *Doktorer, systrar och flickor*, (1992), *Klass, kön och kirurgi*, (1999).

⁶ In Sweden approximately 95 percent of the health care personnel is publicly employed.

study large cut-backs and relocation of personnel had been carried through, and the implementation of new, market-oriented organisational models was in progress.

Below I will first describe what the informal organisation looked like at the time of the first study. Thereafter I will delineate the significance of the organisational changes carried out within health care in the 1990s. Finally I will use sociological theory to discuss and analyse the importance of the informal organisation's change between the two investigations. How was it before and how is it now; what are the implications of the changes for the employees' social work environment? What effects will the new organisation possibly have on the employees' health? I will solely concentrate on the hierarchical relations between the two female dominated groups, assistant nurses and nurses.

Girls and Sisters 1989-90

In the book *Doktorer, systrar och flickor* [Doctors, sisters and girls] I describe an informal organisation which, at the time of the study, was on the threshold of big changes. A grant system and a traditional hierarchy still dominated the organisation. In that organisation I could see that the assistant nurses, i.e. the "girls", had a relative autonomy in their work around the patients. They worked together when cleaning the wards and caring for the patients, and they had the opportunity to withdraw to the wash room for short moments of informal time together. They developed a work culture that has been described and discussed in the terms of a "collective".⁷ Conditional for this collective culture was *the nearness, the similarity and the mutual interpretation of various problems* among the girls. The organisation led to *nearness* among the girls since they formed their own group at work. The obvious *similarity*, which followed from their position at the ward, was further emphasised by the girls' common background, coming as they did from small farms or a working class environment, and the common life-mode and "marriage contracts" they thereby shared.⁸ In other words they had a lot in common and they *interpreted their working conditions* using a similar frame of reference. The girls developed a strong us-and-them spirit and unity as a collective. The us-and-them spirit also meant that they had to live by the norms of similarity implied by the culture: be loyal and helpful, not try to attain individual advantages, be "female" in a caring sense of the word. The girls upheld this norm

⁷ Lysgaard (1967), Ve (1978) and Sørensen (1982).

⁸ Marriage contract here refers to the fact that they were married to men who were rather traditional in their masculinity. The men had typical working class jobs and were interested in male occupations, hunting, fishing etc. Homework was a female responsibility; he helped out but primarily devoted time to outdoor work, preferably together with other men. The contract can also be described as a life-mode, cf Jakobsen (1998).

system in daily interaction with the group, they corrected deviations from these norms and they endorsed and gave social support to “a true woman”.

Among the nurses (“the sisters”) the ideal type pattern was more complex. Characteristic was a form of corporate culture, based primarily on individuality and personality. They tried to form alliances with their subordinates but mainly with their superiors, the doctors. The sisters were different from each other in terms of life-modes – they represented various segments of the middle class – and struggles between cliques of nurses could be seen. Those who enjoyed the support of their superiors decided the daily work routines. These positions were however insecure and unstable. Since the nurses were divided between themselves they were on the one hand vulnerable to infiltration and rumours, but on the other hand the corporate culture was dynamic, prone to changes and, despite the internal split, a collective in a limited sense. As opposed to the girls’ collective, the corporate group was built on the professional ambitions that united the sisters. That does not, however, mean that the corporate body lived up to the prerequisites of a collective. The sisters were more individualists than collectivists. They tried to attain individual goals and they were therefore active in various organisational matters. They however also protected each other if anyone was attacked for professional reasons. They were always sisters in that sense. The sisters were interested in “what” ought to be changed in the organisation, but they did not agree on “how” at the time of the study.

After this study was carried out, extensive rationalisations and reorganisations within health care have taken place. Let me therefore briefly describe these changes and the new set of ideas.⁹

An Organisation in Line with the Times

Rationalisations typical of the times have long been carried out in the health care sector. Already in the 1940s people were horrified at the great expense of health care. The solution was then found in the Tayloristic principles of differentiating and specialising the work. Work was to be divided according to principles shown to be profitable in industry already in the 1920s. Time studies were undertaken at the hospitals and the so-called round-system was introduced.¹⁰ The tasks best suited for round work were primarily the assistants’ (later the assistant nurses’) work tasks.¹¹ For the nurses instead paper work, supervision, management and guidance became important tasks. Money could be saved if the health care workers were time-studied, low-skilled, cheap and exchangeable. The more expen-

⁹ Maybe we could talk of a new discourse in discussing the organisation.

