Boundaries of Professionalization at Work

An Ethnography-inspired Study of Care Workers' Dilemmas at the Margin

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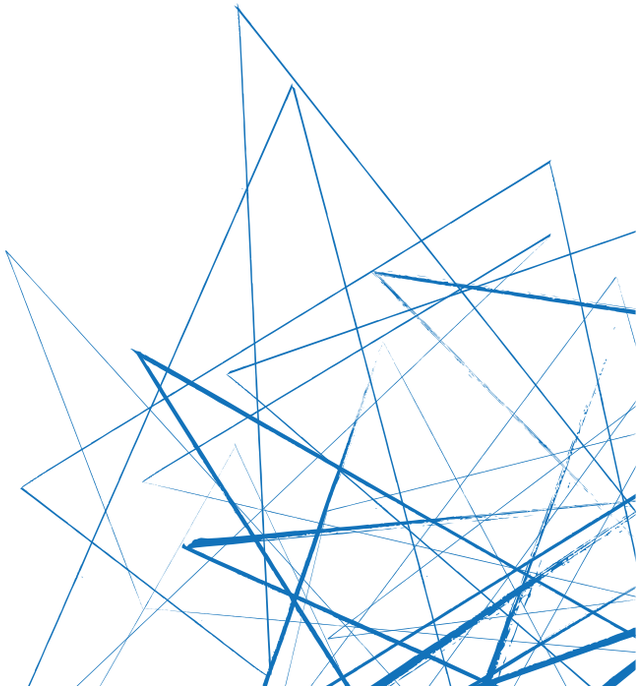

BOUNDARIES OF PROFESSIONALIZATION AT WORK AN ETHNOGRAPHY-INSPIRED STUDY OF CARE WORKERS' DILEMMAS AT THE MARGIN

PhD Series 39-2017

Maya Christiane Flensborg Jensen

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Doctoral School of Organisation and Management Studies | **PhD Series 39.2017**

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The Doctoral School of Organisation and Management Studies (OMS) is an interdisciplinary research environment at Copenhagen Business School for PhD students working on theoretical and empirical themes related to the organisation and management of private, public and voluntary organizations.

CONTENT

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Thank you, my son. I love you more than anything in the world. You have been both my key motivating factor to finish the dissertation, and also a powerful reminder that there are things in the world that are way more important than a dissertation. A dissertation only consists of typed letters. I hope, however, that my typing will make a bit more sense than yours, although yours is undoubtedly more creative.

PREFACE

It is 10 am at a conference centre in Copenhagen. I am, in my capacity as a work environment researcher (my occupation at the time), sitting among 200 home care workers, employees and managers, ready to take notes. We are the lucky participants who managed to get tickets before the conference quickly sold out. We have come from all over the country to hear about the topic of the conference: rehabilitation in home care organizations. The atmosphere is vibrant. We are all familiar with the rumours: that rehabilitation is celebrated as a so-called innovative win-win strategy said to improve the quality and efficiency of home care work, and we are curious to hear more. On the conference poster, two people are shown riding a motorbike. They are smiling, and – judging by their body language – driving at high speed. The wrinkles lining their faces reveal their advanced age. This image of happy, mobile senior citizens seems promising for what we are about to hear.

The first keynote speaker, and one of the few men participating at the conference, is an economist. One of his first slides depicts a graph, which illustrates a proportional relationship between age and health care expenses. He maintains, however that rehabilitation might break this curve. In fact, his studies of "Fredericia" – the first home care organization[1] to implement rehabilitation in Denmark – show that an estimated 14 million Danish kroner has been saved with the introduction of rehabilitation.

The subsequent keynote speaker, a Swedish occupational therapist, is introduced as the original creator and inspiration source to the now so-called "Fredericia model," that won an innovation prize in 2010. She explains that rehabilitation is an antidote to older people's decline. At its core rehabilitation seeks to retrain senior citizens and increase their functionality in order to bring them back to an active life in society instead of stigmatizing them and making them dependent of nurture.

The following keynote speaker, a senior manager from one of the 98 public home care organizations in Denmark, exemplifies how training senior citizens has resulted in savings and happy citizens in her home care organization. She explains, for instance, that rehabilitation has changed the life of one of her (former) 74-year-old care recipients. Prior to rehabilitation, he received one hour and 10 minutes

[1] In Denmark there are 98 municipalities, that each are in charge of a public home care organizations, that provide home care services to all citizens in the municipality without a user's fee if they are perceived as incapable of independently performing homecare tasks (Nielsen and Andersen, 2006). And thus, Fredericia is in fact the name of the municipality.

of help putting on his compression socks. However, since his enrolment in a rehabilitation program he has been able to do it himself using a specific tool: a compression sock aid. The senior manager continues by emphasizing how her employees not only find it professionally more "interesting" to work with restoring care recipients, but also that those working with rehabilitation have been upskilled and gained new professional competences and an opportunity to use them.

The final keynote speaker, a work environment expert also suggests that rehabilitation may improve the home care workers' satisfaction with their work. She highlights that rehabilitation in home care is associated with reorganizing the work. For example, she explains that rehabilitation implies hiring in new expertise (occupational and physical therapists), introducing new cross-occupational team meetings, and new work techniques. New ways to organizing home care work, that she maintains may be an opportunity to improve the workers' qualifications, collaboration, and working condition.

This narrative about the rehabilitation conference is constructed on the basis of field notes I took in my capacity as a work-environment researcher in 2012.[2] In many ways, the event served as the launch pad for this dissertation. What caught my interest at the conference was the fact that the keynote speakers, who had varied backgrounds, constructed rehabilitation as a new win-win policy that would benefit not only public finances and care recipients but also home care workers.

As a work-environment researcher, I was particularly curious about how rehabilitation and the corresponding savings could benefit the workers. I knew that researchers in the fields of sociology, gender studies, and work environment had repeatedly demonstrated that home care work is a type of undervalued, marginalized "women's work" (dominated by females[3]). It is often characterized by low status, low pay and the need to carry out various often stigmatized services in the homes of older people. As such, home care workers have historically struggled to be recognized as professionals (see, e.g., Rasmussen, 2004; Dahl, 2009, Knijn and Verhjagen, 2007).

[2] The narrative is also based on the keynote speakers' slides. I took part in the conference due to my involvement in the ReKoHver research project before starting my PhD studies. I describe this project and my use of data from the project in the method section.

[3] In Denmark, 94.8% of organized-care aides are women. Only 8% of publicly employed Danish care aides are non-skilled (i.e., with less than 14 months of formal training). However, compared to other occupational groups, such as doctors, lawyers and nurses, the 14-month requirement is relatively low. In addition, compared to other publicly employed workers in Denmark, care aides receive the fourth-lowest salary (www.krl.dk; FOA, 2014).

Given these struggles, the professionalization promises made under the label of rehabilitation in terms of promising the workers more professionally interesting tasks and skill enhancements seemed encouraging. At the same time, they were puzzling. I knew that attempts to professionalize not only public-care workers but also the management of public organizations were not new – they began in the 1980-90s. However, none of these professionalization attempts had been able to radically change home care workers' marginalized position as professionals.

A common explanation for this professionalization failure is that attempts to professionalize public management by ensuring more efficient and accountable services have been counterproductive for attempts to upskill the workers. In this respect, I was puzzled by the idea that promises of efficiency and upskilling could suddenly be united under the label of rehabilitation, and by the fact that professionalization continued to be hailed as the right tool for releasing home care workers from their marginalized positions as professionals.

Several questions surfaced: How could attempts to centre professionalization on the concept of rehabilitation succeed in professionalizing home care workers? By what means of regulations and practices? By whom, for whom and in which situations? What were the alternatives? What was the likelihood that the workers' marginalized position would remain unchanged? These initial questions gave rise to this dissertation.

CHAPTER 1: INTRODUCTION

1.1 Professionalization and marginalization in home care organizations

Public care workers tend to sustain a marginalized professional status in society despite ongoing attempts to professionalize their area of work. This has puzzled academics (e.g., Sullivan, 2007, 2014; Cheney and Ashcraft, 2007; Davies, 1996), who have increasingly questioned whether we have fully understood the complexities and particularities of how professionalization processes are constituted and function. The scholars suggest that care workers' marginalized positions are difficult to change by means of professionalization because professionalization processes are not neutral or evolutionary. These scholars encourage us to look into how definitions of "professionals" and the modes of organizing "professional" work in the west tend to privilege some workers (i.e., white, white-collar, heterosexual males) and marginalize others, especially female workers who perform "dirty", private household services for the aging or disabled, such as home care workers (Sullivan, 2007).

This dissertation contributes to this academic debate by studying the relationships between professionalization and marginalization processes in Danish home care organizations. Since the 1990s, Danish home care workers have faced an ongoing range of new reforms and demands that have focused on professionalizing home care work by imposing new so-called professional structures, skills or status on the workers. These sources to professionalize the work have been heavily contested and often portrayed as paradoxical. For instance, aims of making home care serives more efficienct and accountable has been accused of undermining home care workers' new skills (e.g., Davies and Thomas, 2002). However, as shown in the narrative about the 2012 conference in Copenhagen, the introduction of rehabilitation in home care organizations seemed to rhetorically air the hope that different aims of professionalization can be combined in non-controversial "win-win" ways – an optimistic rhetoric that indeed appeared promising. However, in acknowledging the complex nature of professionalization processes and care workers' historical risk of marginalization, this dissertation suggests that we should not take the optimistic rhetoric for granted. Therefore, this dissertation delves into the various layers of complexity, challenges and dilemmas that rehabilitation may give rise to in home care organizations. As such, I use rehabilitation as a particularly relevant case for exploring the particularities of how marginalization processes are avoided and/or silenced in contemporary publicly funded care organizations. This focus contributes to a more complete understanding of the mechanisms through which contemporary professionalization processes silence marginalization processes at work.

1.2 Historical struggles over professionalization

The optimistic rhetoric that flourished with the introduction of rehabilitation can only be understood by examining the historical struggles related to professionalization that have characterized home care work since it became a new type of public-service job in Denmark through the introduction of the "housewife replacement legislation" in 1949. Since that time, publicly-funded home care services have expanded[4] and home care workers and their areas of work have been influenced by numerous reforms and changes. Since the 1990s, these changes have affiliated with the professionalization etiquette. However, the professionalization attempts have followed different paths, and they have often been portrayed as polarized or even paradoxical in public debates.

Some of the loudest, most influential voices in the professionalization debate have argued that home care organizations and publicly-funded organizations in general have been poorly managed. Such voices suggest that public organizations have generated inefficient, expensive and unaccountable welfare services, and that new, more professional ways of managing these organizations are required to ensure the survival of public-welfare provision despite the pressures of, for example, demographic transformations and economic crises (Rasmussen, 2004; Rose, 1996; Dean, 1999). Influenced and informed by management scholars and their studies of private organizations, this argument has typically been put forth by different governments. Under the label of "new public management" (NPM), it has triggered the introduction of several market-oriented models and tools in public organizations. For example, outsourcing, free-choice arrangements, provider-performer models and Taylor-inspired time-control initiatives have been implemented to control expenditures and ensure the accountability of publicly-funded home care organizations (Nielsen and Andersen, 2006; Hansen et al., 2011; Ryberg and Kamp, 2010).

Simultaneously, other influential voices in the professionalization debate have argued that it is necessary to define, formalize and upskill home care workers' professional skills and qualifications. Such professionalization demands crystalized in 1991 when a formal care-worker education programme lasting 14 months was introduced (Ryberg and Kamp, 2010). This programme provides

[4] The expansion in the use of home care is affiliated with women's increased employability in Denmark and the fact that home care has been prioritized as an alternative to more expensive nursing homes (Nielsen and Andersen, 2006).

training to care aides, the dominant occupational group within home care organizations. This attempt to professionalize home care workers through increased formal training and (re-)education has predominantly been supported by the care aids' trade union (FOA) and viewed as a means to secure the status of care aides as professionals.

These movements to ensure more professional management of home care organizations (through marketization and NPM) and home care workers' status as professionals (through upskilling) have often been portrayed as paradoxical and dichotomous. Participants in the public debate argue that the path to upskilling and ensuring the status of public care workers as professionals is undermined by NPM, especially by its aims of making home care services more efficient and accountable. In particular, NPM has been accused of intensifying the workload and eroding workers' autonomy. As such, some view NPM as a path to deprofessionalisation, de-qualification and even proletarization of the workers (see, e.g., Davies and Thomas, 2002; Dahl, 2009). This critique has been publicly expressed by FOA. In 2007 and 2008, FOA organized demonstrations in which Danish home care workers carried banners with slogans such as "Union of disregarded workers" and "Poor and overworked" (Dahl, 2009: 634).

Different ideas about how to achieve professionalization (i.e., either through marketization or upskilling) have thereby been heavily contested and often portrayed as paradoxical within public debates. However, contemporary policies in public organizations, such as rehabilitation, seem to suggest a new professionalization path that blurs the image of a clear-cut paradox between the marketization and upskilling paths. Such contemporary policies propose that efficiency and upskilling purposes can be combined in non-controversial (win-win) ways (see also, e.g., Dahl, 2009; Rasmussen, 2004). These policies brings to the foreground a common assumption that has historically characterized the different voices and paths in the public debates about professionalization – that professionalization *is* a valuable goal for publicly funded welfare workers and organizations to pursue. By investigating the case of rehabilitation, this dissertation explores how contemporary policies blur the picture of a clear-cut paradox between efficiency- and upskilling-oriented professionalization processes, and how such processes may influence home care workers' marginalized professional status.

1.3 Rehabilitation: An appealing and valuable professionalization opportunity?

Rehabilitation is not a novel label. According to the Oxford Dictionary[5], the term can be traced back to the late sixteenth century, when it referred to a way to restore and/or re-establish a "reputation", "privilege" or "condition" after a period of disfavour. Rehabilitation has since been applied to a wide range of areas that have been "disfavoured" during certain historical moments. Katz (2000) argues that the idea of restoring and re-establishing older peoples' "favour" started to circulate in gerontological circles in the 1970s. However, as shown in the opening narrative from the 2012 conference in Copenhagen, although rehabilitation is not a novel idea within eldercare, rehabilitation has recently been revitalized as a professionalization path that unites efficiency and upskilling concerns.

The rising interest in rehabilitation in home care organizations across western countries, such as the UK, the US, Germany, Norway and Sweden, is remarkable. The label has proliferated under such names as "hemrehabilitering", "reablement" and "restorative care" (Gustafsson, Gunnarsson, Sjöstrand and Grahn, 2010; Kjellberg, Ibsen and Kjellberg, 2011a; Social Care Institute for Excellence, 2010; Helsedirektorartet, 2012). In Denmark, a single publicly funded home care organization, known as "Fredericia", introduced rehabilitation in 2010 and consequently received an innovation prize. Within two years, 92 of the 98 public home care organizations in Denmark had officially implemented the "innovative" rehabilitation solution (Kjellberg et al., 2013). The Fredericia model was viewed as an innovation within home care policy and practice not only because it was framed as a replacement for the narrow efficiency- and market-oriented professionalization initiatives that had emerged in the 1990s (i.e., NPM) but also because the evidence from Fredericia suggested that rehabilitation could generate the desired win-win outcomes (see the preface). A report on the Fredericia experience entitled "From nurturing to rehabilitation[6]" summarized the win-win outcomes as follows:

> Fredericia has *several* examples of citizens [home care recipients] who have become more self-reliant [through rehabilitation] and who view becoming independent of home care as highly beneficial. (…) The employees (…) are *generally* proud of the results (…). The budget reveals that the consumption of services fell by approximately DKK 14

[5] https://en.oxforddictionaries.com/definition/rehabilitate
[6] Danish title "Fra pleje og omsorg til rehabilitering – erfaringer fra Fredericia kommune"

> million, which corresponds to 13.9% per citizen. (Kjellberg et al., 2011a: 6-7, emphasis added)

The evaluation report emphasised that the implementation of rehabilitation in home care organizations could lead to more satisfied recipients, more satisfied and proud professionals, and overall (short-term)[7] savings. These potential positive outcomes suggested that efficiency and upskilling purposes could be intermingled in non-paradoxical and valuable ways under the rehabilitation label. More specifically, the evaluation report stressed that efficiency could be ensured through rehabilitation not by introducing new market-oriented, time-control models but by investing in the upskilling and professionalization of the home care workers' approach to care. In other words, the goals could be achieved by teaching home care workers to shift their focus from nurturing the elderly toward rehabilitating them to become (more) self-reliant and thereby reducing the services required (see preface; Kjellberg et al., 2011a).

The report and the keynote speakers at the 2012 Copenhagen conference point to three upskilling initiatives that were expected to underpin the change from nurturing to rehabilitating services: 1) the introduction of *new experts* (i.e., occupational and physical therapists) who could teach the care aides to perform rehabilitation work, 2) the introduction of *new team meetings* during which the professionals could discuss their progress with rehabilitation work, and 3) the introduction of *new practices and tools* that would support the workers in their performance of rehabilitation (see also, Kjellberg et al., 2011b). The three initiatives for upskilling workers were associated with more professional tasks and competences, and were therefore expected to give rise to more pride among home care workers. This focus on enhancing qualifications and investing in human resources may explain why FOA generally support the indtroduction of rehabilitation in home care organizations.[8]

[7] The evaluation of the financial gains is based on data collected over a two-year period (Kjellberg et al., 2011a).

[8] FOA (the care aids' trade union) describes its overall view on rehabilitation on its home page, where the organization indicates that it supports rehabilitation because it "is always exciting [for workers] to get new tasks", and because it is "crucial for FOA to ensure that care recipients can sustain their independence and their self-reliance, and actively participate in their own lives as long as possible". FOA also argues that this "benefits the recipient and society". The union adds that it "actively works" to ensure a "worker's perspective", which requires that "rehabilitation is *not only* introduced to ensure savings in the municipalities" (emphasis added). This is the only hesitation evident on FOA's webpage (https://www.foa.dk/forbund/temaer/a-i/hverdagsrehabilitering/det-mener-foa).

The dominant optimistic voices in home care policy add to the idea that professionalization under the label of rehabilitation is a valuable path for home care workers to pursue. However, a few crucial empirical studies indicate that rehabilitation may not be frictionless in home care organisations. These studies indicate that some recipients and workers have some reservations and concerns about the reduction in care and costs that follows rehabilitation (Anker, 2011). In addition, a recent study of censorship in the Danish public sector suggests that up to one-third of employees working in elder care fear retaliations from their managers if they speak critically of conditions at work (Pedersen and Jespersen, 2017). These studies do not discuss in debt why some workers have reservations about rehabilitation or what underlies censorship in Danish eldercare (i.e., how or why home care workers may censor themselves). However, the empirical evidence shows that examining how workers benefit from the rehabilitation opportunity and whether critical voices have been silenced may be worthwhile.

More fundamentally, some of the core assumptions associated with rehabilitation in home care policy may be questionable from a critical academic point of view. For instance, recent studies of NPM raise doubts about whether rehabilitation actually replaces NPM or is a continuation of NPM in a new format.[9] More importantly, feminist-inspired academics with a particular interest in care work and its management raise questions about whether professionalization is actually valuable and the right way to release care workers from their marginalized position in western societies (see, e.g., Sullivan, 2007; Davies, 1995; Davies, 1996; Hearn, 1982; Bolton, 2006; Twigg et al., 2011; Butler et al., 2012). Such studies encourage us to not lose sight of the dilemmas that professionalization processes have historically posed for groups of workers. The home care workers' fight to be recognized as professionals has taken place within a western context in which "professionals" and their privileges have marginalized and stigmatized the personal attributes and areas of work that home care workers tend to embody, symbolize and practice.

The studies (Ibid) indicate that the marginalized position of home care workers is bound up in understandings of professionalization for at least two reasons. First, in western countries, professional labels have historically been reserved for occupations and work that take place outside the home (e.g.,

[9] For instance, Dahl (2009) decribes how NPM is not a homogeneous discourse. Rather, she propose NPM is a complex discurse that is affiliated with both neo-liberal economics, but also with Human Ressource Management studies that stresses good leadership, self-governance and co-operation.

lawyers and doctors), while other occupations, such as care aides, have been excluded from such labelling. For example, personal care has typically been associated with household duties that "could be done by 'any' women" (Rasmussen, 2004: 262; Davies, 1995). Second, hierarchical ways of organizing work have tended to relegate some occupations, such as care aides, to (lower-status) support roles (e.g., occupied with taking care of bodily waste and emotional issues). People in these roles often serve those in more privileged, higher-status occupations, such as doctors (e.g., occupied with administrative and technically sophisticated tasks) (Twigg et al., 2011; Davies, 1996; Hearn, 1982).

Such academic studies indicate that definitions of professionals and the ways of organizing professional work tend to marginalize groups of workers, such as home care workers. Or in other words, the studies propose that the home care workers' struggle with professionalization has historically been closely linked to what I refer to as "boundaries of professionalization". These boundaries encompass discursive and more material divisions at work that privilege the professionals (e.g., actors, skills, techniques, labels and positions) at the expense of non- or semi-professional others (e.g., care workers). Due to such boundaries, the latter group risks social, technical and economic marginalisation at work. These academic studies, in tandem with the empirical studies that indicate that rehabilitation is not frictionless in home care organizations, highlight that that rehabilitation may be constituted in far more complex ways than the dominating optimistic rhetoric seem to propose. Therefore, in inquiring into the various layers of complexity and potentially hidden dilemmas, challenges and marginalization processes that rehabilitation may give rise to at work, I adopt a critical stance in this dissertation.

1.4 Critical voices on professionalization and marginalization

The goal of this dissertation – to investigate how dilemmas and marginalization processes were avoided or silenced in rehabilitative home care organizations – reflects my critical stance. This stance implies that I am committed to studying processes of professionalization as centred around divisions, differences and often oppression (see also Hearn and Parkin, 2001). In other words, I aim to investigate the processes associated with the new privileges and types of inclusion that might emerge with the introduction of rehabilitation, as well as the potentially intersecting processes of (re)marginalization. I propose that the notion of boundaries of professionalization, which I presented briefly above, may be particularly useful for analytically guiding this commitment. The formulation of this notion as well as

my critical stance have predominantly been inspired by the aforementioned feminist literature on professionalization. In particular, the literature has encouraged me to define this notion in ways that allow for an analysis of how boundaries of professionalization may be discursively and more materially constituted at work. However, to ensure a critical stance, I did not restrict my reading to feminist literature. Rather, I searched more broadly for critical discursive-oriented and more materially-oriented studies that could help me denaturalize the ways in which boundaries of professionalization are constituted and function in rehabilitative home care organizations.

The discursive-oriented research comprises a range of critical studies interested in describing how the boundaries of professionalization are discursively constituted and regulated through intersecting managerial discourses of difference, and their general implications for workers' professional identities. Such research involves investigations of how western notions of professionalization are often associated with new, externally imposed managerial policies. It also focuses on regulative discursive activities that segregate the professional from the non-professional. For instance, discursive activities that a) include and privilege connotations of masculinity in the notion of professionalism, while excluding and marginalizing the feminine (Ashforth, 2007; Davies, 1996; Davies and Thomas, 2002); b) include and privilege what is conceived of as "clean" and "civilized" in the notion of professionalism while marginalizing what is associated with moral, physical and social pollution; stigma and dirt (Ashforth and Kreiner, 1999; Ashforth et al., 2007) or c) include and privilege what are conceived of as "entrepreneurial" and "committed" workers while excluding "disloyal" workers (Barker, 1993; du Gay, 2008). These studies adopt a critical view of how the political and symbolic sub-contexts regulate boundaries of professionalization, and they pay attention to how definitions of the professional are often congruent with objectives defined by management or the elite. Therefore, discursive boundaries of professionalisation function to conjoin, mobilize and regulate workers to identify with specific professional identities, self-images, expertise and feelings (i.e., hopes, aspirations and fears) while disidentifying with others. Sometimes, with resistance and identity struggles as a result (Alvesson and Willmott, 2002).

The material-oriented studies are more concerned with describing the less abstract, more "material" or practice-oriented dimensions of how professionalization boundaries are embedded or "marked up" at work. In contrast to the discursive-oriented studies, which predominantly rely on data from interviews

and document analyses, the material-oriented studies typically draw on ethnographic data. For instance, classical scholars (Hughes, 1958; Strauss et al., 1997) and feminist-inspired scholars (Sullivan, 2007; 2014; Twigg et al., 2011) have used ethnograpic data to analyse how the boundaries of professionalisation are embedded in socio-technical ways of organizing and working in organizations. The research exemplifies how boundaries of professionalization are embedded in task trajectories, diagnosis processes, face-to-face interactions, occupational hierarchies (e.g., the division of labour), knowledge systems and technologies, actors' bodies, and the material artefacts that characterize the surroundings (e.g., uniforms, bodies, furniture). These studies suggest that socio-technical ways of organizing and practicing work demarcate boundaries of professionalisation because they materially influence who or what are included in the imperatives to "be professional" and "do professional work". At the same time, they determine what is excluded as not being professional or doing professional work.

As the discursive-oriented and material-oriented studies on professionalization rely on different concepts, focal areas and methods, we might expect some kind of tension between them.[10] Such tension may be seen as problematic within a positivist paradigm, which tends to rely on the incommensurability thesis as a guiding principle (Sullivan, 2007). The incommensurability thesis views combinations of different paradigms as problematic, and suggests that scholars should choose among scientific and theoretical approaches to avoid "messy confusion" (see e.g., Alvesson and Kärreman, 2011). However, the incommensurability thesis is increasingly contested by a growing number of academics who argue that the material and discursive distinction makes little sense[11] (see e.g., Butler, 1990), or that the tension and a focus on the co-emergence of material and discursive processes may be used productively to ensure a more nuanced understanding of the relationship

[10] This tension is evident among the scholars I include in the two sub-perspectives. For example, I have included Alvesson and Willmott (2002: 619, 621) in the discursive-oriented sub-perspective. They have broadly accused "classic" material and practice-oriented studies of focusing too narrowly on the design of work and "outside" regulation of workers (i.e., bureaucratic, mechanistic, technocratic and behavioral aspects of control), while neglecting how modern business regulates the "inside" of workers (i.e., identities and feelings). This critique can be conceived as rooted in the "cultural turn", a movement within academia that puts notions of culture, meaning and symbols at the center of methodological and theoretical focus, and as a response to studies that neglect of these aspects of organizational life (Ashcraft, 2007). Wolkowitch (2006), whom I have categorized as a material practice-oriented scholar, has accused the discursive regulative-oriented scholars of exaggerating the discursive malleability of, for example, the body while overlooking the bodily, more material distinctions that work involves.

[11] Butler (1990) argues for instance that the dichotomy between materiality and discursivity is itself a social construction.

between professionalization and marginalization (Hearn and Parkin, 2001; Davies, 1996; Sullivan, 2007). In terms of my development of the notion of boundaries of professionalization, I follow the latter position. My intent is to use this notion to generate a more nuanced, complex understanding of how processes of professionalization and marginalization are regulated, negotiated and practiced in intersecting ways at work, and the dilemmas and challenges that such intersections may produce for workers in terms of their being economically, socially or technically marginalized.

1.5 An ethnography-inspired exploration of rehabilitative home care organizations

To move the focus from the optimistic rhetoric about rehabilitation towards the complex ways in which the boundaries of professionalization may be regulated, negotiated and practiced in rehabilitative home care organizations, this dissertation draws on an eight-month ethnography-inspired study of five rehabilitative home care organizations. The five home care organizations introduced rehabilitation activities just before the study began. I focused, in particular, on how the traditional home care workers (i.e., care aides) and their managers (typically nurses) were influenced by the introduction of the three aforementioned means to professionalize home care workers: new experts (i.e., occupational and physical therapists), new team meetings, and new rehabilitation practices and tools (Kjellberg et al., 2011b). More specifically, I observed how rehabilitation was handled by different workers in the recipients' homes and how those activities were discussed during team meetings. These observations were supplemented with focus groups, which gave the different groups of professionals an opportunity to express their experiences with the introduction of rehabilitation.

1.6 Towards a research question

Within the last decade, rehabilitation has been framed as a new professionalization opportunity within home care policy and practice in both Denmark and across Europe. Rehabilitation is said to reconfigure home care work in ways that result in improved working conditions, better quality of services, and cost savings. However, this dissertation take a crtical stance to the optimistic rhetoric that surround the notions of rehabilitation. In acknowledging home care workers' historical tendency to remain marginalized in western societies despite waves of professionalization attempts, I build on research that closely unites professionalization and marginalization processes to suggest that the ways in which rehabilitation appears to have avoided or silenced marginalization processes, challenges and dilemmas

should not be ignored. Rather, they should be critically explored from both practical and theoretical purposes.

Practically, the aim of the dissertation is to add a nuance to the public debates about rehabilitation and its potential by shifting the focus to the dilemmas and challenges that home care workers might face as a result of the professionalization processes, and in particular their ongoing risks of being socially, economically and technically (re-)marginalized at work. My theoretical proposition is that to explore potential intersections between the professionalization and marginalization processes in rehabilitative home care organizations we need to combining building blocks from critical discursive- and material-oriented oriented studies on professionalization. The aim is that this combination should advance both our empirical and theoretical understanding of the material and discursive constitutive processes through which the boundaries of professionalization are regulated, negotiated and practiced in organizational settings. To guide the practical and theoretical aims, I propose the following research question:

How are the boundaries of professionalization regulated, negotiated and practiced at work in rehabilitative home care organizations, and with what implications for the home care workers and their risk of being socially, economically and technically (re-)marginalized?

1.6.1 Clarifying reflections on the research question

The wording of the overall research question emphasizes my approach to the issue of professionalization in this dissertation. The focus on the phenomenon of professionalization boundaries shows that I am not engaging with the issue of professionalization in a neutral, apolitical or evolutionary way. Instead, this focus demonstrates the critical stance I develop in this dissertation.

In addition, the research question emphasizes the focal level of analysis for my study of the intersections between professionalization and marginalization. I centre on the particularities and complexities by studying how such boundaries of professionalization are constituted "at work" in rehabilitative home care organizations. For this purpose, the dessertation draws on ethnography-inspired data from five rehabilitative home care organizations that may serve as a window into the multiple work sites, actors and practices that characterize rehabilitative home care organizations.

Furthermore, the research question highlights the three analytical topics on which I focus on in my conceptualization of how boundaries of professionalization are discursively and materially constituted in rehabilitative home care organizations. More specifically, I focus on how professionalization processes and, by implication, marginalization processes are *regulated*, *negotiated* and *practiced*.

Finally, the research question emphasizes that I am interested in the implications that boundaries of professionalization might have for home care workers. As I discuss in the dissertation, home care work in Danish rehabilitative home care organizations predominantly involves three occupational groups: nurses, (physical and occupational) therapists and care aides. However, when I use the term "home care workers" in this dissertation, I am generally referring to the dominant and lowest-status occupational group: the care aides.

To answer the research question, the dissertation includes three articles that together forms the dissertation's analytical body. Each article is a product of an explorative writing process in which I moved back and forth between the empirical data and different theoretical building blocks to explore the multiple ways in which boundaries of professionalization were constituted at work and the implications of those boundaries. As a result of this process, each of the three articles focuses on how the professionalization processes and, by implication, the marginalization processes are:

1) *Regulated* through the introduction of new experts in rehabilitative home care organizations (article 1);

2) *Negotiated* during the newly established team meetings in rehabilitative in home care organizations (article 2) and

3) *Practiced* through the introduction of new techniques and tools in rehabilitative home care organizations (article 3).

While the analytical focus of the three articles has been explained above, the empirical foci that surround each of the three analytical topics — the introduction of new experts (i.e., therapists), new team meetings, and new techniques and tools – require some elaboration. These empirical foci are unpacked in the articles because the analytical investigation of the data showed that all three foci were naturalized as ways of professionalizing home care workers through the introduction of rehabilitation.

Therefore, in line with my critical stance, I felt that the empirically grounded naturalization of these three apparent means of professionalization offered excellent starting points for exploring and deconstructing the implications of such opportunities and the potential risk of marginalization.

The three articles also focus on how the regulation, negotiations and practices, respectively, influenced the care aides' risk of being socially, economically and technically marginalized at work. More specifically, article 1 examines how the professionalization process influenced the care aides' struggles to be recognized and socially valued as professionals at work (i.e., their identity struggles). Article 2 analyses how care aides' work and reflections may be socially rewarded and sanctioned during team meetings. Article 3 focuses on how the new technical practices and tools that care aides were expected to use affected their often stigmatized and devalued tasks and areas of work. This article also addresses the issue of their economic rewards.

Due to the centrality of boundaries of professionalization in my research question and the dissertation, I offer a final reflection about this notion. The term "boundaries" might be associated with a rather static, binary distinction that "exists" and is visible to the eye. Such binary distinctions divide social reality into strict binary demarcations (e.g., men/women, masculine/feminine, public/private, empowering/harming, including/excluding, professional/non-professional). However, I use boundaries of *professionalization* (instead of, e.g., "professional boundaries") in order to emphasize the multiple ways I explore boundaries at work. I understand boundaries, their constituents and their implications in the plural. I view them as products of ongoing efforts, and of historical, social, economic, technical and geographical influences that, despite their often hierarchical and oppressive character, may be contested and negotiated in the workplace. Similarly, I believe that the extent to which the implications of boundaries of professionalization are, for instance, empowering or harmful is an empirical question (see also Sullivan, 2007). In fact, this notion entails both a cautionary view of such binary perspectives, and a call to focus on the powerful ways in which such binaries are constituted in organizational settings (e.g., by whom and by which means) and how they serve to silence marginalization processes.

1.7 Structure of the dissertation

This dissertation is divided into 8 chapters. In this chapter, I have briefly introduced the theoretical and empirical sources that inform the dissertation. More specifically, I have discussed: (a) my critical

theoretical lens that experiments with combining discursive-oriented and material-oriented studies on how boundaries of professionalization may be regulated, negotiated and practiced at work, and; (b) my empirical study, which is based on ethnography-inspired data collected from five home care organizations that recently introduced rehabilitation.

In Chapter 2, I unpack the focal case: rehabilitative home care organizations. This introduction of the case reflects my intention to avoid abstract ideas about rehabilitation and to focus on the particularities of how rehabilitation is introduced in home care work. More specifically, I explain how rehabilitation has changed the multiple work sites, actor, tasks, and ways of organizing home care organizations.

In Chapter 3, I introduce the critical theoretical framework in more detail. I begin by unpacking my critical, feminist-inspired stance, and what this stance meant for my readings, and the way in which I have grouped and combined the discursive-oriented and material-oriented studies on professionalization. I then review the discursive-oriented studies and the material-oriented studies. I end the chapter by introducing an idea of how these two sub-perspectives on professionalization might be fruitfully combined in different ways to capture both the discursive and material constitution of boundaries of professionalization and their implications for the worker.

In Chapter 4 I unfold the methodology of the dissertation. I begin by outlining my explorative and evolving research design, which I call a "workography" approach, and the methods I used to collect the data used in the dissertation. In addition, the chapter describes the coding and analysis of the data, as well as my decision to write the three articles included in the dissertation. I end the chapter by reflecting on my overall knowledge production.

Chapter 5 is an English-language article entitled "Performative identity regulation: An empirical analysis of how co-working 'experts' legitimize managerial ideology and moderate resistance". This article combines theoretical building blocks from studies on (discursive) identity regulation and critical (Science and Technology-inspired) performativity theory. These building blocks are used to explore how the boundaries of professionalization are discursively and materially constituted through the new type of *regulation* of home care workers that my co-author Sara Louise Muhr and I propose arises through the introduction of new experts (i.e., therapists) in rehabilitative home care organizations. More specifically, the article puts forth the notion of "performative identity regulation" to discuss how

the introduction of therapists at work mobilizes home care workers' to adapt a new identity and role in two interrelated ways. To begin with, it shows how the therapists' presence promotes a discursive cultivation of a new "tough", "entrepreneurial" and "professional" rehabilitative persona, that is contrasted with the home care workers' 'traditional' (now marginalized) "soft" and nurturing persona. In addition, it shows how the therapists promote the new "professional" persona by embody this new ideal in their own performance at work at the frontline. We propose that both types of identity regulation affect the home care workers' behaviour, and ambiguously generate identity struggles among the care workers, while simultaneously moderating and silencing such struggles.

Chapter 6 is an article in Danish called "Teammøder i rehabilitativ hjemmepleje – effektiv ensretning eller nuanceret faglig dialog?". This article combines critical studies of postmodern team organization with classical studies on the complex and unpredictable nature of care work. These theoretical building blocks are used to explore how boundaries of professionalization are discursively and materially constituted through home care workers' negotiations during the newly introduced team meetings. The article shows that the meetings were characterized by asymmetrical relations in which the lower-status care aides shared stories about their complex rehabilitative work with the higher-status therapists who orchestrated the meetings. These stories were not equally received by the therapists, who celebrated and labelled some of them as "success stories," while others were received with less enthusiasm. After analysing these stories and their associated rewards and sanctions, the article proposes that the team meeting serves as an important new platform on which norms associated with successful and professional work efforts and outcomes are constituted through group dynamics. The article suggests that these norms are formed through a negotiated consensus that functioned at work by allocating social rewards to some workers and sanctioning others in a way that seemed to narrow down, rather than expand, ideas and discussions about what it means to work professionally in a home care context.

Chapter 7 presents the last article, called "Gender stereotypes and the reshaping of stigma in rehabilitative eldercare". This article combines dirty-work and body work studies. These theoretical building blocks are used to explore how, in conjunction with the introduction of rehabilitation, home care workers are offered new discursive and material practices and techniques for managing and negating areas of their work that are often stigmatized (i.e., their "dirty" work with aging bodies). To guide this investigation, I put forth the notion of "stigma shaping", which I use to discuss how the

workers' new practices and tools seem to reshape their approach to work that is often stigmatized and the content of that work. The article shows that in their role as "tough" professional rehabilitative entrepreneurs (article 1), the home care workers performed practices that created a distance to what were often stigmatized aspects of their work (Twigg et al., 2011). For instance, through these practices, the workers became capable of refocusing on the resources (rather than the decline) of older people and to physically distance themselves from the older people's ("dirty") bodies. However, the article suggests that this professional distance did not negate the aspects of work that were stigmatized (e.g., some of the older people were still declining and dirty). Rather, the findings indicate that a practice mechanism emerged that seemed to function at work by reinforcing the idea that it is stigmatizing and non-professional to have a dirty, declining body or to work with such bodies, and that such work should be avoided, silenced or reshaped instead of being socially and economically rewarded.

Finally, in chapter 8, I summarize the articles' most important answers to the overall research question. In so doing, I discuss the empirical findings and the core contributions to existing studies on professionalization. I also critically reflect on ways of extending my knowledge production and methodology through other studies of professionalization and marginalization. On a final note, I summarize the overall conclusion and address the ways in which that conclusion can be used in future attempts to professionalize workers at the margin.

CHAPTER 2: THE CASE

2.1 Rehabilitative home care organizations

Five public home care organizations make up the empirical foundations of this dissertation. These home care organizations had all recently implemented rehabilitation at the time of my inquiry. Therefore, I refer to them as rehabilitative home care organizations[12]. Inspired by classical studies on professionalization (Strauss et al., 1997; Hughes, 1958), I have approached these organizations from the perspective that they were comprised of multiple work sites, actors, tasks and ways of organizing. This implies that I have not focused on comparing them. Rather, my focus has been on their various characteristics. As I describe in detail in Chapter 4, although there were clear differences among the five organizations (e.g., size, geographical span, budgets), there were also parallels in the ways they implemented rehabilitation. This was not surprising, as key actors in all of the organizations explained that they had been inspired by the Fredericia model, that they had read the aforementioned report ("From nurturing to rehabilitation"), and that they had participated in conferences during which the model was explained. Some had even visited Fredericia for inspiration. As such, the purpose of this chapter is to provide a brief introduction to the characteristics of rehabilitative home care organizations and how they differ from ordinary home care organizations. I begin with a short introduction to the rehabilitation ideal as it was framed in the Fredericia report.

2.2 The ideal: From as long as possible in one's home to as long as possible in one's own life

As described in Chapter 1, rehabilitation was introduced into home care policy as "new" and "innovative" because attention was moving from nurturing to rehabilitation services. In addition, the Fredericia report launched rehabilitation as a paradigmatic change by situating it in a historical context (Kjellberg et al., 2011b: 6). The report explained that that the coverage provided by home care organizations expanded radically in the 1970s because home care was increasingly viewed as a preferable alternative to institutionalization in hospitals or nursing homes. In those years, the vision was to keep citizens in their *homes* for as long as possible, as doing so was expected to benefit those citizens and society alike. Rehabilitation was launched with a new vision of keeping citizens in their own *lives* as long as possible. According to the report, this moving of attention reflected a paradigmatic

[12] Some of the five home care organizations we studied had only implemented rehabilitation in parts of their organizations e.g. in some districts, however during our fieldwork we only focused on those parts that had implemented rehabilitation.

change because citizens were now expected to stay independent as long as possible rather than receiving help in their homes (Kjellberg et al. 2011b; Nielsen and Andersen, 2006). Notably, however, the reasoning that keeping citizens in their own *lives* as long as possible would benefit both those citizen and society was the same. The Fredericia report used Figure 1 to illustrate how rehabilitation would both "postpone" and "reduce" the recipients' need for help.