¹⁰ Gustafsson (1987).

¹¹ Wendt (1998).

sive nurses could be reduced in numbers. To quite some extent, theoretically educated workers supervised the work from behind the windows of the office.¹²

When hospital work became centralised and rationalised, health care was also standardised all over the country. New expenditures were however sky-rocketing. One of them was the cost of specialist care. All the hospitals could not be specialised. From this followed a division of the hospitals into different categories during the 1960s. Normal hospitals, county hospitals and regional hospitals appeared, the latter the most specialised. But also these specialist hospitals now outgrew themselves; the number of specialities increased rapidly, as did the number of employees. Education was expanded at the regional hospitals and they became colossus supplying assembly-line health care.¹³

At the large specialist hospitals the inner work organisation was characterised by Taylor's principles of efficiency, i.e. specialisation, job splitting, coordination through hierarchy, limited areas of responsibility, top-down information, rigidity and rituals. This organisation was still more or less at hand in 1989-90, when I did my first study. It was an organisation where the doctors, the nurses and the assistant nurses all lived their separate work lives in the hierarchical order. They had their own worlds wherein they developed level-differentiated cultures such as the collective and the corporative culture described above.

Modern Organisational Models

The market for organisational models simply exploded in the 1980s. Just like with Taylor's principles, this continuously expanding market was created with a view to the private economy's need for competitive solutions. For health care the same set of models now came to be of interest. New management with an education in business administration entered the hospital boards. Privatisation and divisionalisation of hospitals were discussed and realised.

In *The Machine that Changed the World* the authors' claim that, in Japan, to produce similar goods as in the western world fewer employees are needed, the time of production is shorter, and less capital and less space are needed.¹⁴ Organisations could be lean when it comes to the number of subcontractors, employees, storage space etc. "Just-in-Time" delivery to the customer replaced the earlier system, which, with an ironic twist, is called "Just-in-Case". Downsizing and outsourcing became central buzzwords. In just a few years the employees met such phenomena as Quality Circles (QC), Time Quality Management (TQM), Time Based Management (TBM), Business Process Reengineering (BPR), Limitless Flow Organisations (Gränslösa flödesorganisationer, GFO), Learning organi-

¹² Evertson (1995) p 105.

¹³ Gardell & Gustafsson (1979), Gustafsson (1987).

¹⁴ Womack et al (1990).

sations, etc.¹⁵ The pace in the development of new organisational models (the fashion changes) is constantly increasing. The turnover increases and it seems as if we will soon speak of the model of the year.¹⁶

The most successful models are naturally also attractive for management. Management is held in high esteem in the models and the new organisations bring with them new means of control and power for management.

The Models Applied

Since my first study new organisational models have become visible in the health care organisations. As a result many activities within health care have been merged and personnel has been fired or relocated. Relevant here are mainly the altered relations between assistant nurses and nurses. At the particular care units there no longer exist any girls in work groups of their own since the work is carried out in pairs. This means that each assistant nurse together with a nurse make up a team and that they are tied to a particular doctor's patients (approximately 8), who are cared for by this team.¹⁷

Earlier the work was performed under a grant system, i.e. the different clinics applied for means and had a budget to keep to. Performance was seldom systematically checked in relation to the size of the means supplied. The doctors' professional calculations were rarely questioned. Nowadays a purchaser-provider split has been established, and the units get paid afterwards and according to performance. The unit (for instance the clinic) and the employer (the county) formally agree on what is to be done and at what cost. Parallel to this, management is trained in economics and leadership. The chief senior physicians are also trained in their new role as employer representatives; they can no longer hide behind their loyalties to colleagues and patients, which they used to do according to the hospital management. Individual pay based on performance, efficiency and competence is introduced.¹⁸

Assistant nurses can compare today's situation with how it used to be. For them, the changes have meant that they have continuous contact with "their" nurses as well as with the doctor. Earlier, when they worked in a collective of their own, they mainly had contact with each other. Today the girls are split up and separated in the team organisation and their closest fellow worker is a nurse. These, on the other hand, have gained more responsibility and more work tasks. They are expected to take an increased part in the care of the patients together with the assistant nurse whenever needed. Parallel to this they have more documents to handle, they have to keep a journal and they have to safeguard the quali-

¹⁵ Abrahamsson (1998).

¹⁶ Björkman (1997).

¹⁷ Team is from now on only used in connection with multiprofessional teams.

¹⁸ Lindgren (1999).

ty of the care. The employees work different shifts to make sure that there is always someone to cover for those who are absent. The beds are used more efficiently through the coordination of various clinics' needs and thereby flexibility increases. The turnover among patients is higher and the time spent in hospital is reduced.

Let us now look more closely at the relations among and between assistant nurses and nurses and how these have been affected by these organisational changes.

The Departure of the Collective

In my first study, the sisters claimed that the girls had insufficient skills, were less committed to their work and lacked ambition.¹⁹ I interpreted this as an expression of the different worlds developed by the different work cultures in the "old" organisation.²⁰ The girls wanted to be autonomous and decide for themselves; they put up resistance when the sisters tried to enforce their knowledge and ideas on how to care for the patients. They had a collective culture to defend and to protect them, and they were proud of it.

Today, in the "new" organisation, when the assistant nurses no longer work with their old collective but together with a nurse, this cultural difference is looked upon as a personal lack of skills in the individual assistant nurse. The nurses think that:

"the assistant nurse, she also needs to be independent and able to plan the job and organise, because she has a big responsibility for the care and well-being of the patients. But I have to assume the medical responsibility, because the assistant nurse cannot take that. I have to, and I can take responsibility for all of it, and I do, but I cannot be directly responsible for all of it... there are assistant nurses who cannot do anything on their own, and that can be hard work."²¹

In the new, as well as in the old interviews, the sisters are those who worry about the girls' ignorance, lack of commitment and independence. Their statements are of course strongly related to the collaboration required in the organisation. Because of the organisation in pairs, the collisions between the old and the new norms have become frequent. The nurses look upon it as their task to "help" the assistant nurses up and out of the collective tradition. The nurses see themselves as administrators of the "correct" way of organising care work. To make the team effective they need to alter the ways of the assistant nurse – to reeducate her. The

¹⁹ Lindgren (1992).

²⁰ The "old" organisation will henceforth be used for the 1992 years' study, whereas the "new" organisation will be used for the study of 1999.

²¹ The thoughts of a nurse, cited in Lindgren (1992).

sisters act in good faith, there is no doubt about it. But what are the latent effects and implicit consequences for the assistant nurses who are the subjects of this?

In the old organisation the girls worked together and managed on their own, independently but under the guidance of a head nurse. In the work collective, help and protection from the group could be counted on. It did happen that this freedom was used for long smoke and washroom breaks, but these were also opportunities to support each other and share the pleasure of work. These opportunities are lost in the new organisation since the *nearness* between the girls no longer is at hand.²²

For the nurse however, the transition to team work meant a more independent position vis-à-vis their superiors. Parallel to this she is expected to take a more active part in the practical care of the patients, e.g. help the assistant nurse get the patients up in the morning and make the beds. The nurse thus today has a more direct insight into how the assistant nurse goes about her work (which used to be the role of the head nurse) and increased control of the whole caring process; in fact she sees herself as the true generalist today. Earlier the nurse was more of a tool subordinated to the head nurse. A situation which meant that:

“...we ran around a lot since we had all the patients in the ward to care for and we only knew a few details of each patient. You couldn't really answer any questions. Today, however, I can give detailed answers to all questions, which is very nice, and the relatives are satisfied.”²³

Today the nurse has the general view of the situation and responsibility for her patients. It is for instance she who makes the plans when the patient is to go home. The assistant nurse, the nurse and the doctor are linked to each other in the hierarchical team whereas the chief nurse has been rationalised.