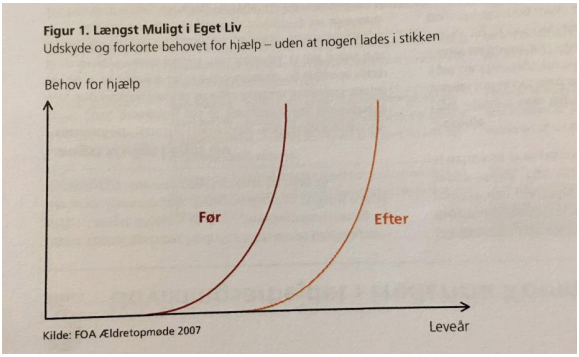

Figure 1. The rehabilitation ideal (Kjellberg et al., 2011b: 6).

While the extent to which this ideal reflects a paradigmatic change has been subject to debate (see e.g. Kamp, 2013), it was around this ideal that the new organizational changes were made.

2.3 The division of labour

Danish publicly-funded home care organizations are characterized by a hierarchical division of labour and many organizational layers. As the organizational diagram presented in Figure 2 exemplifies, rehabilitative home care organizations are usually organized with a top manager at the top of the hierarchy (i.e., a health-care or eldercare director) and two layers of middle managers (i.e., area leaders and district leaders). These leaders are typically in charge of either home care districts and services (domestic and personal care, e.g., cooking, cleaning, bathing, dressing) or nursing districts and services (e.g., wound care, insulin injections). Two sets of services that comprise home care provision in Denmark.

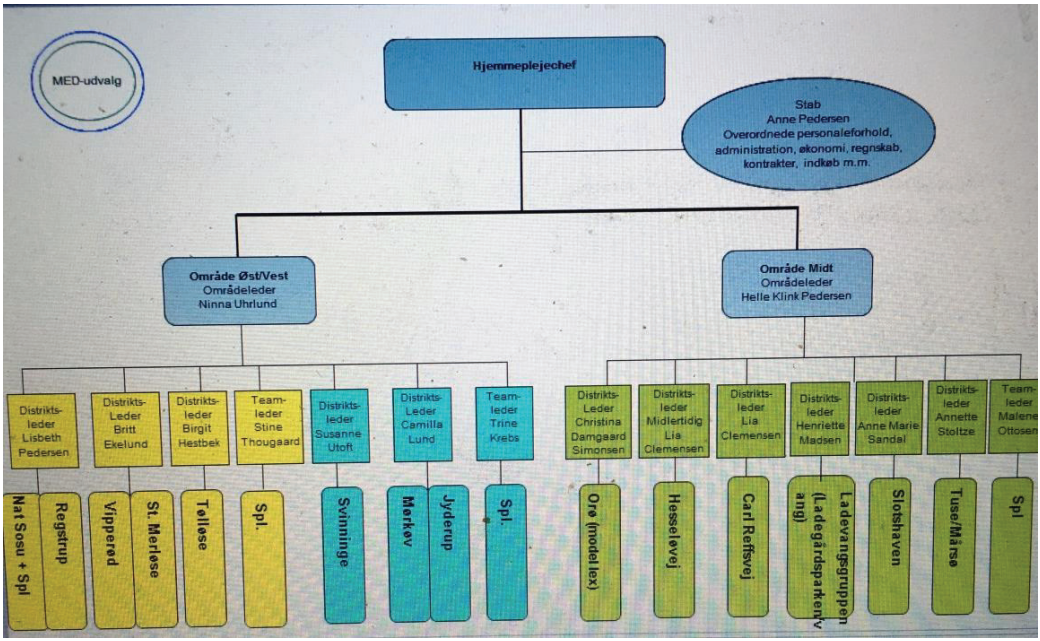

Figure 2. Organizational diagram from a rehabilitative home care organization.

In this dissertation, I focus on the home care districts and services rather than the nursing districts and services. Danish home care districts typically vary considerably in terms of the number of employees (from 12-40) and the geographical areas they cover (e.g., rural areas or cities). However, they are similar in the sense that they before the introduction of rehabilitation were managed by a nurse located in an office in the town hall or in a nursing home, while care aides[13] carried out the home care work in the homes. This division of labour changed, however, with the introduction of rehabilitation because a new occupational group (i.e., occupational and physical therapists) was added and defined as rehabilitation experts (see Figure 3).

[13] "Care aides" is a reductive term. It comprises workers who are called *sosu-assistenter* and *sosu-hjælpere* in Danish. *Sosu-assistenter* have had more training than *sosu-hjælpere* and, therefore, often perform tasks different from those handled by *sosu-hjælpere* (e.g., nursing-related tasks). The care-aide group also comprises workers with no education, although this segment is relatively small.

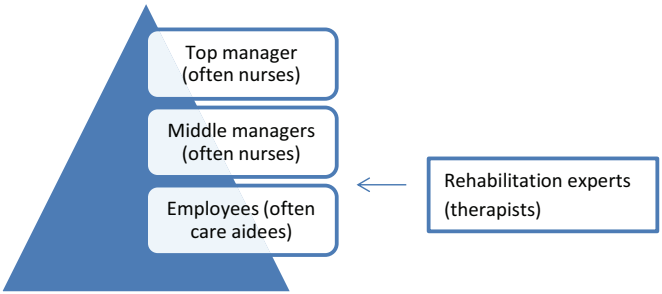

Figure 3. The division of labour in rehabilitative home care organizations.

In their expert position, the occupational and physical therapists were expected to underpin the change to rehabilitation by providing the care aides with rehabilitation expertise. In contrast to the managing nurses, therapists performed their work at the office and in the homes (and sometimes at training centres). Therefore, they held an "in-between" position in the organizational hierarchy, as suggested in Figure 3.

The hierarchy portrayed in Figure 3 also reflects that home care workers with different occupational backgrounds held different places in the division of labour. In Denmark, therapists and nurses typically have at least 3.5 years of formal training, while care aides have at least 14 months of training.

2.4 Recipients of care

The change associated with the introduction of rehabilitation was not only evident in the division of labour but also in the approach to care recipients. All Danish citizens living in Denmark can receive home care without paying a user's fee if they are determined to be incapable of independently performing home care tasks (Nielsen and Andersen, 2006). As in other western countries (England and Dyck, 2011; Knijn and Verhagen, 2007), home care recipients in Denmark are typically of advanced age, and suffer from some form of physical, social or mental incapacity. Accordingly, 133,000 of the 158,000 Danish home care recipients are over 65 years old, with an average age of 81.7. In 2009, 25% of these recipients suffered from mental and/or neurological disorders, and 66% of the Danish population over 75 years old suffered from a chronic disease (Hjemmehjælpskommissionen, 2013).

Prior to the introduction of rehabilitation, these care recipients could expect to receive home care services according to their legal rights (i.e., based on the municipality's interpretation of those rights), often on an ongoing basis. However, rehabilitation introduced new criteria for how recipients could secure their services and for how long they could expect to receive them (Kjellberg et al., 2011a, 2011b). This was because the shift toward rehabilitation involved the introduction of time-limited rehabilitation programs.

Interestingly, however, my fieldwork showed that the home care organizations often did not clearly define which citizens would be covered by these time-limited programmes or whether some recipients would be considered incapable of becoming self-reliant due to their advanced age and other social, psychological or physical vulnerabilities. Moreover, there was little information on whether care recipients could choose not to be included in the program. The typical response to such questions was that all recipients were expected to be enrolled in the long run. However, when I began my fieldwork, most of the five organizations focused on enrolling new potential home care recipients in the rehabilitation programmes in order to "harvest the lowest-hanging fruits". In other words, managers of these organizations expected newcomers to be more easily rehabilitated. Nevertheless, during my fieldwork, I found that an increasing number of the "old" home care recipients were re-assessed and included in rehabilitation programs, often based on the argument that all care recipients could be made more self-reliant "in some way or another". To the question of whether recipients could refuse rehabilitation, the common answer was that rehabilitation was "sold" to the recipients in such an appealing way that they would not refuse it. However, some managers indicated that rehabilitation was not optional (i.e., that the alternative to rehabilitation was no service at all). The enrolment of citizens in rehabilitation programmes changed the worksites and tasks of the employees.

2.5 Plural workplaces and events

Prior to the introduction of rehabilitation, middle managers and care aides worked, as mentioned, at different locations. The middle managers (i.e., nurses) were typically situated at one location – usually an office located at the town hall or in a nursing home – where they did administrative tasks. In contrast, the care aides carried out their work at numerous work sites and their work involved numerous events. Thus, the care aides' workplace was comprised of the office (where they typically met in in the morning, ate lunch and held meetings with other care aides and the nurses), the various

private homes they visited every day, the various work sites in the homes (e.g., living room, bathroom), and their cars (when traveling from location to location). The therapists' workplaces were "in-between", as they handled administrative tasks at the office and went to the homes (with the care aides). Figure 4 illustrates the care aides' multiple workplaces.

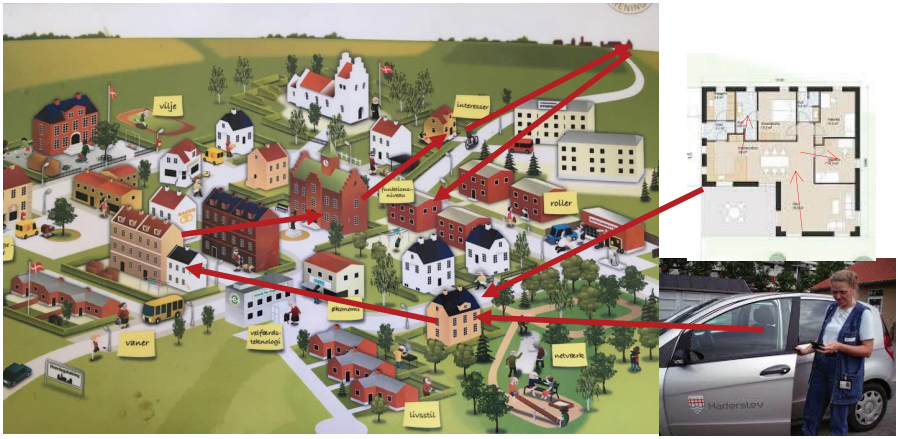

Figure 4. The care aids' multiple work sites.

The multiple events and sites that comprised the care aides' workplace were typically linked together by means of a "driver list". Care aides' were given new lists every morning (typically encoded in an electronic device that they could bring from home to home). The lists specified the homes that the aides would visit during the day and at what time. They also detailed the tasks they were expected to carry out and the amount of time they had for each task. Table 1 presents an example of a driver list used prior to the introduction of rehabilitation.

Navn	Tidspunkt	Ydelse	Tid	Bemærkninger
A	07.05-07.35	C3 Pleje – 3	30 min	Hjælp til forflytninger. Bruger stålift, 2 personer på besøget. Skal på daghjem. Færdig 08.15
B	07.45-07.50	06.10 Medicingivning	5 min.	Kom 5 stk. Bendoal i seksløber – gives derefter til B på sengekanten, hvor han får 1 sug.
	07-50-08.15	C2 Pleje – 2	25 min.	OBS skal på dagcenter 08.45. Nedre hygiejne i sengen, støttes med resten på badeværelset, barberes i køkkenet. Der lægges nattøj + pants frem på sengen.
C	09.15-09.40	C2 Pleje – 2	25 min.	OBS ring ankomsttidspunkt. Hjælp til bad, påklædning og morgenmad.
D (gift m E)	09.45-10.30	C4 Pleje – 4	45 min.	Nedre pleje i sengen. Smøre ben. Øvre pleje på badeværelset. Hårvask + fodbad efter ønske/behov. Morgenmad: en portion yoghurt, lave 4 kopper kaffe. Medicinæske stilles i køkken og stue.
E (gift m D)	10.35-11.10	C2 Pleje – 2	20 min.	Morgenmad: 1 portion yoghurt. Medicin. Frisk væske i stue og i køkken. Smøre frokost til begge. Opvask affald.
		C2 Pleje – 2	15 min.	BAD
F	12.05-12.50			Hjælp til bad og påklædning på Othello. Badetid fra kl. 12.15-13.15. F er på daghjemmet.
I alt	Borgerrelateret tid: 4.45	Administrativ tid: 0.00	Total varighed: 4.45	

Table 1. Example of a driver list in an 'ordinary' home care organization (Kjellberg et al., 2011b: 20).

However, the introduction of rehabilitation meant that new events and worksites surfaced.

2.6 Programmed care: New tasks and practices

The introduction of rehabilitation involved new tasks and "event programs" for care aides. As mentioned in Chapter 1, the care aides were expected to gradually replace their nurturing services with what was often referred to as "training" (see also Kjellberg et al., 2011a, 2011b). "Training" implied, for instance, that care aides who used to vacuum *for* a home care recipient were expected to "train" the recipient to do the task on his or her own. Such training could involve giving recipients tools to, for example, enable them to put on their own socks. In addition, training also implied that care aides were expected to "keep their hands behind their backs", a notion referring to idea that the care aides should encourage care recipients to do tasks themselves. Training could also involve specific exercises. The images below illustrate this replacement.

Figure 5. Images illustrating the shift from a 'ordinary' to rehabilitative tasks and practices.

The new orientation toward training was organized around the care recipients' individual time-limited rehabilitation programs. These programmes often comprised three phases and involved different actors. The first element of the programme was a start-up meeting during which a care recipient, a therapist and a care aide typically met to plan the recipient's individual rehabilitation program. At these start-up meetings, the care recipients were expected to formulate their own self-reliance goals (i.e., how they wanted to become self-reliant). On this basis, the therapists and care aides would develop a specific programme including specific training activities, amount of time, and care intervals. The second element of the programme was training. Care aides would typically carry out the planned activities within the scope of the time-limited program. During this time, therapists could come by and coach the care aides. Third, an evaluation meeting would be held just before the programme was scheduled to end. The recipient, the care aides and the therapists typically participated in these meetings, during which a decision would be made to end the programme or formulate a new one.

The organization of the care aides' work around the rehabilitation programmes did not change the fact that the care aides moved from house to house during the course of the day. Moreover, the programmes did not affect the use of driving lists, although new headlines and tasks were added to those lists (see example Table 2).

Navn	Type	Emne	Tid	Interval	Beskrivelse
U1	Praktisk hjælp	Rengøring	45 min.	1 gang/uge	Optræning i at klare opgaverne omkring rengøring af hjemmet. Der arbejdes med, at borger inddrages aktivt, trænes i at udføre opgaven selv. Der ses på behov for hjælpemidler og metoder til at blive mere selvhjulpen. Der arbejdes ud fra målene i borgers plan.
U2b	Praktisk hjælp	Tøjvask (fælles vaskeri)	40 min.	1 gang/uge	Optræning i at klare opgaverne omkring tøjvask i fælles vaskeri. Der arbejdes med, at borger inddrages aktivt, trænes i at udføre opgaven selv. Der ses på behov for hjælpemidler og metoder til at blive mere selvhjulpen. Der arbejdes ud fra målene i borgers plan.
U5	Personlig pleje	Bad	30 min.	Op til 7 gange/uge	Optræning i at klare brusebadet selv. Der arbejdes med, at borger inddrages aktivt, trænes i at udføre opgaven selv. Der ses på behov for hjælpemidler og metoder til at blive mere selvhjulpen. Der arbejdes ud fra målene i borgers plan.
U6	Personlig pleje	Daglig hjælp, 1 besøg	40 min.	Alle ugens dage	Optræning i at klare personlig pleje selv. Der arbejdes med, at borger inddrages aktivt i opgaverne omkring at blive vasket, få tøj af og på, at få anrettet måltider, at få tilstrækkeligt med væske og ernæring, at få ryddet væk efter måltider, at komme i og af sengen mv. Der ses på behov for hjælpemidler og metoder til at blive mere selvhjulpen. Der arbejdes ud fra målene i borgers plan.

Table 2. Examples of rehabilitative packages (Kjellberg et al., 2011b: 22).

The new programmes, however, implied that the care aides no longer necessarily visited the recipients on their own and they no longer "just" carried out the tasks. In addition, after the introduction of rehabilitation, the care aides were sometimes present when the lists were made (at the start-up meetings) and they sometimes went to the homes accompanied by the therapists.

There was a clear division of tasks between the care aides and the therapists in the homes. While the therapists were authorized to plan the programs, often by using specific interview techniques (e.g., such as the Canadian Occupational Performance Measure),[14] and to evaluate the programs, the care aides were expected to carry out the training.

2.7 Team meetings

To underpin the rehabilitation program, new team meetings were introduced. These meetings were typically organized either within a district or across several districts. The therapists or the district leader

[14] This is a specific structured interview method used to plan a programme targeted at maximizing the recipient's potential for physical and social self-reliance.

usually orchestrated the meetings, the purpose of which was to discuss the care aides' progress with the individual programmes (see Figure 6).

Figure 6. Picture from a rehabilitative team meeting in a home care organization (http://vpt.dk/hjemmepleje/tvaerfaglig-modemodel-i-hjemmeplejen-styrker-kerneopgaven)

Although the care aides had held team meetings before, they had primarily been concerned with administrative issues. In contrast, the new meetings were focused on the provision of care in the home.

2.8 Ensuring efficiency through investments in upskilling

The organizational changes associated with the introduction of rehabilitation in home care organizations required investments in new human resources on several levels. First, the introduction of rehabilitation required the establishment of training courses to educate care aides in the rehabilitation mindset and tasks. These courses took from one to three weeks depending on the municipality, and they were expensive in terms of the man-hours they took from the daily work. Second, the hiring of therapists required investments. Third, the time used for the new team meetings reduced the time available for work in the homes and, as such, had a price. Finally, the tools needed for the rehabilitation tasks required investments.

These investments were expected to pay off and to result in increased efficiency (Kjellberg et al., 2011b). Therefore, the budgets in the five rehabilitative home care organizations studied in the dissertation were developed with the expectation that the return on these investments would be over

100% within one year. The argument was that the recipients' increased self-reliance would lower costs because the recipients would need less service. On this basis, managers expected to be able to reduce the number of care aids through retirement-based attrition. For example, Figure 7 implies that the hiring of therapists was balanced by a decrease in the number of care aides in home care organizations.

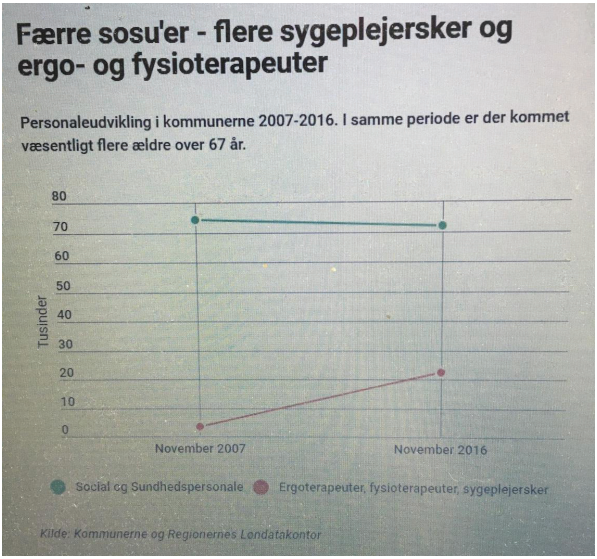

Figure 7. Illustrating the balance between care aides and therapists/nurses (http://www.ugebreveta4.dk/forsker-sosuers-arbejde-mister-status-naar-kommuner_20710.aspx).

This chapter has foreshadowed some of the professionalization opportunities associated with the introduction of rehabilitation in home care organizations, as well as some of the risks these new opportunities entailed. The rest of the dissertation is devoted to examining what happens to home care workers' risk of marginalization when they are confronted with these professionalization opportunities (i.e., new experts, new team meetings, and new tasks and practices). I argue that the new regulations, negotiations and practices associated with these professionalization opportunities give rise to some dilemmas for home care workers.

CHAPTER 3: LITERATURE REVIEW

3.1 Critical building blocks for understanding matters of professionalization

Academics have long explored how professionalization and marginalization processes may intersect at work. The purpose of this chapter is to review the literature in order to uncover the concepts and theoretical building blocks that informed my exploration of the discursive and material ways in which the boundaries of professionalization are regulated, negotiated and practiced in rehabilitative home care organizations.

I open the chapter by elaborating on the critical stance I take in the dissertation and its influence on the ways I have reviewed, read and ultimately experimented with combining building blocks from the different streams of literature on professionalization processes. I then review the group of studies that I have referred to as critical discursive-oriented studies in Chapter 1. Although some of these studies have a vague concept of "the professional", they are valuable for this dissertation because they show a close link between contemporary managerial policies (e.g., rehabilitation) and different attempts to discursively regulate and construct (non-)professional identities at work. I argue, however, that these studies did not, for the purpose of this dissertation, pay sufficient attention to the more material and enduring aspects of professionalization processes. And thus, in the search for optics and concepts to address these blind spots, the dissertation turns to review what I have called the critical material-oriented studies in Chapter 1. This group of studies include classical and more recent literature on how "the (non-)professional" is embedded and embodied in the actual doing of the work (i.e., in the occupational division of labour, task divisions and working bodies).

Based on this review, I present some ideas on how we may fruitfully combine building blocks from the two groups of studies to advance our understanding of the discursive and material ways in which the boundaries of professionalization are constituted in rehabilitative home care organizations.

3.1.1 A critical stance on matters of professionalization

The critical stance I apply in this dissertation has implications for the way I explore, conceptualize, read about and understand matters of professionalism and professionalization processes. According to Van Fraassen (2002), the term "stance" denotes an "'attitude, commitment, approach' that can characterize a scientific position" (Van Fraassen, 2002: 47-48, cited in Hauge, 2017: 25). Thus, when I say that I apply a critical stance in the dissertation, I do so to specify that the way I see (ontologically)

and gain knowledge (epistemologically) about my field of study is by adopting a specific critical "commitment" and "attitude". As I have explained, I have sought to denaturalize some common understandings and assumptions regarding professionalization processes, especially professionalization opportunities found in the focal field of study. More specifically, inspired by Foucault (1981), my critical stance implies that I have tried to drive out of hiding some of the self-evident modes of thought and practices that are often automatically accepted within home care policy. This implies that I have not studied professionalization processes as neutral, linear or evolutionary operations, but rather as complex, multifaceted, and often hierarchical or suppressive processes (Hearn and Parkin, 2001). The feminist literature and related discussions have been crucial for informing this critical stance.

3.1.2 Seeing organization and professionalization processes: differences, divisions and oppressions

Feminist studies were valuable for forming my critical stance on professionalization and marginalization processes because feminists have long argued that the majority of the professionalization literature (often written by men) has neglected or silenced the suppressive, gendered aspects of professionalization processes (see for example Davies, 1996; Hearn, 1982; Hearn and Parkin, 2001). In contrast, these studies highlight that organizations and professionalization processes are gendered because they generate hierarchical, often suppressive relations that tend to privilege some professionals (often men) by suppressing others (often women). More specifically, Hearn and Parkin (2001) highlight that a feminist approach to matters of professionalization implies seeing organizations and organizational life through a specific lens – by approaching "what organizations are and what is taken to happen in most work organizations as fundamentally constituted in the interrelations of gender, sexuality, violation and other *oppressions, divisions and differences*" (Hearn and Parkin, 2001: 22, my emphasis). As such, my critical commitment to denaturalizing professionalization processes by focusing on the boundaries of professionalization (i.e., oppressions, divisions and differences) is inspired by this feminist ontological understanding of organizations and how they function.

3.1.3 Exploring differences, divisions and oppressions as materially and discursively constituted

Feminist studies have also shaped my epistimolgical approach in the dissertation. Especially, my commitment to gaining knowledge about boundaries of professionalization by exploring differences,

divisions and oppression at work as materially and discursively constituted. Feminists have long discussed the (in-)appropriateness of combining discursive-material approaches and constructive-essentialist approaches when studying how organizations and professionalization processes are gendered. For instance, Davies (1996) and Hearn and Parkin (2001) clarify that although feminist studies share the idea that organizations are gendered, they often research and approach this genderedness from different perspectives.

Some researchers study gender as an attribute. These researchers see a close affiliation between gender and the biological sexuality of men and women (i.e., as a rather essential, material and fixed matter) (Davies, 1996). Their studies show, for instance, that women are often suppressed by men in organizations and professionalization processes (Davies, 1996; Hearn and Parkin, 2001). Other researchers study gender as a relation (Davies, 1996). They argue that the dichotomy between sex and gender is itself a suppressive heterosexual social construction (see, for example, Butler, 1990). They suggest that gender should be studied as a relation or construction that can be challenged and transformed, and thereby requires active maintenance "in the process of daily reproduction" in organizations or professionalization processes (Davies, 1996: 664).

Davies (1996) argues that studies of gender as a relation (discursive-oriented studies of gender) have been increasing at the expense of studies of gender as an attribute (material-oriented studies of gender). This displacement of the gender focus, Davies suggests, draws "attention away from the behaviour of particular men and women towards historically and culturally constructed masculinities and femininities which are one resource, among others, from which subjectivities, identities and behavioural regularities emerge" (Davies, 1996: 663-664). Davies (1996) and Hearn and Parkin (2001) problematize this displacement because it draws attention away from other potentially important sources of divisions, differences and oppression at work, especially more material sources. On this basis, they argue that a focus on both discursive and material constitutive processes may provide a more nuanced perspective on how gendered differentiations and suppressions are constituted at work than a rather/or approach would allow. As such, Hearn and Parkin (2001) remind us that discursive matters are often a material accomplishment in the sense that gender discourses are constructed in relation to sexuality (the biological-material). In addition, they propose that the material is not

necessarily fixed but can have multiple natures (e.g., a body and embodied practices can take many shapes and change). Such views encourage a focus on not only the conflicts between the material and discursive approaches to gender but also the common grounds and systems of reference across the traditions that "allow explanations from different viewpoints to be compared or integrated" (Sullivan, 2007: 8). My commitment to denaturalizing the boundaries of professionalization by focusing on the discursive and material ways that such boundaries (divisions and differences) are constituted is, thereby, inspired by these feminist elaborations.

Overall, feminist studies have informed my critical stance and scientific approach. The feminist lens has encouraged me to group the literature on professionalization into the discursive-oriented studies and material-oriented studies. In addition, the lens has also led me to combine concepts and optics from these two groups of studies in order to ensure a more complex, nuanced picture of the relationship between professionalization and marginalization. However, I describe my stance in the dissertation as "critical" rather than "feminist", because my empirical work showed that although gender was a crucial factor in the regulation, negotiation and practice of boundaries of professionalization in rehabilitative organizations, it was not the only dimension on which differences, oppressions and divisions occurred (see also Hearn and Parkin, 2001; Sullivan, 2007; Cheney and Ashcraft, 2007). Accordingly, the literature review I will turn to now must be read from the perspective that I did not review the literature independently of the data analysis (see Chapter 4). Rather, the review lay out a range of theoretical building blocks that seem particularly relevant for understanding how "the (non-)professional" was not only discursively constituted at work in rehabilitative home care organizations but also embedded and embodied in the actual work.

3.2 Defining "the (non-)professional" at work

Due to the dissertatin's empirical focus on how a policy, such as rehabilitation, that encompasses both efficiency and empowering or liberating promises (i.e., professionalization opportunities) affects care workers and their work, I began to review critical management studies at an early stage of the PhD process. Although the terms "professionalization" or "the professional" were not always used or vaguely defined (see also Cheney and Ashcraft, 2007), some of these studies provided crucial concepts to understand how workers' (non)-professional identities are regulated and defined by managerial

discursive activities in contemporary western workplaces often times by means of "discourses of difference" (Ashcraft, 2007). That is, discourses that generate and discursively constitute differences, boundaries and distinctions between the privileged professional identities and "others". Moreover, the studies provided crucial tools to understand how such policies – and discourses of differences - are closely affiliated with processes of marginalization and/or shaped by the marginalized sub-context in which they are introduced, and/or by the workers' attributes or markers (such as level of education and training, gender, sexuality, class).

In my review of the discursive-oriented studies, I focus on three mechanisms through which such discursive distinctions may be generated in western workplaces: a) gendered distinctions between feminine/masculine and men/women; b) distinctions between loyal and non-committed workers, and c) distinctions between civilized and "dirty" workers. These distinctions emerged as particularly important for understanding how boundaries of professionalization are discursively regulated, negotiated and practiced at work in rehabilitative home care organizations. However, before I introduce these three mechanisms, I will briefly introduce the common key concepts, assumptions and models on which the literature relies.

3.2.1 Discursive identity regulation: Professional identities and organizational control

Given the "discursive" and "cultural turn" in organization studies, "scholarly energies" appear to be "guided by a loosely shared interest in organizational realities as produced in discourse, or through the ongoing communicative activities of people collectively making sense out of a vast array of possible meanings" (Ashcraft, 2007: 15). This scholarly focus on how organizational realities are produced through discourse has involved an attention to new organizational policies, especially those that might fall under the labels of NPM and "post- bureaucracy" (Barker, 1993), and how such policies are associated with the regulation, promotion and cultivation of new professional subjectivities and identities in western societies[15]. The scholars even argue that NPM can be seen as an identity project in western societies (see du Gay, 1996; Davies and Thomas, 2002; Thomas and Davies, 2005a).

[15] These societies have often been characterized using different labels, such as "post-modernity", "advanced liberalism" (Rose, 2001) and "the new spirits of capitalism" (du Gay and Morgan 2013).

In their seminal article from 2002, Alvesson and Willmott provide an informative overview of the core concepts and assumptions emerging from the "discursive turn" among management and organizational scholars. Alvesson and Willmott propose that that the discursive-identity relationship is becoming increasingly important because attempts to regulate and control workers in organizational settings are often focused on cultivating the "appropriate individual". As their research predominantly focuses on how the appropriate individual is shaped at work in organizational settings through management policies, I extend their terminology to "appropriate professional individual".

More specifically, Alvesson and Willmott (2002) argue that classical takes on organizational control, such as the view found in Mintzberg (1983), tend to focus on the "outside" regulation of the workers. A focus that they argue reduce organizational control and regulation to "impersonal" and "behavioural features" that are only related to the design of work "with scant regard to how meaning, culture or ideology are articulated by and implicated in structural configurations of control" (Ibid: 619). This argument is controversial within and outside critical management studies. Rhetorically, however, Alvesson and Willmott (2002) use this portrayal of classical studies' on control to argue that classical understanding of control do not capture the new ways more contemporary policies are often directed towards "managing the 'insides – the hopes, fears and aspirations – of workers [and thus their identities and understandings of 'who they are'], rather than their behaviour directly" (Ibid: 620).

To address this blind spot on identity as an increasingly important mode of organizational and managerial control, they put forth the concept of "identity regulation", defined as "discursive practices concerned with identity definition that condition processes of identity formation and transformation" (Ibid: 627). Given their notion of identity regulation, they suggest that mechanisms and practices of control do not work "outside the individual's quest(s) for self-definition(s), coherence(s) and meaning(s)". Rather, organizational control is accomplished by influencing the "inside" of workers through managerial discursive practices concerned with the "'manufacture' of subjectivity".

Alvesson and Willmott (2002) suggest that employees may use such management-manufactured subjectivities in their individual quests to position themselves as employees and professionals in the organization (i.e., as a resource in their identity-transformation processes). In contrast to what the

authors call “bureaucratic” or “Taylorist” means of control in which workers are forced to pursue organizational targets through the design of work (e.g., explicit time-control designs), the control exercised through the cultural manufacturing of subjectivities is different. This is because employees with this source of control are regulated by “seductive means” (Ibid: 624). In other words, they are regulated by a language of liberation, creativity, innovation, self-actualization and empowerment that, at least rhetorically, offers “feel good effects” (Ibid: 624) that may transcend the bureaucratic “iron cage” (Ibid: 624). More specifically, empowerment and professionalization promises offer workers meaning in their work, and often give rise to more conditioned responsibilities and room to take initiative.

However, this new meaning and self-realization have a price. As Alvesson and Willmott (2002) argue, organizations benefit from providing workers with self-realization promises and infusing their work with meaning because those actions may increase workers’ commitment to the organizational targets, including efficiency targets, as well as their motivation to pursue them. Therefore, workers with this language of liberation may work harder for the organization. In addition, Alvesson and Willmott argue that although the employees may be offered forms of micro-emancipation (e.g., promises of professionalism), that emancipation “may also make employees more vulnerable and less inclined to engage in forms of resistance” (Ibid: 626). In this respect, control and regulation may be sustained or even reinforced by the new policies (see also Barker, 1993). Alvesson and Willmott (Ibid: 622) emphasize that although identities become a forceful target and medium of organizational control and regulation, the management-manufactured subjectivities are not “totalitarian unmediated constraints upon individuals”. Rather, they propose that identity regulation may “spark dissent or catalyse” resistance and counter-discourses because employees are not passive carriers of discourse – they “actively interpret and enact” it (Ibid: 628). Thereby, Alvesson and Willmott highlight that multiple discursive and counter-discursive practices concerned with identity definition are present in organizational settings.

Even though they pay attention to discourses and counter-discourses, Alvesson and Willmott do not explicitly address how identity regulation evokes discourses of differences. However, they do specify the potential ways (Ibid: 629ff) in which identity regulation may define and seek to transform workers’

professional identities though discursive practices: 1) by defining the professional directly or by defining the professional by defining the others; 2) by defining the professionals' belonging and differentiation (i.e., group categorizations and hierarchical locations; superior/subordinate relationships), 3) by defining the organizational targets and norms that apply to the professional (e.g., skills, knowledge, values, moral, rules of the game), and 4) by defining the context of the organization. This specification of discursive resources of identity regulation is useful because it emphasizes that (non-)professional identities can be defined directly (by defining the individuals) and indirectly (by defining anti-identities, group categories, norms and contexts). To unpack and specify how specific discourses of differences and definitions of the (non-)professional become powerful means of identity regulation, and how such discourses may generate and regulate boundaries of professionalization, I now turn to the aforementioned three mechanisms through which privileged-otherness differentiations may emerge in contemporary western workplaces, such as rehabilitative home care organizations.

3.2.2 Defining the (non-)professional through gender stereotypes and gendered attributes

As explained above, distinctions between feminine/masculine (gender) and men/women (sexuality) are one of the primary mechanisms used by people in the west to classify each other. As such, these distinctions are also a crucial discursive resource through which the (non-)professional is defined at work (see e.g. Sullivan, 2007). Nevertheless, relatively few studies examine how gendered discourses are affiliated with the introduction of new policies that combine efficiency and professionalization promises, or how such discourses influence ordinary workers (rather than the managers)[16] in organizational settings (for a review, see, e.g., Davies and Thomas, 2002). The few exceptions (Rasmussen, 2004; Dahl, 2009; Davies and Thomas, 2002) that focus on how new contemporary policies influence the everyday life of ordinary employees argue that a close relationship between gender, managerialism and professionalization exists. These studies (Ibid.) show that many women in ordinary positions (and feminine stereotypes in general) across different public workplaces (e.g. female-dominated, male-dominated, low-skilled and high-skilled) are continually subject to marginalization in current professionalization processes. In other words, these studies suggest that males (and masculine stereotypes) are once again privileged and recognized in contemporary policies

[16] Alvesson and Willmott (2002) point out that most gender studies focus on women in managerial roles.

as “professionals,” while women (and feminine stereotypes) become marginalized as “others” (i.e., non-professional).

For example, Davies and Thomas (2002) study how NPM at male-dominated British universities influence the everyday work of historically marginalized, but highly skilled, female academics[17]. They begin by arguing that NPM gave rise to renewed requirements to publish and to generate income for the university. Performance requirements which cultivated a culture of “competitiveness, instrumentality and individuality” at the universities and gave rise to increased “self-protecting”, “self-serving”, and “less collegiate” workers and a “more ‘rule and divide’ atmosphere” (Ibid: 383). The authors link this culture and atmosphere to the introduction of “new forms of masculinities” that conflict with what they call “feminine discourses of empathy, supportiveness and nurturing”. In showing this affiliation between NPM and gendered connotations, they propose that NPM not only maintains the already gendered substructure in the organization but also “reinforce[s]” these structures or culture. They suggest that the implications of this culture for female academics are not only an intensified workload but also a “feeling, as a women, marginalized, silenced, the ‘other’”.

In other words, Davies and Thomas (2002) show that the gendered discourses that are affiliated with NPM reinforce privileged-otherness distinctions at work. Interestingly, however, they nuance such distinctions by showing that women adopt different responses to new forms of masculinities. For example, they argue that some women coped with the new pressure by becoming what they call “social men” – they complied with the masculinist discourses or professional ideals. Davies and Thomas (2002) argue that the women who adopted this response resisted the gendered discourses that view women as passive, supportive and caring. However, they also propose that this process of “fitting in” had a cost – these women became easy targets of criticism and often felt anxious. This study of female academics is important because it shows that NPM is not a gender-neutral discourse. Instead, it is gendered in ways that have marginalizing and negative effects for women who try to adapt to new, “appropriate” professional identities, and for those who do not try to adapt. In addition, the study is valuable because it shows that NPM decouples notions of the “professional” from feminine stereotypes.

[17] Female academics have long been a minority group at British universities (Davies and Thomas, 2002)

However, although Davies and Thomas (2002) explain how women suffer from NPM, they say little about empowerment or liberation. It is unclear whether this lack of focus on the liberating aspects of NPM can be explained by the fact that female academics are already an empowered and autonomous groups or whether it is the result of their descriptions of versions of NPM that only focus on efficiency targets.

Ramussen (2004) and Dahl (2009) focus on a different context and group of workers – female home care workers with little training in Scandinavia. While these authors also show that the introduction of NPM is gendered, they demonstrate that the language of liberation is an important control mechanism in contexts where workers have historically struggled for professional recognition. In her study of Norwegian home care units, Ramussen (2004) proposes that NPM increases the lowest-status care aides commitment to their work by offering them more responsibility and more "interesting" tasks (e.g., nursing tasks). Rasmussen proposes that these new tasks allow care workers to achieve more recognition of their skills in the organization, while their former tasks (centered on housework and cleaning) had "no status at all" (Ibid: 515). In line with Alvesson and Willmott (2002), Rasmussen finds that the workers' willingness and motivation to work harder increase with the offer of more "meaningful" jobs and autonomy. However, in contrast to Alvesson and Willmott (2002), she points out that this motivation is closely affiliated with the lowest-status workers' desire to be recognized as *professionals* in the organization.

Notably, Rasmussen finds that the renewed autonomy and recognition as professionals is only upheld as long as the workers are willing to work harder and without complaint. When the workers she studied started to complain "that they were not able to take in more patients, or that the care that they were able to give was sliding below acceptable standards" (Ibid: 523), they were silenced in two ways. First, from an organizational standpoint, NPM implied that management (and the resources) had been "disconnected" from the daily work. Therefore, as the workload increased, the workers were unable to request more resources from their closest co-coordinators (who no longer were in control of providing those resources). Second, if the employees complained to the male co-coordinator, they were confronted with gendered discourses. More specifically, the male co-coordinator accused the women of "whinging and complaining" (Ibid: 523), and suggested that the core problem was that they cared too

much as women and did not know how to set limits. In other words, the co-coordinator constructed the female workers as "unprofessional (mothering) women" (Ibid: 523) whose assessments of the situation were not to be trusted due to their female attributes. The co-coordinator used this portrayal of his female colleagues as an opportunity to construct himself as "the professional".

Given Danish home care workers' similar historical struggle to become recognized as professionals, Dahl (2009) suggests that the introduction of NPM in Danish home care organizations has also been associated with new efficiency demands and offered workers increased self-governance potential. In line with Davies and Thomas (2002), Dahl finds that home care workers interpret and respond differently to NPM reforms depending on the subjectivity they identify themselves with at work. More specifically, she argues that the introduction of NPM in home care organizations evokes three co-existing subjectivities: the "manual worker", the "housewife" and the "professional". She defines the housewife figure in the following way.

> *"[The housewife has] an ethical obligation to care for the dependent person regardless of the costs involved for oneself. Caring for the other in [the housewife's] understanding includes a broad understanding of caring as caring for the well-being of the elderly person e.g. going for walks as well as creating cosines in the home involving a particular aesthetic and emotionally infused idea of cosines. Cosines here refers to decorating the home with flowers or plants and having time for a chat while drinking coffee together (Dahl, 2009: 642)."*

In contrast, Dahl (2009: 642) defines the "professional figure" as associated with "rationalities of development and autonomy, remaining silent on issues of cosines. S/he [the professional] is mostly focused on keeping the elderly person physically active through exercises and/or joining in with the cleaning and attending to more medical aspects e.g. treating potential wounds".

Dahl's study is interesting because she finds that employees who identified with the housewife figure often found themselves in conflict with NPM, especially the efficacy demands, because these workers viewed care as more complex than what the new management tools could] capture. However, those individuals who identified with the professional figure often saw NPM (e.g., a shared language) as an opportunity and a useful tool for accomplishing the work (e.g., NPM could be used to document and visualize the workers' accomplishments). However, her own labelling of the subjectivities seems

problematic. For instance, she offers no discussion of how the subjectivities of "the housewife" and "the professional" emerged in the first place. We learn from Rasmussen's study that these notions are highly gendered terms that can be used for political purposes, but Dahl neglects this fact by not showing how these figures and subjectivities were constructed or by whom.

These studies on gender as a discursive mechanism are extremely valuable because they clearly illustrate that as NPM and professionalization processes begins to influence the everyday lives of ordinary employees, it evokes gendered discourses of differences that cultivate specific kinds of boundaries of professionalization by regulating definitions of (non-)professional identities. These boundaries closely link the discursive constitution of the "professional" with social men, males and masculine stereotypes (e.g., of autonomy, rationality, individuality and competitiveness) while simultaneously marginalizing women and feminine stereotypes (e.g., of empathy, supportiveness and nurturing) as non-professional. Overall, these studies ask us to pay attention to how rehabilitation may rely on gendered resources as a means of regulating workers' professional identities. However, given Rasmussen's study of the role played by hierarchical relations between managers and employees in regulating employees' everyday work, the two other studies may have been well served by focusing more on the role that managers play in defining and regulating the workers' (multiple) identities with the introduction of NPM instead of portraying NPM as a gendered, faceless policy that penetrates organizations.