The nurses are positive to the new organisation. The assistant nurses however do not appreciate it to the same extent. They enjoyed the collective/their own group, but the team was said to be better for the patients. The assistant nurse and the nurse were supposed to work together in the mornings and in the evenings when the patients have to be lifted and moved. On that condition the assistant nurses agreed to the teamwork, but, they say:

“...we have seen that it doesn't work. In reality we assistant nurses make the beds alone, one here and one there (with their patients, the author's comment). The nurses have so much to do, distributing medicine, IVs and shots so they can't find the time. Like this morning, I made all the eight beds on my own, got all the patients up, while my nurse was busy with other things. So I don't think it is any good. At the moment we have patients here

²² I wish to remind the reader of the collective's conditions: nearness, similarity and mutual interpretations of problems, Lysgaard (1967).

²³ Nurse, cited in Lindgren (1999).

who can walk when someone supports them, but if they can't do that, I couldn't get them up myself. Then I'd have to wait until the nurse comes. But above all I don't think it is any fun. It used to be more fun, when we worked together in the team. There are others who also think so.”²⁴

The assistant nurses clearly miss the collective culture that existed in the old organisation. The division of work between nurses and assistant nurses has not been affected by the new organisation. The areas of responsibility are the same and the hierarchy remains. The assistant nurse performs the same work tasks as before, but today she has to work alone. The nurses understand that the assistant nurses have a boring time alone in the team, because:

“...the assistant nurses perhaps find it boring to make the beds on their own, that is the hard part of having patients who need a lot of care, that is when you realise that you just don't have enough time. On the one hand you have all the other tasks, medication, preparations, operations and documentation, all the contacts with the relatives and the doctors, so you have to have an assistant nurse who understands that all this takes time. Not all of them do, and that is when problems arise.”²⁵

Because of the work schedule at the particular unit, no constellation can last. The pair changes for both the sisters and the girls. Some of the teams work well and some do not. The nurses evaluate different girls as partners and the girls evaluate the sisters as partners. Which combinations work well? One of the nurses, who was part of starting the team work, claims that well functioning pairs have a history together.

“Those who remain of the assistant nurses after we started working in pairs, they think it is good. They think it is hard work sometimes, and it is, it can be too much. You could see that these people (the assistant nurses, the author's comment) really became more confident, grew, when we started working in pairs and they got more responsibility. They are really good, three of them are about to become nurses.”²⁶

The assistant nurses who were present when the team was introduced were often younger (often younger than the nurse in the team). Most of them have however been fired in the downsizing that later followed. The assistant nurses who finally came to dominate in the pairs have all quite a few years on the job.²⁷ Many of these have further been relocated from other wards within the county. In other words they have no experience from the first enthusiastic years with the teams. They have not “grown” with or on the job as team members. They have all left

²⁴ Assistant nurse, cited in Lindgren (1999).

²⁵ Nurse, cited in Lindgren (1999).

²⁶ Nurse, cited in Lindgren (1999).

²⁷ The principle of seniority was applied.

their souls in the former collective community and claim that “it was better before”.

But even the few assistant nurses who have been part of the whole process are ambiguous to the meaning of the expression “grow with the work” for their own part. Note my italics in the citation that follows:

“If you need to be two to get the patients up, you try to be that because it is too hard otherwise. But then I ought to say that it doesn’t always work, it depends on which nurse I am working with. It is different but with most of the nurses it works well. There are nurses who don’t help out, but then *you have to dare to tell* them. Because we decided to work in pairs and then I shouldn’t be working on my own, because it gets too heavy for us assistant nurses... I think it is more fun working in pairs because you get closer to the patient, I know more about the patient and her illness and medication. Earlier you had more patients and were more *anonymous* and it was *easier to slip away* then...now I have my patients and I know that this I have to do together with the nurse and if we don’t, *it won’t get done*...You are more alone at work now and there is the risk that you do things that you shouldn’t do, like for instance lift a patient who is uncomfortable in the bed although you have nobody beside you. And when there is a lot to do *you don’t go and fetch anyone* but you *work a little harder yourself*. The risk is that it isn’t good for either the patient or for me. Otherwise it is *probably up to you* how much you work on your own. Some things I can do on my own, take tests, clean, dust, that I can very well do on my own...But the heavier things, that is when *you have yourself to blame* if you don’t ask anyone for help. But *we assistant nurses*, we’d rather work on our own than *ask for help*. I have some pain in my shoulders and in my back, it is probably something you have to live with.”²⁸

Noticeable here is a kind of self-education that is quite opposite the one so aptly captured by Paul Willis.²⁹ Whereas Willis’ boys, through arrogant behaviour and protest, came to remain in their original position, the assistant nurses accept the new demands on them and put the blame on themselves for not being able to grow with the new tasks. You really have to know how to behave when you no longer have your friends around or the collective norms to protect you. Beyond the collective you have to be able to dare say no, call for help or work a little extra yourself, because if you do not you are irresponsible and independent. There is no one beside you to help out. Nor can you slip away (to the washroom) and rest for a while. If you get worn out you also have only yourself to blame.

²⁸ Assistant nurse, cited in Lindgren (1999).

²⁹ Paul Willis (1977).

Here the conditions of the co-workership become visible. Let me elaborate on this.

Entrance of the Co-worker

The new organisational models introduced the concept co-workers (*medarbe-tare*). In these models the traditional professional cultures and all special interests are seen as obstacles. The teams are therefore meant to establish something new, co-workers, who feel responsible primarily for the organisation and not the well being and status of the own group. The co-worker is the smallest unit in a corporate culture that comprises everyone.

The collective buffer culture has come to be associated with something lingering, something outmoded and old. The co-worker culture on the other hand is looked upon as progressive, forward looking and modern (post material and post-industrial). The co-worker is a prestigious concept in organisations which build upon teamwork, projects, broad skills and flexibility. It has become almost in bad taste to defend and look after the own group's interests. The well being of the totality, of the organisation as a whole, lies in everyone's best interests. In this we find the moving force of the new rhetoric and the co-worker fits nicely into this. Let us below browse through the sociological thinking and ask ourselves how these changes should be understood.

The Lonely Co-worker's Dilemma

The second study's interviews show that the assistant nurses miss the earlier support of the group and that they are faced with new demands on their professional role. They have to step out of the group and be more forward, help themselves, demand the nurses' help etc. Unless they learn this they will become worn out. How can we in sociological terms interpret the dilemmas of the lone co-worker? Sverre Lysgaard provides some of the answers in his theory of the collective.³⁰ According to this theory it is reasonable to interpret the growing co-worker/organisation culture as evidence that the technical-economic system is getting close to its ideal state.

What then does this mean? Lysgaard delineates the abstract organisation as a technical-economic system which all the employees are part of. To be a co-worker in this system implies getting paid for your work, but also that you collaborate in making the organisation as profitable, viable and efficient as possible. The goal of the technical-economic system is increased profitability. The system is, in its abstract form, insatiate in its demands for employees' achievements, one-sided in its demands for efficiency and implacable in its demands for the partici-

³⁰ Lysgaard (1967).

pation of the employees in the system. Because of these demands, in the ideal state all the human capital gets invested in the organisation.

The co-workers are however also part of the human system and people cannot be treated in just any way.³¹ Individuals are guaranteed certain rights and privileges in the culture and society that surrounds them. Besides guaranteeing rights, the human system also lays claims on the individual. The system creates expectations of growth and development; the individual is supposed to satisfy her own needs in agreement both with those closest to her and in accordance with the particular life-mode and gender contract. At the level of the ideal type the human being appears without limits, but the actual individual is always limited with regard to conditions, sex, her responsibility for others and her needs for security.