3.2.3 Defining the (non-)professional through notions of the (dis-)loyal and (non-)committed worker

Critical management studies show that privileged-otherness distinctions in western workplaces also arise from focusing, on the one hand, on compassionate, loyal, entrepreneurial workers who exhibit ownership of and identification with the organization's policies and targets; and, on the other hand, on "disloyal" and "non-committed" workers. In particular, one stream of studies (Barker, 1993; du Gay, 2008: 335) shows that the introduction of policies that combine efficiency purposes with the language of liberation require workers in "post-bureaucratic" organizations "to be committed champions for and enthusiastic advocates of those policies" (du Gay, 2008: 335; Barker, 1993; Alvesson and Willmott, 2002).

Scholars with a specific interest in this commitment mechanism often focus on how the introduction of post-bureaucratic ways of organizing workplaces in the west, such as team organization, changes the modes of organizational control (Sennett, 1991; Barker, 1993; du Gay, 2008). They propose that while bureaucracy is based on behavioural, technocratic, instrumental and explicit rules (i.e., based on constitutional laws) where rewards are merit based, post-bureaucratic organizations are affiliated with value- and norm-based rules. These rules are "less apparent" and collectively constructed and, therefore, "more difficult to resist" (Barker, 1993: 408, 206). Of particular relevance for this study is the fact that some studies describe how privileged-otherness distinctions emerge with the introduction of teamwork or, more specifically, how value- and norm-based systems function in teams.

One such study is Barker's (1993) examination of the introduction of teamwork in the firm ISE. Barker states that members were made responsible for formulating their own visions for the team based on the top management's corporate vision statement (one core value was "We are a principled organization that values teamwork."). The team vision, which Barker calls a "value-based discourse" (Ibid: 412), that emerged on the basis of a "negotiated consensus" (Ibid: 411) was used to infer proper behaviour for the team on a daily basis. For instance, the team collectively decided that the value of teamwork meant that "we all must come to work on time" (Ibid: 412). This value established a reward and sanction system in the team, as Barker (1993: 425) explains:

> "*The team members rewarded their teammates who readily conformed to their team's norms by making them feel a part of the team and a participant in the team's success. In turn, they punished teammates who had bad attitudes, (...) with guilt and peer pressure to conform*".

As an illustration of this system, Barker describes how Sharon, a single mother, struggled to get to work at 7 A.M. and how her peers told her that they were very upset that she was late. Barker explains that, in response, Sharon began to cry. The team ultimately decided that if workers came late on three occasions, they would be fired. Similarly, Casey's (1995) study of a multinational corporation found that management invoked a positive family rhetoric and values as a new form of organizing. After committing to this new rhetoric, team members silenced and censured critique and negative experiences in the team by scapegoating, and by defining critiques as "disloyal" or "selfish". She found that team members did so more often than management.

These studies are crucial because they highlight how the value-based norms and negotiated consensus that emerge from team organizing and peer control indirectly influence and regulate workers' professional identities. They do so by rewarding committed, entrepreneurial, affectionate and loyal workers who live up the organizational targets; and by sanctioning and scapegoating critical voices, as well as people who cannot or will not live up to the norms. This latter group is the "others" – the disloyal, selfish and non-committed workers who "obstruct" the shared work and goals. However, as in some of the aforementioned gender-focused studies, these norms and negotiated orders are "faceless". As I argue in article 2, this focus on abstract norms means that we know very little about the circumstances under which a "negotiated consensus" (Barker, 1993) emerges in teams. For example, these studies only indirectly discuss the actors ("the peers") and how they differ (e.g., the single mom), or how their presence influences the norms or what is discussed. Therefore, more information about what actually goes on during team meetings, who is present, how the meetings are orchestrated, and how the core tasks and products influence the meetings and norms would be useful.

3.2.4 Defining the (non-)professional through signifiers of the civilized versus the dirty workers

A third mechanism through which workers classify each other in the west is a privileged-otherness distinction between the dirty and the clean, and between the civilized and the lower class. More specifically, a stream of studies often referred to as "dirty-work" studies proposes that some types of work are associated with dirt or, more broadly, with stigma. These studies, which are inspired by the work of Goffman (1963, 1968) and Hughes (1958), argue that work becomes stigmatized when it is commonly viewed as "physically, socially or morally tainted" (Ashforth et al., 2007: 149), and that the perceived taint may be projected onto the people who perform it, so that the occupations are seen to personify the dirt or stigma (Ashforth and Kreiner, 1999). These researchers define physically tainted occupations as those that are "'directly associated with garbage, death, effluent and so on' (e.g., janitor, mortician, exterminator)", socially tainted occupations as those that come into regular contact with "'people or groups that are themselves regarded as stigmatized,' (e.g., correctional officer, welfare aid, psychiatric ward attendant)" and morally tainted occupations as those that are "'regarded as somewhat sinful or of dubious virtue' (e.g., exotic dancer, personal injury lawyer, psychic)" (Ashforth et al., 2007: 151). Therefore, these studies argue that such occupations may face dilemmas at work because

workers' "sense of self is largely grounded in one's salient roles within a given context" and "that one looks to others for validation". Moreover, these workers' "sense of 'self' may be withheld, given the taint of their work" (Ibid: 150).

These studies do not directly address policies that combine efficiency and professional or liberating promises. However, they focus on discursive efforts to counter the dilemmas "dirty" workers may face. In other words, they examine how workers are mobilized and motivated to continue their "degrading" and "disgusting" work. For example, Ashforth and Kreiner (1999: 413) suggest that to ensure a "positive sense of self" and what I call a positive professional identity, workers in marginalized workplaces will try to justify their work through what they call ideological techniques. They specify that these techniques are discursive practices that aim to make the work more attractive or socially acceptable by transforming its meaning. They may do so, for example, by reframing, recalibrating or refocusing the stigmatized aspects of the work in ways that render them more positive in the sense of civilized and clean. Alternatively, they may attempt to move the focus from the stigmatized aspects of the work to less stigmatized aspects (i.e., the more civilized and clean aspects). For instance, funeral directors may argue that they work with grief rather than dead bodies to ensure a positive sense of self or a professional identity.

Furthermore, Ashforth, Kreiner, Clark, and Fugate (2007) specify that the 1999 Ashforth and Kreiner article was focused on the "distal outcome of occupational identification," while they are interested in the "proximate outcomes". This implies that they place the managers in a central role in terms of infusing work with positive meaning or "normalizing" the work, where normalization is defined as "processes by which the extraordinary is rendered seemingly ordinary" (Ibid: 150). More specifically, they propose that managers are often the central initiators of ideological techniques (as sense-makers and sense-givers), and that they render the stigmatized aspects of work (less) silent. Therefore, managers are portrayed as figures who counter the workers' risk of stigmatization in the workplace. For instance, these authors explain how the managers attempt to normalize the work and, thereby, protect themselves and their employees from stigmatization by locating the cause of the stigmatization in the clients or by confronting them (e.g., by explaining to clients that "[we] are there to serve [them] but we are not their servants" (Ibid: 162).

These studies are valuable because they show that the content and objects of work (e.g., the clients and their attributes) are crucial defining and regulating signifiers of how boundaries of professionalization and, more specifically, (non-)professional identities are discursively constituted at work. These boundaries are constituted by closely associating "professional" with "clean", "civilized", "normal" and "white-collar" workers, while associating "non-professional" with "abnormal", "tainted", "dirty", "low-class" and "blue-collar" workers. However, although these studies talk about "managers", they tend to portray them in rather faceless and abstract ways by reducing them to their different discursive reframing strategies. In addition, as I argue in article 3, the studies give the impression that managers may be able to successfully manage and negate stigma. For example Ashforth and Kreiner (2007: 150) argue that managers and their normalizing discourses enabled "dirty workers to perform their task without (or with less of) the burden of stigma". However, as the authors draws on data on managers and not on the employees, this seems to be an assumption rather than an empirical observation. Therefore, information on how employees respond to these normalizing discourses and how these discourses affect their daily (dirty) and embodied practices would be welcome.

3.3 From a definition of the (non)-professional to the work of the (non-)professional

This brief review of some of the core mechanism through which discursive distinctions between the professional and non-professional arise through contemporary managerial policies is crucial because it provides key building blocks for understanding how discursive regulation, discursively negotiated consensus and discursive practices may generate boundaries of professionalization in rehabilitative home care organizations. Discursive constitutive processes seem to control and regulate workers by not only defining and cultivating the "appropriate" professional worker who can expect privileges and rewards, but also by defining the "inappropriate" or "non-professional" worker who risks being marginalized and sanctioned.

More specifically, the above discussion shows how discursive constitutive activities and mechanisms often tend, in binary ways, to: a) include and privilege connotations of masculinity and men in notions of "the professional" while marginalizing the feminine and women; b) include and reward committed,

loyal and entrepreneurial workers in notions of "the professional" while sanctioning and scapegoating critics and "disloyal" workers; and c) include and privilege "clean" and "civilized" workers in the notion of "the professional" while marginalizing what is associated with moral, physical and social stigma and "dirt" (see Figure 8)[18]. These mechanisms may serve as crucial analytical tools in our investigation of how boundaries of professionalization are discursively constituted at work following the introduction of rehabilitation in home care organizations.

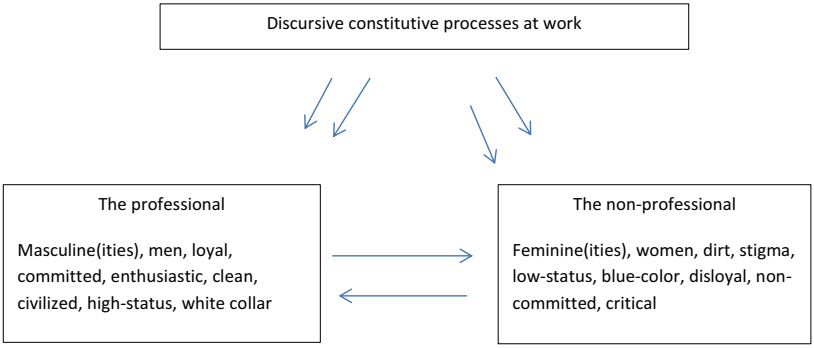

Figure 8. Discursive constitutions of boundaries of professionalization.

The discursive-oriented studies' descriptions of how privilege-otherness distinctions are discursively constituted at work show that these studies do not deny that materiality matters. For instance, they show that workers' biological sexuality (e.g., women) and material aspects of the work (e.g., dirt) are important discursive resources for making privileged-otherness distinctions, and that the work arrangements (e.g., teamwork) shape the emergence and negotiation of such distinctions. Therefore, as argued by feminist scholars such as Hearn and Parkin (2001), the discursive distinctions are often a material accomplishment in the sense that the (non-)professional is constructed in relation to gender and let me add other materialities. In this regard, I disagree with Cheney and Aschcraft (2007: 153),

[18] As the figure illustrates, I propose that the binary forms of these discursive constructions imply that the definitions of the professional and the non-professional are interrelated (i.e., that it would make little sense to be defined as a professional if a construction of the non-professional did not exist; see also Davies, 1996).

who argue that discursive and communication scholars "have overwhelmingly neglected the body, the material environment, and all things physical".

However, as I have argued throughout this review, the focus on discursive constitutive processes often draws attention towards abstract or faceless discursive policies, negotiated norms, and reframing practices. These discursive influences are often analysed by moving up the analytical ladder (e.g., by associating them with NPM, post-bureaucracy or other societal diagnoses; see also Vikkelsø, 2015). Therefore, the analyses tend to move away from the more situated, practical and ongoing ways in which "the (non-)professional" is embedded and embodied in the actual doing of the work in terms of behaviours, task accomplishment, labour and face-to-face relations (see also Vikkelsø, 2015; Cheney and Aschcraft, 2007; Davies, 1996; Hearn and Parkin, 2001). In short, the discursive-oriented studies seem to draw attention away from the more material ways in which boundaries of professionalization may be regulated, negotiated and practiced.

Based on Alvesson and Willmott's (2002) line of argumentation, such displacement seems rather intentional and reflects the tendency evident within the "cultural turn" – the turning away from classical organizational theories that focus on the "outside", and on explicit regulation, hierarchical or bureaucratic occupational systems, behavioural control, and workers' occupational affiliations (see Alvesson and Willmott, 2002). However, for the purpose of this dissertation, such displacement seems problematic. In particular because, as discussed in Chapter 2, the implementation of rehabilitation did not completely change the bureaucratic character, the labour or task divisions, or the working bodies in the home care setting. Rather, rehabilitation seemed to supplement, reshape and replace these factors in new ways. For these reasons, I turned to review more material-oriented studies that include what Alvesson and Willmott (2002) may have called critical classical organizational studies as well as more recent studies that may serve as building blocks to (re-)address the more material and enduring matters of how professionalization processes are regulated, negotiated and practiced in rehabilitative home care organizations.

This review of material-oriented studies focuses on examining how we can form a theoretical framework that is capable of attending to both the material and the discursive ways in which boundaries of professionalization are regulated, negotiated and practiced in rehabilitative home care organizations. More specifically, I emphasize a limited number of studies that I found particular useful for this inquiry. The first, which examines how the division of labour, occupational systems and socio-technical arrangements in organizational settings influence the more material *regulation* of professionalization processes at work, is primarily inspired by the work of Abbott (1988) and Callon (2008). The second concerns how the tasks, task divisions and trajectory debates at work influence the *negotiated* consenus in professionalization processes. It is informed by such scholars as Strauss et al. (1997) and Hughes (1958). The third focuses on how the working bodies and their embodied practices and positions in the division of labour are influenced by processes of professionalization. It is based on feminist classics and the relatively new bodywork studies. Thus, in the following sections, I briefly unfold these studies in order to find building blocks that ensure a focus on the co-emerge of discursive and material constitutive aspects in professionalization processes. I also introduce how I explore such co-emergence in the analytical body of the dissertation.

3.3.1 Regulating the (non-)professional through the division of labour and occupational systems

While the discursive-oriented studies often talk about "regulation" as a discursive ideology or practice concerned with defining subjectivities and infusing them with meaning, some classical studies on professionalization processes (e.g., Abbott, 1988; Hughes, 1958) remind us that regulation is not only a discursive endeavour based on written or voiced text. These authors propose that regulation of the professional is embedded in the division of labour, which they refer to as the independent occupational system, in organizational settings. This focus is valuable because these studies do not refer abstractly to authority as something that is exercised through managerial ideologies, or "managers". Rather, they describe regulation as something that is exercised by "somebody" over "somebody". For instance, actors with authority are not only described as "managers" but also as actors with specific occupational affiliations (e.g., doctors) that often automatically and silently place them in high positions, thereby giving them the authority to regulate employees with other, lower-status occupational affiliations (e.g., care aides). Therefore, they argue that regulation is embedded in the asymmetrical but interdependent system of occupations.

This focus on occupations and the division of labour directs our attention to the fact that matters of authority are embedded within organizational systems and divide some actors from others due to their different occupational backgrounds, not only due to their titles as "managers" or "employees". The focus on occupational affiliation is also important because it explicitly links higher-status occupations to the authority to "regulate" others due to the former's knowledge, expertise and "superior" tasks. In this regard, Abbott (1988: 33) describes how each profession[19] in the occupational system is "bound by a set of tasks by ties of jurisdiction". Therefore, Abbott (1988: 316) claims that there is a close link between the workers and their tasks, as he says professions "create their work and are created by it". On this basis, he argues that the link between the workers and their tasks places them in a specific position in the occupational system, and that this placement is based on a "jurisdiction" or "claim" from a specific profession. In other words, specific occupations will claim that they are bound to specific tasks in the organization because they can use their expertise and capacity in ways that will solve those tasks in the best possible way. For example, surgeons will claim that they are bound to surgery tasks because they can use their knowledge and specific technics to accomplish those tasks.

However, Abbott is well aware that these claims are political and may be attacked by competing groups, especially if treatment or task failures occur. For example, he shows how the problem of "alcohol" has been redefined over the course of history and how that redefinition has been associated with claims of jurisdiction from new occupational groups. For example, when the problem of alcohol was viewed as a moral or spiritual issue, priests were seen as experts. When alcohol was affiliated with health issues, doctors were seen as the experts. When alcohol became a legal issue, the police were the experts. When alcohol was viewed as a problem that could be regulated, politicians were the experts.

In this way, Abbott argues that the division of labour and superior-subordinate positions in organizational settings are defined, to a great extent, by individuals who can claim not only that they have certain (abstract) knowledge needed to define problems, but also that they can *use* that knowledge to solve these problems by carrying out specific tasks. Therefore, not all individuals can become managers or reach superior positions in an organization. Often, individuals who achieve a superior position in the occupational system will claim that they have a particular expertise and, perhaps, that

[19] Abbott (1988: 1, 54) defines professions by how they *use* their knowledge at work, and not in terms of their knowledge or expertise

they can use specific technologies to solve certain tasks that, in contrast to other groups, makes them better equipped to solve the organization's problems. This gives them authority and power over other groups in the organization. Consequently, links between specific occupational groups (e.g., doctors), their expertise, their ways of using that expertise to accomplish tasks (e.g., by using certain techniques) and their position in the division of labour have been institutionalized. However, they are not completely fixed, as Abbott's alcohol example shows.

Abbott's way of linking specific knowledge, techniques and power positions is also recognizable and has been further elaborated in a more recent research tradition, which is often referred to as Science and Technology Studies (STS). In this field, the notion of materiality is more clearly defined as encompassing technologies, the social practices that constitute them and the myriad of ways in which we interact with them (Callon, 2008: 3). A key figure within this tradition is Callon, who argues that individuals at a workplace only exist when they are "institutionalized and therefore tied up, entangled and caught in mechanisms of coordination". This coordination is affiliated with what Callon (2008: 32) calls socio-technical arrangements that is not only social institutions (rules, routines, incorporated skills, incentives, norms, interpersonal relations) but also materiality and technology, in particular heterogeneous material devices.. Thus, in line with Abbott (1988), Callon is interested in how occupational groups are tied to specific tasks and in the interdependent nature of organizational life. He argues, for instance, that a pilot can only make goals and enact actions (e.g., fly an airplane) because the collective actions of humans (e.g., stewards) and non-humans (e.g., technological devices in the plane and the control tower) enable the airplane to fly and are ordered in ways that *give* the pilot a crucial role.

These studies made me aware that the regulation of professionals may not be reducible to new contemporary ideologies associated with, for example, rehabilitation policies or generic managers who voice such ideologies. Rather, the studies imply that the expressed policies and ideologies would have insufficient or limited power to change and regulate professionals without the existence of "materiality". Thus, they understand regulation as something that emerges in interdependent systems of human and non-human actors. These systems are ordered in ways that give certain humans authority because they claim to have expertise (often due to their occupation) that makes them capable of performing and solving certain tasks in what they claim are the most appropriate ways. Notably, this

autority is bound up in collective actions with other (non-)humans. This understanding of authority and regulation offers important building blocks for studying what happens when a new occupational group, such as therapists, is introduced as a mean to professionalize home care workers in rehabilitative home care organizations. It may also help us comprehend how therapists underpin and co-constitute the more discursive attempts to regulate home care workers' professional identities through the introduction of rehabilitation. Thus, in article 1, my co-author Sara Louise Muhr and I develop the notion of "performative identity regulation", and explore how the discursive attempt to define the (non-)professional in rehabilitative home care organizations is supported by the division of labour and the work of the therapists as new experts on care (see Figure 9).

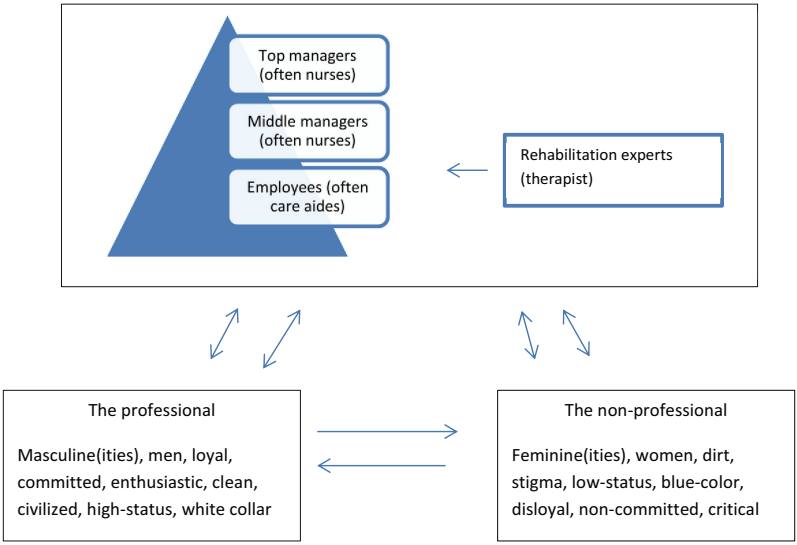

Figure 9. Regulating boundaries of professionalization in the nexus of discourses and materiality.

3.3.2 Negotiating (non-)professional task accomplishment: Occupational interaction systems

The discursive-oriented studies, especially Barkers (1993) and Caseys (1995) studies of the introduction of teamwork, are valuable because they emphasize how the definition of the (non-)professional reflects a negotiated consensus among team members. However, perhaps due to the focus on peer-control and workload issues, we seldom hear about how the more material content and design of the work (e.g., tasks, task divisions and meeting setups) underpin, influence and/or challenge the negotiated consensus. In contrast, classical organizational scholars, such as Hughes (1958) and Strauss et al. (1997), stress that the content of work is crucial for understanding the interaction systems and negotiated orders that emerge, at least in health-care organizations.

Strauss et al. (1997) points out that health-care work tends to be complex, unpredictable and prone to failure.[20] He argues that its complexity results from the fact that patients move in and out of hospitals and in and out of specialized units at hospitals. The treatment of patients is also complex because it involves different actors, different techniques, different skills and different types of medicine, which are not necessarily predictable (Ibid: 8). In addition, Strauss et al. suggests that another layer of complexity is associated with the "product" of care – the fact that people are the ones being "worked over, or through". Due to these complexities, care work is seen as non-coherent (Ibid: 9) and as involving unexpected contingencies that may produce new treatment(s). Therefore, Strauss et al. (1997: 8) argues that illness cannot be reduced to "the physiological unfolding of a patients disease". Instead, it must be perceived as involving "the total organization of work done over [the unfolding of the disease], plus the impact of those involved with that work and its organization", which he calls "trajectories".

Strauss et al. (1997: 27) uses ethnography-inspired case descriptions to show that the patients' diseases and the organization that these diseases involve are characterized by multiple actors and their "trajectory debates". Thus, Strauss et al. (1997) argues that when things goes wrong, many actors with different occupational affiliations voice their opinions about why, and they do so in different situations and locations. Both Strauss et al. and Hughes (1958) suggest that such interactions and debates, which they refer to as trajectory debates and occupational interaction systems, respectively, are not

[20] Strauss also acknowledges that there are cases of routine work within health-care work, which he defines as cases that unfold as expected.

characterized by consensus or democracy. Instead, these debates are characterized by multiple viewpoints, especially because the complexity of work makes success criteria hard to achieve and difficult to define (Hughes, 1958).

Hughes (1958) and Strauss et al. (1997) argue that the power to define success and failure criteria (or sustain the idea that such criteria exists) is closely related to the division of labour. Accordingly, they suggest that the medical ideal within a health-care organization often defines the success criteria (i.e., that doctors can make clinical and linear diagnoses that can be carried out). Clearly, however, this medical ideal and the doctors' definition power are vulnerable due to the complex nature of the work. Therefore, Hughes argues that the division of tasks in organizational settings helps to sustain and protect the medical ideal or vision. For example, he proposes that physicians often attribute mistakes and risks to other occupational groups with less formally acknowledged skills, such as nurses. He proposes that these groups serve as "shock-absorbers" between the patient and physician in general, and for the mistakes of the physicians in particular. By delegating or downgrading certain tasks to nurses, physicians can diagnosis the patient, plan the operation and carry it out under relatively controlled conditions (e.g., the patient is under anaesthesia). However, it is often the nurses who are there when the patients wakes up after the operation feeling sore and confused. As such, this division of tasks between different occupations gives the actors different views about how and why things go wrong (i.e., deviate from the medical vision).

From these studies, I take the idea that a negotiated consensus about ideals and norms in workplaces (and deviations from such norms) tends to be vulnerable, at least in health-care organizations, because the work is unpredictable and performed by different actors with different occupations in different spaces who have different viewpoints about the work because they are part of different socio-technical realities. Therefore, a consensus about norms and ideals about care work requires that such ideals be actively sustained, often by the higher-status workers and through the design of the work itself. As I unfold in article 2, these elaborations serve as important theoretical building blocks for unfolding how the discursively negotiated consensus about the (non-)professional ideal(s) and vision(s) that may emerge with the introduction of team meetings in rehabilitative home care organizations requires a focus on the content of work and the setup of the team meetings (e.g., who the actors are, what their backgrounds are, how the meetings are orchestrated and by whom) (see Figure 10). Thus in article 2, I

follow this path by investigating how consensus about the rehabilitation vision that emerged at team meetings discursively constituted ideas about the (non-)professional and how that consensus (and its violation) was underpinned by the actors and their understanding of their work with rehabilitating the elderly.

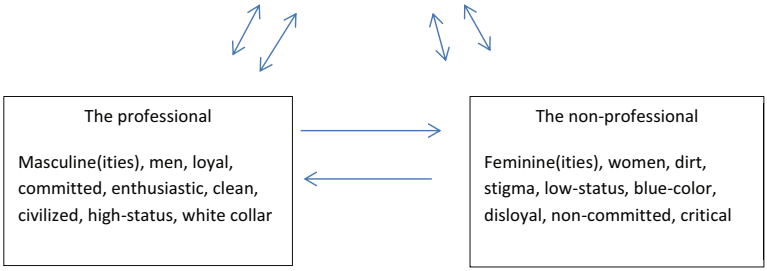

Figure 10. Negotiating boundaries of professionalization in a nexus of discourses and materiality.

3.3.3 Practicing the (non-)professional tasks: Working bodies and their practices

The discursive studies, especially the "dirty work" studies, are valuable because they illustrate how the content of workers' tasks and practices (i.e., the extent to which they are perceived as socially, morally or physically "dirty") matters for how (non-)professional identities are discursively constituted at work. However, these studies tend to focus on how managers can normalize and manage these aspects of work through discursive practices, as if stigma and taint can be discursively negated. This implies that these aspects of work do not have a material character. We seldom hear about how such normalizing attempts affect the daily practices of the "dirty" workers (for an important exception, see Johnston and

Hodge, 2014). This is problematic when seen from the perspective of classical (feminist) studies of professionalization (Hearn, 1982; Davies, 1996) and the more recent feminist tradition of "body work" (e.g., Gale, 2011; Måseide, 2011; Sullivan, 2012; Twigg et al., 2011; Wolkowitz, 2006).

In response to the fact that bodies and embodied practices have often been largely ignored in research, the body-work tradition focuses directly on describing how workers carry out "body work", which is defined as work that is concentrated on others people's bodies (Twigg, 2011). In this regard, matters of materiality become unavoidable, because body work is practiced on a subject and an object. In other words, body work requires awareness of the recipient's personhood and expression of emotion, as well as a recognition of the "fleshy materiality of the body" (Twigg, 2011: 2; Måseide, 2011). According to the literature, this materiality of the body implies that it cannot be reduced to discursive (re-)constructions or (re-)framing attempts. Twigg (2004: 63, 70) argues that although, for example, the association of death and decline with ageing bodies may be culturally constructed, death is not personally optional. Instead it is a feature that "exist[s] at a bodily level". Similarly, although it is possible to rhetorically move attention away from dirt through discursive efforts, the dirt may still exist on the bodies or in their surroundings (i.e., their homes), such that someone is still required to remove it.

The focus on how workers work with living bodies also shows that occupations are differently equipped to distance themselves from and frame the body and bodily waste. More specifically, the body work studies suggest that the status of professionals in the occupational division of labour is marked by their ("dirty") body work and "distance from the body" (Twigg et al., 2011). Thus, these studies indicate that as workers (often men) progress up the hierarchy, they increasingly become involved in administrative or technical tasks, while moving away from devaluated bodily tasks, including close contact with bodily waste and emotional interactions with care recipients. These latter tasks are often carried out by women.

The "moving away" from risk of stigma occurs in two ways: 1) restricting one's presence to certain spaces or areas in the workplace, and 2) drawing on material "distance techniques" (Twigg et al., 2011: 5). First, to ensure their privilege and auras as professionals, the studies suggest that higher-status occupations (e.g., doctors) will tend to be present in certain areas of the workplace and avoid other

areas. To do so, higher-status professionals rely on other occupations (often female dominated) in support roles to perform the ("dirty") support tasks (Davies, 1996; Hearn, 1982). For instance, in a study of a nursing home, Lee-Treweek (1997) found that nurses only worked front stagein the clean public areas, while nurse auxiliaries worked behind the scenes, where they handled physical care (e.g., in the clients' bedrooms). Therefore, the body work studies propose that the ability of higher-status occupations to protect their privileged status depends on lower-status occupations to which they can transfer stigmatized aspects of work (rather than heroically sheltering those lower-status occupations from stigma, as proposed in the dirty-work literature).

Second, the body work studies argue that, depending on their status, workers use different material devices or their own body parts (e.g., their hands) to accomplish their body work and tasks. Thus, the higher-status workers are authorized to use distancing techniques not only to remain physically clean but also to de-emphasize the bodily character of work that cannot be fixed discursively (Sullivan, 2012, Twigg et al., 2011: 5). Examples of these techniques include the use of protective clothing, such as uniforms and gloves (Jervis, 2001; Sullivan, 2012; Wainwright et al., 2011); technical devices to measure respiratory capacity; surgical tools; and medicines for sedating bodies (Gale, 2011; Måseide, 2011; Twigg et al., 2011).

From these studies, I adopt the view that the practices and content of work at workplaces in which ("dirty") body work is performed cannot be reduced to discursive efforts or constructions. These studies suggest that the materiality of this kind of work and its embodied practices limit the extent to which the work can be discursively (re-)constructed. In addition, these studies show that the extent to which occupations may be (in-)capable of distancing themselves from the stigmatized aspects of work (e.g., their ability to use certain techniques or restrict themselves to certain spaces) is a matter of (non-)professional status. As I discuss in article 3, these ideas are useful as supplementary optics for studying how the discursive and material practices that may accompany rehabilitation influence the workers, their performance of the work and the content of that work. More specifically, in article 3, I develop the notion of "stigma shaping", which I use as a critical lens to examine the ways in which discursive and material practices are evoked in rehabilitative home care organizations to re-frame and physically distance certain actors from stigmatized aspects of work. I also use this notion as a lens to

understand how such practices might reshape stigmatized aspects of work and transfer them to other actors (see Figure 11).

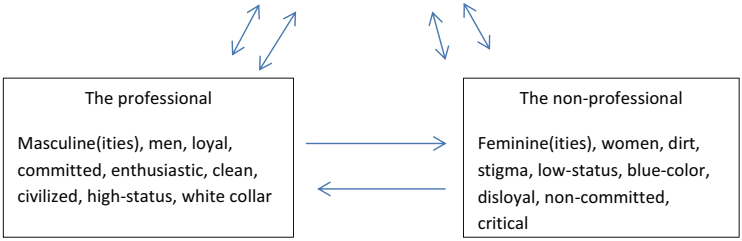

Figure 11. Practicing boundaries of professionalization in a nexus between discourses and materiality.

3.4 Material and discursive co-emergence

With my critical lens and feminist literature as guides, I have reviewed two types of studies on professionalization in this chapter: discursive-oriented and material-oriented studies. My aim has been to lay out a range of theoretical building blocks from which to draw in order to ensure a focus on both the discursive and material ways in which boundaries of professionalization can be regulated, negotiated and practiced in rehabilitative home care organizations. I have also addressed some of the implications that such boundaries may have for workers and their areas of work. When looking into the theories, I found that they did not rigidly describe either the discursive or the material aspects of work. In this respect, my review is a simplification of the two sub-perspectives on professionalization. However, this separation of the studies is important for analytical purposes because the two types of

studies give primacy to different aspects of how boundaries of professionalization are drawn at work. Therefore, the grouping of the studies ensured that I did not displace or collapse either the discursive or the material aspects of work, and allowed me to maintain my focus on the discursive and material co-emergence of the boundaries of professionalization. I also avoided becoming dedicated to an entire theoretical framework associated with a particular concept or line of argument in the reviewed studies. Notably, I viewed the studies as offering a selection of useful theoretical building blocks that could help improve our understanding of how boundaries of professionalization may be regulated, negotiated and practiced in rehabilitative home care organizations.

I am indebted to the discursive-oriented studies, which helped me understand how newly introduced managerial policies and discursive practices, such as rehabilitation, may function in contemporary organizations, such as home care organisations. These studies not only informed my understanding of how and why promises of liberation and professionalization intermingle with efficiency purposes in contemporary organizations, but also how such intermingling may be both problematic and beneficial for workers. It may be beneficial because managerial discourses may offer workers who risk marginalization a more "positive" professional identity (see the "dirty work" studies), but it may also be problematic because actors who fight to ensure such a positive professional identity are vulnerable. Such actors may be forced to work harder, or they may even be re-marginalized or sanctioned as non-professionals if they do not enthusiastically advocate and enact the policies as committed champions. Therefore, the most important building blocks I take from these studies reflect the fact that workers may be mobilized to adopt certain professional identities by means of discursive regulation, discursively negotiated consensus and discursive practices that generate boundaries between the (rewarded) professional and the (sanctioned) "others" (the non-professional).

However, given the aim of this dissertation, the discursive studies have some blind spots. In particular, they draw attention away from more material aspects of how the (non-)professional is embedded and embodied in the actual work. The material-oriented studies provide important building blocks in this regard. Instead of leaving the discursive insights behind, however, I intend to combine views from both the material-oriented and the discursive-oriented studies to ensure an analysis that opens up for the study of the discursive and material ways in which boundaries of professionalization may be regulated,

negotiated and practiced in rehabilitative home care organizations. For this purpose, as described in Chapter 1, the analytical body of the dissertation consists of three articles.

In article 1, my co-author Sara Louise Muhr and I develop the notion of "performative identity regulation". This notion is primarily based on the concept of identity regulation (Alvesson and Willmott, 2002) but it is further developed by drawing on ideas from critical STS-inspired performativity theory (Cabantous et al., 2016). These ideas are used to explore what happens when the therapists are introduced as a means to professionalize home care workers in rehabilitative home care organizations. The article illustrates how therapists' communication and their work as new experts in the home care context regulate and underpin attempts to redefine the home care workers' understanding of (non-)professional identities as well as their behaviour at work.

In article 2, I address how ideals about (non-)professional efforts and outcomes are constituted through negotiations at work. For this purpose, I combine building blocks from Barkers' (1993) theorizations on team organizing and negotiated consensus with Strauss' et al. (1997) and Hughes' (1958) conceptualizations of the design and unpredictable nature of health-care work. I use these building blocks to explore what happens when team meetings are introduced with the aim of supporting the professional dialogue in rehabilitative home care organizations. The article illustrates how consensus about the rehabilitation vision and the possibility of realizing this vision within the context of home care work was discursively constituted at team meetings, but also underpinned by the setup and orchestration of those meetings in ways that established specific ideas about (non-)professional efforts and outcomes at work.

In article 3, I develop the notion of "stigma shaping". This notion is based on a combination of ideas from dirty-work studies and body work studies. These ideas are used to explore what happens when home care workers are introduced to new practices and tools designed to support their professionalization in rehabilitative home care organizations. The article shows that rehabilitation provided the home care workers with new discursive and material practices they could use to re-frame and physically distance themselves from stigmatized aspects of their work. However, the article also highlights that this professionalization seemed to reshape stigmatized aspects of work and transfer dirt to other actors (i.e., the elderly), rather than manage or negate those aspects.

CHAPTER 4: METHODS

4.1 Methods – Constructing an Organizational 'Workography'

To study how boundaries of professionalisation are regulated, negotiated and practiced in marginalized organizational settings, this study draws on an ethnography-inspired methodology. This methodology has inspired my choice of methods, as well as the analytical and scientific approach I apply in the dissertation (Van Maanen, 2011: 218). In Chapter 3, I describe the critical stance and theoretical building blocks that inform this dissertation. However, that description masks the more processual aspects of how this dissertation has taken shape. Therefore, the aim of this chapter is to unpack in further detail and from a more processual angle how my research process has evolved and the methodology that underpins the dissertation. This chapter shows that my research process was not linear or settled a priori. It was characterized by ongoing reflections and often conflicting (re-)considerations of my position in the field. These reflections crystalized in an ethnography-inspired methodology that I believe is particularly useful for studying how matters of professionalization and marginalization intersect in work settings.

I introduce the chapter by describing the evolution of my research design. I then discuss my multi-method framework, and my approach to managing, analysing and writing up the multiple data sources. Finally, I reflect on my overall knowledge production and my positioning as a researcher.

4.2 Research design: An evolving and explorative endeavour

My research process can best be described as an explorative and sometimes messy endeavour. Consequently, my research design evolved in a processual manner. This is not surprising as such. As Cunliffe (2010: 231-232) highlights, ethnographies and ethnography-inspired studies should not be "nice neat ones where everything fits". While ethnography-inspired research should "aim to bring out the experimental, interpretive, dialogical and polyvocal processes at work", this kind of research also requires ongoing reflection on behalf of the researcher. These reflection should allow researchers to exploratively determine not only "what tale to tell", but also who they are as ethnographers "because who you are influences what you see and say – your fieldwork and text work" (Cunliffe, 2010: 232). In other words, ethnography-inspired research requires ongoing reflection concerning fundamental issues, such as one's analytical and scientific approach (Van Maanen, 2011: 218).

However, the idea that the research process should be reflexive and emerging does not imply that all ethnography-inspired work adopts a similar scientific approach. Rather, Cunliffe (2010: 230) distinguishes among three research traditions within organizational ethnography. Realist-oriented studies are concerned with identifying and measuring (causal) patterns and processes in organizations, and telling the "truth" about "sociality". Interpretive-oriented studies, which view organizational sociality as socially constructed and intersubjective, search for multiple voices and complex processes rather than "one true" voice or process. Critical-oriented studies perceive sociality in terms of the "power-ridden nature of social relations" in organizations and try to denaturalize the ways in which power dynamics work, often by investigating not only polyvocal voices but also minorities' voices. These three research traditions within organizational ethnography see and study organizations in different ways. However, they share the view that the study of organizations requires multiple fieldwork methods and reflexivity because organizations cannot be understood a priori (i.e., before the researcher undertakes fieldwork).

These considerations are important for my research process. My fieldwork and my ongoing reflections led me to (re-)consider my position and my study design during the research process. In the following section, I unpack this evolving design, my research process and the ongoing reflections that lead me through that process. My ultimate aim is to demonstrate how this dissertation has moved from what Cunliffe (2010) refers to as a realist-inspired ethnographic study to what I call a "workography". I feel the description of this shift is important, as it makes the premises and processes by which I have (re-)constructed and (re-)approached the study during the course of my PhD work transparent. This transparency is crucial in critical interpretive studies, where traditional scientific assessment criteria, such as validity and reliability, make little sense (Justesen and Mik-Meyer, 2010; Brymann and Bell, 2011).

4.2.1 The initial research design: ReKoHver – A realist-inspired project

This dissertation was grounded in the changes in home care work and working conditions that resulted from the introduction of rehabilitation activities while I was employed as a work environment researcher and consultant at Teamarbejdsliv A/S. Teamarbejdsliv A/S is a Danish firm that specializes in research and consultancy within the area of safety environment. Due to the generally positive descriptions and atmosphere that characterized the proliferation of rehabilitation and its win-win

outcomes (see Chapter 1), I could not avoid noticing the renewed importance of the concept and the changes it seemed to imply, not only in the home care industry but also throughout the Danish public sector. As this century's first decade came to an end, everyone in our networks was talking about rehabilitation. As the firm specialized in safety environment, we were particular interested in the seemingly positive relationship between the new ways of organizing rehabilitative home care work and the improvement in workers' work environment suggested by the influential evaluation report from Fredericia (Kjellberg et al., 2011a, 2011b).

I mention this grounding of the dissertation in order to explain that, from the beginning, my empirical interest and the focus of the dissertation were the work and working condition of professionals active in rehabilitative home care work. This discussion also serves to show that the initial research design took shape while I worked at Teamarbejdsliv. In this capacity, I decided, in collaboration with my colleagues Karen Albertsen, Hans-Jørgen Limborg, Inger-Marie Weigmann and Flemming Pedersen, to apply for funding to conduct a more focused, in-depth exploration of changes in the working conditions that rehabilitation gave rise to in home care organizations. In 2010, Teamarbejdsliv A/S received a research grant from the Danish Working Environment Research Fund (Grant number 45-2011-09) to conduct what we referred to as the ReKoHver project (Albertsen et al., 2014). This project provided the majority of the empirical data used in this dissertation. For this reason, I explain in the following the initial ReKoHver research design, which was inspired by a rather realist-oriented organizational ethnographic approach. Thereafter, I explain how and why I reshaped that design as a PhD Fellow.