Here the motives for the third system, the collective, arise. Since the employees are limited, versatile and in need of security vis-à-vis the economic system, the collective is needed. The individuals need to establish a buffer between themselves and the technical-economic system. Those who are subordinated in the organisation experience the hardest pressure and therefore spontaneously organise a collective system, a group norm, behind which the demands can be defined and limited. In the old organisation the girls created, in line with Lysgaard's perspective, a room for the mutual establishment of the limits of work. At times even this buffer culture was insatiate, one-sided and implacable, but the costs in terms of personal denial were outweighed by what the group could contribute.

Lysgaard's model of the three systems is also dynamic. The relative strength between the technical-economic system, the human system and the collective is not once and for all given but develops and changes over time. It is also highly dependent on the organisation's surroundings and on alterations in the power relations on the labour market and in politics and economics. Today's emphasis on economic issues makes it reasonable to assume that today the technical-economic system is more viable than the collective system.

Can we find further partial answers to our questions regarding the lone team worker? I am reminded of the Hawthorne results. Among the many experiments in the Hawthorne study there are two of particular interest for my line of reasoning: The Relay Assembly Test Room and The Bank Wiring Observation Room.³² For the relay room six women were appointed who did not know one another and who were given a group piece rate which directly linked the individual's performance to the group's (earlier a group of 100 employees had had the same piece rate). All the tests, whether involving an improvement or a deterioration of the women's work environment (working time, breaks, dinner breaks etc) showed a positive influence on the productivity of the group. The women beat the

³¹ The human system has a dual quality and has to be understood by looking at the power relations that exist between the sexes, i.e. the system establishes different norms for men and women, cf Lindgren (1985).

³² Asplund (1987).

production record when all the benefits, which had been gradually introduced, were removed in the final test.³³ Asplund notes that the women showed an almost pathetic willingness to perform progressively better and sums up the results by noting that they obviously were quite unable to set a limit to their work – why, I will return to below.³⁴

In the male group the results were different. The participants in the Bank Wiring Observation Room were studied on the spot without any changes in the work process. The 14 men showed a stable productivity level which was upheld by their group norm. Whoever deviated from the norm was punished, and this was particularly the case if someone produced more than the norm. We should add that because of the norm the men earned less than they could have. The researchers could thus conclude that the amount of pay was not decisive for performance – something else was, namely the group.

What then do these two experiments show if they are looked at in relation to the co-worker's dilemma? First of all, the girls in my old study can be compared with the men in the Bank Wiring Observation Room, i.e. the collective norm worked as the group's buffer against employer demands; the girls themselves set the limits. Parallel to this the new organisation's teamwork can be compared with the women in the Relay Test Room, because in neither case do we have a group but rather what Asplund calls an elementary community. Such a community is the result of a forced "group" which lacks history, where the participants are not similar and furthermore lack a mutual problem definition. Or, we could say that the elementary character of the social responsiveness was revealed.³⁵

It is not always wise or rational to be immensely responsive. Quite often it is, if not lethal, at least hazardous to your health. Experiences from many different situations make most of us suspicious and therefore we develop both our own and collective norms for how to react to our surroundings. In some instances, e.g. in an elementary community (which we end up in through no fault of our own), we lack the possibilities to see how the land lies. If we lack the opportunity to interact with others and in that way arrive at mutual interpretations, we easily slip into a one-sided responsiveness in relation to whoever pays attention to us, such as the researchers in Hawthorne. The Hawthorne results are in this way almost shameless in that they point to our utter exposure and vulnerability as human beings. The fact is, that when norms exist which delimit how responsive we are and to whom, actual experiences of the system have given rise to protective collectives. This implies that the dismantling of groups, the splitting up and relocation of the normative centres of the organisation, would be an attractive strategy for anyone who wishes to seize power, control and change things. As a way of thinking, the

³³ Ibid p 202.

³⁴ Ibid p 210.

³⁵ Ibid p 208 f.

Hawthorne results have influenced today's organisational models. In this perspective the seemingly harmless concept co-worker needs to be critically analysed and penetrated.

The Emptiness of Being a Co-worker

A condition for the system of co-workers is a weakening or disintegration of existing group cultures in the organisation. As a phenomenon, co-workership is blind to gender and class and perhaps even inhuman in that it fails to see the actual conditions which influence people's lives. To talk of co-workers implies talking of an ideal type in an ever changing organisation, i.e. an individual without a history, whose individual life-project is intimately tied to the workplace.³⁶ The co-worker construction is by origin limited to the goals and means of the work organisation. The co-worker, it is assumed, wishes to improve and develop through work and to look for success and confirmation solely in work. The co-worker is alone and willing to compete. The co-worker becomes a sort of post-structuralistic prototype, self-evidently aiming for development, flexibility, mobility and continuous skill development in life. As a construction the co-worker has no actual life and no responsibility for other people. The relations between the co-workers can be compared to the characteristics of an opinion; i.e. the relations arise and spread at a mental collective level. New packages of thought sweep everyone along in these media-fixated times. They arise among persons who do not have any contact with one another, who do not have to see or listen to each other, who only constitute an audience.³⁷ Opinions cannot be compared to for instance traditions, because opinions lack antecedents and concrete origins.

But does the co-worker then exist? Naturally the answer is no, but in the health care organisation we can detect a similarity between the abstract and the concrete co-worker among some of the nurses: those who have their footing in the middle of the organisation, i.e. in the organisational space occupied by the middle class. Many nurses and their union representatives have, as mentioned earlier, struggled for more independent work roles and have thus had an interest in developing team-organised work, primarily to include the doctors. In their struggle for an extended professional space they have formed alliances with management. We could even dare say that they have been forced to embrace the technical-economic system to fight their prime opponents – the medical doctors with their monopoly over medical know-how and superior status in the organisation.

The nurses have focused on the agreeable side of the two-sided teamwork, the one that could also persuade the doctors to participate. The team creates opportunities and promises in the modern organisational models. The team is said to lead

³⁶ The thinking around life-projects is developed in a dissertation by Allvin (1997).

³⁷ Tarde (1901), cited in Asplund (1987) p 163.

to the dismantling of traditional work boundaries, to the establishment of co-operation and to furthering skill development across professional borders. In short, the need for buffer cultures will cease to exist since the technical-economic system has come to coincide with the human system.³⁸ The other, more problematic side to team work has been overlooked. The spokesmen and -women of the new organisation have underestimated the risks of subjecting the team workers to excessive demands from not only each other, but also from patients and employers as well, particularly in a lean organisation which has removed all its reserves. In such a context the co-workers become isolated and experience individually the implacable demands of the technical-economic system. This is most obvious among the assistant nurses who joined the team. They were picked from different wards and teamed up with nurses they did not know and who belonged to another professional group. For the assistant nurses the team therefore came to be comparable to an elementary community, or a constellation where the social responsiveness can be expected to be boundless. We would thus expect the co-workers to invest their entire human capital and be immensely responsive to whoever “sees” them. The assistant nurses are no longer seen by each other but by the nurses. These evaluate the performance of the assistant nurse in accordance with their own needs, i.e. an assistant nurse ought to deal with most of the patient care on her own. The assistant nurse on her part would rather work with a nurse who is available and helps her with heavy lifting and making the beds.

Are then the nurses as co-workers immune to the risks of the new organisational development? No, that is not my conclusion. Many nurses have certainly fought a winning professional battle, to some extent at the expense of both assistant nurses and doctors. But the nurses have also agreed to a largely unacceptable workload to get ahead. They have today an ever greater need of setting limits, in fact they actually need a buffer culture. Under the guise of what is “good for the patients”, the team has increased the individual scope of responsibility, and an increasing amount of high-quality work has been squeezed out of fewer and fewer employees. The nurses have become overburdened in this process and have been left alone to carry a large responsibility, while power has become more and more centralised and attired in the language of technical rationality.