The project was labelled ReKoHver for two reasons. First, the name was chosen due to its associations with the word "recovery". As rehabilitation is said to restore and "recover" people, we found this name appropriate. Second, the name reflected our interest in exploring the new kinds of work and working conditions that underpinned this idea of restoring older people. More specifically, by attending conferences, reading about rehabilitative home care work and speaking with actors in our network, we had the impression that home care workers' relations were changing owing to the introduction of rehabilitation (e.g., the introduction of therapists), and the same appeared to be true for the coordination of the work and related tasks (e.g., the introduction of team meetings). We believed that the ReKoHver

title reflected our interest in the new relations ("Re") and coordination issues ("Ko"[21]) that we expected rehabilitative home care work to create. We also hoped that it reflected the theoretical perspective of "relational coordination" ("ReKo") (Gittell et al., 2010) that we expected to apply at the time.

To better understand how the new relations and modes of coordination in rehabilitative home care work emerged and influenced the conditions and working lives of home care workers, we decided to conduct an organizational ethnography-inspired study. In line with most other organizational ethnographic studies, our research design encompassed multiple fieldwork methods (e.g., interviews, focus groups, observations and surveys) (Ybema et al., 2009; Van Maanen, 2011). However, two aspects of the ReKoHver design reveal the realist-oriented nature of our study. First, the initial research design was based on a combination of qualitative data (i.e., focus groups, interviews and observations) and quantitative data (i.e., surveys). Second, the design included the comparison and collection of data from five (out of 98) publicly-financed home care organizations in Denmark that had recently introduced rehabilitation activities. This design was realist in the sense that we not only wanted to collect qualitative data to gain a detailed understanding of the complex processes and working conditions within the five organizations, but we were also interested in collecting quantitative data to produce generalizable knowledge that would allow us to compare and measure the organizations as aggregated units.[22] As such, we hoped that the quantitative data would help us identify (causal) organizational patterns and relationships. More specifically, we hoped to uncover the organizations that had been (most) successful in improving working conditions, and to understand how this success was affiliated with the organizations ability to ensure good relations among workers and efficient coordination. Our ultimate aim was to pinpoint criteria that could inspire improvements in the working conditions in rehabilitative home care organizations in general (Albertsen et al., 2014).

Given this dual purpose of gaining in-depth and generalizable insights, the ReKoHver project was designed to consist of a qualitative and a quantitative phase, and it was to be carried out from January 2012 to June 2014. In the first phase, which ran from February 2012 to September 2012, the qualitative

[21] In Danish, coordination is koordination.

[22] We selected the five organizations to ensure variance. Therefore, they differed in terms of such factors as geographical location, size, local budget and the length of time employees had been trained in rehabilitation (training courses varied from 3.5 days to three weeks).

data were collected. The key findings were presented at dialogue and feedback seminars held in each of the five home care organizations between September 2012 and January 2013. In the second phase, quantitative data were collected from the five organizations, and the findings were again presented in dialogue and feedback seminars in the five organizations. As a researcher involved in the ReKoHver project, I played an active role, not only when our organisation applied for funding but also in the project's first phase. In other words, I participated in the qualitative data-collection process and the feedback process. More specifically, I was responsible for the data-collection and feedback processes in two of the five organizations[23]. In addition, I was tasked with developing the initial parameters that would help us compare all five organizations. It was during this fieldwork that I decided to apply for a PhD.

My role as a ReKoHver project member provided me with a platform from which I could depart as a PhD applicant. At the same time, the ReKoHver project and my employment as a consultant and a researcher (with many other tasks) were restrictive. As with most research projects, the project team was restricted by factors included in the initial application: our proposed (realist-inspired) comparative research design, our theoretical perspective, the timeline and the promised deliverables. Therefore, although the project provided me with a research site, multiple rigorous data sources, interesting insights and numerous questions about what was actually going on in rehabilitative home care, it was restrictive in the sense that the practical setup allowed limited time and space to engage reflexively with the areas of confusion or the puzzles, or to write the rich descriptions that are considered crucial within ethnography-inspired research (Cunliffe, 2010; Ybema et al., 2009). Thus my eager to undertake further exploration of the data became the launch pad for this dissertation. Of particular importance was the fact that Teamarbejdsliv A/S generously allowed me to use all of the qualitative data from the project (i.e., the data I had collected as well as the data other project members had collected). However, although the ReKoHver project provided me with a research site and data, I still faced the challenge of determining my precise foci and object of inquiry as a PhD Fellow. This process was rather messy, as I found myself moving among different sources of data and theoretical sources of inspiration.

[23] There were five project members. One project member, Karen Albertsen, was the project manager. The rest of us had equal status as members of the project. Therefore, although my colleagues were senior researchers, we all had the same tasks and status in the project. Four of us collected the qualitative data, while the fifth project member was primarily in charge of the quantitative data.

4.2.2 Reconsidering the design and foci: Getting lost in abstractions

In my endeavour to consider the foci of my dissertation and to re-explore what was at stake for professionals in rehabilitative home care organizations, I did not start with a careful, systematic re-investigation of the ReKoHver data and the home care context. Instead, I began by investigating the concept of rehabilitation. During the ReKoHver project, I was intrigued by how fast rehabilitation had spread within the home care industry and by the similar ways in which the five-home care organizations had implemented rehabilitation (e.g., team meetings and work tools; see Chapter 2). It was easy to figure out some of the reasons for this development. As mentioned in Chapter 2, during our fieldwork, the key agenda setters in the five organizations (who had been driving forces in implementing rehabilitation) explained that they had been inspired by descriptions of the Fredericia model. They had all read the evaluations (Kjellberg et al., 2011a, 2011b), participated in conferences on the topic and/or visited Fredericia to gain inspiration. When I present this explanation model in academic circles, I often received the critique that the spreading of rehabilitation could not be reduced to the Fredericia model, and that I had an overly narrow and ahistorical understanding of the rehabilitation concept.

In responding to such criticisms and inspired by critical management studies (e.g. Power, 1997, Dean, 2006, Rose, 2001), I started to explore the historical roots of rehabilitation by conceptualizing rehabilitation as a particular program, mentality and rationality. For this purpose, I spent several months researching the phenomenon in academic literature, in international and Danish policy papers, and in the Web of Knowledge (WOK) database. For example, I used the WOK to map the use of the rehabilitation concept in academic literature over the past 100 years (see Figure 12). This mapping, which covered approximately 40,000 papers, clearly suggested that the concept has a long history, even though consideration of the concept exploded after WWII and again increased significantly after 1995. In addition, the WOK database showed that the concept had been linked with various knowledge fields and, thereby, with organizations since 1900. For example, the concept had been used within medicine, biology (e.g., sanitation), economics, gerontology, criminology, psychology, penology, law, education, computer science, social work, sociology and robotics.

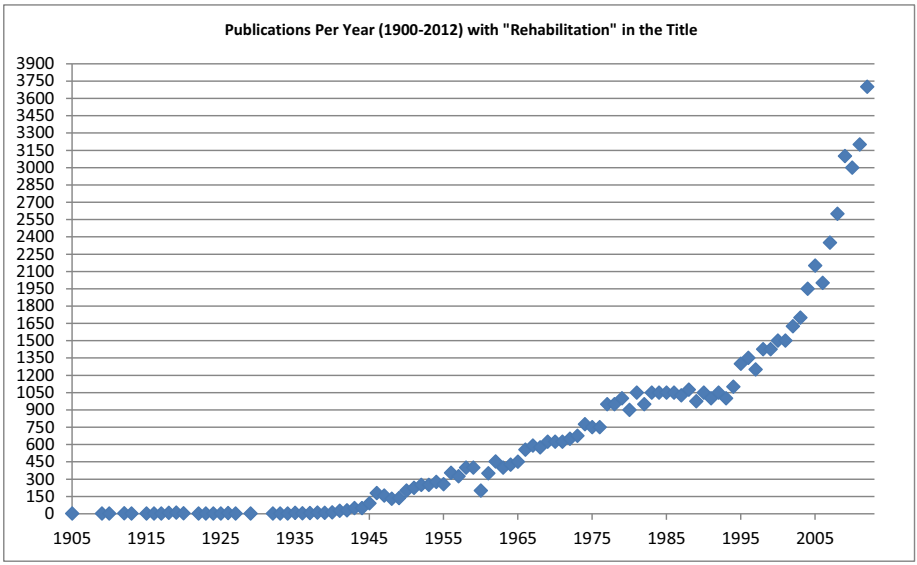

Figure 12. Results of the WOK analysis ('All databases', Web of Knowledge).

While this analysis clearly showed the historical roots of the rehabilitation concept and contradicted my ideas about the concept's novelty, it also illustrated the fuzziness of the concept, which did not appear to be easily reducible to a generic program with a single history. The descriptions of the concept throughout its history and across knowledge fields shared similar kinds of abstract ideas and ideals concerning the restoration or reestablishment of humans' and non-humans' reputations, privileges and conditions after a difficult period. However, I felt increasingly lost in this data until I started to read Michael Power (1997). Power (1997: 4) argues that it is often the simple and vague idea and spirit of concepts that allow them to immigrate to diverse environments and policy arenas. This gave me some comfort.

While presenting these findings at a doctoral course, I described how the document study had taught me that rehabilitation was not a new concept confined to the home care industry. The new vague win-win idea of restoring economies and recipients' and workers' reputations seemed to have mobilized and committed actors in the home care industry to adopt the concept (Power, 1997). However, this

presentation left me feeling even more lost when my colleague, Signe Vikkelsø, asked what this document study had taught me about rehabilitative home care work. At that point, it became clear that my detour from the ReKoHver data had done little to support my attempt to understand what was at stake in rehabilitative home care organizations – how and why home care workers were mobilized as they were, why they articulated their work and acted as they did, and why they managed their day-to-day situations in certain ways. In fact, the document study seemed to have moved me further away from exploring these issues. It was clear that I had to make some crucial decisions. Should I further investigate the concept of rehabilitation? Should I start over and return to my ReKoHver data, as Signe suggested?

Again, Power (1997) was helpful in this process. Power (1997: 9) argues that the fuzziness of proliferating concepts means that understanding what concepts, such as rehabilitation, "really are" is not necessarily important. Rather, he argues that it is crucial to investigate how affixing a new concept and, thereby, a new idea or hope to an organization or field mobilizes the commitment of actors within a specific context to reshape their activities, values and goals (i.e., their understanding of problems and solutions). When reconsidering the foci of my study, I therefore decided to return to my ReKoHver data, and my foci on work and workers without losing focus on how affixing the new rehabilitation concept to the context influenced the work and workers.

4.2.3 Consolidating the design: Returning to ethnography in the form of a multisite workography

My "return" to the ReKoHver data implied that I also returned to my ethnography-inspired field work methods and design. I started this process by re-reading and coding all of my data (e.g., notes and transcripts), and by engaging with new streams of literature that might help me re-conceptualize the data and what was at stake in the focal organizations. This re-engagement with the data and various streams of literature, as well as the period during which I was distanced from the data (Ybema et al., 2009, Cunliffe, 2010), allowed me to gain new insights and, as such, reconsider my research design. I unpack this process in detail in the section on analytical and coding processes later in this chapter. At this point, I elaborate on two aspects of this process that had crucial consequences for how I ultimately designed the dissertation.

First, my re-engagement with the data and the literature gave rise to new questions and helped me clarify the foci of my study. I started by investigating 1) how the link between rehabilitation and home care organizations emerged, and 2) how the linking of rehabilitation to home care organizations influenced the workers and their area of work. The data clearly revealed that rehabilitation was linked to home care organizations in multiple ways. Moreover, the ways in which rehabilitation influenced the workers and their area of work seemed ambiguous. For example, the observations showed that rehabilitation gave raise to tensions on the front line. However, especially among higher-status workers, these tensions were masked and/or ordered in an ambiguous way that I struggled to conceptualize. In my endeavour to gain a deeper understanding of why and how the observed tensions were masked, suppressed and/or ordered in the focal context, I realized that it might be the historical work-related processes in home care organizations, rather than the rehabilitation concept, that I did not understand. Therefore, in trying to understand the empirical ambiguity, I started to engage with often feminist-inspired classical and newer literature on healthcare, home care work and female dominated work (cf., Chapter 3). This theoretical framework taught me that rehabilitation could be conceptualized as the most recent example of a broader ongoing attempt to professionalize care work, and that the data's ambiguity might be related to a tension between professionalization and the type of work that home care workers undertake. This led me to refocus on the power dynamics (Cuncliff, 2010) in the data and to address a range of new questions, such as how (e.g., among who), by what means (discursive and material) and when (in what situations and events) the issue of rehabilitation (i.e., professionalization) generated divisions, differentiation and oppression, or what I have called boundaries of professionalization (see Chapter 1).

Second, I reflected on designs or frameworks that could help me explore these new questions. In particular, I considered what kind of organizational ethnography-oriented study I intended to construct in order to expose the multiple ways that boundaries of professionalization were constituted and functioned in rehabilitative home care organizations. As I had already collected the data, that aspect of the design could not be reconsidered. Therefore, I focused on how I wanted to approach and study the data. As mentioned above, the framework of the ReKoHver project had been guided by a realist-oriented organizational ethnographic approach that aimed to compare the five organizations. However, when I began to re-engage with the data and investigate literature that directed my attention towards

marginalization and professionalization processes, I found that this design's utility for exploring my questions was limited. Most of the work-oriented studies, (e.g. Hughes, 1958, Strauss et al., 1997) that I found inspiring were also categorized as organizational ethnographies in the literature on ethnographic methods (Cunliffe, 2010, Ybema et al., 2009; Foley, 2002). However, they did not investigate organizations as aggregated, comparable units with causal patterns and processes. Rather, these studies were critical-interpretive oriented in the sense that they were concerned with exposing the multiple (sometimes constructed and sometimes more material) power dynamics and sites found in organizational settings, often through case illustrations (see, e.g., Strauss et al., 1997). Thus, instead of comparing organizations and studying the organization as an outcome, these scholars studied organizations in a state of becoming something else by focusing on the multiple, but specific, situations, events, core tasks, trajectories, functions, divisions of labour, professionals and purposes that were affiliated with specific kinds of organizing in certain types of organizations, such as hospitals and schools. In other words, instead of being interested in a particular organization as such (e.g., one hospital compared to another), they were interested in specific modes of organizing at, for example, hospital*s*.

This way of investigating organizations inspired me in many ways and brought out some of the puzzles that I had struggled with during the fieldwork. One thing that had intrigued me during the ReKoHver project was the similarity of the work done by workers across the five organizations. After my investigation of the literature, this was no longer surprising. All five home care organizations consisted of professionals with similar occupational backgrounds, status and functions. They all participated in the same kinds of events and routines (e.g., team meetings, home visits, training seminars), and they were responsible for similar kinds of core practices and tasks in their organizations. This did not mean that the workers and situations were similar or easy to understand. However, I was struck by the fact that the diversity within the organizations was just as extensive as across organizations.[24] For example, during the observations, I often observed events, such as an occupational meeting, in two distinct organizations that were so similar I felt that I had only been in one organization. In contrast, over the

[24] In this regard, Hearn and Parkin (2001: 5) suggest that the notion of "the organization" is somehow problematic, complex and ultimately a "fantasy". The notion is often used to refer to the "individual organization" even though the "organization comprises many different organizations within it".

course of a day, I could move from one type of work event/situation to the next (e.g., from an occupational meeting at the office to a start-up meeting in the home of a care recipient) within one organization and notice significant differences (see also Glerup, 2015).

I became increasingly aware that organisational comparisons might not be the most useful approach to analysing the particularities and complexities of the intersection of professionalism and marginalization in a home care organizations. In particular, when trying to understand this intersection, it seemed relevant to utilize a multisite case study. In such a study, I would document and compare the polyvocality and specificity of the multiple "micro" work situations and events within and across the focal organizations rather than conduct an abstract comparison of the five organizations. I am not claiming that these puzzles and reflections are ground-breaking. In fact, I think most interpretive ethnography-inspired organizational scholars would find them relatively banal, as ethnography-inspired work attempts "to see the world in a grain of sand" (Ybema et al., 2009). However, I ask the reader to remember that my starting point was a realist-oriented comparative design and that I am discussing these reflections because they inspired the methodological framework and design that ultimately guided the disssertation, which I term a "workography".

By using the term "workography", my intention is not to introduce a new type of ethnographic tradition, but to specify my level of analysis and the type of organizational ethnography I am ultimately conducting in the dissertation. I have found this important for addressing the critique that Pedersen and Humle (2016: 2) direct towards organizational ethnographies in general. In their book, these authors criticize organizational ethnographies for reducing organizations to "empirical sites", "contextual settings" or "spaces". They argue that this is problematic because these studies often draw on ethnographic methods to study organizations but forget to reflect on how these methods affect our understanding of organizations and organizing.

Although I agree that the reduction of the organization to an anonymous or abstract site is problematic, I disagree with the authors' argument because it relies on a specific definition of organizing.[25] Yet, as

[25] Pedersen and Humle (2016: 1) define organizing as "an overall polyphonic, emerging, and processual concept (Kornberger, Clegg and Carter, 2006; Humle and Pedersen, 2015) based on the multiple voices, discourses, frames, tensions, practices, interactions, and narratives of organizational life".

Vikkelsø (2015:424) highlights, there is a myriad of ways to define an "organization" and "organizing". For instance, scholars who do not approach organizations as aggregated or closed units use a wide variety of abstract terms to depict organizations – such as "open systems", "networks of activity systems", "interpretive communities" or "actions-net" (Vikkelsø, 2015:419). Therefore, from my perspective, scholars who claim to conduct organizational ethnography must more clearly address how they define (and redefine) the organization(s). This (re)definition is crucial when scholars want to reflect on how the ethnographic methods may have affected their understanding of organizations and organizing.

The notion of workography becomes relevant in this context. This notion serves to emphasize the fact that I view and investigate home care organizations by looking at the work events, the work tasks, the working actors, the work techniques and the workflows that unite humans and non-humans in the organizations for some length of time (Strauss et al., 1997, Vikkelsø, 2015). In other words, I want to avoid any expectations that this dissertation will help us understand the focal organizations as aggregated units, abstract open systems or networks. In Chapter 8 I ultimately seek to reflect on what my methodological framework says about how we can study and write up stories about the work and workers in marginalized organizational settings that are undergoing some form of professionalization. In addition, my decision to use work as the unit of analysis reflects the practical and political aims of the dissertation. In order to engage in a dialogue with practitioners about their work, I shift the focus from the abstract (e.g., opportunities) towards more specific dilemmas. As Vikkelsø (2015:418) argues, attempts to understand organizations through abstract concepts, such as networks, or by comparing them as aggregated units entail a "diminished ability to specify and intervene into the practical reality of organizations, while seeing the organization through the mundane everyday tasks and work it comprise, may provide greater potentials to intervene in them".

The aim of providing this detailed outline of my research design was to clarify how the design, questions, data collection and analytical approach evolved prior to and during the PhD process. For the remainder of the chapter, I focus on describing my workography framework in terms of how I collected the ReKoHver data and how I analysed that data after I shifted my attention to the work focus.

4.3 Data collection on work and professionals: A multi-method framework

As described above, the idea for this dissertation emerged when I carried out the data collection in relation to the ReKoHver project. A data collection that has been the cornerstone of my empirical study. Accordingly, in the following, I offer a detailed discussion of this data in terms of our fieldwork, our data collection and our engagement with the data based on multiple methods. As the ReKoHver project involved several project members, I refer to "we" in this section to emphasize the fact that decisions and data collection were collective endeavours at the time.

In the qualitative phase of the ReKoHver project, we were interested in understanding and exploring the complex ways in which the professionals in home care organizations managed, discussed and performed their day-to-day work in rehabilitative home care organizations. This interest was inspired by the theoretical perspective of relational coordination (Gittell et al., 2010), which centred our focus on the various relations among occupations with different status (e.g., managers and employees) and affiliations (e.g., nurses, care aides and therapists), and on the coordination of their work and tasks in relation to the core task (i.e., services for predominantly older people in their homes). From the beginning, therefore, the ReKoHver fieldwork was concerned with identifying multiple sites in the home care organizations where this coordination took place and with the many actors who made up the relations within these sites. We were particularly curious about how the coordination activities and relations had changed with the introduction of rehabilitation, and about how rehabilitative home care work was accomplished. Accordingly, we decided at an early stage to combine interviews and observations in order to understand, first, how home care work had been carried out before rehabilitation and how the professionals viewed the change process (interviews) and, second, the particularities of how rehabilitative home care work occurred (observations).

Therefore, after identifying the five home care organizations, we spent some time collecting and reading internal documents from the five organisations (e.g. descriptions on the aims of rehabilitation, and on the labour requirements, task divisions and procedures associated with rehabilitation). We also worked on planning the fieldwork with key actors in the five organizations. In this pre-study stage, we tried to identify not only the actors, and how the work and tasks were organized and coordinated in the focal organizations, but also how to obtain access to the field. In particular, this pre-study investigation helped us consider who we wanted to include in the interviews and where we needed to conduct the

observations. Undoubtedly, this process was partly "gated" by our key contacts, who were often managers, in the five organizations. Accordingly, although our readings of the local documents allowed us to specify and qualify the sites we were interested in observing and the actors we wanted to include in our interviews, it was ultimately our key contacts in the organizations who invited the respondents to the interviews and arranged our contacts for the observations. The key contacts also ensured that the people we interviewed and observed had been informed about the project and had agreed to participate. To help the contact persons in this endeavour, we had written an orientation letter that included pictures of ourselves, and described the aim of the project, the participants' roles and rights, and our own role.

During this planning process, we realized that the rehabilitative home care organizations were more complex than first anticipated. We quickly understood that rehabilitation was not a singular organizational phenomenon but rather multiple phenomena that were affiliated with plural initiatives that involved multiple sites, events and actors (See Chapter 2). Our planning process also revealed that despite rehabilitation's polyvocality, the five organizations, as mentioned, had implemented some of the same polyvocal initiatives (e.g., new team meetings, new experts, new working tools and new rehabilitation programs, including start-up and evaluation meetings). We hoped this would allow us to compare the five organizations as aggregate units in the analytical process (due to our initial realist design). Accordingly, we also found it important to try to ensure that similar types of data were collected from each of the five organizations. In the following, I offer a more specific discussion of how we collected data from our key sources: focus groups, individual interviews and observations.

4.3.1 Focus groups and individual interviews

Due to our focus on relational dynamics, especially among professionals, and on how the work was accomplished and coordinated before and after rehabilitation, we decided that focus groups should be our main interview method. A focus group can be defined as a discussion among a group of people aimed at generating insights about specific topics or issues with the help of a moderator (Liamputtong, 2011). We viewed the collective nature (Liamputtong, 2011) of the focus groups as an advantage for several reasons.

First, we expected the collective nature of focus groups to allow us to explore not only different voices but also the relational and social aspects of the expressions of those voices. In this regard, focus groups

create a platform in which professionals can articulate, censure, negotiate, reflect on, and make their work and change processes meaningful in each other's company (Dahl, 2009; Liamputtong, 2011). Second, we felt that the collective nature was particularly relevant because our knowledge about the sector was limited and because we were focused on a complex change process. In this respect, focus groups are often described as a relevant method for collecting data in new fields and capturing processes because the respondents can assist the researcher in asking interesting and relevant questions, and because they can enhance group members' memories about the processes by adding information, or by contradicting and disagreeing with each other's (re)construction of the process (Wilkinson, 1998: 118). Third, the participants in our focus groups queried each other and explained themselves to each other, which we believed would make us sensitive to people's own vocabularies concerning the framing of their work and the context (Morgan, 1996; Wilkinson, 1998: 117). Fourth, we were aware that some of the professionals did not have much training or education. In this respect, we saw the collective nature of focus groups as an advantage because they are often described as one way of giving a voice to marginalized groups who might feel less intimidated among peers than in individual interactions with an unknown external researcher (Liamputtong, 2011: 6; Wilkinson, 1998; Morgan, 1996).

Two types of focus groups were conducted in each of the five organizations (10 in total). One type of focus group included professionals who engaged in day-to-day rehabilitation work (e.g., in recipients' homes), while the second type included the managers responsible for managing this work (predominantly situated in the office). We chose to separate professionals who worked with rehabilitation on a daily basis (i.e., on the front line) from managers in order to ensure a safe environment in which the participants felt comfortable enough to discuss their opinions without fear of sanctions (Liamputtong, 2011). The employee focus groups (5 in total) typically included a nurse, two therapists, four care aides and a medical officer. The management focus groups (5 in total) included top or middle managers, most of whom were nurses. Eight participants were invited to each focus group (Morgan, 1996). However, due to cancellations, the number of participants varied from four to eight. A total of 64 individuals participated in the focus groups (28 managers and 36 employees).

Each focus group lasted two hours, and two moderators (A and B) participated in each interview. Moderator A introduced the topic – rehabilitation in home care – and supported the participants'

discussion. To benefit from the advantages of focus groups, moderator A used a semi-structured interview guide that was designed to allow the home care professionals to express themselves, and to ensure enough room for different voices and negotiations among the participants. The broad sub-themes were: 1) participant details (e.g., name, occupational background, function, length of service), 2) the reasons for introducing rehabilitation into the home care arena, 3) the hopes, support, fears and barriers participants experienced in connection with the introduction of rehabilitation, 4) the organization, core tasks and practices affiliated with rehabilitative home care work, 5) the key professionals involved in rehabilitative home care work, including their skills, expertise and techniques, 6) the target group for this type of work, 7) patterns of cross-occupational collaboration and core changes in work, and 8) the main results and challenges for the organizations and the workers (see appendix 1). Although this list may appear comprehensive and structured, we viewed the sub-themes and related questions as a source of inspiration that could facilitate the dialogue rather than as questions that had to be asked in specific ways. Moreover, we tried to involve the participants as much as possible. Accordingly, as a supplement to these broad sub-themes, moderator A asked other questions, such as "Do you have other examples?" and "Did you experience that in the same way?" in order to facilitate interactions and dialogue among the participants (Liamputtong, 2011; Morgan, 1996). Moderator B audio-recorded the discussion, and took notes on both speech and behaviour. In addition, many of the focus-group interviews were transcribed.

We decided to supplement the focus groups with individual interviews. Therefore, we conducted interviews with our key contacts in the five organizations, who had typically played a key agenda-setting role in the implementation process. We also attempted to interview those who had cancelled their participation in a focus group at the last moment. Some of these interviews were done by phone, while others were conducted at the respondents' offices. A total of 10 people were interviewed. These interviews were guided by the semi-structured interview guide used for the focus groups, although in some cases we made slight changes to accommodate the focal respondent and his or her role.[26] These interviews lasted an average of one hour and were audio-recorded. Most of them were also transcribed.

[26] As a PhD fellow, I also conducted interviews with five Danish experts active in the field of rehabilitation in 2013. The aim of these interviews was to familiarize myself with the rehabilitation concept, and its historical roots and expansion in

In total, the focus groups and individual interviews generated approximate 30 hours of audio recordings. While we considered interviews in general and focus groups in particular as particularly relevant data-collection methods given the purpose of our study, we were aware of the methods' limitations. More specifically, a focus group is not an event that naturally occurs in day-to-day work and organizational life. Accordingly, although focus groups and interviews are valuable for researchers because it allows them to explore how participants voice, negotiate and interpret specific issues related to their everyday work, it is frequently critiqued for limiting opportunities to grasp the complexity and mundanity of common work activities, such as how care work is actually carried out (Twigg et al., 2011: 17; Cunliffe, 2010). Accordingly, Twigg et al. (2011: 17) argue that when professionals translate their work into words in interviews they risk "bleach[ing] out" the "corporeal nature" of work and the actors' actual appearance, bodily practices and relations at work. Thus, as we were curious about the corporal nature and particularities of work, we decided to supplement the focus groups with observations of the professionals' everyday work.

4.3.2 Observations

In order to explore the particularities and corporal nature of rehabilitative home care work, we spent approximately four full working days observing each of the five rehabilitative home care organizations, which I also refer to as research sites. In total, we spent approximately 20 working days of 7 hours each on observations. Through our readings and discussions with our key contacts in the five organizations, we became particularly interested in two locations that seemed to be the most central in relation to rehabilitative home care work (see Figure 13): a) the *homes* of the recipients, where the rehabilitation programmes were planned, executed and evaluated, and b) the *office*, where the professionals gathered for such activities as occupational team meetings and discussions of their progress in their day-to-day rehabilitative work. In addition, we wanted to ensure that the various kinds of central events in the homes (location a, Figure 13) were observed. These included the planning of individual programs (often referred to as start-up meetings), the execution of those programs (often referred to as training) and the evaluation of the programs (often referred to as evaluation meetings).

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the Danish and international contexts. Although these interviews provided important background knowledge, I do not directly refer to them interviews in the thesis.

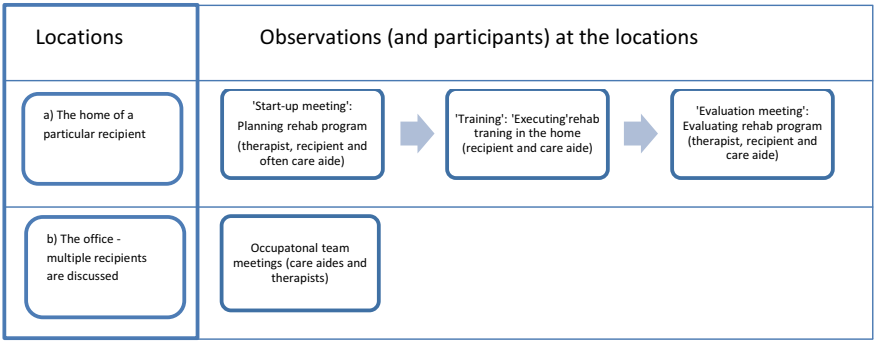


Figure 13. Observed locations (and typical participants).

When we planned observations with the key contacts, we focused on two aspects. First, we tried to ensure that the observations would take place at times that would at least allow us to observe the above-mentioned locations (office and homes) and events (occupational meetings, start-up meetings, training and evaluation meetings) at each of the five research sites. Second, we felt that the most natural way to mingle into and develop an understanding of the professionals' work and working conditions would be to shadow a specific professional for a full work day (Bruni, Gherardi and Poggio, 2004). Therefore, we shadowed a therapist or a care aide, as these actors were described as the key providers of rehabilitation. Our initial idea was that by shadowing these professionals we would be able to observe not only the mentioned locations and events but also what happened between those events, which each lasted between 30 minutes and three hours. However, when we started to collect the data, we realized that while occupational meetings at the office were usually carried out as planned, the events in the homes did not necessarily take place as scheduled. Events were often cancelled or changes were made at the last moment, mainly because the care recipients' situations had changed (e.g., they became sick or were hospitalized). Although this was disappointing, it highlighted the unpredictable, complex nature of the work and gave us an opportunity to observe other aspects of the everyday work, such as the significant amount of time spent driving between different homes and the office.

We compiled field notes during the observations. We had developed an observation template in order to remind ourselves of aspects to consider during the observations, and to make sure that other project members could use the notes and understand the situations afterwards. The template consisted of three categories that were to be completed during or shortly after each observation:

1) Background information: descriptions of date and place; event; participants; and the physical circumstance/situation/space,
2) Actions and speech observed, and
3) Areas in which theoretical insights or puzzles could be noted.

These three categories were included in the template to ensure that sensory details related to the observed situation and participants were recorded, and to be certain that the actual observation of actions and speech in these situations were described separately from our own generalizations, emerging puzzles and interpretations (Emerson, 1995). As I discuss in the section on knowledge production, due to the varied nature of these events and the participants' various responses to our presence, we took on different roles as observers, ranging from a rather passive observer role to a role as a participant observer who asked (evaluative) questions (Bryman and Bell, 2011).

In addition to these ReKoHver observations, I also began to observe conferences and industry meetings due to my increased personal interest in the topic. For example, I participated in and took notes at the conference on rehabilitation in the home care industry in 2012. In addition, I attended a national conference on rehabilitation that concerned the intensified proliferation of rehabilitation across industries in Denmark, and I participated in two dialogue meetings[27] about rehabilitation. At these meetings and conferences, I took comprehensive notes and kept copies of the slide packs.

4.3.3 Archival materials

While undertaking the ReKoHver project, we also obtained access to official and unofficial internal documents, including organizational diagrams, rehabilitation project descriptions, job descriptions and

[27] At these meetings, representatives from different healthcare and social unions were invited to discuss cross-occupational collaboration opportunities within the rehabilitative context.

evaluations of the rehabilitation effort (e.g., estimations of cost savings). We primarily used these documents to familiarize ourselves with the five home care organizations and to qualify the data collection.

4.3.4 Overview of the data

The complete ReKoHver data set included the following data sources:

- Archival material on rehabilitation and the home care industry,
- Interviews with five Danish experts on rehabilitation,
- Documents from the five focal organizations,
- Field notes from conferences on rehabilitation and rehabilitation in home care organizations,
- Transcripts of individual interviews with 10 ReKoHver respondents,
- Transcripts of focus groups held with a total of 64 respondents with different status and occupational backgrounds, and
- Field notes from approximately 140 hours of observation in the five focal organizations.

While these sources of data all shaped the research process in some way, the interviews, focus groups and observations from the ReKoHver project were the core data sources for my dissertation. As mentioned above, TeamArbejdsliv A/S allowed me to use the data I had collected and the data other project members had collected. The only requirement was that I had to mention the project's name and the grant number for the funding.

In Tables 3 and 4, I provide a more detailed overview of the ReKoHver data set from which I draw in my dissertation. More specifically, Table 3 specifies the number of focus groups and the overall number of respondents on which the analytical body of the dissertation (i.e., the three articles) is based. Table 4 provides an overview of the observations. Although I adopted a multi-site study approach, I have specified how the data were collected at the various sites in order to provide the reader with an overview.

	Org 1	**Org 2**	**Org 3**	**Org 4**	**Org 5**	**In total**
Focus gr. managers	1	1	1	1	1	5
Focus gr. employees	1	1	1	1	1	5
Total number of focus groups						**10**
Number of respondents at manager focus gr.	6	7	4	5	6	28
Number of respondents at employee focus gr.	7	8	8	5	8	36
Total number of focus group respondents						**64**
Total number of respondents in single interviews	**1**	**0**	**5**	**3**	**1**	**10**
Total number of respondents all in all	**14**	**15**	**17**	**13**	**15**	**74**

Table 3. Overview over the focus group and interview data.

	Org 1	Org 2	Org 3	Org 4	Org 5	In total
Events in the homes:						
'Start-up meeting'	2	2	2	2	3	11
'Training'				1	1	2
'Evaluation meeting'					1	1
Events at the office:						
Occupational team/office meetings	2	3	2	1	2	10
'Other types of events'					3	3
Total number of observed 'events'						**26**

Table 4. Overview over the observations (reduced to 'events').

4.4 Data coding and analysis

The aim of this section is to unpack the coding and analysis of the ReKoHver data sources within my workography framework. Although my analytical process began prior to my re-engagement with the ReKoHver data, it was ultimately this re-engagement that gave rise to the three articles that constitute the analytical body of the dissertation. In the following, I take a step back from the articles to explain this process, which has much in common with the basic steps and procedures associated with grounded theory, as I was concerned with finding core codes and categories in the empirical data, and saturating them theoretically (Strauss, 1987, Strauss and Corbin, 1990, 1998).

The analytical process consisted of five phases. In the first phase, I again listened to all of the audio-recoded interviews and focus groups from the ReKoHver project, and I transcribed many of the interviews that had not previously been transcribed. I then entered all of the transcribed texts into an interview database, Nvivo 10. In addition, I started to develop an observation database in Microsoft Word. In this database, I gathered all of the observation notes from the five home care organizations. The database amounted to 100 pages. To maintain an overview of the data, I assigned headlines that

grouped the notes from the five organizations together as well as sub-headlines that indicated the type of event observed (e.g., team meeting, start-up meeting, evaluation meeting and informal talk). This phase of the analytical process served two purposes. First, it gave me an opportunity to re-familiarize myself with the data I had collected as well as the data collected by the other ReKoHver project members. For example, I found it helpful to listen to the recordings of those focus groups I had not conducted myself because doing so allowed me to hear the tones and dynamics of the voices, which are not always easily captured in written form. Second, this process allowed me to develop a tool I could use to manage my data. The database gave me an overview of the data and made it easier to analyse it without losing track of the organizational origins or the potentially important aspects of inter-organizational differences.

In the second phase, I systematically performed what grounded theory labels "open coding" (Strauss and Corbin, 1990, 1998). I started out by re-reading the transcripts of the interviews and focus-group discussions, and coding them line by line in the Nvivo database. Initially, I expected to code the observations in a similar way in the Nvivo database. However, I decided not to do so because the dynamics of this data seemed to get lost when I started to code the data in the Nvivo system. Therefore, in order to maintain the dynamic and processual insights, I read through all of the field notes and coded them using the comment tool in Word. While undertaking the open coding of the transcripts and field notes, I focused on what was being said about rehabilitative home care work in terms of for instance practices, tasks, outcomes and actors, as well as their functions and the relations among them. I also listened for details on what was being done by whom, how, where and with what implications (e.g., tension, happiness). Overall, this initial coding gave rise to 45 empirically grounded codes, such as "success stories", "nurses", "manager", "maid", "women", "experts", "expertise", "optimize professionalism", "a good life", "resources", "self-reliance", "decline", "passive", "sadness", "relatives", "hands on the back", "a care gene", "nurturing", "training", "withdraw", "distance", "traditional", "new", "tension", barriers", "labour division", "pride", "cost-effectiveness" and "improvements". Although I found this empirically grounded open coding intriguing and encouraging, it was also frustrating in the sense that the material and the high number of codes seemed overwhelming.

In the third phase of the analytical process, I began to group codes for similar content into aggregated categories (Strauss and Corbin, 1990, 1998). Some codes could be grouped under aggregated empirical categories such as "recipients and their (aging) bodies" (e.g., "resource", "decline"), "professional roles and their (embodied) characteristics" (e.g., "nurse", "manager", "maid", "women", "expertise", "professionalism"), "professionals' practices and tasks" (e.g., "training", "hands on the back", "nurture", "tools", "hands on"), "rehabilitation initiatives" (e.g., "teamwork"), "outcomes of rehabilitation" (e.g., "success stories", "cost effectiveness", "improvements", "barriers", "failure"), "relational dynamics" (e.g., "tension in the home", "tension among colleagues", "division of labour", "recognition/rewards among colleagues"), "emotional expressions" (e.g., "pride", "anger") , "new versus traditional", and "nurturing versus rehabilitation". Some of these categories overlapped. For instance, "new versus traditional" and "nurturing versus rehabilitation" cut across most of the categories. Therefore, some pieces of text were assigned multiple codes.[28].

In the fourth phase, I used Nvivo to gather all transcript-based pieces of text with similar codes together under the affiliated aggregated categories. I did so in lengthy Word documents in which I also manually added the extracts from the observation transcripts with similar codes. At this point in the process, I started to become aware of the multiple, ambiguous ways that rehabilitation influenced the workers and their work. It was clear that there was some tension that was masked in a way that made it difficult for me to understand and conceptualize. For example, in the "professional roles and their (embodied) characteristics" category, multiple signifiers of the workers' roles coexisted (e.g., "maid", "women", "professionalism" and "expert"). However, these signifiers did not coexist peacefully – rather, they emerged in conflicting ways. For instance, "maids" and "women" were contrasted with "professionals" and "experts". At the same time, these tensions signifiers seemed to be ordered around some kind of boundary or distinction. For example, it was clear from the text that "maids" and "women" were continually associated with each other and shared the same illegitimate connotations, while they were contrasted with "professionals" and "experts", which were two signifiers that seemed to share legitimate connotations. Similarly, the codes in the "professionals' practices and tasks" category revealed that "training" and "hands on the back" were contrasted with "nurture" and "hands on". This (dis)order appeared to emerge around the "new versus traditional" and "nurturing versus

[28] For example, if a piece of text described professional roles and their practices, it would be assigned multiple codes.

rehabilitation" categories. Nevertheless, this insight taught me little about what was at stake in this (dis)ordering. At this point, I turned to critical litterature, and started to raise new questions.

Phases three and four were, to some extent, influenced by the review of the literature that I undertook during the analytical process. In order to pursue my curiosity and focus on (dis)ordering, in the fifth phase I started to move systematically between the aggregated empirical categories and the literature that resonated with those categories. More specifically, I started to experiment with applying different theoretical building blocks that might explain the (dis)order within each aggregated category. For instance, when trying to analyse the recurring category of "professional roles and their (embodied) characteristics", I found it increasingly helpful to engage with concepts and literature that described professionals' identities, the regulation of such identities through discourses of differences and the outcomes of such regulation attempts (e.g., Du Gay, 2008, Davies and Thomas, 2002, Alvesson and Willmott, 2002). In addition, as descriptions of workers' practices and their relations with recipients were plentiful, I found it natural to engage with concepts and literature that focused on care workers' relational and embodied work practices in order to understand why, for example, "hands-on" practices were contrasted with training practices in this context (e.g., Twigg et al., 2011; Sullivan, 2007). Moreover, given the fact that actors continually talked about "success stories" in relation to their rehabilitative work in ways that seemed to contradict other stories, I found it increasingly informative to engage with literature that could help me theorize about the implications of professionals' sharing such stories and norms in each other's company (e.g., at team meetings) (Barker, 1993, Orr, 1998). Through this process, I realized that my data called for different theoretical building blocks and toolkits and, as such, a multi-paradigmatic framework that could cover such core concepts as identity, regulation, power dynamics, gender, distancing techniques, narratives/war stories, group norms, embodiment and performativity. It was also in this phase that my critical, feminist-inspired stance was formed. The fifth phase was an abductive analytical phase (Bryman and Bell, 2011) in the sense that while I used the literature that resonated with the empirical categories, I used it and literature on the history of home care organizations in order to reconsider and specify the empirical categories, the core problem and the overall research question(s).

Thus, my intensified readings in the fifth phase helped me understand that the reoccurring contrasts, tensions, complexities and ambiguities revealed by my categories could not be reduced to "traditional

versus new" or "rehabilitation versus nurturing". Rather, they concerned the coexistence of multiple overlapping and conflicting ways to both discursively make up and more materially mark up what professional home care work involved. For instance, the hands-on practices were rhetorically made illegitimate not only by discursively associating the practices with (female) over-nurturing but also because this work was usually carried out by low-status care aids. As such, I began to understand that the contrasts, differences and divisions, which I labelled the "boundaries of professionalisation", were important in this context because they were not neutral, even if they seemed to be. Instead, they represented a professionalization mechanism that constituted professionalism, and that had ambiguous implications for the workers and their risk of (re-)marginalization. However, despite the profound dominance and effects of this mechanism, it was still contested. In addition, I started to understand that these boundaries of professionalisation could not be reduced to home care work, as they expressed more generic but historically and socially constructed contrasts that, in the name of professionalisation, seemed to differentiate and draw boundaries between the included and the excluded, the legitimate and the illegitimate, the valorised and the non-valorised, and the professional and the non-professional in organizational settings in the west, especially in female-dominated workplaces on the margins.

Through this new problem identification and understanding, I was able to begin qualifying my key analytical focus. In the final analytical process, I re-coded the data using a core, guiding analytical approach in which I systematically focused on how matters of professionalization and marginalization intersected at work, how boundaries were established to legitimize and privilege certain elements (e.g., actors, technologies and structures) and marginalize other(s), and the implications of this boundary drawing for the work itself and for workers' risk of marginalization. In other words, I began to re-analyse the empirical categories by raising new questions about how the boundaries of professionalisation were constituted and how they functioned in rehabilitative home care workplaces – by whom, how and with what implications for the work and the workers. As mentioned in Chapter 1, I did not explore the boundaries of professionalisation in a pre-determined, fixed, binary sense. Rather, I sought to explore the polyvocal and ambiguous aspects of the boundaries that were drawn between what was (un)acceptable to say and do as home care professionals in multiple sites and multiple situations, as well as the implications of this saying and doing, and of the locations where these activities took place for the work and workers. Consequently, I focused on the boundaries that the

actors voiced and interpreted on their own, and on the less obvious boundaries that were implicitly embedded in the practices, face-to-face interactions and tools at different sites and situations. Ultimately, my focus was the co-emergence of both the discursive-regulative and the more material-practice-oriented aspects of the boundary drawing. As I discuss in the next section, the development of this re-coding system was closely affiliated with the three articles that comprise the analytical body of the dissertation.

4.5 Writing up the analysis and articles: Three core topics

After specifying the foci of the dissertation and the key questions, the next challenge was determining how best to write the dissertation and to specify my overall research question.[29] As implied in the section on the analytical process, the boundaries of professionalization did not emerge in the context in a single way, and there was not one kind of implication for the work and workers. As such, I had to make some decisions in order to reduce the amount of noise and complexity in the data, and focus on a few core topics. As described in Chapter 1, I ultimately decided to write three articles that zoom in on three topics. From different angles, these articles show how boundaries of professionalisation are: 1) *regulated* by the introduction of new experts i.e., therapists (article 1), 2) *negotiated* by professionals at the newly introduced team meetings (article 2) and 3) *practiced* by using various new techniques and tools (article 3). In the following, I discuss how I selected these three topics and how I formulated my overall research question.

First, my analytical and coding process led me to choose these three topics. Throughout this process, three of the recurring categories – "professional roles and their (embodied) characteristics", "outcomes of rehabilitation"; and "professionals' practices and tasks" – showed what I conceived as the most central tension and ambiguity concerning how boundaries of professionalisation were constituted in rehabilitative home care organizations as well their implications. In addition, these three categories provided plentiful and varied data (from observations and focus groups) that could show how the boundaries were constituted and how they functioned from different perspectives. More specifically,

[29] I have broken down the discussion of the analysis process and how I wrote up my these into two separate sections in this chapter for the sake of simplicity. However, throughout the project, I continually wrote conference papers, presentations and summaries of my work. I used pieces of those texts in the final write-up phase in which the articles took on their current shape.

the tension and contrasts I observed in the "professional roles and their (embodied) characteristics" category directed my attention towards how therapists and nurses played important roles in (dis)ordering and regulating what were understood as (non-)professional identities (topic 1/article 1). Similarly, a key tension I identified in the "outcomes of rehabilitation" category was that boundaries between successful (i.e., professional) and non-successful outcomes were constituted through negotiations among the different actors, most profoundly during team meetings (topic 2/article 2). Finally, I found that the "professionals' practices and tasks" category indicated that the new techniques and tools introduced in conjunction with rehabilitative home care work evoked boundaries between professional and non-professional ways to carry out the work (topic 3/article 3). This does not mean that the three articles I present in the dissertation can be reduced to these three aggregated categories. However, these three categories helped me to identify and differentiate the central topics in the dataset at a point where all topics seemed interrelated (and non-differentiable). After defining these three topics, it became easier to work across, recode and focus the readings of the categories in relation to each article.

Second, I reasoned that the three empirically grounded aspects of the topics – the introduction of a new expert (therapists), the introduction of team meetings, and the introduction of new tools and practices – were particularly important because they were naturalized by both practitioners and mainstream researchers as three means to professionalize home care work and workers. Therefore, in line with my developing critical stance, I figured that a denaturalization of the three empirically grounded topics would provide my audience with an intriguing, and potentially surprising and thought-provoking window through which they could see themselves and their practices through new or different eyes (Ybema et al., 2009; Cunliffe, 2010).

Third, I found the more theoretically informed aspects of the three topics – the focus on regulation, negotiations and practices – particularly relevant because they allowed me to initiate different dialogues with the various research traditions and academic audiences that I increasingly engaged with in the analytical and coding process. The research traditions from which I draw in this dissertation tend to, as described in Chapter 1 and 3, prioritize either the discursive-managerial aspects or the material-practice oriented aspects of professional differences and distinctions (boundaries). In so doing, they

often position themselves such that there is some kind of tension between them. However, I seek to turn the tension in critical organizational and management studies into an advantage by experimenting with different combinations of building blocks in each article in relation to a particular empirical phenomenon. For this purpose, the topics of the articles seemed particularly appropriate because I could simultaneously focus on a topic that was interesting for the different research traditions (and my research question as such), while simultaneously experimenting with how the discursive and material constitution of boundaries of professionalization was relevant and, ultimately, how this could generate new insights within each research tradition. From a more practical perspective, the three topics were also appropriate because they allowed me to combine data from the observations and the focus groups. The triangulation of the data was crucial in documenting the co-emergence of the discursive-materiality relationship affiliated with boundaries of professionalisation, and the implications of that relationship for work and workers.

Consequently, my decision to write three articles focused on three specific topics to answer the research question is ultimately a result of my coding and analytical process, my endeavour to specify the audiences for my research, and my intention to provide those audiences with a window into my findings. However, the process of writing those three articles was much messier than indicated above. Although all three articles and the key topics emerged from the same analytical starting point, the accumulation, composition and specification of each article were the result of integrative movements between (re-)codings of the empirical categories and readings of literature on the focal topics (the specification process is described in detail in the method section of each article). In other words, each article reflects an integrative movement between the analytical process and the writing process, which was also influenced by various review processes, presentations of my work at conferences, my engagement in doctoral courses, and comments from my supervisors and colleagues on various pieces of my work.

4.6 Reflections on knowledge production concerned with work and workers

The implications of my evolving research design and my emerging role as an ethnography-inspired researcher require some discussion. In this chapter, I have tried to demonstrate that who I was or am as a consultant, researcher and ethnographer prior to and during the PhD process has influenced what I

have seen and wanted to say. Ultimately, my role as a researcher and my knowledge production have not been static or neutral. Instead, they are products of my experiences and conversations during the fieldwork, academic discussions, and my reviews of the literature (Cunliffe's, 2010: 232ff). The role of the researcher, especially the ethnographer, has been discussed at length in the social-science field. Therefore, in the following, I highlight some of the core social, ethical and representational challenges and insights that my research process has uncovered. Thus, the aim of this section is to bring to the foreground central aspects that have influenced my overall knowledge production.

4.6.1 Social challenges: researcher-researched issues

The social challenges I faced as a researcher concerned what the literature refers to as researcher-researched issues (Ybema et al, 2009: 11). These issues emerge because ethnography-inspired research, especially observations, relies on close engagement with the people and processes studied. My relationships with the respondents were by no means objective or predetermined. Rather, although we planned to observe certain events, the unpredictable nature of home care work quickly made us realize that we had to adapt to changes on the spot. In other words, we had very limited control over the researched and the events. In fact, we had to follow the researched.

Notably, we were unable to decide which roles and practices we wanted to adopt as observers in a setting, or how we affected the setting because our roles, practices and influences on the setting were often shaped by the particular researcher-researched relationship and dependent on how the researched (i.e., home care recipients or professionals) in specific locations (i.e., in homes or offices) responded to our presence. For instance, in some instances, we were hardly mentioned or introduced. At other times, we experienced the opposite – a major effort was made to introduce us and the project. Accordingly, while some of the observed (seemed to) completely ignore our presence, others addressed us during the observations by, for example, asking questions, or by asking their colleagues or the home care recipient to explain something in further detail for our sake. In other words, we had to be able to change roles (e.g., from being a passive observer to a participating, obvert observer) and research practices (e.g., from writing notes on the spot to writing them after completing an observation) (Bryman and Bell, 2011).

Furthermore, the researcher-researched relationship influenced the observations on a more subtle level related to how comfortable the relationship was for the researched and the researcher. For instance, as we moved from home to home, we typically took on a participant observer role that allowed us to discuss the work and events we had observed with the participants. Some of these discussions were aimed at gaining new insights about the influence of our presence. In particular, I recall recognizing the subtle impact of my presence when I followed a therapist. Although I had done everything to ensure a safe environment and explain my role as a researcher, she seemed nervous and worried. She asked me when we returned to her car after an observation in a home how well she had performed. I reiterated that I was not there to evaluate her performance or her as a person. She replied that even though she knew that, she still felt like she was taking an exam. The researcher-researched relationship also influenced the observations when we, as researchers, did not feel comfortable in our role. For example, we sometimes came into older people's homes that were very dirty, or we met older people who were hardly dressed; had not taken a bath for a while; or seemed sick, sad (e.g., crying) or in pain. In these situations, we had to be highly aware of acting appropriately and ensuring that we did not intimidate the respondent. For instance, we had to do some face-work (Goffman, 1959) and carefully consider whether it would be appropriate to take notes during certain observations.

These relational challenges reveal that although the research was carried out in a natural setting, the researched were still affected by our (non-natural) presence. My overall approach to dealing with this factor was to avoid rigidly sticking to a pre-determine observer role or research practice, and to instead flexibly adapt to the situation (see also Glerup, 2015).

4.6.2 Ethical challenges

I also faced ethical issues during the research process, especially in relation to my fieldwork. These ethical challenges typically concerned my responsibility as a researcher to ensure a safe environment, and to ensure that respondents did not risk reprisal due to their expressions or actions during or after the data-collection process.

During the data-collection process, several ethical challenges emerged even though we had tried to predict and prevent such challenges. First, we sought to live up to ethical standards by ensuring that the respondents were informed about the project and that they had volunteered to participate. However,

several of the older people we visited in their homes had poor memories, or their mental state seemed to be affected by narcotics or medications. Accordingly, some of them were confused when we arrived at their homes with the professionals and they had to be reminded about the project. This posed an ethical dilemma that needs to be carefully addressed in future research. The issue here is how best to study people of advanced age who suffer from poor memory, dementia or drug-induced confusion. In these situations, we made sure that the home care recipients still felt comfortable about our presence and still wanted to participate in the project (none of them refused). Second, we also tried to take ethical precautions in relation to the conduct of our focus groups in an effort to avoid researcher-researched problems. For example, we separated managers and front-line employees into two sets of focus groups to ensure a safe environment in which the participants felt comfortable enough to discuss their opinions without fear of sanctions (Liamputtong, 2011). However, we soon faced a challenge related to the therapists' role. The therapists were engaged in front-line work but they were also authority figures due to their expert status. Therefore, prior to the focus groups (which took place before the observations), we extensively discussed whether therapists should be in the manager or employee group. Due to their front-line activities, we decided to place them in the employee group because we were particularly interested in how they interpreted their *front-line* work in their colleagues' (especially care aids) presence. Had we understood at the time that significant tension existed between some care aides and therapists, we would probably have considered another solution. At the same time, however, the tensions that were exposed in the focus groups became a crucial finding. Accordingly, in future research involving hybrid actors with multiple functions, it may be crucial to consider creative ways to solve such ethical dilemmas.

I also had to deal with some ethical dilemmas and make some difficult trade-offs in the writing process. Ybema et al. (2009: 4) refer to this as making ethical compromises between "information privacy versus scientific norms for public dissemination of findings". One key ethical challenge I faced concerned my intention to include extracts from the observations notes in my articles. The aim of including these extracts was to provide readers with detailed, rich and thick (rather than generalized) descriptions that would serve as a window into the specific, complex dynamics that characterized the individual actors' agency in everyday work life (Cunliffe, 2010: 231). The challenge was to find a balance between my intention to include sensitive information that demonstrated the richness of the

setting, the situation and the actors, and my need to ensure the actors' anonymity. A related challenge was my intention to include multiple voices in my articles. As is clear in the articles, some voices were more legitimate than others. Unpopular voices were often silenced, while those who dared to speak up were often ridiculed or pitied as non-professionals. Accordingly, as the latter voices were relatively rare, there was a greater risk that these individuals would be recognized and sanctioned if I cited them. In trying to deal with this dilemma between information privacy and scientific norms, my first step was to anonymize the respondents' names. In addition, in the case of the observation extracts, I slightly changed or censured some of the information about the respondents in order to obscure their identities and locations (e.g., slightly changing their age or the location). In addition, I found the fact that I had data from five organizations to be valuable in tackling this dilemma. For instance, in my article on teamwork, I could include observation extracts from different meetings across the five organizations. I found this to be important for keeping specific respondents and their stories about particular citizens anonymous. Simultaneously, this strategy limited my options for showing the dynamics of any one meeting.

4.6.3 Representational challenges: What world am I constructing and for whom?

While the social and ethical challenges I faced concerned important, rather practical and in-situ problematics, the representational challenges concerned more analytical aspects of my knowledge production. In particular, they related to determining the "world(s)" I was trying to understand and for whom, and to how I wanted to depict the objects I studied. In other words, the representational problematics concerned my own "world making". As I have already discussed, the core representational challenge was striking a balance between zooming in and out on my data or, more specifically, finding a balance between not getting lost in abstractions and not becoming too absorbed by the assumptions within the field (Cunliffe, 2010; Ybema et al., 2009: 8-9).

My zooming-out process started when I enrolled as a PhD Fellow. In particular, my academic conversations and enrolment at the university taught me that I found it difficult to distance myself from the ReKoHver data because I had (unconsciously) adapted some of the assumptions in the field, and had lost track of the social and historical embeddedness of my data. Therefore, I lacked a critical distance to the assumptions in the field. These conversations encouraged me to go in a completely different direction. In fact, I zoomed out so far from my ReKoHver fieldwork (by exploring the history

of the rehabilitation concept) that I ended up at the other end of the scale – I got lost in abstractions and failed to utilize the sensitivity of my data. Thus, my representational challenge increasingly became to see and explain "the world in a grain of sand" or, more specifically, "exploring and exemplifying the general through the local and the particular" (Ybema et al., 2009: 6). As I have discussed in this chapter and in Chapter 3, addressing this challenge (i.e., to exemplify the general through the particular) and understanding the implications of the introduction of rehabilitation to home care required me to engage with different theoretical paradigms, draw on intertextual analyses, and investigate the history of home care work and workers. In other words, I could not focus on rehabilitation as an abstract concept, or use a singular theory or data source.

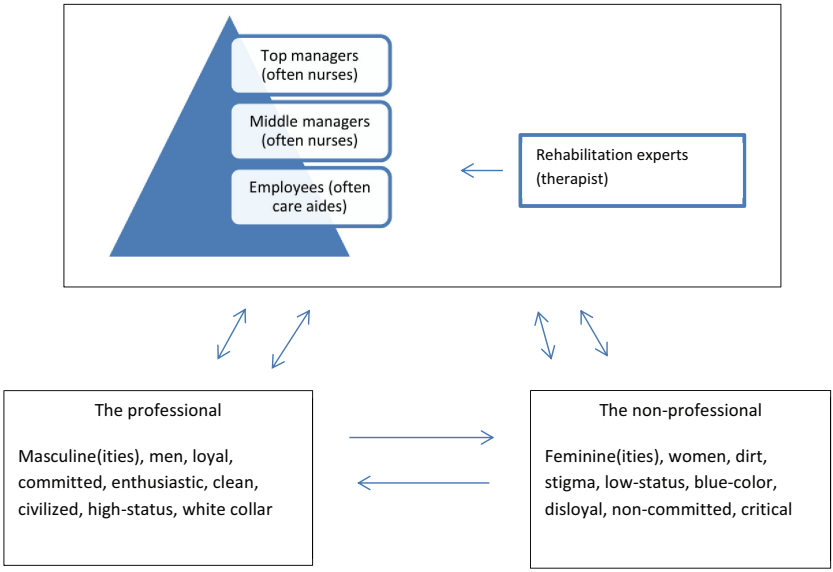
This inclination to explore and exemplify the general through the local and the particular led me to construct the workography framework used in the dissertation. As such, it gave rise to a shift from studying rehabilitative home care work through a realist lens of five comparable macro units towards the investigation of this work as multiple sites and polyvocal processes. This inclination has also cultivated my positioning as a scholar in the field as well as my critical stance. My intention has not been to critically exemplify the general through the particular by separating the evil from the good. Rather, I have aimed to produce knowledge that would make the professionals see their world through different eyes and to offer accounts that, although familiar, would be surprising and somewhat confrontational (Cunliffe, 2010,Ybema et al., 2009). It was also this inclination to exemplify the general through the particular that made it crucial for me to combine observation extracts and citations from the interviews because the former are typically valuable in representing the sensitivity of the context, while the latter are valuable for representing more general interpretations.

This brings me back to the more practical representational problematics emerging from the more abstract considerations. In particular, due to my intention to zoom in and offer sensitive descriptions of my fieldwork in the articles, I faced at least two challenges. The first concerned the fact that I did not conduct all of the observations myself. From an authenticity point of view, this is problematic because sensitive descriptions require some kind of "been there" quality (see Geertz, 1988). To deal with this challenge, I have only used quotes from the observations that I conducted myself, even though the analysis is based on all of the observations. The second challenge concerned the fact that the data were collected in a Danish context and that I needed to translate them into English (at least in articles 1 and

3). This was a significant challenge, especially, because different (home-) care terms are used in different English-speaking countries, such as Canada, the US and the United Kingdom. For example, the Danish terms *social- og sundhedshjælper'* and/or *social- og sundhedsassistent* are associated with terms such as both "care aides" or "nursing assistant" in English. In other words, it has been challenging to find words and describe the context in English in a way that accurately captures the meaning of the Danish words and context. I have tried to deal with this by discussing the focal issues and possible terms at length with academic scholars from English-speaking countries.

CHAPTER 5:

REGULATING BOUNDARIES OF PROFESSIONALISATION



Article 1: Performative identity regulation - An empirical analysis of how co-working 'experts' legitimize managerial ideology and moderate resistance

5.1 Short introduction to the article

The purpose of this chapter is to present the first analytical topic on which I focus in my conceptualization of how boundaries of professionalization are discursively and materially constituted in rehabilitative home care organizations. More specifically, in this chapter I present my first article on how professionalization processes and, by implication, marginalization processes are *regulated* at work through the introduction of new experts in rehabilitative home care organizations. Previous versions of the article have been presented on different occasions, including EGOS in 2013, sub-theme 05 (SWG): Strategizing Activity and Practice: Connecting the Material to the Social; and EGOS 2016, sub-theme 07: Institutions and Identities. Yet, clearly it has been revised several times since 2013. In this version of the article, Sara Louise Muhr is my co-author, and the following version is almost identical to the one we submitted to *Culture and Organization* in June 2017.

5.2 Abstract

This article explores how the introduction of a new professional group – therapists – influences the ways in which a managerial discourse of rehabilitation is communicated, legitimized and adopted by frontline workers (care aides) in home care organizations. We show how the managerial discourse of rehabilitation mobilized the care aides to transform their roles from traditional nurturing to rehabilitation, as a result of promoting the latter as more 'professional'. While the traditional managers/nurses promoted the role transfer through more classic discursive regulation at a distance from 'the office', the therapists did so through what we label performative regulation. Performative regulation is exercised by the therapists performing the desired role at the frontline and thus embodies the ideal and transfers it by embodied practices, not directives. With this notion of performative regulation, the article emphasises the material, physical, embodied and performative dimensions of professional identity regulation.

Keywords: home care work, identity regulation, performativity, rehabilitation, resistance

5.3 Introduction

Many public healthcare workers struggles with the risk of being marginalized as dirty (concerned with washing, feeding, changing and in other ways servicing older people) and/or non-professional (not based on a legitimate body of knowledge) (Hughes 1958; Ashforth and Kreiner 1999; Butler et al. 2012). As a result, in contrast to other more-established occupations such as lawyers, a legitimate professional identity is often not available for public healthcare workers, who often find themselves characterized as semi-professionals (Hearn, 1982, Butler et al., 2012). They are always measured and evaluated against (perceived) more-professional occupations and thus lose their claim to professional work. Consequently, the status of the work and workers suffers. Because of this marginalization and lack of professional status, home care workers and care aides in particular (who work at the frontline, in the homes of the recipients) often find it difficult to justify themselves to others as professionals, as their work is perceived as lacking in dignity (Butler et al. 2012).

To combat such stigma/marginalization, a general tendency among marginalized (semi-) professionals is to attempt to (re-)professionalize the image of their work (Rankin 2001; Ashforth et al. 2007). However, the urge to (re-)professionalize workers at the margin is not only an individual or occupational endeavour. Rather, organizations also have an interest in minimizing the stigma and re-professionalizing the work of their employees through new organizational policies. In public organizations, these policies are often affiliated with what has been labelled 'new public management' (McDermott et al. 2013; Ashworth et al. 2013). The policies share an attempt to provide employees with an identity boost, which increases work satisfaction and thus work effort (Muhr et al. 2012; Muhr and Kirkegaard 2013) while simultaneously making the marginalized professions more efficient, effective, optimized and streamlined through management practices that are used in private organizations, which are often perceived as more 'professionally' managed than public organizations are. Home care work is no exception. Within this line of work, recent attempts of implementing rehabilitation have been promoted as a way to make the work more efficient and professional by both optimizing the work tasks and trying to move the work away from the stigmatized direct servicing of the citizens (e.g. by making the recipients of home care work more self-reliant) (Kjellberg et al. 2011; Katz 2000).

Such organizational (re)professionalization attempts are, however, often controlled and directed 'from the top', with little understanding of what goes on at the frontline and how it influences workers (McDermott et al. 2013; Ashworth et al. 2013). Several of these initiatives have thus been critiqued for trying to enforce a managerial ideal that frontline workers tend to resist (McDermott et al. 2013; Thomas and Davies 2005). Interestingly, however, we see in Danish healthcare organizations that a new level/function has been implemented between managers and frontline workers: experts. This article explores how the introduction of this new professional group – therapists working as experts at the frontline – influences the ways in which the managerial discourse of rehabilitation is communicated, legitimized and adopted by frontline workers (care aides) in home care organizations. To investigate this role, we ask the following question: 'how does the introduction of a new professional group influence the legitimacy with which the managerial discourse of rehabilitation can be communicated in home care work, and how does it influence the way that it is adopted by frontline workers?'

To analyse this research question, we draw on an in-depth ethnographic study of five Danish home care organizations. In the analysis, we focus on how the managerial discourse of rehabilitation emerged as a (re-)professionalization attempt and the central role that the therapists play in enforcing the discourse at the frontline, where they work together with the care aides. In particular, we show how the therapists, through performing the managerial ideal together with the care aides, seem to have a much larger influence on the care aides than the traditional nurse-managers do. We label and discuss this effort as performative regulation, as the care aides are regulated not by the repetition of an ideal discourse but by practising the ideal together with the ambassadors (the therapists) of the discourse. As the therapists do the work with the care aides, they are seen as anti-managerial but still promoting the managerial discourse, which helps to legitimate identification with the managerial discourse and moderates resistance.

5.4 Marginal professions and the urge to professionalize

The notions of 'professionals at the margin' and 'marginal professions' have recently attracted attention as particularly relevant to understanding identification and professionalization processes in certain stigmatized organizational settings (see Butler et al. 2012). Marginal professions are defined as occupational groups who perform – or are associated with – work that due to social, political, cultural,

economic, geographical and epistemological influences tends to have a degrading reputation in society. Professionals are said to be marginalized or risk marginalization and stigmatization if their work is associated with physically, morally or socially tainted tasks that others, given the option, "would prefer not to do" (Chiappetta-Swanson 2005, 93) or in other ways receive low social recognition by doing (Ashforth et al. 2007). In this way, marginalized professional groups typically find themselves sidelined, fighting for legitimizing their work and their group identity as professional while other professional groups have achieved high levels of social recognition (Ashcraft 2013; Ashcraft et al. 2012; Butler et al. 2012; Hearn 1982). Classic examples of marginalized professionals are correctional officers (Lemmergaard and Muhr 2012; Tracy 2004), nurses (Jervis 2001), welfare aides (Ashforth et al. 2007), butchers (Meara 1974) and massage therapists (Sullivan 2012).

According to Ashcraft et al. (2012), there are two major explanations for why some professions become marginalized. The first (and predominant) view shows that some professions have historically been constituted through a process whereby certain groups have been excluded from attaining professional status (Ahuja 2002; Dick and Nadin 2006; Hearn 1982). The second approach, however, shows that when these marginalized groups do achieve the qualifications required, alternative forms of exclusion arise, such as culturally produced stigma, which keep the work stigmatized as less professional (e.g. Davies 1996; Tracy and Scott 2006). 'Professional' (and non-professional) subjects in this way become situated in a political subtext where the 'professional' is defined by not only 'official' occupational affiliation and 'certification' (e.g. as lawyer, nurse, care aide, etc.) but also culturally embodied signifiers of identity/difference, such as gender, race and class (Ashcraft 2013; Butler et al. 2012; Sullivan 2012; Davies and Thomas 2002).

As Butler et al. (2012) highlight, the main theoretical interest within this stream of literature is how certain occupations, particularly within (low-paid) care work, remain excluded at the margin because they are perceived as 'women's work' and are carried out by predominantly female workers. This has prompted a lot of feminist work in the area (e.g. Ashcraft 2013; Ashcraft et al. 2012; Hearn 1982; Sullivan 2012). As such, it is argued that workers in care jobs, such as home care work, which this article focuses on, often find it difficult to justify their professional identities because their task is associated with household duties that were once performed in a domestic 'private' environment (the home) by women, not in a historically accepted professional setting. Consequently, workers (of both

sexes) risk their professional identities being reduced to that of non- (or semi-) professionals (Hearn 1982; Ashcraft 2013) and stigmatized as dirty or unworthy (e.g. Ashforth and Kreiner 1999; Hughes 1958).

Because of this contested professionalism, many employees in such marginal professions are attempting various acts of (re-)professionalization of their occupations. Professionals, especially the higher-status occupational groups, at the margin use individual or group strategies to distance rhetorically and materially from the marginalized aspects of their work in order to legitimize their professional status (Twigg et al. 2011; Ashforth et al. 2007; Jensen forthcoming). For example, in her study of a nursing home, Jervis (2001) found that nurses actively refused to do certain tasks, such as taking older people to the toilet (instead they found a lower-status care aide to do it), and that they used this avoidance strategy as a "statement about their status in the nursing home and the nursing profession" (Jervis 2001, 89).

5.5 Discursive managerial identity regulation and control

This urge to professionalize, however, is far from an individual endeavour. On the contrary, organizations also have an interest in minimizing the stigma and re-professionalizing the work in order to provide employees with an identity boost, which increases work satisfaction and thus work effort (Muhr et al. 2013; Muhr and Kirkegaard 2013). For this purpose, organizational and political policies are increasingly being crafted in ways that offer employees in marginal professions promises of the (re-)professionalization and (re-)qualification of their work (Thomas and Davies 2005; Rasmussen 2004; Dahl 2009). For instance, Rasmussen (2004) and Dahl (2009) have shown how the so-called modernization of Scandinavian home care organizations is associated with new organizational policies that are framed and branded as a professionalizing opportunity – offering more 'interesting' and 'professional' tasks and roles to the workers, just like the rehabilitation policy we look at in this article. Organizational policies, and affiliated discourses, are therefore closely tied to the formation of professional identities at work (e.g. Alvesson and Willmott 2002; Ashcraft 2005; Ashcraft et al. 2012; Davies and Thomas 2002; Muhr and Kirkegaard 2013). The central roles that identities and identity formation play in these organizational policies make them identity projects (du Gay 1996). The policies and identities are intertwined because the policies typically aim at transforming and redefining workforce ideas and feelings about basic identity concerns, such as 'who am I?' and 'what are we?'

(Alvesson and Willmott 2002, 625). Concerns also relate to matters of professionalism and professional group identities, such as 'who am I as a (care) worker?', 'who are we as a professional group?' and 'how do we relate to other professional groups?' Marginal professionals can thus often rely on a broader (re-)professionalization discourse from their organizations and occupations as sources to understand themselves as professionals.

However, these (re-)professionalization policies/ideologies are not easily adopted. Although there is a general desire to be perceived as professional, the means to which such professionalization is achieved are contested. As management typically has an interest in boosting a *specific* professional identity when a new professionalization policy is introduced, there often arises a dispute between managers and employees. The policies do therefore not always result in professional freedom and legitimacy, as they promise, because they are closely tied to (often-ambiguous) *managerial* discourses (e.g. Davies and Thomas 2005, Muhr and Kirkegaard 2013; Laine and Vaara 2002). In this way, professionalism becomes the locus and target of managerial control (e.g. Alvesson and Willmott 2002). More specifically, when new contemporary policies (such as rehabilitation) are introduced, professional identities are typically regulated, transformed and reproduced by a *preferred* managerial discourse, which not always concurs with that of employees. For example, Rasmussen (2004) reports from a study of home care professionals that the managerial promotion of new so-called 'professional' and 'interesting' tasks and responsibilities led to an intensification of the workload, due to a lack of – and/or centralization of – resources to accomplish these new tasks.

Alvesson and Willmott (2002, 627) define this type of discursive practice, which influences the way that identity is formed and transformed, as "identity regulation". Discursive practices concerned with identity regulation have ontological power in identity formation processes because the concepts, objects, subject positions, expertise and actions associated with professional identities and professionalism are defined and conditioned by discursive and symbolic activities and interactions (e.g. Hardy and Phillips 2004; Vacchani 2006). These discursive practices are, however, often ambiguous because promises of professional freedom do not come alone but, as mentioned, with a preferred managerial ideology. In this way, several studies (Ashcraft et al. 2012; Butler et al. 2012; Jensen forthcoming; Sullivan 2012) have shown how the identity regulation and control that follow new (re-

)professionalization policies seem to reinforce the aforementioned exclusion processes at the margin, where new types of exclusion or suffering arise, although workers gain in so-called qualifications.

5.6 Beyond discourses / towards performativity: Professional identity struggles and resistance at the margin

A range of identity studies (e.g. Davies and Thomas 2002; Merilainen et al. 2004; Hoyer 2016) emphasize that although discursive managerial identity regulation is effective, it does not condition workers' identity formation in any deterministic or homogeneous way. Rather, studies convincingly show that workers may exploit the multiple, potentially conflicting, 'available' discourses in organizations to resist managerial attempts to regulate and prompt professional identity transformation in the workplace (Contu 2008; Fleming 2005; Fleming and Spicer 2003; Laine and Vaara 2007). Thus, it is argued that professionals are not "passive receptacles or carriers" (Alvesson and Willmott 2002, 628) of managerial discourse but rather critically interpret, challenge and resist it (through counter-discourse) (see Watson 1994; Laine and Vaara 2007). For example, Dahl (2009, 642) found in her study of home care professionals that a new managerial policy did not evoke one discourse about the workers' identities. Rather, the workers – employees and managers within the context – struggled over identities by evoking three competing discourses: the 'manual worker', 'the housewife' and 'the professional'. This multiplicity resulted in ambiguous identification processes, where the workers simultaneously identified with some identity discourses and dis-identified with other professional identity discourses (see also Hoyer 2016). The term 'identity struggle' is therefore invoked by scholars to better understand how attempts to navigate and regulate matters of professionalism are complex and involve both managerially produced discourse and employees' various struggles of incorporating or resisting the discourse (Sveningsson and Alvesson 2003; Alvesson 2010).

Identity struggles have also been addressed in studies of professions at the margin, showing how managerial attempts to discursively regulate lower-status groups' identities give rise to resistance and identity struggles. For example, England and Dyck (2011) found that male elder care managers justified a low-pay policy for their subordinates by referring to their female gender and assumed corresponding 'natural' skills and motivation to undertake altruistic tasks. Similarly, Rasmussen (2004, 506) found that managers responded to workers' experiences of an overly heavy workload as a result of

a new policy by (re-)constructing their experiences as a result of their gender and [non-professional] "'mothering' and their inability to set limits". These studies show how managers actively produce a certain stigmatized female care worker identity to reduce and manage resistance against managerial policy.

Overall, research has successfully shown the complex and omnipotent nature of identity regulation through – and resistance to – corporate attempts of (re-)professionalizing professions at the margin. Such attempts are therefore not unambiguous but may involve both image boosting and identity degrading, as well as both subjugation and resistance to managerial discourse (Egan-Wyer et al. forthcoming; Hoyer 2016; Thomas and Davies 2005; Sullivan 2012).

5.7 Danish home care organizations: A site of struggles over professionalism at the margin

The reason why Danish home care workers' status as professionals is a contested arena, and typically is seen as risking marginalization and stigmatization, is related to the political context of home care work. The first Danish legislation on home care from the 1950s was labelled 'house-mum replacement', thereby signalling that home care services were meant to substitute the traditional role that women had been carrying out as mothers in private homes. Retracing these historical roots, evidence suggests that home care workers have long fought to be recognized as professionals, rather than stigmatized as blue-collar workers who use their 'private' mothering skills. Beyond these historical links between mothers and home care work, there are still reasons why home care workers continue to be associated with housewives in Denmark and other European countries. To begin with, the labour force in home care across countries predominantly comprises women (England and Dyck 2011; Knijn and Verhagen 2007). In Denmark, for example, 94.8% of the organized care aides working in home care are women[30]. In addition, the service descriptions still mimic the intimate and private sphere and the comfort that housewives traditionally offered in their homes, such as "domestic care (cooking, cleaning, laundry, etc.), personal care (bathing, dressing, toileting etc.), and/or nursing services (wound care, insulin injections, administering prescribed medication, etc.)" (Knijn and Verhagen 2007, 452-

[30] Statistics received through email correspondence on 15th July with the FOA, the main union for home care workers. The number comes from the FOA's member database.

453; see also England and Dyck 2011). This over-representation of women and the associations of the tasks with the private sphere and comfort may contribute to upholding a stereotypical linkage between home care work and untrained housewives. Reinforcing this, the citizens cared for are predominantly older people, who are often conceived of as being in their 'terminal' stage of life, requiring 'dirty' tasks such as elimination care.

However, over the years, several factors have directly or indirectly contributed to the fact that we today see several competing and coexisting discourses about home care provider identities in home care organizations (Rasmussen 2004; Dahl 2009). To begin with, new narratives and ideas about older people's wellbeing and how workers *should* care for older people have been introduced. In particular, concepts such as 'activation' and 'empowerment' (self-governance) have replaced or supplemented ideas about older people's decline and dependency, as well as the importance of nurturing them (Katz 2000). Simultaneously, ideas about how home care organizations and their workers should be managed – often to become more efficient – have become more dominant (Ryberg and Kamp 2010). Accordingly, since 1995, public Danish home care organizations have experienced a number of modernization reforms (under the umbrella of new public management), focusing on the standardization of a shared language, time-control programmes, benchmarking ideals, contract governance, outsourcing, free-choice arrangements (between public and private home care), audit programmes and principle–agent distinctions (Nielsen and Andersen 2006; Ryberg and Kamp 2010). In addition, the levels of education and certification of the workers have increased. For example, today, most workers are organized in unions, and only 8% of publicly employed welfare care aides are non-skilled in Denmark (they have one year of training or more). Similarly, in Denmark, organizations are organized in small hierarchical units, where nurses typically are hired as middle managers to administrate the work of care aides.

5.8 The introduction of rehabilitation

The rehabilitation policy we focus on in this article seems to mirror this general tendency in many aspects. Rehabilitation strives to change the approach towards older people and thus focuses on mobilizing, activating and training them to become self-sufficient in their own homes. The intention is to improve the quality of home care services while lowering their costs by making older people less dependent on care and more self-sufficient. As such, rehabilitation has been boosted as more

'professional' because it aims at training people to become self-sufficient, rather than nurturing them (Anker 2011; Kjellberg et al. 2011).

Of specific interest to this article is the introduction of a new occupational group into the way that home care work is managed: physical and occupational therapists (hereafter 'therapists'). Therapists as an occupational group have long worked in elder care. In Denmark, they have typically done so in training centres. With rehabilitation, however, therapists are hired to work directly in home care organizations (Kjellberg et al. 2011). Interestingly, therapists have been inserted into occupational hierarchies; they have not replaced any of the existing occupations in the hierarchies. The traditional managers, typically the nurses, have sustained their traditional positions as managers, and the care aides have sustained their positions as subordinates who work at the frontline (i.e. in the older people's homes). The therapists have been placed 'in the middle' as 'experts' and 'drivers' of rehabilitation and are positioned somewhere between the managerial and frontline functions, as Figure 14 illustrates. Due to this labelling and positioning, we refer to therapists as 'working experts' in this article.

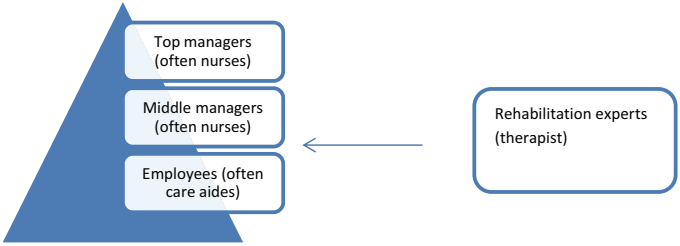


Figure 14. Labour division: the introduction of a new 'expert'.

As working experts, the therapists are generally given authority and responsibility for designing and evaluating older people's rehabilitation programmes. However, they are not defined as managers but rather as 'experts', 'coaches' and 'trainers'. The therapists are therefore said to differ from nurses because they have specific expertise and knowledge concerning training, resources and self-care. In

addition, in contrast to nurses, who perform their traditional managerial role from the 'office', therapists often exercise their expert role directly at the frontline in the homes of the care recipients.

5.9 Method

The research was designed to investigate the role of this new occupational group – therapists – in the professionalization attempts of home care work and workers: a type of work that as a starting point we knew suffered from marginalization and a bad work environment. The study was conducted as part of the research project ReKoHver over an eight-month period in 2012.

5.9.1 Data collection

To capture the complex aspects of what the new work division implied for the work and workers (and their marginalized position), the data was collected in five Danish home care organizations that had recently implemented rehabilitation. It included a multi-method framework, consisting of archival material, focus groups and observations.

5.9.2 Focus groups

Focus groups were chosen as a key data source to explore how care workers with different occupational affiliations and positions reflected on, resisted and negotiated the new changes, professionalization opportunities and regulation of their work (see also Dahl 2009; Liamputtong 2011). Due to the collective nature of focus groups, they are particularly apt to study organizational changes because respondents (often with a shared memory) 'assist' the researcher by asking each other interesting questions and by adding information and contradicting and disagreeing with each other's (re-)construction of stories (Wilkinson 1998). Further, they are particularly suitable to use in marginalized workplaces for two reasons. First, focus groups are seen as particularly apt to give voices to marginalized groups, who might feel less intimidated among peers than in individual interactions with an unknown external researcher (Liamputtong 2011; Wilkinson 1998; Morgan 1996). Second, focus groups are recommended as an effective way to investigate how workers at the margin assign meaning to – and struggle over the meaning of – their work (Dahl 2009).

Two types of focus groups were conducted in each of the five home care organizations (10 in total). The first type of focus group included workers who engaged in daily rehabilitation work at the frontline

(i.e. in homes), whereas the second type included workers who predominantly managed this work from the office. Due to this distinction, the management focus groups included top or middle managers, predominantly nurses, while participants in the frontline focus group typically included two therapists, four care aides and a medical officer. It was a long debate whether therapists should be included in the management or the frontline focus groups, due to their between position as 'experts'. However, ultimately, they were included in the frontline focus groups, due to the interest in how actors with different occupational affiliations at the frontline would assign meaning to and negotiate their shared work.

As recommended by Morgan (1996), eight participants were invited to each of the 10 focus groups; however, due to cancellations, the number varied between four and eight participants. A total of 64 respondents participated in the focus groups (28 managers and 36 employees). Each focus group lasted two hours. To allow the home care workers to express themselves, our semi-structured interview guide addressed three broad sub-topics related to the introduction of rehabilitation: a) the aim and organizing; b) the expertise, tasks and cross-occupational collaboration; and c) the challenges and benefits for the organization, workers and recipients. All focus groups were recorded and transcribed.