The co-workers are furthermore unable to create an interaction with each other which is concrete and rewarding in a sense typical of the old buffer cultures. A reason might be that the team not only appears as, but also is, an abstract community of joined professional roles. Between roles there is no actual responsiveness, no feelings of either comfort or discomfort and thereby no social support. Many co-workers, particularly the assistant nurses, become insecure due to demands on

³⁸ Here I mainly think of the doctors’ buffer culture and their professional ethic which up to now have excluded the nurses from any real influence in the health care system (Lindgren 1992 and 1999).

social skills, individuality and individual responsibility, and they fear that they will be held accountable for any mistakes they might make. There is an obvious risk that the co-workers of the team will get neither confirmation nor feedback in their daily work.

To me it seems as if the co-worksip and the new organisational culture first and foremost are dominated by risks; the inhuman side expands in times of cut-downs. For the good side to co-worksip to be developed, something else is required. In the strangling grip of insufficient resources, the norms of the co-worker culture become mainly formed by the implacable demands of the technical-economic system.

A Field Experiment in Human Burn Out?

Finally let me return to the phenomenon of the group as a collective buffer and the group as a team. The group as a collective may, as I have argued, be thought of as a buffer against excessive demands from the employer, colleagues and patients. But these groups today have been replaced more and more by different forms of multiprofessional teams. This is a positive development to quite some extent, but it can also be associated with social health risks. Among other things this organisational change gives rise to the lonely team worker's dilemma in today's greedy care organisation.³⁹

One theoretical interpretation can, however, be put forward finally. Lately our attention has been called to numerous reports of burn out among health care personnel. According to Asplund we could expect precisely this of an organisation which systematically eliminates the concrete sense of belonging to a group. Co-worksip can, as has been shown, almost be compared with an opinion in Tarde's sense.⁴⁰ Important in this comparison is that it directs our attention to an abstract kind of social belonging. Burn out is thus coupled to a specific form of interaction with colleagues (and patients) which may result in *emotional loss* or *emotional death*.⁴¹ People get burnt out because they have no real feedback or support from their equals. In a work situation signified by a lack of common interpretations in the social interaction (abstract sociality), the social responsiveness becomes reduced and turned into its opposite, that is, asocial unresponsiveness. The background to this line of reasoning is built on the assumption that we can talk of abstract individuals in an abstract society. Furthermore it assumes that we can discuss the origins of a pure sociality and view the social responsiveness as concrete within the boundaries of a concrete sociality and abstract within an abstract sociality. Whenever the responsiveness is concrete, it gets constant in-

³⁹ A much too lean organisation without any reserves can be labelled greedy. No matter how hard the personnel work they can never do enough (Kvande 1998, Lindgren 1999).

⁴⁰ Tarde (1901), cited in Asplund (1987).

⁴¹ Ibid p 144.

puts and changes continuously, i.e. there is no risk of burn out among those who are part of the interaction. Health care has increasingly, through the new organisational models and the dominance of the economic discourse over the caring discourse, developed in ways which further the abstract sociality at the expense of the concrete. In my studies I have shown how this occurs in the transition from concrete work groups to abstract teams and through the introduction of the prototype co-worker. In the groups that were built upon similarity and the definition of mutual problems, the concrete sociality dominated. The members established their own norms and the input of emotions was unlimited, for better or worse; you may argue in these groups but you will not get burnt out. In the latter – the teams – the members take on solely an artificial role and their patients are clients, costs and illnesses; here the sociality and the responsiveness become abstract, and a process of burn out together with feelings of guilt may get the upper hand.⁴²

A conclusion of this is that the organisation's concrete ability to "refuel" its members must receive attention for the problems of burn out to be uncovered. It is not merely a matter of more stress, more pressure or less time to rest, recover and sleep. Nor is it just a matter of securing more control, experiencing fewer demands and gaining social support from an appreciative management. It goes deeper than this: what is needed is the support of concrete relations with people who share the daily conditions at work, support of those who know the problems and with whose help the individual can set the necessary limits.

Eventually we need to ask whether this gigantic field experiment in abstract co-workship in the so delicate caring organisation ought to have been exposed to ethic examination before it was launched. At the present this experiment has to be regarded as a health risk project whose consequences we probably have only seen the beginnings of.

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⁴² Ibid p 173.

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What do we mean by “work environment”?
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