5.9.3 Observations

Focus groups' ability to reveal the ways that managers and frontline workers assign meaning to and negotiate the changes and regulation of their work and the implications for them as professionals is both a strength and a weakness of the focus group method. Focus groups give limited access to the material, complex and situated circumstances that characterize the 'actual' interactions and work at the frontline (Twigg et al. 2011). As a result, the focus groups were supplemented with observations at the frontline, collected over approximately four full working days in each of the five home care organizations. More specifically, home care workers were observed at two different locations considered most central to the introduction of rehabilitation: a) the *homes of individual recipients*, where rehabilitation programmes were planned, executed and evaluated, and b) at *occupational supervision meetings* at the office, where progress with the programmes was discussed. The observation of the events in the homes and the office involved shadowing (Bruni et al. 2004) a therapist's or a care aide's workday (typically driving from house to house and back to the office). See Figure 15 for an overview of the observed events.

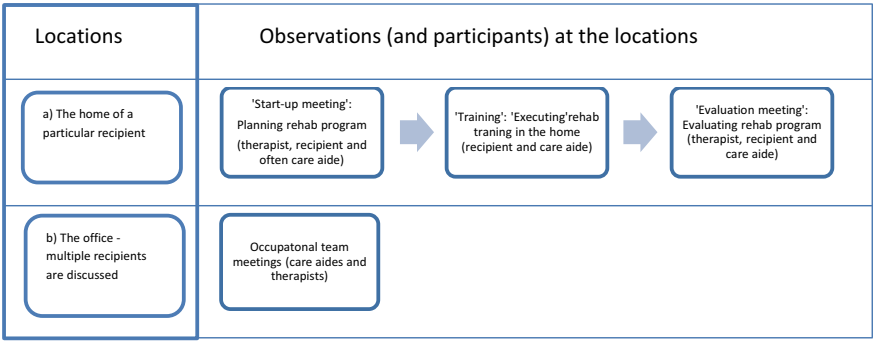


Figure 15. Observed locations (and typical participants).

Approximately 140 hours of shadowing were performed. The observations lasted between 30 minutes and two hours. During the observations, extensive field notes were compiled regarding the concrete sensory details of actions (Emerson 1995).

5.9.4 Data analysis

The analysis was conducted through a process inspired by grounded theory (Glaser and Strauss 1967), including a constant movement back and forth between theory readings and the multiple sources of empirical data – field notes, documents and transcriptions. To avoid developing static predefined themes and codes, the material was systematically coded in NVivo 10 through an open coding process.

The first initial coding amounted to around 40–50 codes, such as ‘managers’, ‘maids’, ‘women’, ‘therapists’, ‘expert’, ‘professionalism’, ‘expertise’, ‘resource’, ‘decline’, ‘nurture’, ‘passive’, ‘self-reliance’, ‘training’, ‘distance’, ‘withdraw’, ‘tension’, ‘new’ and ‘traditional’. These empirical codes clearly showed that some codes could be grouped under aggregated empirical categories, such as ‘the recipients and their (aging) bodies’ (‘resource’ and ‘passive’); ‘the professional roles and their (embodied) characteristics’ (‘nurse’, ‘expert’, ‘manager’, ‘maid’, ‘women’, ‘expertise’ and

‘professionalism’); ‘time bounds’ (‘new’ and ‘traditional’); and ‘the professionals' practices and tasks’ (‘training’, ‘nurture’ and ‘self-reliance’). There were some tensions within each category (e.g. resource vs. passive, maid vs. professional, expert vs. maid, new vs. traditional, and training vs. nurturing). This categorization happened in tandem with the exploration of various theories. As the data was re-viewed, re-theorized and re-coded on an ongoing basis, literature on regulation, control and identity struggles emerged as particularly helpful.

Through this literature, it was possible to specify three broad topics that could help us to analytically address our initial interest in the new occupational group and the associated professionalization opportunities and changes. The first analytical topic, which we label ‘the discursive regulation of the workers’, emerged at a basic level from the three aforementioned analytical categories: ‘the professional roles and their (embodied) characteristics’, ‘the professionals' practices and tasks’ and ‘time bounds’, as well as from literature on discursive identity regulation and control (e.g. Alvesson and Willmott 2002). The literature helped us to pay particular attention to how rehabilitation could be conceptualized as a managerial discourse, voiced by higher-status actors. The second analytical topic, which we label ‘care aides' role struggles and resistance’, emerged from the same three categories and more-narrow readings of the literature on identity struggles and resistance – particularly at the margin (e.g. Thomas and Davies 2005; Sullivan 2012). Thus, this literature helped us to pay particular attention to, and conceptualize, how the targets of the regulation (the care aides) responded to the regulation attempt. Having settled on these two topics, we found that the regulation experienced in home care work still seemed unexplained. Thus, the field notes in particular, which showed the corporal aspects of the therapists’ and care aides’ exchanges (their physical practices, their actual interactions and the material environment in which these interactions took place), implied something interesting about the regulation attempts that was difficult to conceptualize through the aforementioned literature. Drawing on literature (e.g. Cabantous et al. 2016) that could help us to conceptualize the more-corporal or -material aspects of our observations (and informed by the workers’ own descriptions of the differences between the nurse-managers’ and the therapists’ roles in the focus groups), we became aware that two types of regulation were happening in rehabilitation home care work: the aforementioned discursive regulation and a more-corporal type of regulation, which we labelled ‘performative regulation’, which eventually became the label of our third topic.

In writing up the analysis, it became clear that in order to give depth to our final analytical topic in particular, it would be helpful to present an excerpt from the field notes, in order to provide the reader with a window into the corporal nature of the work, which we had learned a lot from ourselves (Flyvbjerg 2010). The excerpt is also helpful in exemplifying our two other topics and the central role that therapists in general play in the context as working experts. Thus, we begin the analysis shortly by presenting what we label 'the Leila case'. The case is not representative in the sense that it does not fully reflect all the complexity we found at work, nor is it an extreme case (Flyvbjerg 2010). Rather, the Leila case is chosen as what Flyvbjerg (2010) calls a paradigmatic case: it functions as a prototype for the work conducted in the organizations.

5.10 Analysis

The findings are analysed in three sections to show how therapists, as working experts in rehabilitation home care, influence the way that (managerial) attempts to (re-)professionalize home care are perceived and adopted. In the first section, we show (1) how the managerial discourse of rehabilitation was aimed at regulating and transforming care aides' professional identities by drawing on a discourse of professionalization. We then show (2) how the managerial discourse triggered and prompted struggles among some care aides and recipients, who resisted, dis-identified with or challenged the value of the role transfer. Finally, the third section shows (3) how therapists, positioned as working experts in the organizations, emerged as a crucial source/condition through which the role transfer was 'activated' (and performatively constituted) and as a result how resistance was moderated.

The Leila case: Observing the 'working expert' at work

To set the scene of the empirical field and to illustrate how therapists in their functions as working experts practise their role, we start by giving an excerpt from the field notes taken in the home of the home care recipient Leila. Leila has received home care provision from (among others) the care aide Maria for several years. However, she has recently been enrolled in a so-called rehabilitation programme. This enrolment involved the therapist Sophia being authorized to design a rehabilitation programme for Leila, and Sophia is now positioned in a function directly at the frontline. In this position, Sophia frequently visits Leila in her home to evaluate her progression on the programme and to support the care aide Maria's work with Leila. On the day of this observation, the care aide Maria

and the therapist Sophia were gathered to evaluate Leila's (and Maria's) progression on the programme. In the sections that follow, we will, together with interview quotes, systematically elaborate on the excerpt.

> *The care aide Maria and the therapist Sophia meet up outside Leila's home. Sophia explains that the aim is to reduce Maria's service in the home from two to one time per week, or maybe completely end it. As we enter the home and sit down around Leila's table in the living room, Leila starts to cry. Sophia asks how she is feeling. Leila replies "Not that well". After a while, Sophia gently asks how Leila would feel if they reduced the bathing from two to one time a week. "That is fine", Leila says, but adds "However, I cannot dry my toes myself". Sophia asks "why not?" Leila explains that she had an operation and unfortunately did not recover well. Sophia asks "Can you stand on a towel?" Leila responds "No, the problem is that I am suffering from diabetes" [toes need to be completely dry]. Maria suggests "You could use a hairdryer?" Sophia responds "That is a really good suggestion, Maria"; Leila says "The problem is that I am dizzy". "When?" Sophia asks. "Most of the time", Leila replies. Sophia looks puzzled. "Last time you said it was only when you took a shower". "No", Leila explains "I am trying acupuncture treatment now". Then Sophia changes the subject. She asks how often Leila takes walks outside. Leila explains that she cannot walk that long because her "legs start to shake". "That is a sign of a lack of training", Sophia explains. "I will encourage you to walk a little longer every day". What about visits from your family – how often do you get them? "Only once a month", Leila says and starts crying again. "That must be tough", Sophia acknowledges. "Have you thought about getting a 'visiting friend'?" "Yes", Leila replies. "I am on the waiting list". Sophia says that she acknowledges that Leila is going through a "difficult time" and that she can always call the home care unit if she feels bad. In addition, she explains that she has decided to reduce Maria's visits from twice to once a week. Outside the house, Sophia and Maria have a short conversation. Sophia explains that she did not end Maria's visits in the home because she is afraid that "Leila's situation will worsen". However, she explains to Maria that she is new in her position and asks in a worried voice: "was I too soft [on Leila]?" Maria replies: "I think you did well, but it is hard to tell what parts of it are just good acting".*

"Yes", Sophia says. "It is hard to know whether she is playing us or whether she actually needs help".

5.10.1 The managerial discourse: Prompting a role transfer from 'nurturing' to a 'professional' role

As the Leila case illustrates, in their positions as working experts at the frontline, the therapists used particular vocabulary in their interactions with home care recipients and care aides, which was closely related to the broader managerial discourse of rehabilitation and the prompting of a new 'professional' worker role. This managerial discourse of rehabilitation was communicated through various channels and events in the organizations (training seminars, internal instruction documents for employees, materials given to recipients, etc.). Across these channels, rehabilitation was highlighted as a new and better way to provide higher-quality and more-efficient home care. 'New' and 'better' were in this way positioned as being in contrast to the former less-efficient focus on care and nurturing. Below, a therapist articulated how this differentiation between a 'former' and a 'new' way of providing home care was emphasized (by her) at training seminars where the home care workers were introduced to the managerial discourse of rehabilitation and the new approach to care it implied:

Anne (therapist): …the emphasis [at the training seminar] has been put on how to focus on [older people's] resources, rather than nurturing [them]. [Our care aides] need to understand how the traditional care actually made the citizens dependent on home care and how they now [with rehabilitation] can make citizens independent from home care. Now the providers have to withdraw and focus on self-reliance.

The quote illustrates that the managerial discourse of rehabilitation portrayed former traditional ways of providing home care as a nurturing approach to older people. This nurturing approach is affiliated with service activities, which make older people dependent on help and care. This approach is further contrasted with – and differentiated from – the new rehabilitation approach. The rehabilitation approach is articulated as making older people independent from home care by focusing on their resources and on withdrawal from older people and training them in self-reliance. The quote clearly illustrates that this differentiation of nurturing and rehabilitation – as respectively a traditional and a new approach – directly aims at regulating and changing how the care providers accomplish their tasks

and approach their work. The therapist Anne clearly emphasized that the providers – the care aides – were directly asked at training seminars to change their behaviour from nurture to rehabilitation and were taught that this approach would be valued and rewarded. To compare, if we go back to the Leila case, the therapist Sophia explained to the care aide Maria that the purpose of their visit was to reduce (and perhaps completely end) the care provided to Leila in her home. When she focused on Leila's (potential) capability to become more self-reliant (do the bathing herself), she was in fact re-enacting the broader managerial rehabilitation discourse and reminding Maria about the new approach to care: withdrawal and self-reliance.

This attempt to regulate the care providers to change their behaviour from a nurturing to a rehabilitation approach was underpinned by a professionalization discourse. The two quotes below show how the care workers were motivated to readjust to the new rehabilitation approach by positing it as a professionalization opportunity that would influence not only what the workers would gain from doing rehabilitation work but also who they were as workers:

> *Paul (nurse): [Rehabilitation has been implemented based on the belief that it] increases the life quality of older people – but also to optimize that which we are educated to do: that is, to re-establish older people's loss of ability and to maintain this ability, rather than just doing the chores for them.*
>
> *Helen (nurse): Rehabilitation is basically about getting their [care aides'] professionalism up front again and to get them to understand that we help them [older people] by training them, not by a passive approach of nurturing.*

In the above quotes, Paul and Helen positioned rehabilitation as a professionalization opportunity by associating the readjustment to rehabilitation with the workers' transformation into professionals, where the workers (again) use their training, skills and qualifications and produce quality outcomes. This argument is underpinned by the differentiation between what is and what is not perceived as professional in the discourse of rehabilitation. In the quotes, Paul and Helen argued that rehabilitation would optimize and bring back the workers' professionalism: an argument that implies that the workers so far – with nurturing – have not optimized or used their professionalism or, in short, have been non-professional. Thus, we see that Paul and Helen defined that to be professional as a care worker was to do rehabilitation and training activities with the care recipients. To strengthen the discourse, they

constructed an anti-discourse by defining a non-professional worker as someone who performs nurturing activities – "just doing the chores for them" – and who has a "passive approach" to older people. The discourse of rehabilitation in this way mobilized the workers to readjust to the rehabilitation approach by viewing it as a professionalization opportunity but also by articulating a marginalized non-professional nurturing identity that the workers could (and should) dis-identify from. Thus, when the therapist Sophia, in the Leila case, articulated potential solutions to overcome Leila's problems with drying her toes, and praised Maria for coming up with a solution (using a hairdryer), she was acknowledging Maria for her capability to dis-identify with the nurturing role and for her attempt to transfer into what was framed as a professional role in the broader managerial discourse.

5.10.2 Employee reactions: Resistance and tensions associated with the role transfer

As the Leila case illustrates, the care workers' role transfer to the new rehabilitation trainer role was, however, not straightforward in practice, in particular because recipients like Leila challenged the rehabilitation approach and the ideal. The Leila case, like many others, shows that the recipients often questioned whether they would be better off by being trained to become independent of care by highlighting that they still needed help (due to their physically – or mentally – aged bodies) or preferred and valued help and social contact with the care aides. Despite this resistance, the Leila case also shows that Maria, like many of her care aide colleagues, did try to locate herself in the professional rehabilitation role (e.g. by suggesting the hairdryer) and as such lived up to the role transformation required in the discourse of rehabilitation. However, Maria and the therapist's conversation outside Leila's house also reveals that it was not always an easy endeavour to live up to the role expectations. They expressed difficulties in judging whether Leila's situation was as bad as she said (or whether she was just a good actor) and how to avoid identifying with the nurturing role (of being too soft). Thus, their conversation implies that their positioning in the new rehabilitation role did generate some uncertainty and role struggles. In the focus groups, the care aides elaborated how they had experienced these observed role struggles. More specifically, as we show below, they voiced struggles that seemed to both affirm and resist the discourse of rehabilitation. We relate these struggles to the discursive managerial attempts to (re-)regulate them.

5.10.3 Type 1 – Struggles to avoid marginalization as non-professionals

One type of struggle that the care aides experienced when trying to align their work with the discourse of rehabilitation concerned external barriers, such as resistant recipients, who made it difficult for the care aides to identify with the professional rehabilitation approach and role. We saw this clearly in the Leila case, where Leila continuously tried to resist the care aide's and therapist's suggestions of self-help. As Clare explained in the quote below, resistant recipients meant that the care aides struggled to maintain their identification with the rehabilitation role in their everyday work and to not give in to the now-marginalized nurturing role that some recipients still seemed to request.

> *Clare (care aide): To give an example [of resistant recipients], I had this particularly difficult recipient, Hannah, where I in the beginning thought that I would never be able to leave her house. It was really difficult [to rehabilitate her]. Of course, she could do it herself. She was totally capable of taking breakfast from the fridge and carrying it to the table, but she wanted me to do it. She almost shouted from the bathroom "could you…", "I would like that and that…" and "it has to be in that and on that plate…". It was really difficult to rehabilitate her because it was really nice for her that I was there. So I had to have a heart to heart with her and explain that she did have an emergency button if she needed more help.*

As this quote shows, Clare was of the opinion that some recipients, like Hannah, were obstructing her attempts to align with the professional rehabilitation role because they wanted Clare to do the things for them, although Clare found that Hannah "could do it herself". Thus, the recipients were often described as pushing the care aides into performing what, in the rehabilitation discourse, was marginalized as the traditional non-professional nurturing role. Clare explained that she had tried to dis-identify with this attempt to push her back into the old nurturing role – or what sometimes was labelled a "waiter role" by several respondents – and overcome it by negotiating with the recipients: telling the recipients that they could get help somewhere else. We see that this type of struggle – where the care aides argued that they had struggled to maintain the professional role and avoid the nurturing approach – was clearly located in an attempt to align with the discourse of rehabilitation because it replicated the role hierarchy that the discourse produced. The discourse about the non-professional nurturing role was even reinforced by Clare's way of associating it with being at the whim of, in this case, Hannah's demands

and shouting (and as such performing housewife/waiter activities). Yet, simultaneously, this attempt to position herself as one of the professionals, by trying to avoid the marginalized non-professional role, also emphasized a difference from the discourse. Clare voiced that this recipient did not associate life quality with independence from nurturing, as articulated in the discourse of rehabilitation; rather, Clare highlighted the opposite: that this recipient seemed to prefer to be dependent and passive and as such associate the nurturing role with life quality. This clash between the recipient's and her own role expectations caused struggles because it required her to, on an ongoing basis, negotiate with the recipient in order to avoid the now-marginalized nurturing role.

5.10.4 Type 2 – Struggles over pressure to 'become' professionals

Another type of struggle that the care aides experienced when trying to align with the discourse of rehabilitation concerned internal barriers, such as their own personal difficulties with identifying with the new professional rehabilitation role. As Christina explained, the care aides generally struggled and found it difficult to (dis-)identify with the nurturing role:

> *Christina (care aide): Many of us have the problem that we are nurturers by nature, so if we are present in the home, it is difficult not to wash that back [laughs].*

As illustrated here, some of the care aides, such as Christina, articulated themselves as having a "problem" because they continuously struggled to avoid identifying with the old – and from the management's side, unwanted – nurturing role and the tasks that came with it (e.g. washing someone's back instead of insisting that the person needs to learn to do it themselves). Thus, some of the care aides acknowledged that they had difficulties performing the rehabilitation discourse because they had a tendency to identify with the nurturing role (rather than dis-identify with it) and thereby implied that they sometimes resisted the discourse (and ended up washing the back, for example). However, the quote also illustrates how this resistance simultaneously confirmed the superiority of the discourse of rehabilitation, rather than opposed it. Rather than objecting to the discourse, we see that Christina problematized and blamed herself for her continuous inability to dis-identify with the nurturing role. By referring to it as a "problem" and relating it to a culturally embodied signifier of her (female body) – her nurturing nature – she reinforced the discourse of rehabilitation. More specifically, she used the identity hierarchy that rehabilitation prompted to (de-)valorize her own approach as wrong (a problem).

This generative reification of the discourse generated identity struggles and required her to control and keep in check (distance herself from) her inclination to identify with the nurturing role that she valued.

5.10.5 Ongoing discursive identity regulation from the 'office'

The tensions and struggles expressed by the care aides were widely known among the managers, and they had explicit ways to address them and control their scope. In the below quote, we see how a nurse explained her managerial work and the way she had to control care aides to align with the new rehabilitation ideal so that they did not "give in" to nurturing:

> *Lena (nurse-manager): We start a citizen on a rehabilitation programme and agree with the citizen what they have to do on their own. But then the care aides come along with their "aw, I feel bad for him/her" [said with a somewhat mocking laugh]. So we [the managers] focus quite a lot now on communicating the fact that it is not loyal towards your colleagues [the ones who perform the rehabilitation discourse]. We have many conversations about this, and they are inevitable, but then again I don't think it surprises anyone that we then have to say "hello, listen up, you [the care aides] have to make an agreement [about rehabilitating the citizen] and then agree to stick to it". But I think we [the managers] are good at keeping an eye on it and dealing with it immediately if it happens.*

The quote shows how the nurses were well aware of the resistance and struggles among care aides. As a response to this resistance, the nurse-manager Lena explained how she tried to re-regulate the struggles and position them against a higher professional ethos by pointing out that nurturing preferences, like the one Christina above expressed as important to her, were destructive and a sign of being a bad colleague. As another nurse-manager explained: "[rehabilitation] is obstructed if someone comes along with a nurturing nature and says 'ok, you don't have to do this today; I can fix it for you'". In that way, care aides who felt sorry for citizens or 'just' wanted to fix things for the recipients (as waiters) were problematized as having a "nurturing nature" and contrasted against the managerial ideal. This problematization was reflected in the way that Christina above problematized her own feelings and behaviour in relation to preferring nurturing to rehabilitation and the way that Clare associated nurturing with waiter activities. Thus, the discursive re-regulation that the nurses performed seems to

reinforce the framework that care aides understand their own roles through (and their struggles to align with) the ideal, thereby adding to the reciprocal relationship between the discourse of rehabilitation and the voiced identity struggles in the context. Simultaneously, we see that the struggles and the managers' discursive attempts to control the struggles and resistance reinforced the hierarchy between the nurturing (non-professional) and rehabilitating (professional) roles. The hierarchy was reinforced because in the home care context, as illustrated in the Leila case – where Maria and Sophia discussed whether they had been "too soft" – the managerial discourse of rehabilitation was linked with broader gendered professionalization discourses (e.g. Ashcraft 2013; Hearn 1982).

5.10.6 Therapists as guardians of the discourse: A performative legitimization of the managerial ideal

As the above section shows, the role transfer that the rehabilitation discourse prompted gave rise to role struggles among the care aides because they, on the one hand, wanted to avoid being marginalized as non-professionals but, on the other, found it difficult to perform the professional rehabilitation role either due to 'personal' barriers or recipients' resistance to the new role. They therefore had a difficult time aligning to the discursive regulation of the nurses. However, as we show below, the therapists performed a very important function in identity regulating the care aides: one that was very different from the discursive regulation coming from the nurses.

The therapist – Branded as a working expert

The therapists generally explained that they saw themselves as playing a crucial role in rehabilitation home care organizations because they – as experts on rehabilitation – had been introduced to show the care aides the new and "right path" for home care, as one therapist explained:

> *Jenny (therapist): [Rehabilitation] is the core of our occupational expertise, so we could clearly imagine that this [change] was what we had to do – that it was the right path to make care recipients self-caring, responsible for their own lives, so… that was our motivation. We simply had the occupational vision to get it tested professionally and see if it worked [in home care] – because we believed it did – and as we have seen, it does.*

In the quote, Jenny explained how the therapists identified themselves with the new rehabilitation discourse and saw it as a professional call to support change in home care organizations. They were clearly seen as playing a different role from the nurses, as a nurse-manager explained:

> *Karen (nurse-manager): Fundamentally, nurses don't take a rehabilitation approach to their work. We have a lot of other competences, but regarding the rehabilitation mindset that, for example, occupational therapists have, we are miles away. So now we are asking the therapists to support care aides in learning this so that they can start working from a rehabilitation logic.*

As the quote illustrates, the therapists not only branded themselves as experts but also were directly branded as experts by nurse-managers, who also defined the therapist's role as someone who should "support" the work of care aides in the homes and ensure that the care aides readjusted to the rehabilitation discourse at the frontline.

The therapists – A source to activate the rehabilitation discourse and performatively constitute it

As working experts, the therapists did not influence the care aides through abstract discourses voiced in the office (at a distance from the actual work carried out at the frontline) like the nurse-managers did. Rather, in their capacity as working experts, they seemed to activate the professional rehabilitation expertise and role as they did the work, not just talking about it like the nurse-managers. Thus, as the Leila case illustrates, the therapists were positioned in a function where they influence the care aides' daily work and their situated practices with the recipients. In this position, they were able to activate the discourse of rehabilitation in the situated practices in two respects. First, as already mentioned, in their position at the frontline, they were able to use the vocabulary of rehabilitation in ways that activated (the performativity of) the discourse because it led directly to behavioural changes in the homes of the recipients (Cabantous et al. 2016). For example, in the Leila case, we see how the therapist Sophia reduced the care provision from two to one day per week. Second, through personifying the rehabilitation discourse and/or embedding the rehabilitation expertise, the therapists also became living/human examples of how a 'professional' persona was supposed to appear, how to 'do' the work and how to deal with challenges – such as resistant recipients – in the context. A nurse-

manager exemplified how and why this performance of the discourse was crucial in changing the care aides' behaviour:

> *Lena (nurse-manager): The care aides in my division tell me that they need to get it both explained and shown and that they preferably want it shown in the homes of the citizens. So I spend a lot of time discussing with my therapists how we can disseminate this [the rehabilitation principles] in a pedagogical way that makes sense for the care aides. And care aides stress to me that their learning style is that: "we need to hear it, we need to see it and we need to do it". It is of course a learning style that is time-constraining, but it works.*

The quote shows that the manager Lena viewed it as crucial that the therapists could make the rehabilitation role 'visual' to the care aides by being at the frontline (e.g. in the homes) and 'showing', 'voicing' and 'doing' the role. In other words, the value of the therapists' presence at the frontline seemed to be that they represented a 'living', 'situated' and 'human' guideline / role model of an otherwise abstract discourse that the care aides did not fully buy into (or could not translate to the particular situations they faced). As human guidelines, the therapists were able to regulate the care aides in more-subtle ways through their own performance/activation of the discourse, showing how a professional rehabilitation trainer looked, worked, thought, talked and even felt in relation to particular (resistant) recipients. In addition, the care aides could mirror and perhaps better relate to a performance (activation) of the discourse than an abstract discursively articulated policy based on coercive control. Two therapists explained their roles themselves:

> *Emma (therapist): I have become more aware of how I can make things work… In the beginning, I took control of the situation [e.g. with a resistant recipient] very fast... However, we have been told [by the nurses] to try to make the care aides take more and more responsibility [when it comes to rehabilitation]. I believe it works when I ask "do you mind drafting it [the rehabilitation plan] today?" I think it is really good because it is an exercise for them [the care aides] to try to do it themselves ... it is good to get 'hands on' because when they have tried it a couple of times, they say "ah, this is how you do it".*

> *Anna (therapist): I make sure to always remember to say [to the care aides and recipients]: "remember to continue!"; "come on! We can do it"; "wow, this is good!" You have to keep up that fighting spirit and stick to it, otherwise I am worried that it [the change to rehabilitation] won't be a success.*

These quotes show that the therapists were highly aware of not only activating the rehabilitation discourse through their own behaviour but also 'exporting' their expertise and mobilizing the care aides to use it in the daily work. In addition, the therapist Emma discussed a technique where she asked the care aides whether they would "mind" taking up a task, rather than dictating them to do it. Returning to the Leila case, it is now easier to understand how Sophia, like the other therapists, by her sheer presence as a human actor/agent in the home – making the rehabilitation discourse performative – influenced what the care aide Maria was supposed to *do* (and not do). Thus, Sophia directly influenced the goal and task accomplishment in Leila's home (e.g. by her power to plan whether or not Maria should help Leila with showering in the future). In addition, we can see how Sophia influenced Maria more indirectly by showing her how she – in the professional rehabilitation role – was supposed to *talk* to (resistant) recipients like Leila who claimed that they needed help (e.g. due to their diabetes and dizziness). Namely, Sophia shows how the self-perception expressed by Leila (i.e. one where the recipient focuses on their sickness, rather than their resources) needs to be problematized and highlighted as an area for intervention. Thus, we can better understand that when Sophia rewarded Maria for the hairdryer solution, it was not only because Maria had indicated that she had attempted to transfer into what was framed as the professional role in the broader managerial discourse but also because she was mirroring Sophia's behaviour. Similarly, when Sophia revealed in her situated interaction with Maria that she was afraid that she had been too soft, she was in fact (purposely or not) infusing the professional rehabilitation role and persona with a particular emotional stage or way of *feeling*. Namely, she expressed that in the professional role, it was necessary to be tough (not too soft) in order to evaluate to what extent recipients like Leila, who say they are sick and feel sad, were actually 'sincere' or were 'playing with emotions'. Thus, we also see that Maria ensured that Sophia had not been "too soft" – she clearly knew that being too soft and feeling sorry for older people were not valorized in relation to the role.

Thus, the therapists seemed to be able to exercise a different kind of identity regulation than the nurses. Rather than having to 'sell' the managerial discourse through a managerial position, the therapists exercised control by performing the roles and tasks together with the care aides to regulate the care aides' perceptions of themselves as professionals and 'good' employees, which was seemingly much more effective than the nurses' discursive regulation. Performative regulation, then, where regulation is exercised by performing a role and task (in front of others), seemed to strengthen and supplement the discursive regulation because the therapists could relate the preferred managerial role directly to the situated practice and the actual accomplishment of the role. They showed *particular* behaviour, rather than demanding *abstract* behaviour and role transformation.

5.10.7 The effects of performative control

Besides mirroring the therapists' performance, the care aides also adopted and embodied it. Elsie explained:

> *Elsie (care aide): Many of us experienced an eye-opener [working with the therapists]. We realized that we did a lot of different things that the citizens could do themselves.*

Further, the introduction of the therapists (and rehabilitation) seemed not only to change how the care aides looked at care recipients and in tandem their own behaviour in the homes but also, as the below quote shows, embodied this perception even deeper and ended up being something that the care aides now passed on to their trainees:

> *Karen (care aide): I use rehabilitation every day. Today I had a trainee with me, and I used it to teach her "turn your back to him [the care recipient they visited] and leave. Let him handle it himself". But I've also received great support from Leanne [therapist].*

Karen explained that she used rehabilitation every day and was starting to teach her trainees how to do it and that this behavioural change was a product of the therapist Leanne's "great support" and teaching. An important aspect here is the way that the therapists managed to turn their work from being controlling (like the nurses' managerial work) into support. The following excerpt from a conversation at a focus group shows this dynamic:

> *Leanne (therapist): Ok, I'm looking at you [the care aides], as I am a little curious… When we [the therapists] have been out on the job with you, have you ever felt that we 'looked over your*

shoulders' – that we controlled you? Because I have a few times wondered if any of you perceived it that way. Because that's definitely not why we are there. We were with you to support your work. But I wonder how you felt?

Elsie (care aide): No, I don't think so [that it's controlling]. In any case, I haven't heard anyone saying that. It was, after all, not us who were in focus – it was the citizens you focused on, to see what they could actually do. So nobody has mentioned that [they felt controlled].

Beth (care aide): It has only been positive [that the therapists have been with them at work].

Joan (care aide): But you [talking to Leanne] do know that I thought so [that it was controlling]. That's why she [referring to Leanne] is asking [looking at the others]. I hate when someone is standing behind me [when I work].

We can here see how the focus group conversations helped the therapists to voice a core message concerning their role: that they wanted to be seen as 'supporters', rather than as 'sources of control'. The two care aides who bought into this argument are prime examples of effective performative regulation. As we can see, instead of understanding the therapists as yet more managers who controlled *their* work, Elsie at least perceived the therapists as embodying their common goal: working with the recipients, and this was perceived as 'positive'. The care aide Joan clearly agreed with Elsie that control was not seen as a positive thing, yet she revealed that she viewed Leanne as a source of control. However, interestingly, she mentioned that she had already discussed this with Leanne, and thus Leanne clearly wanted to see how general this idea about control was. Her core message subtly managed this idea, for example by allowing the 'positive' care aides to explain her role to the more-sceptical care aides.

This indicates that the therapists played a crucial role as 'human guidelines' who could (and often did) support the care aides in their identity struggles and taught them (1) how to avoid the so-called marginalized nurturing role and (2) how they could become so-called professionals and thus how their identity struggles could potentially be decreased. Thereby, the therapists also played a key role in legitimizing the managerial discourse on an ongoing basis and in moderating (oppositional) resistance.

5.11 Concluding discussion

Home care as an occupation is struggling to gain professional status and as such is marginalized. In Denmark – as in many other countries – home care management have in recent years introduced rehabilitation as a way to (re-)professionalize the work and bring more status to the occupation (Rasmussen 2004; Kjellberg et al. 2011). As with many other managerial initiatives, rehabilitation has received both positive and negative feedback from the people doing the work, the care aides, who on the one hand appreciate the (re-)professionalization of their occupation, as it brings more status to their work, but on the other hand struggle with the professional role due to clashes with their more-personal desires to nurture and help the care recipients. Taking this as its point of departure, this article has explored how the introduction of a new professional group – therapists working as experts at the frontline together with the care aides – has influenced how the managerial discourse of rehabilitation has been communicated, adopted and legitimized by care aides in home care organizations.

The article contributes theoretically and empirically to the study and conceptualization of the complex and omnipotent nature of identity regulation and the struggles and resistance that emerge because of managerial attempts to (re-)professionalize professions at the margin in three interrelated respects, which are visualized in Figure 16.

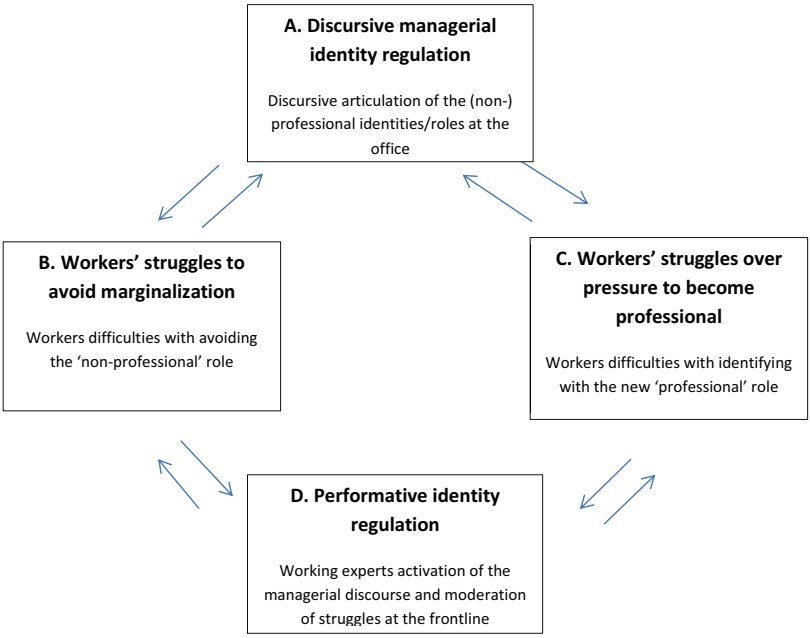


Figure 16. The relationships and interactions between the discursive and performative identity regulation and struggles over professional identities.

1) First, the article empirically shows how organizational policies such as rehabilitation are discursively regulated (Box A, Figure 16) in ways that are closely tied to the formation of professional identities at work because they offer employees in marginal professions promises of (re-)professionalization and (re-)qualification (e.g. Alvesson and Willmott 2002; Ashcraft 2005; Ashcraft et al. 2012; Thomas and Davies 2005). Yet, it also extends these studies by showing that it is not only a new professional identity/role that is discursively crafted and prompted by the discourse of rehabilitation. Rather, our analysis shows that, in rehabilitation home care, an anti-identity (the nurturing role) is crafted along with the new professional identity. Thereby, the discourse of rehabilitation mobilizes workers to readjust to the rehabilitation approach not merely by introducing a new identity hierarchy that clearly defines the professional identities that are valued and rewarded in the managerial discourse but also by defining the role that the workers are expected to dis-identify from (in order to not be sanctioned as

non-professionals). This discursive crafting of an identity hierarchy may reflect an enforced effort to regulate (by ordering) the previously documented (Dahl 2009; Hoyer 2016) plural identities that are available in home care organizations (which workers tend to use as a source of resistance). In addition, the analysis shows that this discursive regulation is not static but ongoing. More specifically, we see that the struggles that the discourse of rehabilitation give rise to among care aides are widely known by managers and that the struggles re-inform their ongoing discursive regulation. In particular, in an attempt to control the scope of the struggles, the nurse-managers reinforce the identity hierarchy by relating the nurturing identity with being a disloyal colleague and feminine stereotypes, such as classically embodied signifiers of being soft, having a female gender and doing housewife/waiter activities in the home. Signifiers, which other studies (Hearn 1982; Lee-Treweek 1997; Tronto 1993; Rasmussen 2004; England and Dyck 2011; Lipsky 1980) have also shown, are typically used to emphasize the degrading and marginalized image of a worker role. Thus, overall, we see that discursive managerial regulation relies on the dynamic construction of an identity hierarchy that simultaneously offers the potential to both boost and degrade workers' identities.

2) Second, by specifying two types of struggles (Boxes B and C, Figure 16) that the discourse of rehabilitation prompts for the care aides, the article expands the literature on resistance and identity struggles (in marginalized workplaces) (e.g. Contu 2008; Fleming 2005; Fleming and Spicer 2003; Alvesson and Willmott 2002; Watson 1994; Laine and Vaara 2007). A noteworthy aspect that characterizes both types of struggles is that they are not expressed as "worker corps kicking back against" a managerial discourse (Thomas and Davies 2005, 685), nor do they reflect that workers are "passive receptacles or carriers" of the managerial discourse (Alvesson and Willmott 2002; Watson 1994; Laine and Vaara 2007). Rather, they reflect a type of struggle that seems to both affirm and resist the discourse of rehabilitation simultaneously (see e.g. Thomas and Davies 2005 for another analysis of the omnipotence of resistance). The first type of struggle (Box B, Figure 3) concerns the care aides' attempts to avoid marginalization and thus to dis-identify with the traditional nurturing role, which is labelled 'non-professional' by management. The way that this type of struggle is expressed shows resistance because some care aides prefer the nurturing role to the professional role communicated through the discourse of rehabilitation. Yet, simultaneously it also affirms the identity hierarchy in the managerial discourse because the care aides are willing to negotiate with the recipients in order to avoid the now-marginalized nurturing role (despite the recipients' desire for this role). The second type

of struggle (Box C, Figure 3) is over the pressure to adopt the professional identity defined by the managerial discourse. The way that this type of struggle is expressed shows that some care aides resist the discourse because they at times identify with the nurturing role and perform nurturing tasks (e.g. washing the back of an older person), even though the managerial ideal would tell them not to. Yet, simultaneously, by problematizing this resistance as wrong and a result of their own (embodied) 'personal' difficulties, they affirm the identity hierarchy that the discourse prompts.

We argue, however, that the reasons why this resistance is rather vague and defensive, and does not as such represent opposition to the discourse, cannot only be reduced to the discursive (re-)regulation of the workers. Rather, the therapists play a crucial role in prompting the care aides' role transfer and adaption of the discourse.

3) The specification of how the therapists are positioned as 'working experts' at the frontline as crucial sources to condition the role transfer and moderate the resistance by activating and performatively constituting the professional rehabilitation persona (Box D, Figure 16) leads us to the third contribution of the article. While the nurse-managers from the 'office' exercise classic identity regulation based on repeating and disseminating the managerial discourse (Alvesson and Willmott 2002; Willmott 1993; Kunda 1992; Kunda and Van Maanen 1999) to ensure the care aides' alignment with this new professional role, the therapists' regulating function as 'working experts' is branded and performed differently – and with different results. The therapists – as human actors (Callon 2008) – seem to embed the discourse of rehabilitation (and affiliated expertise) in the work itself, thereby performatively constituting the professional rehabilitation persona at the frontline (i.e. in the recipients' homes). Inspired by Cabantous et al. (2016), we more specifically argue that the working experts due to their presence at the frontline supplement the discursive regulation by activating the performativity of the managerial discourse and the professional persona through what we define as performative regulation. We show that performative regulation, defined as regulation that is exercised by performing a role and task (in front of others), has two dimensions. First, the working experts activate the vocabulary of rehabilitation in a way that leads to behavioural changes through their "performative utterances" (Cabantous et al. 2016, 200) in the recipients' homes. For example, by continuously repeating that the aim of their own and the care aides' visits is to reduce the help in the homes (which the Leila case illustrates), the therapists maintain a focus on the homes, where rehabilitation is

supposed to be exercised, rather than just directing it from the basis of the office. Second, the working experts' presence activates the 'professional' rehabilitation persona at a more embodied level by their performance of this persona.

Thus, we propose that the reason why the care aides actually changed their behaviour (in contrast to other studies) cannot be reduced to either the therapists' or the nurses' utterances. Rather, by personifying the professional persona and showing it should look in practice, including thoughts, behaviour, language and tackling difficulties such as recipients' resistance in the situated work, and by exporting this expertise directly into the homes in front of the care aides (e.g. by mobilizing the care aides to draft rehabilitation plans), the therapists became a living, situated and human guideline that the care aides seemed to better relate to. They could better mirror and apply the new discourse in their situated work when it was practised with them, compared to when it was merely an abstract discursive policy. Thus this indicates that the performative regulation exercised by the therapists became a powerfull source to legitimize the managerial discourse of rehabilitation, because many care aids did not see this type of regulation as control. While the ongoing discursive regulation exercised by the nurses from the office to a higher extent were based on blaming and scapegoating directions (negative control), the performative identity regulation exercised by therapists where experienced as positive (not regulation), because it operated through the therapists' support and explanatory practices, which many care aids saw as a 'positive' source to help them to accomplish their work, and more specifically for instance as a source that could help them navigate their own struggles with resistant recipients (e.g. by mirroring how therapist handled similar types of resistance themselves, although the therapist also were a source to this very resistance). In this way, performative regulation was more easily accepted by the care aides (i.e. it worked better as a control mechanism for regulating their identities). The notion of performative regulation, therefore, seems important to further our understanding of how regulation is not only discursive and cultural but also material and embodied and thus performative.

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CHAPTER 6:

NEGOTATING BOUNDARIES OF PROFESSIONALISATION

The professional	The non-professional
Masculine(ities), men, loyal, committed, enthusiastic, clean, civilized, high-status, white collar	Feminine(ities), women, dirt, stigma, low-status, blue-color, disloyal, non-committed, critical

Article 2: Teammøder i rehabilitativ hjemmepleje – effektiv ensretning eller nuanceret faglig dialog?

6.1 Short introduction to the article

In this chapter I present the second topic on which I focus in my conceptualization of how professionalization processes and, by implication, marginalization processes are discursively and materially constituted in rehabilitative home care organizations. More specifically, this chapter presents the second article of the dissertation. A key focus is on how boundaries of professionalization are *negotiated* during the newly established team meetings in rehabilitative home care organizations. Previous versions of the article have been presented at different workshops, for example the PhD workshop at Alberta Institution Conference in Banff in 2015. The following version is a slightly changed version of a Danish version of the article that was submitted to the journal Tidsskrift for Arbejdsliv in March 2016, and after a revise-and-resubmit process it was published in *Tidsskrift for Arbejdsliv*, Vol. 18, Nr. 4, 12; 2016, s. 24-41.

6.2 Abstract

Tværfagligt samarbejde og teammøder hyldes i den aktuelle moderniseringsbølge af den offentlige sektor. Her ses de som svaret på, hvordan faglig vidensdeling, kvalitet og effektivitet kan højnes i arbejdet. I artiklen udfordres imidlertid denne antagelse ved at diskutere en række barrierer, der medvirker til at forhindre, at de gode intentioner omsættes i praksis. Det sker ved at fokusere på de normer- og gruppedynamikker, der kan opstå på teammøder, hvor medarbejdere med forskellig status og faglighed deltager. Gennem observationer af tværfaglige møder i hjemmeplejen analyseres det i artiklen, hvordan møderne iscenesættes og superviseres på en måde, så sosu-medarbejdernes historier, om deres arbejde med at rehabilitere individuelle ældre borgere, modtages og bearbejdes forskelligt af deres kollegaer og supervisorer. I artiklen fremhæves, hvordan nogle historier udpeges som 'succeshistorier', og derved resulterer i anerkendelse, mens andre historier giver anledning til frustration og sanktioner på møderne. En central pointe er, hvordan det sanktions- og belønningssystem, der etableres gennem udveksling af historier på møderne, er baseret på én dominerende vision om, hvordan arbejdet optimeres og håndteres 'professionelt', og hvordan dette

paradoksalt nok ensretter snarere end åbner op for en kreativ dialog om alternative tilgange til arbejdet med ældre mennesker.

6.3 Indledning

"Jeg bruger meget, at vi får succeshistorierne frem på teammøderne. Det er vigtigt, synes jeg, for det giver inspiration, og det giver skulderklap og motivation. Det kan være, at én [sosu-medarbejder] kommer og siger: 'sammen med hende [en borger] kom vi så og så langt' [med at rehabilitere hende], hvorefter jeg siger: 'Ej, prøv lige at fortæl det i morgen på teammødet'. Det er en cadeau til medarbejderne!" (Laila, terapeut i hjemmeplejen)

Teamorganisering baseret på tværfagligt samarbejde mellem velfærdsprofessionerne er et fænomen, der spredes i den aktuelle moderniseringsbølge i den offentlige sektor. At velfærdsprofessionerne samarbejder om at løse kerneopgaven, er ikke et nyt fænomen. Alligevel har fokus på og italesættelsen af teamorganisering ændret sig i den offentlige debat. Inden for social- og sundhedssektoren promoveres teamorganisering for eksempel i stigende grad som et strategisk redskab ikke kun til at fordele arbejdet og sikre vidensdeling mellem de professionelle, men også som et redskab til at højne effektiviteten i de professionelles arbejde og til at sikre, at nye innovative kvalitetsstrategier omsættes i praksis (Ferlie and Shortell, 2001; Gittell et al., 2010; Shaw et al., 2005). Set i lyset af de udskældte bureaukratiske og/eller tayloristiske kontrol- og organiseringspraksisser, der er rullet ind over den offentlige sektor i de seneste år, er det da også svært at argumentere imod teamorganisering. Hvem kan reelt være imod teamorganiseringens idealer, der først og fremmest fremhæver potentialet for at øge de professionelles motivation, råderum, problemløsning og vidensdeling på tværs af fag-siloer? Der er således også bred opbakning fra de faglige organisationer til at øge teamorganiseringen i den offentlige sektor.

Kritiske ledelsesforskere (Barker, 1993; Boltanski and Chiapello, 2005; Ekman, 2010) har, primært inspireret af Weber og Foucault, imidlertid længe kritiseret ledelseslitteraturens idyllisering af teamorganisering. Den kritiske forskning fokuserer på nye magt- og gruppedynamikker, der opstår i overgangen fra traditionelt bureaukrati til teamorganisering. Forskningen viser, at selvom de professionelles entusiasme og motivation i arbejdet potentielt højnes med teamsamarbejde, så er dette ikke ensbetydende med, at deres professionelle frihed og råderum i arbejdet øges (Barker, 1993; du

Gay and Morgan, 2013; Ekman, 2010). Snarere peger forskningen på, at bureaukratiets eksplicitte regulering ofte suppleres snarere end erstattes med teamnormer om, 'hvad vi bør gøre her' og en loyalitet overfor 'team-ånden' (Barker, 1993; Kärreman, Alvesson, and Wenglén, 2006). Et supplement, der ifølge forskerne går hånd i hånd med et belønnings- og sanktionssystem, der intensiverer kontrollen af de professionelle og bliver en kilde til stress, fordi kollegaerne i højere grad begynder at disciplinere sig selv og hinanden ved at sanktionere de kollegaer, der ikke lever op til normerne i teamet (Barker, 1993). Den kritiske ledelsesforskning giver dermed et værdifuldt indblik i de belønnings- og sanktionssystemer, der ofte kendetegner teamsamarbejde. Med et par få vigtige undtagelser har forskningen imidlertid en præference for dokumentstudier og større kritiske, generiske samfundsdiagnoser af, hvordan medarbejdere bliver instrumentaliserede af abstrakte kategorier såsom 'systemer', 'kontrol', 'rationalitet' eller 'diskurser' (Ekman, 2010; Vikkelsø, 2014). Vi ved derfor relativt lidt om, hvad der rent faktisk sker og drøftes på f.eks. teammøder i den offentlige sektor, og hvordan teammøder påvirker løsningen af kerneopgaven.

Formålet med denne artikel er at bidrage til den kritiske ledelsesforskning i teamsamarbejde ved at kombinere den med et etnografisk klassisk arbejdssociologisk perspektiv. Klassisk arbejdssociologi (Strauss et al. 1997; Hughes 1958) fokuserer på de arbejdsgange, hierarkier og udfordringer, der præger medarbejdernes daglige arbejde med borgere og patienter i den offentlige sektor – ofte med udgangspunkt i etnografiske casebeskrivelser, der synliggør arbejdets kompleksitet og dilemmaer. Arbejdssociologien tilskynder os således til at flytte fokus fra abstrakte generiske kategorier og dokumentstudier af teamorganisering til etnografiske studier af, hvad der helt konkret sker og drøftes af teammedlemmerne på f.eks. teammøder. En tilgang, der er vigtig for vores forståelse af teamorganisering, fordi etnografiske studier kan give os et bedre indblik i, hvilke konsekvenser stærke teamnormer helt konkret får for medarbejdernes daglige håndtering af deres komplekse arbejde og deres løsning af kerneopgaven. Som Vikkelsø (2015) argumenterer for, vil et sådant fokus på arbejdet og dets kompleksitet bidrage til diskussionerne om - ikke i hvilket omfang f.eks. teamorganisering generisk er et godt eller dårligt organisationsprincip, men snarere om, hvorvidt f.eks. teammøder er en velegnet organiseringsmodel til at underbygge den faglig sparing og løsning af kerneopgaverne i velfærdsstaten og hjemmeplejen mere specifikt.

Artiklens indledende citat stammer fra Laila, en ergoterapeut, der er ansat i hjemmeplejen. Hjemmeplejen udgør en særligt interessant case til en undersøgelse af teamorganisering og dets konsekvenser for opgaveløsningen. Inden for hjemmeplejen har rehabilitering som en ny kvalitets- og effektiviseringsstrategi spredt sig inden for en ganske kort årrække (Kjellberg et al. 2014). Rehabilitering italesættes ofte som en såkaldt 'innovativ strategi', fordi fokus flyttes fra hjemmehjælp til selvhjælp og træning (Kjellberg et al. 2011; Anker 2011). Dermed er medarbejdernes fokus på borgerens ressourcer og deres evne til at genlære eksempelvis at kunne gøre rent og lave mad, fremfor at medarbejderne udfører opgaverne. En omstilling som FOA ofte omtaler som en mulighed for, at sosu-medarbejderne igen kan fokusere på det professionelle arbejde efter en tid, hvor arbejdet i hjemmeplejen har været præget af alene-arbejde og nøje tids- og kontrolregulering. I forbindelse med rehabilitering har man i stort set alle kommuner ansat ergoterapeuter, som føromtalte Laila, der fungerer som såkaldte 'drivere' i omstillingsprocessen (Kjellberg et al. 2011). En af terapeuternes kerneopgaver er at deltage i og supervisere de tværfaglige teammøder, der ligeledes er etableret i forbindelse med rehabilitering. På disse møder deler sosu-medarbejdere løbende deres hverdagshistorier om deres arbejde med at rehabilitere individuelle borgere i deres hjem og modtager ligeledes feedback på deres indsats af deres kollegaer. Som terapeuten Laila fortæller, bruger hun teammøderne som et strategisk redskab til at få 'succeshistorierne' frem. Hun mener, at det både inspirerer, motiverer og giver medarbejderne anerkendelse for deres arbejde. Umiddelbart lyder det positivt, at terapeuterne fokuserer på sosu'ernes succes og anerkendelse, især fordi sosu'er ofte beskrives som en stigmatiseret faggruppe med et dårligt arbejdsmiljø[i]. Men et nærliggende spørgsmål er, hvordan denne promovering af succeshistorier påvirker etableringen af normative belønnings- og sanktionssystemer på teammøderne og muligheden for at skabe dialog om arbejdet?

For at få indblik i de normer og gruppedynamikker, der udvikler sig på teammøderne i hjemmeplejen, samt hvordan de påvirker mulighedsbetingelserne for at skabe faglig dialog om det komplekse arbejde, benyttes en narrativ analytisk optik i artiklen (Boje, 1991; Humle and Pedersen, 2010; Orr, 1998). Fremfor tidligere studiers tendens til at fokusere på relativt abstrakte kategorier og analyser af arbejdet giver denne optik mulighed for at fokusere på, hvordan det komplekse arbejde om borgerne bliver genfortalt i situerede og forskelligartede hverdagshistorier på teammøderne, samt hvordan disse historier modtages, navngives og bearbejdes forskelligt af kollegaer og supervisorer på møderne. I

artiklen argumenterer jeg således for, at hverdagshistorierne giver et indblik i, hvordan kompleksiteten af arbejdet håndteres og kontrolleres gennem team-normer, og hvordan denne 'håndtering' – eller mangel på samme, påvirkede det faglige spillerum. Mere specifikt adresserer jeg følgende forskningsspørgsmål i artiklen: *Hvilke normer og gruppedynamikker kommer til udtryk i medarbejdernes udveksling af historier om arbejdet på teammøder i hjemmeplejen, og hvordan påvirker disse mulighederne for at skabe en faglig dialog om det komplekse arbejde?*

Artiklen falder i fem dele. Først præsenteres artiklens teoretiske ramme, casen og metoden. Herefter analysen, hvor omdrejningspunktet er tre forskellige typer historier fra observerede teammøder, der hver især illustrerer, hvordan medarbejdernes historier om arbejdet med at rehabilitere borgere modtages, belønnes og sanktioneres forskelligt, og hvordan dette påvirker mulighed for at udtrykke sig i det faglige rum. Artiklen afrundes med en konkluderende diskussion.

6.4 Teamsamarbejde og kontrol af arbejdet

Teamsamarbejde defineres ofte meget bredt som 'en gruppe af individer med ekspertise', der har et fælles mål, og som mødes for at *"kommunikere, dele og rodfæste viden og på den baggrund lave planer og influere fremtidige beslutninger og handlinger"* (Mezey et al., 2002: 4). I ledelseslitteraturen sættes teamorganisering ofte i kontrast til rigide bureaukratiske og tayloristiske organiseringsformer, der relateres til tidskontrolsystemer samt professionelle siloer og hierarkier, hvor medarbejdernes viden er fastlåst og 'sticky' (Ferlie and Shortell, 2001: 295). I modsætning hertil fremhæves teamsamarbejde som designet til at sikre vidensdeling og synergi mellem sundhedspersonale med forskellig faglig baggrund og ekspertise. Teams anses dermed som en kilde til både at øge kvaliteten af arbejdet gennem mere integrerede og sammenhængende patientforløb, og som kilde til at øge medarbejdernes motivation, mening og faglige spillerum i arbejdet, bl.a. ved at højne lavstatus-professionelles synlighed og selvrespekt i fagteams (Denvir 2015; Mezey et al. 2002). Litteraturen fremhæver endvidere, at teamorganiseringen også er et middel til at højne effektiviteten af arbejdet, f.eks. betegnes organiseringsformen ofte som et 'high performance system' (Gittell et al., 2010) og som et effektivt middel til at understøtte forandring og indførelsen af nye 'innovative' politikker (Ferlie and Shortell, 2001). Effekter, der imidlertid ikke genereres automatisk. Tværtimod fremhæver litteraturen, at såkaldte 'effektive teams' kræver styring og støtte, så team-medlemmerne udvikler fælles mål, effektiv kommunikation og fælles værdier (Ferlie and Shortell, 2001; Gittell et al., 2010; Shaw et al., 2005).

Kritiske ledelsesforskere retter imidlertid en skarp kritik mod ledelseslitteraturens anbefalinger og idyllisering af teams. De fremhæver, at det netop er, når kulturer og værdier i teams bliver for stærk, homogen og effektiv, at teams bliver problematiske, fordi dette resulterer i, hvad organisationspsykologen Janis (1972) referer til som 'groupthink'. Kritisk ledelsesforskning indskriver typisk teamorganiseringen i en større samfundsmæssig ændring, der ofte går under betegnelsen 'advanced liberalism' (Rose, 2001) og 'the new spirits of capitalism' (du Gay and Morgan, 2013), hvor arbejdet intensiveres og ansvaret for arbejdets resultater individualiseres gennem nye motivations- og organiseringsformer, f.eks. teamsamarbejde (Sennett 1999). Disse er kendetegnende ved, at medarbejdernes adfærd ikke længere primært styres gennem formelle og eksplicitte regler, men i højere grad gennem deres værdier og 'indre liv' ('spirit'). En overgang, som forskningen peger på øger kontrollen i arbejdet, selvom – eller netop fordi – medarbejderne samtidigt loves mere medbestemmelse og fleksibilitet (du Gay and Morgan, 2013; Ekman, 2010). Barker (1993) viser for eksempel, i undersøgelsen af overgangen fra bureaukratisk organisering til teamorganisering i firmaet ISE, hvordan kontrollen med den enkelte medarbejder blev øget og gjorde spillerummet for at komme med kritik mindre, fordi det interne pres blandt kollegaerne for at overholde de værdibaserede normative regler, blev intensiveret. Medarbejderne havde selv, på baggrund af direktørens vision, formuleret disse normer og beskrevet, hvad der konstituerede både kollektivt og individuelt godt arbejde. Normer, som team-medlemmerne benyttede til at give mening til og guide deres interaktioner. Mere specifikt observerede Barker (1993, 425), at teamet *"belønner de kollegaer der tilpassede sig normerne, ved at få dem til at føle sig som en del af teamet, og som medskaber af teamets succes. Mens kolleager, der modsat havde en dårlig attitude, blev sanktioneret"*. Kritiske ledelsesstudier er værdifulde, fordi de sætter spørgsmålstegn ved antagelsen i ledelsesteorien om, at det professionelle spillerum øges med teamsamarbejde. Både ledelseslitteraturen og kritikken heraf har dog en fælles tendens til at navigere uden om situerede etnografiske studier af medarbejdernes daglige udførelse af arbejdet og i stedet fokusere på abstrakte eller kvantificerede forestillinger om teams enten negative eller positive konsekvenser. Vi ved således relativt lidt om, hvordan arbejdets kompleksitet helt lavpraktisk diskuteres i teams.

6.5 Arbejdets kompleksitet

Fokus på arbejdets dilemmaer og kompleksitet i forbindelse med at løse kerneopgaven var et centralt emne i sociologisk forskning for 40 år siden. Især forskere som Anselem L. Strauss og Everett C. Hughes udgjorde centrale figurer. En af deres hovedpointer var, at sundhedsarbejde per definition er fejlbarligt, komplekst og uforudsigeligt. Først og fremmest fordi det 'produkt', der arbejdes på og 'igennem', er en patient/borger, der ikke har en identificerbar og fikserbar kerne – og derfor skal involveres processuelt i arbejdet. Men også fordi borgerens/patientens sygdom, tilstand, livsstil og historie – samt de relationelle og organisatoriske rammer, der omgiver arbejdet med borgeren, gør det svært at kontrollere udviklingen i arbejdet med borgeren. Mere specifikt gør arbejdets karakter det sværere for de professionelle at forudsige sygedomsforløbet, behandlingens og medicinens effekter samt borgerens/patientens samarbejdsvillighed (Strauss et al. , 1997: 25). Især når arbejdet koncentrerer sig om borgere, der, som i hjemmeplejen pga. deres høje alder, ofte lider af en kompleks blanding af mentale, fysiske og/eller sociale problemstillinger[ii] (Hjemmehjælpskommissionen 2013). Et par nyere danske studier har således også vist, hvordan både medarbejdere (Jacobsen et al. 2008) og ledere (Rennison, 2014) i den offentlige sektor står overfor en række krydspres og dilemmaer, der gør deres arbejde med borgere yderligere komplekst, fordi de f.eks. mødes af og skal balancere med en række politiske, økonomiske og pædagogiske hensyn.

Ved at tydeliggøre arbejdets modstridende, fejlbarlige, komplekse og uforudsigelige natur, viser forskningen, hvor svært det i praksis er at kontrollere arbejdet samt fastlægge og opnå konsensus om universelle succes- og fiaskokriterier inden for denne type arbejde. Hughes (1958) peger for eksempel på, at det ikke er et sjældent fænomen inden for sundhedsarbejde, at de professionelle argumenterer for, at arbejdet har været en succes, mens patienten anklager disse for at have lavet fejl og ikke have levet op til deres forventninger. Det betyder imidlertid ikke, at arbejdssociologerne er uenige med Barker (1993) i, at sådanne normer om succes og fiasko – og dermed belønning eller sanktioner – alligevel søges etableret og stabiliseret inden for denne type arbejde. De peger imidlertid på, at sådanne kriterier ofte udspringer af medicinske idealer om professionalisme og af dynamiske og situerede statuskampe mellem professionerne (og patienterne). Nemlig et medicinsk ideal om, at lægen kan lave kliniske og lineære diagnoser, der kan udføres succesfuldt (Strauss et al. 1997).

Ved at bygge bro imellem kritisk ledelsesteori og arbejdssociologien får vi mulighed for at forstå, hvordan etableringen af normative sanktions- og belønningssystemer helt konkret søges skabt på teammøder. Og hvordan disse påvirker det komplekse sundheds- og omsorgsarbejde.

6.6 Casen: En vision om rehabilitering og teamsamarbejde i hjemmeplejen

I artiklen benyttes et kvalitativt studie af hjemmeplejen i fem kommuner som case til at studere teammøder og faglig sparing, fordi man med introduktionen af rehabilitering på tværs af landets kommuner har intensiveret det tværfaglige samarbejde, bl.a. i form af etablering af teammøder (Kjellberg et al. 2014; Albertsen et al. 2014). Før introduktionen af rehabilitering havde medarbejderne i de fem kommuner, der indgår i studiet, som en konsekvens af løbende bestræbelser på at standardisere og opsplitte hjemmeplejearbejdet (ofte med New Public Management som overskrift), været præget af alene-arbejde hvor opgave- og tidsramme var fastsat af visitator (Kamp 2013). Medarbejderne havde haft gruppemøder, der dog primært havde administrative forhold såsom vagtplanlægning på dagsorden. Det nye ved de teammøder, der blev indført med rehabilitering, var imidlertid, at sosu-medarbejderne fik et kollegialt forum, hvor de formelt kunne diskutere deres daglige arbejde med at rehabilitere borgerne.

På tværs af kommunerne varede møderne typisk mellem 1-3 timer. Der deltog omkring 1-2 mellemledere og mellem 10-20 sosu'er på møderne. Et fællestræk ved møderne var, at de var casebaserede og dermed bygget op om diskussionen af op til ni borgeres rehabiliteringsforløb. Det var som oftest[iii] en terapeut (der deltog på møderne som 'eksperten' i rehabilitering), der orkestrerede dagsordenen samt gav feedback til sosu'erne, når deres arbejde med at rehabilitere en konkret borger blev gennemgået. Sosu'erne havde typisk været på kursus i, hvad rehabiliteringsvisionen indebar. Nedenfor er et repræsentativt eksempel på, hvad der blev lagt vægt på, når den nye vision og tilgang blev præsenteret for sosu'erne på kurserne:

> *"Vi har lagt vægt på, at man selvfølgelig [med rehabilitering] ser på ressourcer frem for det kompenserende. I stedet for bare at skulle komme ind og gøre noget for borgeren, og så blive ved med at gøre det. Fra at faktisk gøre borgeren afhængig af, at vi kommer, skal vi nu prøve at gøre borgeren uafhængig af, at vi kommer. Og vi arbejder hen imod,*

at vi kan trække os mere og mere ud og have fokus på deres egenomsorgsevne" (Terapeut).

Sosu'erne fik således af vide, at de med rehabilitering skulle gøre op med deres 'traditionelle' tilgang til arbejdet, hvor man 'bare' gjorde noget for borgeren og kompenserede dem på ubestemt tid. Som citatet viser, blev denne tilgang anset som passiviserende og afhængighedsskabende. I stedet skulle sosu'erne tænke i rehabilitering og fokusere på borgerens 'egenomsorgsevne' og 'ressourcer', hvilket blev kædet sammen med at trække sig mere og mere fra hjemmene og gøre borgeren uafhængig af hjælp. Der blev ikke lagt skjul på, at overgangen til rehabilitering var forbundet med besparelser (fordi forventningen var, at færre borgere skulle have hjælp), men i alle kommunerne fremhævede lederne, at rehabilitering var mere 'smart' og 'rationelt' end tidligere effektiviseringsstrategier, fordi den samtidig sikrede borgerens livskvalitet og et mere spændende arbejdsindhold for bl.a. sosu'erne. En grundantagelse, der blev gentaget på tværs af kommunerne, var således, at ældre menneskers tilfredshed og velbefindende var direkte relateret til deres frihed og uafhængighed af hjælp. Nedenfor er en illustration af antagelsen fra en af kommunernes pjecer:

"Ældre ønsker at bestemme over eget liv og vil i størst mulig grad være selvhjulpne og uafhængige af andre."

Denne vision om rehabilitering, og distinktionen mellem uproduktiv, 'traditionel', kompenserende hjemmepleje og livskvalitetsskabende og produktiv rehabilitering, er, som jeg vil vende tilbage til i analysen, et vigtigt fundament for de normer og dynamikker, der blev etableret på teammøderne (Barker 1993).

6.7 Metode – en narrativ analytisk optik på teamsamarbejde

Data fra studiet af hjemmeplejen, der anvendes i artiklen, stammer fra forskningsprojektet Relationel Koordinering i Hverdags Rehabilitering (ReKoHveR) (Albertsen et al., 2014). Projektet er gennemført med støtte fra Arbejdsmiljøforskningsfonden (projekt nr. 45-2011-09). Det kvalitative materiale er indsamlet i 2012 i samarbejde med mine tidligere kollegaer i Teamarbejdsliv A/S – Karen Albertsen, Inger-Marie Wiegman, Hans Jørgen Limborg og Flemming Pedersen. Materialet består af 12 fokusgruppeinterviews med ledere og medarbejdere, fem individuelle interviews og 24 observationer af bl.a. teammøder og hjemmebesøg.

Datamaterialet blev systematisk analyseret i forskellige faser. Den første fase bestod i en såkaldt 'åben kodnings-'fase (Strauss 1987). Her kodede og tematiserede jeg det empiriske materiale. I denne fase bemærkede jeg, at et tilbagevendende tema i materialet var etableringen af professionelle normer om, hvad godt og succesfuldt arbejde er i det rehabiliterende hjemmehjælpsarbejde. Dette blev især tydeliggjort ved, at der både i interviews og observationer blev refereret til såkaldte 'succeshistorier' om arbejdet, men også til erfaringer og oplevelser, der tydeligvis ikke var succeser. Dette gav mig en første ide om, at ikke alt arbejde blev fremhævet eller bedømt lige succesfuldt i konteksten. Særligt kodningen af noterne fra de otte observerede teammøder gav en vigtig indsigt i, hvordan der dynamisk blev grundlagt normer om det succesfulde arbejde på teammøderne.

I den anden fase analyserede jeg mere systematisk, hvordan teammøderne og udvekslingen af hverdagshistorier på møderne kom til at danne rammen om gruppedynamikker og etableringen af normer om det komplekse rehabiliterende arbejde. Her fandt jeg særligt en narrativ analytisk optik velegnet til at få indblik i *både* de normer, der blev etableret på teammøderne og i arbejdets kompleksitet. Mere specifikt tilbød Boje (1991), Downing (1997) og Orr (1998, 62) en analytisk optik, hvorigennem jeg kunne analysere aktiviteterne på teammøderne som en 'fælles diagnostisk aktivitet', hvor mødedeltagerne forsøgte at udfolde forskellige (fragmenterede) storylines og plots om borgerne og det komplekse arbejde. En kollektiv (gen-)fortælling af historier om arbejdet, som anses for normativ i den udstrækning, at fortællinger situerer et eksempel på, hvad der fremadrettet vil blive forstået og belønnet som en succes i fællesskabet. Særligt Humle og Pedersen (2010) bidrog desuden med analytiske greb såsom 'succes'- og 'fiasko'-diagnoser, der bistod mig i analysen af historiefortællingernes normative karakter. Humle og Pedersens (2010) pointe er, at medarbejdere diagnosticerer deres arbejde som enten succes- eller fiaskohistorier for at retfærdiggøre og legitimere deres arbejde. Ved hjælp af den narrative analytiske tilgang var det således muligt at identificere tre idealtypiske historier, der florerede på teammøderne i hjemmeplejen samt de relaterede normer og gruppedynamikker.

I den tredje fase analyserede jeg, hvordan de normer og gruppedynamikker, der kom til udtryk på på teammøderne, påvirkede sosu'ernes forståelse af deres professionalisme og deres oplevelse af at kunne udtrykke sig og dele information i det kollektive faglige rum. Her benyttede jeg især fokusgrupperne, da de gav medarbejderne et talerør til at reflektere over og fortolke deres egen praksis.

Resultatet af de analytiske faser er opsummeret i Tabel 5, og tabellen vil blive udfoldet i to overordnede analysedele. I den første analysedel vil jeg præsentere og eksemplificere de tre idealtypiske historier, jeg identificerede på teammøderne: 'succeshistorien,' 'bufferhistorien' og 'pushhistorien.' De tre typer historier er udvalgt for at synliggøre de forskelligartede (snarere end de mest dominerende) typer af hverdagshistorier, der sameksisterede på teammøderne, med henblik på at vise kompleksiteten i arbejdet, og hvordan denne blev søgt håndteret – sanktioneret og belønnet af henholdsvis sosu'er og terapeuter. I den anden analysedel vil jeg med afsæt i fokusgruppeinterviewene udfolde, hvordan normerne og gruppedynamikkerne påvirkede sosu'ernes forståelse af professionalisme og deres mulighed for at udtrykke sig og dele information i det faglige rum. Personfølsom information og respondenternes navne er anonymiseret i analysen.

	Tre idealtypiske hverdagshistorier/ gruppe-dynamikker fra teammøder				
Fortæller	**Succeshistorien**	**Bufferhistorien**	**Pushhistorien**	**Analytisk pointe**	
Sosu'ers hovedplot om borgeren.	Borgeren er motiveret. Han/hun er blevet mere selvhjulpen og hjælpen er reduceret.	Borgeren er mentalt/fysisk/socialt ustabil og ikke i stand til at blive selvhjulpen.	Borgeren er ikke motiveret. Forventer luksus og opvartning.	Idealtyper, der tilsammen udtrykker kompleksiteten i rehabiliteringsarbejdet (selvom hvert narrativ samtidigt stabiliserer kompleksiteten).	Analyse-del 1
Terapeuternes feedback og narrative teknikker.	Fremhæves og udnævnes som en 'succes'. Der gives anerkendelse og ros.	Aktivt forsøg på at genfortælle borgerens historie ved at fokusere på borgerens ressourcer. Ros er fraværende.	Afventende – understøtter og prioriterer plottet. Der gives af og til ros for entreprenørånd.	Idealtyper, der tilsammen viser, hvordan forskellige 'plots' bliver modtaget og skaber forskellige sanktioner eller belønninger i fællesskabet.	
Eksempel	Jørgen	Anne	Inge og Agnes		
Sosu'ers selvforståelse af professionalisme ift. de tre historier.	Udtrykker, at de føler stolthed.	Udtrykker, at de føler sig angste og bekymrede.	Udtrykker, at de føler sig vrede og omstillingsparate.	Viser sanktions- og belønningssystemets konsekvenser for medarbejderen.	Analyse-del 2

Table 5 Analytiske resultater.

6.8 Tre typer hverdagshistorier fra teammøderne

I den følgende analyse vil jeg illustrere de normer og gruppedynamikker, der udviklede sig i forbindelse med den fælles diagnostiske aktivitet af det rehabiliterende arbejde på teammøderne. Analysen tager udgangspunkt i de tre identificerede idealtypiske hverdagshistorier – succes-, buffer- og

pushhistorier (se Tabel 5). Den ene hverdagshistorie repræsenterer en såkaldt succeshistorie, mens henholdsvis buffer- og pushhistorien repræsenterer forskellige versioner af ikke-succeshistorier. De tre typer hverdagshistorie viser forskellige aspekter af sosu'ernes komplekse arbejde, og hvordan kompleksiteten stabiliseres gennem sosu'ernes plots og den måde, historierne hver især modtages og bearbejdes på i det kollegiale fællesskab, særligt af terapeuten og i skyggen af den omtalte rehabiliteringsvision. Hverdagshistorierne behandles individuelt i analysen og eksemplificeres med udgangspunkt i observationsnoter fra teammøderne om fire konkrete borgere. Historierne florerede dog typisk i deres mangfoldighed på teammøderne.

6.8.1 Succeshistorien

Der var en gennemgående type hverdagshistorier, som ofte i det kollegiale fællesskab fik betegnelsen 'succeshistorier', 'succesoplevelser' og 'solstrålehistorier'. Nedenstående eksempel fra et teammøde illustrerer, hvordan disse historier og forståelsen af succes i rehabiliteringsarbejdet blev skabt og dynamisk stabiliseret gennem sosu'ernes og terapeuternes fælles diagnostiske aktivitet.

Efter en kort samlet status fra gruppelederen tager Ergoterapeuten Heidi over. Hun indleder diskussionen om de individuelle borgere ved at kigge på sosu-medarbejderen Ellie: 'Du har en solstrålehistorie, Ellie!', siger hun med en entusiastisk stemme. Ellie smiler: 'Ja! I morges besøgte jeg Jørgen. Han fik 70 minutters hjælp [før rehabilitering], nu får han 10 – og han siger: 'Ved du, hvad jeg kan? Prøv lige at se her!', og så sprang han ud af sengen – og han var simpelthen så stolt, ... Man står helt med en klump i halsen, og så tænker man: 'Hold kæft, hvor er det godt altså'. Så bliver man da stolt. Det synes jeg var en god oplevelse.

En succeshistorie var, som ovenstående observation illustrerer, kendetegnet ved, at borgeren viste tegn på, at de var blevet mere selvhjulpne gennem medarbejdernes indsats med at rehabilitere dem. Succeshistorierne bekræftede dermed typisk, at øget livsglæde og frihed for de ældre kunne gå hånd i hånd med effektivisering, og at visionen om rehabilitering kunne omsættes i praksis. I eksemplet ovenfor ser vi, hvordan sosu'en Ellie for eksempel fremhæver, at Jørgen ikke kun er blevet mere selvhjulpen og stolt som resultat af træningen, men også at hun har reduceret tiden i hans hjem fra 70 til 10 minutter. Som det også fremgår af eksemplet, var sosu'ernes fremførelse af succeshistorier typisk

tæt forbundet med deres udtryk af personlig tilfredsstillelse og glæde (Humle and Pedersen 2010). Ellie nævner f.eks. selv, at hun er 'stolt' over at kunne leve op til visionen om rehabilitering – det lader til at give hende værdi som medarbejder.

Observationen eksemplificerer ligeledes, hvordan fastsættelsen af succesfuldt arbejde bliver formet af de statusrelaterede dynamikker på teammødet, hvor især terapeuter spiller en vigtig rolle. Ligesom Heidi i eksemplet benyttede terapeuterne på teammøderne typisk en narrativ taktik, hvor de aktivt fremhævede de historier om borgere, der bekræftede rehabiliteringsvisionen, samtidigt med at de navngav dem som en 'succeshistorie'. Dermed blev terapeuterne, i kraft af deres status som eksperter og mødeledere, aktive og magtfulde medskabere af, hvad og hvem der blev defineret og promoveret som en succes i rehabiliteringsarbejdet. En aktivitet, der samtidigt situerede et eksempel for, hvad der fremadrettet ville blive forstået og belønnet som en succes på teammøderne (Downing 1997). Møderne viste således også, hvordan terapeuternes adfærd havde en afsmittende virkning på sosu'erne, der roste hinanden indbyrdes på møderne, hvis succeser med borgerne blev genfortalt eller var blevet observeret af en kollega i et hjem. Teammøderne viste imidlertid, at det ikke var alle historier om borgere, der blev opfattet som succeser.

6.8.2 Bufferhistorien

Der var en anden type hverdagshistorier, som blev delt i det kollegiale fællesskab og tydeligvis ikke gik under betegnelsen 'succeshistorier'. Jeg har valgt at kalde dem bufferhistorier, fordi sosu-medarbejderne i disse historier agerede 'buffer' (Hughes 1958) i forhold til forskellige initiativer til at rehabilitere sårbare borgere. Nedenstående eksempel illustrerer, hvordan denne type historie kom til udtryk gennem den fælles diagnostiske aktivitet på teammøderne:

Ergoterapeuten Mette spørger til, hvordan det går med borgeren Anne. Hun vil gerne vide, om Anne kan stå op, mens hun smører mad. Sosu-medarbejderen Karen svarer: 'Nej, hun har for usikker en balance'. Mette holder fast: 'Hvad nu, hvis der står en stol bag hende, så der ikke er fare for at falde?' Forslaget hverken afvises eller accepteres. Karen siger, at man skal huske at stille stolen ind under køkkenbordet, når man har været hos Anne, for det kan hun ikke selv. Hun sagde, sidst jeg var der: 'Hvor er det dejligt, at du stiller stolen ind, det er der andre, der ikke gør. Og jeg kan ikke selv'. Mette

siger: 'Det kunne der jo også være træning i at gøre'. Karen svarer afvisende: 'Stolene er ikke egnet til træning'.

Historien om borgeren Anne er et eksempel på, hvordan information om borgerens mentale, sociale og/eller fysiske sårbarhed blev fremhævet af sosu'erne i bufferhistorierne som en barriere for at gøre borgerne selvhjulpne. For eksempel ser vi sosu'en Karen fremhæve, at Anne har en dårlig balance, og at hendes hjem ikke er indrettet til, at hun kan trænes på en ansvarlig måde. Generelt fremhævede sosu'erne i lignede historier, at borgerne f.eks. var meget gamle, havde en kronisk sygdom (KOL), lige var blevet opereret (f.eks. havde fået en ny hofte) eller var mentalt ustabile (f.eks. alkoholikere eller Alzheimerpatienter). Ved at fremhæve denne sårbarhed satte bufferhistorierne, i modsætning til succeshistorierne, (indirekte) spørgsmålstegn ved, om visionerne om rehabilitering kunne indfries i praksis ift. kerneopgaven. Det vil sige, i hvilken udstrækning rehabilitering kunne gøre sårbare borgere selvhjulpne og sikre dem en bedre livskvalitet.

Som det fremgår af eksemplet, indtog terapeuterne typisk en anden rolle i bufferhistorierne end i succeshistorierne. Vi ser, at terapeuten Mette også bliver medfortæller af Annes historie, men i modsætning til succeshistorierne roser Mette ikke Karen for hendes observation af Annes sårbarhed. Snarere tværtimod ser vi, at Mette, som andre terapeuter på teammøderne, reagerer på denne type historie ved at forsøge at benytte en narrativ taktik til at ændre Karens plot om Anne. Det gør hun ved selv at fokusere på Annes potentielle ressourcer og træningsmuligheder. Typisk for bufferhistorierne kunne terapeuterne også foreslå, at de kunne tage med ud til borgeren for at se, om der var nogle oversete træningsmuligheder, eller direkte fremhæve, at sosu'ernes fortællinger undrede dem, fordi de selv havde oplevet, at borgeren f.eks. kunne gå i bad, når de selv var tilstede. Møderne viste, at stemningen blev relativt dårlig i relation til bufferhistorierne. I eksemplet ovenfor ser vi f.eks., at Mettes forsøg på at re-diagnosticere Anne resulterer i, at Karen aktivt afviser Mettes forslag og agerer buffer eller 'advokat' (Christensen et al. 2014) for Anne. Terapeuternes narrative taktik ift. bufferhistorierne situerede således i fællesskabet et eksempel på, at de som eksperter ikke umiddelbart anerkendte (eller i hvert fald ikke belønnede) argumenter om borgernes sårbarhed og manglende selvhjælpspotentiale.

6.8.3 Pushhistorien

Der var en tredje type hverdagshistorie, som blev delt i det kollegiale fællesskab. Denne betegner jeg 'pushhistorien'. Pushhistorierne var lige som bufferhistorierne ikke-succeshistorier, men de fremstod alligevel som en anden type historier. Dels fordi sosu'erne i disse historier fremhævede andre informationer om borgerne – primært borgernes manglende motivation – samt agerede drivkræft i forhold til at 'pushe' og tage nye initiativer overfor borgerne, og derudover fordi terapeuterne reagerede anderledes på denne type historier. Som de to nedenstående eksempler illustrerer:

Ergoterapeuten Helene spørger, hvordan det går med Inge. En sosu-medarbejder, Karin, siger, at hun har vanskeligt ved at motivere hende til at vaske op. Hun fremhæver, at hun i øvrigt mener, at det er for galt i disse besparelsestider, at de kommer hos folk 'bare for at ryste dyner' [hvilket hun tilsyneladende mener, de gør hos Inge]. 'Det er jo ren luksus', konstaterer hun. Helene nævner, at hun allerede har taget mange ydelser fra Inge, og at hun 'er meget sur' på hende. En anden sosu-medarbejder, Lene griner 'Ja, hun kan slet ikke lide dig'. Karin fortsætter: 'Jeg har brugt rigtig mange indgangsvinkler [til at motivere Inge], men jeg tror, at hun godt kan lide at have os. Lene tilføjer: 'Hun elsker også at snakke. Hun snakker lige fra man kommer, og så kan hun en masse - købe ind, eksempelvis'. Helene kigger på Lene og Karin: 'Skriver I ned, hvad hun kan? Det er jo dokumentation for, at hun ikke er berettiget til hjælpen'. Lene siger: 'Jamen hun kan kun købe små ting ind, f.eks. Billed-Bladet – jeg tror ikke, hun kan købe store ting'. 'Nej', tilføjer Karin, 'fliserne ligger ikke så godt for hendes rollator. Men hun kan altså godt vaske op.'

Terapeuten Heidi spørger til en anden borger, Agnes: 'Bliver hun stadig liggende i sengen, hvis ikke der kommer nogen?' 'Ja', det mener sosu'erne. En af dem, Sasha, tilføjer dog: 'Selvom hun smutter ud af sengen, så snart hun ser os'. Heidi nævner, at Agnes jo også har fået lykkepiller, og at hendes adfærd kan hænge sammen med det. En af sosu'erne, Charlotte, foreslår, at de kommer på forskellige tidspunkter for at se, om hun så står op. 'Det har vi prøvet', siger en af de andre. Charlotte spørger: 'Har I tilbudt hende aktiviteter?' 'Nej', siger Sasha og tilføjer, 'hun er inkontinent og lugter af tis'. Maria, en anden sosu-medarbejder, nævner, at Agnes godt kan lide at lave 'sin egen rede inde i sengen med frugt osv.', men Maria undrer sig over, hvorfor de skal sætte frugt frem, når Agnes 'godt selv kan gå på toilettet'. Charlotte pipper: 'Det lyder jo heller ikke som om, hun har noget at stå op til'. Heidi

konstaterer, at 'borgeren nok har brug for et skub' og foreslår, at medarbejderne ringer til hende og siger, at de kommer om halv time, og om hun ikke er gået i bad og har lavet kaffe til, når de kommer.'

Historierne om Agnes og Inge eksemplificerer, hvordan borgerens manglende motivation fremhæves af sosu'erne som en barriere for at gøre dem selvhjulpne i pushhistorierne. For eksempel ser vi, hvordan sosu-medarbejdere overvejende fremhæver informationer om de aktiviteter, borgerne kan, f.eks. gå på toilettet, tale løs og vaske op. Disse informationer bliver, som i lignende pushhistorier, brugt som tilløb til at problematisere, at borgeren får hjælp, enten fordi borgeren ikke er villig til at udføre opgaven selv eller får hjælp til opgaver, f.eks. til at ryste dyner eller til at få en frugtskål, som medarbejderne mener er 'luksus' ift. deres vurdering af borgernes evner. Ræsonnementet lader til at være, at borgerne godt *kan*, men ikke *vil* være selvhjulpne. Ved at fremhæve informationer om borgerens potentielt manglende motivation for at blive selvhjulpne synliggjorde sosu'erne, lige som i de føromtalte bufferhistorier, at rehabilitering gav anledning til ikke-intenderede resultater, og at visionen ikke altid kunne omsættes i praksis. Modsat bufferhistorierne benytter sosu'erne dog ikke informationerne som en anledning til at agere 'buffere' ift. udmøntningen af visionen. Snarere tværtimod bliver deres indignation og frustration over borgerens adfærd et afsæt for forslag om at intensivere og 'pushe' indsatsen (f.eks. tage mere hjælp væk fra borgeren), fordi borgerens adfærd tilsyneladende ikke opfattes som moralsk i orden.

Som det fremgår af eksemplet, indtog terapeuterne en anden mere tilbageholdende rolle i forhold til pushhistorierne, end bufferhistorierne. Deres tilbageholdende rolle havde dog en vigtig signalværdi i fællesskabet. Ved at indtage denne rolle demonstrerede de indirekte, at de var mere 'tilfredse' med sosu'ernes diagnose af borgeren som umotiverede end sårbare. Dette tydeliggøres også af den mere subtile narrative taktik terapeuterne benytter i hverdagshistorierne om Agnes og Inge. Vi ser således, hvordan der hersker konkurrerende information om Agnes og Inges tilstand. Primært om deres problem er manglende motivation, eller snarere at Agnes er inkontinent og mentalt sårbar og Inge er fysisk sårbar (bruger rollator). Frem for at åbne op for en dialog om denne usikkerhed ser vi terapeuterne støtte op om én dominerende diagnose, nemlig at borgeren har et motivationsproblem. For eksempel konkluderer Heidi, at Agnes sikkert har brug for et 'skub', mens terapeuten Helene opfodrer sosu'erne til at dokumentere de ting, som Inge ikke kan (med henblik på at tage flere ydelser fra hende). Med andre ord synliggør terapeuterne dermed på møderne, at de prioriterer og belønner 'motivations'-forklaringer (pushhistorier) på bekostning af 'sårbarheds'-forklaringer (bufferhistorier).

Overordnet illustrerer de tre typer historier, at selvom rehabiliteringsvisionen opererer med en relativt homogen karakteristik af borgeren, så oplever sosu'erne borgerne som en heterogen gruppe. Sosu'erne møder borgere som Jørgen, som både kan og gerne vil være selvhjulpne (og som dermed lever op til rehabiliteringsvisionen), men også borgere som Anne, Inge og Agnes, der vurderes som værende for mentalt, fysisk eller socialt sårbare - eller blot umotiverede - til at blive selvhjulpne (og dermed ikke umiddelbart lever op til visionen) (se Tabel 5, række 1). Historierne illustrerer ligeledes, at terapeuterne benytter forskellige narrative teknikker afhængig af sosu'ernes plot om borgerne, og at historierne dermed ikke modtages og belønnes ens på møderne. Plots om borgere som Jørgen fremhæves og udnævnes som en succes. Omvendt forsøges buffer-plottet om sårbare borgere som Anne genforhandlet og genfortalt. Endelig udgør pushhistorier om borgere som Inge og Agnes en interessant middelvej, fordi terapeuterne forholder sig mere afventende, og plottet om den umotiverede borger, der skal 'pushes', accepteres (se Tabel 5, række 2).

6.8.4 Faglig ensretning: Historier som bærere af belønninger og sanktioner

I den følgende analyse udfoldes gennem data fra fokusgrupperne, hvordan de normer og gruppedynamikker, der bl.a. blev etableret på teammøderne, påvirkede sosu'ernes forståelse af deres professionalisme og den mulighed og risiko, der var forbundet med at udtrykke sig og dele information i det faglige rum.

Fokusgrupperne viste generelt, at hverdagshistorierne blev genfortalt uden for teammøderegi – især succeshistorierne (selvom disse ikke fremkom hyppigere end de andre på teammøderne), og at sosu'erne forbandt det at opnå og dele, hvad der blev defineret som en succes i fællesskabet, med anerkendelse og belønning. Som følgende fokusgruppedialog udfolder:

> *Karin (Sosu): "(…) Det er blevet, i hvert fald for mig, sjovere at gå på arbejde."*
>
> *Interviewer: "Hvordan?"*
>
> *Birte (Sosu): "Det, at man kan mærke, at der sker noget. At man kan mærke, at man faktisk gør en forskel. Og at man kommer dertil, hvor hun [en borger] ikke kunne det og det – og nu kan hun (…). Altså ja, jeg synes da, at det giver noget selvtillid."*

Som citatet illustrerer, havde medarbejderne i vid udstrækning internaliseret retorikken i rehabiliteringsvisionen; at det, 'bare' at komme og kompensere borgeren, generelt ikke (længere) blev associeret med at gøre en professionel forskel. Sosu'erne udfoldede således, at det, at gøre borgerne selvhjulpne, gjorde dem stolte og gav dem selvtillid, fordi det i tråd med rehabiliteringsvisionen blev kædet sammen med en opfattelse af at udrette noget i arbejdet og gøre en positiv professionel 'forskel'. En belønningsforståelse, som vi også så, at teammøderne understøttede, og som samtidigt forklarer den gode stemning og umiddelbare glæde, der var forbundet med at dele og promovere succeshistorierne på teammøderne.

Omvendt viste fokusgrupperne, at nogle få sosu'er gav udtryk for, at det, at dele bufferhistorier og give udtryk for information og faglig viden om borgerens sårbarhed, omvendt var svært i det kollegiale fællesskab. Som citatet nedenfor eksemplificerer:

> *Joanna (Sosu): "At jeg har oplevet succes har givet mig mod på at fortsætte [med rehabilitering] (...). Men jeg kan også blive ked af det på borgerens vegne. Nu har vi en bruger, der, fordi hun selv kan gå ud, ja, så skal ydelsen tages fra hende. For 'så kan hun selv'! [slår i bordet]. Det har jeg det skidt med i forhold til min faglige stolthed. Og mine observationer siger mig, at det er fordi, jeg kommer om morgenen og laver morgenmad til hende, at hun har overskud til at gå ud om eftermiddagen (...) Og jeg ved, at hvis vi tager hjælpen fra hende, så ryger hun ned med nakken. Nu bliver jeg helt rørt... Og ja, så kan vi samle hende op bagefter – og hvad er værdien så ved at tage det fra hende?"*

Citatet illustrer, at nogle få sosu'er som Joanna sætter spørgsmålstegn ved rehabiliteringsantagelsen om, at det, at gøre borgerne selvhjulpne (tage hjælp fra dem), nødvendigvis – i alle situationer - både ville øge borgerens livskvalitet og effektiviteten af arbejdet. Johanna fremhæver eksempelvis risikoen for, at særligt sårbare borgeres 'overskud' i hverdagen (livskvalitet) kan forringes ved, at man tager hjælpen fra dem, og at omkostningerne kan stige, hvis borgerne ryger 'ned med nakken' og skal 'samles op igen', fordi der, som hun uddyber i interviewet, tænkes i 'her og nu'-besparelser ift. rehabilitering. Joannas oplevelse er interessant, fordi hun viser, at det er følelsesmæssigt krævende at fremhæve denne pointe i det kollegiale fællesskab. Hun bliver rørt og har tilsyneladende behov for at

understrege, at hendes pointe bygger på hendes 'observationer' og 'faglige stolthed'. Det er desuden vigtigt for hende at fremhæve, at hun også har oplevet succeser og ikke per se er imod rehabilitering. En reaktion, der vidner om, at dette faglige budskab, relateret til bufferhistorierne, krævede retfærdiggørelse og var svært at trænge igennem med i det kollegiale fællesskab, fordi det, som teammøderne også anskueliggjorde, var forbundet med en risiko for, at Johanna vil møde modstand og blive sanktioneret.

Fokusgrupperne uddyber ligeledes, hvorfor pushhistorierne, selvom de var ikke-succeshistorier, blev prioriteret på bekostning af bufferhistorierne og var nemmere at dele i fællesskabet. Diskussionerne i fokusgrupperne tegnede således et billede af, at medarbejderne, ved at vise deres vrede i stedet for omsorg overfor borgerne på møderne, signalerede, at de var villige til at gøre en ekstra ordinær 'professionel' indsats for at konvertere ikke-succes til succeshistorier. Succeshistorierne handlede således ofte om at overkomme egne og kollegaers 'forudindtagethed' om borgernes sårbarhed samt om kampe med borgeren, der i sidste ende resulterede i succes. Som et eksempel:

> *Anette (Sosu): "Jeg har været gennem forløb med borgere, der starter med at skælde ud, til at de i dag takker mig for at få livet igen."*
>
> *Hanne (Sosu): "Man skal også passe på med ikke at sætte folk i en eller anden bås på forhånd. Vi havde en borger, der måske kunne trænes til at bruge støttestrømper, og vi havde jo rundet det i gruppen, og vi var helt enige om, at han ikke kunne klare at lære at tage støttestrømper på, for kropsligt, var han så stor, at det… Men så på et tidspunkt var der noget med, at han så skulle køre et barnebarn i skole inde i [nævner by] – og så kunne han ikke få hjælp på det tidspunkt, hvor det passede ind, og så var der nok en eller anden, der havde nævnt: Der er jo også mulighed for prøve det [rehabilitering] af, og det var han helt med på, og han skulle bare se det en gang, så kunne han, så man skal sådan lige lade tvivlen komme borgeren til gode."*

Som vi ser ovenfor, udtrykte sosu'erne en glæde over at have løst en opgave, der i udgangspunktet så svær og umulig ud. Ræsonnementet viser, at det blev fremhævet i fællesskabet, at et aktivt forsøg på at undertrykke nervøsiteten for borgerens sårbarhed kunne være selve præstadiet til at opnå de eftertragtede succeshistorier, og at det dermed var i borgerens egen interesse at 'pushe' dem. Samtidigt

kunne medarbejderne benytte pushhistorierne til at legitimere fraværet af succes ved, gennem 'vreden', at attribuere deres manglende succes til borgere, der ikke gad støvsuge og vaske op, eller til kollegaer, der blev ved med at nurse og agere stødpude for borgerne. Sidstnævnte blev ofte (patroniserende) omtalt som medarbejdere, der havde et stort 'traditionelt omsorgsgen' eller 'moderligt hjerte', og som gjorde borgerne en bjørnetjeneste ved at synes, det var 'synd' for dem og dermed vænne dem til hjælp. En tilvænning, der blev anset som en barriere for motivationsarbejdet. Ved at fremføre pushhistorien var sosu'erne, som teammøderne også demonstrerede, med andre ord ikke, som Joanna, i farezonen for at blive sanktioneret fællesskabet, fordi de synliggjorde, at deres intension var i tråd med normen.

Analysen illustrerer dermed ,at sosu'erne viser tydelige tegn på, at normerne og gruppedynamikkerne påvirker deres professionelle selvforståelse og motivation for at dele information i fællesskabet. De relaterer en positiv følelse af stolthed og belønning til deres succeshistorier, mens de forbinder negative følelser såsom nervøsitet og vrede med at dele ikke-succeserne (se Tabel 1, række 5). Dog er det tilsyneladende lettere at dele push-plottet end buffer-plottet i fællesskabet, fordi dette plot i højere grad er i overensstemmelse med normerne i fælleskabet.

6.9 Konkluderende diskussion

I denne artikel har jeg undersøgt de hverdagshistorier, der bliver delt på teammøder i hjemmeplejen i forbindelse med introduktionen af en ny rehabiliteringsvision. Det er sket med henblik på at få et indblik i de normer og gruppedynamikker, der udvikler sig på teammøderne, samt hvordan disse påvirker mulighederne for at skabe en faglig dialog om det komplekse hjemmeplejearbejde. Gennem et analytisk fokus på tre forskellige typer hverdagshistorier fra teammøderne er det blevet belyst, hvordan sosu'ernes fortællinger afspejler rehabiliteringsarbejdets kompleksitet, men også hvordan denne kompleksitet bliver stabiliseret og reduceret ved hjælp af en række 'plots' om borgernes tilstand og normer om, hvad der udgør og ikke udgør en succesfuld professionel forståelse og håndtering af arbejdet. En proces, der i høj grad er formet af statusrelaterede gruppedynamikker på teammøderne, hvor især terapeuternes feedback på sosu'ernes historier om arbejdet asymmetrisk fordeler belønninger og sanktioner. Der er tale om normer og gruppedynamikker, der tilsammen bevirker, at den faglige dialog om arbejdet med de enkelte borgere ofte ensrettes og kompleksitetsreduceres. Dermed bidrager artiklen til forståelsen af og forskningen i teams i tre henseender.

For det første bidrager artiklen ved at udfordre antagelser i mainstream-ledelseslitteraturen og i den offentlige debat, hvor tværfagligt samarbejde og teammøder fortsat hyldes i den aktuelle moderniseringsbølge. Her ses de som svaret på, hvordan faglig vidensdeling, kvalitet og effektivitet kan højnes i arbejdet. Artiklen problematiserer imidlertid, om potentialet for at skabe kollegial dialog om arbejdet med indførelsen af nye teammøder i hjemmeplejen reelt udnyttes. Analysen viser således, at 'dialogen' imellem især sosu'erne og terapeuterne på teammøderne snarere ser ud til at ensrette og kompleksitetsreducere arbejdet fremfor at åbne op for den usikkerhed og kompleksitet, der præger det rehabiliterende arbejde. På den ene side kan denne ensretning anskues som afgørende for, at medarbejderne kan navigere og handle i arbejdet og ikke går til i kodekaos og forskellige konkurrerende logikker og hensyn, der præger social- og sundhedsarbejdet (Rennison 2014). Og set fra dette perspektiv kan ensretningen, som også typisk anbefales i ledelseslitteraturen, godt opleves som en optimering af kvaliteten og effektiviseringen af arbejdet. På den anden side viser analysen dog, at ensretningen af den faglige 'dialog' på teammøderne i hjemmeplejen er præget af én vision om succesfuldt arbejde og af det faglige hierarki mellem terapeuter og sosu'er. Succes i arbejdet reduceres dermed til visionen om rehabilitering og medarbejdernes evne til kæde to hensyn sammen: hensynet til livskvalitet og effektivitet. Medarbejdere, der sætter spørgsmålstegn ved eller udfordrer denne vision, risikerer sanktioner fra både deres kollegaer og mellemledere og kan blive stemplet som 'traditionelle' eller 'uprofessionelle'. En ensretning, der kan problematiseres, hvis man som Monrad (2010) argumenterer for, at muligheden for at kunne udtrykke faglig uenighed er en væsentlig forudsætning for at fagligheden højnes i socialt arbejde, hvor kerneopgaven er centreret om arbejdet med mennesker og per definition *er* komplekst, uforudsigeligt og fejlbarligt (Hughes 1958; Strauss et al. 1997). På teammøderne lukkes der nemlig ned for en dialog om, i hvilke tilfælde rehabiliteringsvisionen kan forenes med kerneopgaven - arbejdet med ældre mennesker med forskelligartede problemstillinger. I stedet individualiseres et potentielt misforhold mellem den abstrakte vision og arbejdet, da misforholdet forbindes med den enkelte medarbejders faglige uformåenhed og attitude. I tråd med kritisk ledelsesteori (Barker 1993; Du Gay and Morgan 2013) viser analysen således, at selvom teammøderne reelt skaber mulighed for, at sosu'erne entusiastisk kan dele information om arbejdet og glæden ved at opnå succes med deres kollegaer, så indsnævrer møderne ligeledes på paradoksal vis kontrollen af, hvad der kan og må defineres som en professionel succes. En kontrol, der ikke kun kan

give anledning til negative følelser blandt medarbejderne, men også potentielt får negative konsekvenser for håndteringen af kerneopgaven.

Artiklen bidrager ligeledes til kritisk ledelsesteori ved at benytte en narrativ analytisk optik, fremfor at benytte abstrakte koncepter og generiske analyser af teamsamarbejde. Denne optik gør det muligt at gå helt tæt på de dynamiske, flertydige og relationelle aspekter af, hvordan normer samt belønnings- og sanktionssystemer, vedrørende løsningen af det komplekse hjemmeplejearbejde, etableres på team-møderne. Ved at anskue teammøderne som et forum, hvor et netværk af hverdagshistorier om det rehabiliterende arbejde fortælles og genfortælles gennem en kollektiv diagnostiske aktivitet (Orr 1998), er det muligt at vise, hvordan de specifikke historier og plots om borgerne belønnes og sanktioneres forskelligt, og at det er i denne proces, normerne om succes og ikke-succesfuldt arbejde spredes/etableres, og dialogen ensrettes. Set fra et narrativt perspektiv (Downing 1997; Boje 1991) sker denne ensretning, fordi nye begivenheder i arbejdet med borgerne typisk over tid vil bliver farvet og forstået i lyset af de historier, der er gået forud for disse begivenheder. Det vil sige, at medarbejderne i teamet 'lærer' på møderne, hvilken type fortælling de i fremtiden vil blive belønnet for at synliggøre i teamet (og hvilke de bør fortie, hvis de vil undgå sanktioner). Et system, som analysen illustrerer skaber et normativt pres for at medarbejderne fortæller succeshistorier på møderne og konvertere ikke-succeshistorier til succeshistorier. Analysen nuancerer ligeledes, gennem denne situerede optik, kritisk ledelsesteoris forståelse af selve karakteren af belønnings- og sanktionssystemer. Mens f.eks. Barker (1993) fokuserer på, hvordan team-normer henholdsvis belønner de medarbejdere, der tilpasser sig normerne, og sanktionerer de, der ikke gør, fremstår især pushhistorierne som en interessant gråzone. Pushhistorierne demonstrerer, at man som team-medlem godt kan tilpasse sig normerne, selvom man skaber et resultat, som teamet ikke umiddelbart anerkender som en succes. Som analysen viser, giver fortælleren i pushhistoeriene udtryk for, at de ønsker at leve op til normerne i teamet ved bl.a. at bebrejde de umotiverede borgere for at være kilde til ikke-succesen. Et narrativ, som imodsætning til andre ikke-succeshistorier (bufferhistorierne) i bred udstrækning godtages og bakkes op i teamet. Ifølge arbejdssociologien (se f.eks. Pedersen 2013) kan denne dynamik, hvormed en type ikke-succeshistorie (pushhistorier) godtages i teamet - og prioriteres på bekostning af andre typer ikke-succeshistorier (bufferhistorier) forstås i lyset af det fejlbarlige social-og sundhedsarbejde. Inden for denne type arbejde skelnes der nemlig mellem forskellige typer fejl. Fejl, hvor medarbejderen har fulgt

fællesskabets normer (push-plot) vil typisk blive accepteret og tilgivet i det kollegiale fællesskab, mens såkaldte moralske fejl (buffer-plot), der typisk bryder med fælleskabets normer, vil blive sanktioneret i fællesskabet. Pushhistorie-begrebet kan således have relevans for fremtidige studier af teamsamarbejde i social- og sundhedsarbejde.

En praktisk implikation af analysen vedrører, hvordan og hvorfor ledelsen har en afgørende betydning for, om den faglige dialog højnes i teams. Analysen viser, hvordan terapeuterne på teammøderne fremmer og kultiverer en ensretning af dialogen gennem teknikker, der reducerer arbejdets kompleksitet. Disse kompleksitetsreducerende teknikker, som Rennisons (2014) betegner som ledelsesmæssige 'af-paradokseringsstrategier', kan som nævnt være nødvendige for at skabe handlemuligheder. Rennison påpeger imidlertid, at det er afgørende, at ledelsen også benytter 're-paradokseringsstrategier', der producerer kompleksitet og bringer paradokser og værdipluralisme frem i lyset, hvis alsidigheden af arbejdet skal bevares, og der skal gives plads til faglig uenighed. Hvis målet er at fremme en alsidig faglig dialog, må ledelsen dermed spille en afgørende rolle i ikke kun at (over)promovere og stabilisere ideer om succes, men også i at åbne op for arbejdets kompleksitet og usikkerhed, f.eks. hvori 'gabet' mellem en abstrakt vision og en individuel borgers situation ligger. Det kræver dels, at mellemledere såsom terapeuterne fremadrettes undervises i, hvorfor kompleksitetsreduktionen af dialogen kan være problematisk. Her kunne Janis (1972) klassiske anbefalinger for at undgå 'groupthink' være behjælpelige. Særligt anbefalingerne om 1) at mindst et (skiftende) gruppemedlem skal have rollen som 'djævlens advokat' ved hvert møde, 2) at ledelsen ikke skal udtrykke sin mening, når den tildeler gruppen en opgave, og 3) at alle alternativer skal vurderes. Derudover kræver det, at de ressourcemæssige (eksempelvis tid) og politiske rammer for teammøderne understøtter kerneopgaven. I hjemmeplejen er terapeuterne imidlertid under et politisk pres for at fremvise resultater i forbindelse med rehabilitering, og da økonomiske besparelser er mest synlige og målbare, er det ofte dem, der fokuseres på. Både styrkerne og svaghederne ved dette studie ligger imidlertid i dets identifikation af narrative teknikker, der af-paradokserer arbejdets kompleksitet. Det er således op til fremtidig forskning at undersøge, hvordan strategier til at re-paradokserer arbejdet (Rennison 2014) kan skabes i forbindelse med teamorganisering.

Slutnoter

[i] Det Nationale Forskningscenter for Arbejdsmiljø har bl.a. forsket i sosu'ernes arbejdsmiljø i projektet 'Arbejde i ældreplejen,' der bl.a. omfatter etableringen af en kohorte af sosu'er (http://www.arbejdsmiljoforskning.dk/da/projekter/arbejde-i-aeldreplejen---for-sosu/formaal)

[ii] I Danmark er 133.000 af de 158.000 borgere, der modtager hjemmehjælp, over 65 år med en gennemsnitsalder på 81,7 år. I 2009 havde 25 % af hjemmehjælpsmodtagerne enten en mental eller neurologisk sygdom. Generelt lider 66 % af den danske befolkning over 75 år af en kronisk sygdom (hjemmehjælpskommissionen, 2013).

[iii] Alternativt var det en sygeplejerske (gruppeleder) og en terapeut i samspil, der superviserede teammøderne.

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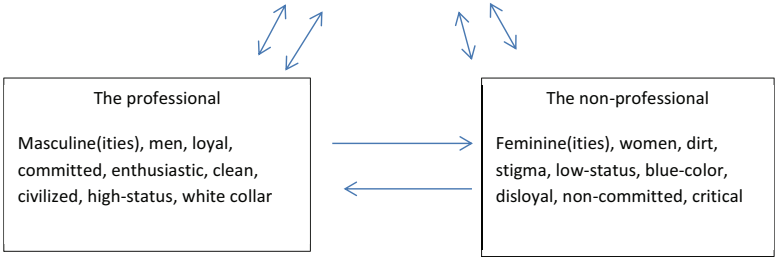
CHAPTER 7:

PRACTICING BOUNDARIES OF PROFESSIONALISATION



Article 3: Gender Stereotypes and the Reshaping of Stigma in Rehabilitative Eldercare

7.1 Short introduction to the article

The third analytical topic on which I focus in my conceptualization of how boundaries of professionalization are discursively and materially constituted in rehabilitative home care organizations will be presented in this chapter. More specifically, in this chapter I present my first article on how professionalization processes and, by implication, marginalization processes are *practiced* through the introduction of new techniques and tools in rehabilitative home care organizations. The article was presented at the 8th Biennial International Interdisciplinary Conference, Keele University, in June 2014; stream: Bodies and intimate relations at work. It was submitted to the journal Gender, Work & Organization in March 2015 and publiched in Volume 24, Issue 6, Copyright © 2017 (http://onlinelibrary.wiley.com/doi/10.1111/gwao.12191/abstract). The following version is an identical version of that article.

7.2 Abstract

Rehabilitation policies are becoming increasingly popular in eldercare as a means to ensure dignity and reduce costs. This article examines the implications of rehabilitation within Danish homecare work, a type of work that is often stigmatized due to its associations with low-status 'dirty' body work in old people's homes. The article combines two research traditions: studies of dirty work and studies of body work. It draws on observations and focus groups in Denmark to explore how the introduction of rehabilitation changes the work of care workers, and how such changes are associated with a potential reshaping of stigma. In contrast to previous research, this article shows that although rehabilitation was partly introduced to reduce stigma of this type of work, the practice of rehabilitation paradoxically reinforces the stigma that it attempts to manage. Thus, the analysis helps to improve our understanding of the ambiguous and varying ways rehabilitative eldercare reshapes and reinforces stigma and gender stereotypes among women who do 'dirty' body work.

Keywords: **body work, dirty work, gender, rehabilitative eldercare, stigma**

7.3 Introduction

I see rehabilitation as a completely different way of approaching the citizen, a new way to provide care . . . I tell my employees, 'Listen, what we need to do here is look at the citizen who is sitting in a wheelchair without legs and avoid thinking, "Oh, I feel so sorry for him, how can we help him?" Instead, we should think, "Wow, he has two arms — what can we use them for?"' That is a good image of a paradigmatic change [in homecare]. (Lisa, Manager)

Rehabilitation is a policy that exists under various labels, such as 'reablement' and 'restorative care'. Rehabilitation has been expanding in the homecare industry across western countries, such as in England, the US and Scandinavia (Gustafsson et al., 2010; Kjellberg et al., 2011; Social Care Institute for Excellence, 2010). Rehabilitation strives to change the approach towards older people and thus focuses on mobilizing, activating and training them to become self-sufficient in their own homes. The intention is to improve the quality of homecare services while lowering their costs. As Katz (2000: 135) notes, 'The association of activity with wellbeing in old age' is not novel within gerontological circles. The dominant assumption within these circles is that it is in the best interests of older and/or infirm people to be perceived as a resource and to be self-sufficient rather than remaining dependent on, what is commonly cited as, expensive and morally questionable nursing and hands-on services. Nevertheless, only recently have we seen a radical expansion of rehabilitation in homecare. In the Danish context, this change began with a single publicly funded homecare organization that introduced the policy in 2008. Since then, rehabilitation has spread to the rest of the country. In the quote above, Lisa, a middle manager in a Danish homecare organization, implies that homecare work is in transition due to the introduction of rehabilitation. Lisa explains that rehabilitation endeavours should shift the attention of care aides from notions of 'feeling sorry for' and 'helping' older people to an approach in which older people's resources and potential are empha- sized. At first glance, this outlook seems promising and non-controversial. However, although some studies point in the direction that short-term savings have been achieved (Kjellberg et al., 2011), very little is known about the long-term prospects or how rehabilitation actually affects homecare work and workers.

Domestic and personal homecare work that is performed by mainly women in older people's own homes has traditionally been associated with stigmatized 'dirty' body work. Dirty work refers to 'task[s] and occupations that are likely to be perceived as disgusting or degrading' (Ashforth and

Kreiner, 1999: 413). Body work, in contrast, refers to work that involves the bodies of others (Twigg et al., 2011; Wolkowitz, 2006). Homecare workers risk being stigmatized due to their work because of the 'dirty' associations of body tasks that involve touching unpleasant, deteriorating, aged bodies and bodily waste, such as faeces and vomit (Ashforth and Kreiner, 1999; Twigg et al., 2011; Wainwright et al., 2011). Furthermore, homecare workers' risk of being stigmatized is also related to an over-representation of low-paid female workers with little formal training who perform the associated 'dirty' body tasks1 (England and Dyck, 2011; Knijn and Verhagen, 2007). Homecare workers who lack the status shield offered by higher level qualifications are most affected, but Knijn and Verhagen (2007) argue that even more highly qualified staff risk being undervalued when their work is conflated with that of workers without professional qualifications (see also England and Dyck, 2011 and Jervis, 2001). In this context, body workers whose jobs involve 'dirty work' may use a range of gendered techniques to manage their risk of stigmatization and to secure professional honour and dignity. Body workers who more or less consciously worry about the stigma of body work may attempt to manage stigma through adopting gendered, discursive techniques to reframe their work in more positive ways (Bolton, 2005) and/or material 'distancing techniques' as a way to frame the body and transfer its polluted aspects to lower-status workers (often women) (Twigg et al., 2011: 5; Wainwright et al., 2011). However, insufficient attention has been paid to how these techniques are related to new policies and their potential implications for workers and the associated stigma.

Studies on dirty work and body work have tended to single out stable and uniform techniques associated with 'occupational ideologies' (Ashforth and Kreiner, 1999: 421) and/or workers' education (Twigg et al., 2011; Wainwright et al., 2011). However, little is said about how the techniques might be related to new external policies. This is the case despite the findings of governance literature (Dean, 2006; du Gay, 2008; Rasmussen, 2004; Thomas and Davies, 2005) that public service organiza- tions are targets of new policies under labels such as new public management or rehabilitation. Furthermore, it seems problematic that the notion of management is repeatedly used in dirty work and body work studies as it implies that the techniques intended to manage stigma are successful (in securing workers' dignity) when, in fact, some important exceptions suggest that they may cause emotional distress and/or reinforce gender stereotypes (Johnston and Hodge, 2014; Lemmergaard and Muhr, 2012).

To address these shortcomings, this article explores the dynamic and ambiguous implications of the introduction of a nationally celebrated rehabilitation policy for Danish homecare work and the potential stigmatization of the workers. The study draws on data from focus groups with mainly women homecare workers (nurses, occupational therapists and care aides) as well as observations of their work in five homecare organizations that recently introduced rehabilitation. I found that rehabilita- tion, under the rubric of personal independence for older people and professional dignity, introduced what seemed to be uplifting new ways of articulating and practicing body work. At the same time, I found that rehabilitation paradoxically reinforced the stigma associated with 'dirty' deteriorating bodies and the female workers who work with these bodies. Thus, this article contributes theoretically and empirically to the study and reconceptualization of gendered stigma management. On the one hand, it shows how promising new rehabilitation policies may serve as techniques to reshape stigmatized aspects of 'dirty' body work in eldercare. On the other hand, it notes that in reshaping stigmatized aspects, rehabilitation techniques risk reinforcing that very stigma. The insights garnered from this study may have important implications given the ongoing celebration and expansion of rehabilitation policies in western homecare organizations (Kjellberg et al., 2011; Social Care Institute for Excellence, 2010).

The article is structured as follows. First, I review and connect the dirty work and body work literature while introducing my analytical lens to explore how stigma is reshaped in ambiguous ways in rehabilitative eldercare. Following the methodology section, I present a narrative from the observations to illustrate the situated ways in which the introduction of rehabilitation by higher status occupational therapists to care aides and older people leads to disagreement over the approach that should guide the work. I then unpack the ambiguous implications that are created when occupational therapists' and nurses' attempts to resolve the disagreement by imposing and enhancing rehabilita- tion and the ramifications for care aides and older people and their associated stigma. Finally, I discuss the findings.

7.4 Stigma of dirty body work

Dirty work is the 'work that most people, given a choice would prefer not to do' or would find 'unpleasant and undesirable' (Chiappetta-Swanson, 2005: 94). Drawing on the work of Goffman (1963) and Hughes (1958), Kreiner et al. (2006, 2007) elaborate on why some types of work are

associated with dirt, or what they refer to more broadly as stigma. They argue that work becomes stigmatized when it is commonly viewed as 'physically, socially or morally tainted' (Ashforth et al., 2007: 149). Furthermore, they propose that workers who undertake these stigmatized tasks risk 'the perceived taint of the dirty work' being projected onto them 'so that they are seen to personify the dirt' or stigma (Ashforth and Kreiner, 1999: 415). For the purposes of this article, physically tainted groups and occupations are defined as those groups that are 'directly associated with garbage, death, effluent and so on', whereas socially tainted occupations refer to those in which regular contact occurs with 'people or groups that are themselves regarded as stigmatized' (Ashforth et al., 2007: 151). Workers in homecare in western countries are therefore likely to be associated with stigma because their work generally involves 'domestic care (cooking, cleaning, laundry, etc.)', 'personal care (bathing, dressing, toileting etc.)' and/or 'nursing services (wound care, insulin injections, administering prescribed medication, etc.)' in infirm older people's homes (England and Dyck, 2011; Knijn and Verhagen, 2007: 452–3). Jervis (2001) has, for instance, demonstrated how nurses and care aides working in nursing homes — who have fundamentally the same tasks and background as the workers studied in this article — are at risk of becoming stigmatized due to their physically and socially tainted tasks. This is primarily because they work not only with old, sick and insane people but also deal with bodily waste and fluids, such as faeces and urine.

According to the body work literature, homecare work is a specific type of 'dirty' body work because of its concentration on other people's bodies (Twigg et al., 2011). Body work implies that the work is practiced on both a subject and an object, requiring both an awareness of the fleshy 'materiality of the body and the personhood and emotions present in that body' (Måseide, 2011; Twigg et al., 2011: 2). Body work can be seen indirectly in the interactions between workers and care recipients, referred to as body talk (Måseide, 2011), and more directly in the use of workers' hands to wash ageing bodies (England and Dyck, 2011). Body workers — particularly female workers whose position at the bottom of the eldercare occupation hierarchy ensures their low status — are therefore often assumed to use their own bodies and what are often stereotypi- cally considered their 'natural' and 'mothering' skills as a direct or indirect apparatus of care to undertake intimate body work (Rasmussen, 2004: 506; England and Dyck, 2011). Thus, homecare workers risk stigmatization not only due to associations of

their work with 'dirty' deteriorating bodies but also because they are expected to use their own bodies to accomplish such intimate body tasks.

7.5 'Managing' the stigma of dirty body work through discursive and material techniques

Dirty and body work studies propose that workers who risk stigmatization because of their jobs attempt to manage this stigma by using both discursive and material techniques. Focusing on discursive techniques, dirty work scholars suggest that stigmatized workers, in each other's company or when they are confronted with 'derogatory perceptions' of their work held by 'outsiders' such as citizens or customers, deploy strategies to discursively manage the risk of stigma by negating the stigma or rendering their work more attractive (Ashforth et al., 2007; Ashforth and Kreiner, 1999: 424) or honourable (Meara, 1974). This is described as an attempt to preserve their self-esteem and a 'positive sense of self' (Ashforth and Kreiner, 1999: 413; Chiappetta-Swanson, 2005; Jervis, 2001). Ashforth and Kreiner (1999) have identified three mutually non-exclusive discursive tech- niques whereby those they term 'dirty' workers, such as homecare workers, mediate the meaning of their stigmatized work. These include reframing, refocusing and recalibrating the meaning of their work. In this study, the focus is on the first two of these discursive techniques. By using 'reframing' techniques to manage the stigma of their work, stigmatized workers 'transform the meaning' attached to that work (Ashforth and Kreiner, 1999: 421). For example, Ashforth and Kreiner (1999: 421) suggest that by claiming to 'provide therapeutic and educational services', exotic dancers infuse their work with more 'uplifting values' associated with a larger purpose. Similarly, pimps negate the negative value of their work by denying the 'victim status' of the sex workers they manage and propose that they provide security for the women. By drawing on 'refocusing' techniques, workers required to perform 'dirty' work shift the centre of attention away 'from the stigmatized features of the work to non-stigmatized features' (Ashforth and Kreiner, 1999: 423). For instance, Meara (1974) shows how butchers emphasize the value of their meat rather than highlighting the smell, blood and carcass aspects of their work.

Although the body work literature acknowledges that (dirty) bodies are constructed through a 'plu- rality of social and cultural meanings' (Twigg, 2004: 70), the literature warns against 'exaggerat[ing]' the discursive 'malleability' of (stigmatized) body work (Wolkowitz, 2006: 13). For example, Twigg (2004: 63, 70) reminds us that discursive techniques used to manage the stigmas of ageing bodies may

be limited in so far as 'death' and 'decline' may be culturally constructed, but death is not 'person- ally optional'; its features 'exist at a bodily level'. Instead, the literature proposes that a fuller picture of stigma management can be achieved by focusing on the material techniques necessary to manage stigma and the 'continuing materiality of workplace activities' (Wolkowitz, 2006: 13). The literature convincingly demonstrates that body workers use 'technologies', or what they refer to as 'distancing techniques', not only to remain physically clean but also to de-emphasize the bodily character of work that cannot be fixed discursively (Sullivan, 2012; Twigg et al., 2011: 5). Examples of these techniques include the use of protective clothing such as uniforms and gloves during elimination care (Jervis, 2001; Sullivan, 2012; Wainwright et al., 2011); technical devices to measure respiratory capacity; and medicine for sedating bodies (Gale, 2011; Måseide, 2011; Twigg et al., 2011).

Accordingly, we might expect body workers, such as homecare workers, to attempt to manage the stigma associated with their 'dirty' body work by drawing on both discursive and material tech- niques to reframe and physically distance themselves from (dirty) body work. However, the extent to which these techniques actually successfully manage and negate stigma is questionable, as I will elaborate below.

7.6 Gendered implications of stigma 'management'

Dirty work and body work studies emphasize the gendered implications of discursive and material techniques for dealing with stigmatized work. Both areas of literature suggest that these techniques may be gendered in that they reinforce stereotypes traditionally associated with men and women, for example stereotypes that associate masculinity and men with notions of culture, reason, mind, toughness and disembodiedness and stereotypes that associate femininity and women with intimacy, interdependence and emotions (Davies, 1995; Johnston and Hodge, 2014; Sullivan, 2012; Twigg, 2004; Twigg et al., 2011; Wainwright et al., 2011).

Various dirty work studies show that some workers, such as homecare workers, celebrate stereo- typical notions of their essential gender identity as an integrated part of their attempt to discursively manage stigma and ensure a positive sense of self (Bolton, 2005; Chiappetta-Swanson, 2005; Jervis, 2001; Johnston and Hodge, 2014; Meara, 1974). For example, Bolton (2005) and Chiappetta-Swanson (2005) found that women in female-dominated occupations, such as gynaecological nurses, celebrate

their status and unique insights as caring women by hiding dead foetuses and the concomitant smell from parents. Similarly, Maera (1974) and Johnston and Hodge (2014: 511) have shown that men in male-dominated low-status occupations, such as butchers and security guards at hospitals, take pride in their macho 'alpha male status' as a way of negating the emotional impact of dealing with death, odour and blood. However, Johnston and Hodge (2014) suggest that the gendered 'macho' celebra- tion may also lead to problems for workers themselves. They found that a minority of security guards, primarily women, fear reprisals from their colleagues for being too weak. Furthermore, they suggest that the 'macho' atmosphere gives workers little opportunity to 'release' the burdens associ- ated with their 'emotionally disturbing work' (Johnston and Hodge, 2014: 552).

In a similar vein, the body work literature argues that material techniques have gendered implica- tions because they reflect 'gendered occupational hierarchies of healthcare' (Sullivan, 2012; Twigg et al., 2011: 4; Wainwright et al., 2011). The occupational hierarchy is gendered because it privileges not only the high professional status associated with masculine stereotypes (for example, the disembodied and the tough) but also men within the hierarchy (Davies, 1995; Martin-Matthews, 2007; Palmer and Eveline, 2012; Rasmussen, 2004; Sullivan, 2012; Twigg, 2004; Twigg et al., 2011; Wain- wright et al., 2011). Twigg et al. (2011: 5), argue that professional workers' statuses are marked by their 'distance from the body' and their ability to employ material techniques that direct them towards administrative or technically sophisticated tasks while distancing themselves from bodily waste and emotional interactions with the recipients. As workers progress up the hierarchy, any engagement of high-status staff (often men) in body work involves transferring the demeaning aspects of dealing with bodily waste to lower-status and lower-paid workers (often women), for instance those who clean the bodies before surgery (England and Dyck, 2011; Twigg et al., 2011). As such, studies suggest that this gendering places female body workers in a paradox. On the one hand, England and Dyck (2011) found that eldercare managers used their subordinates' female gender to justify their low pay by referring to their 'natural' skills and their motivation to undertake altruistic tasks. On the other hand, Sullivan (2012) and Wainwright et al. (2011), found that female body workers (in this case, massage students) were continually educated to keep their gender ('female bodies') 'in check' to maintain their professional dignity, an attempt to desexualize the female body worker was accomplished through wearing uniforms, removing earrings and keeping clients at arm's length.

In summary, body work and dirty work studies address an important and complex relationship between stigma, techniques to manage stigma and the ambiguous, gendered implications of these tech- niques. However, most studies imply that in fact workers can successfully manage stigma, perhaps be- cause the term, management, is often used. This present study suggests that this impression is misleading. In particular, it seems highly questionable to what extent material and discursive tech- niques enable body workers to successfully manage and negate stigma or to enhance their concomitant positive sense of self. In fact, questions remain regarding the extent to which body workers, such as homecare workers, who risk stigmatization due to their intimate work with deterio- rating bodies and their own gender and lack of professional status actually are able to successfully manage stigma or instead reshape and reinforce stigma by practising the techniques. To address this puzzle, the study develops an analytical lens that moves attention from the ways stigma is successfully managed by workers towards the ambiguous ways stigma is potentially reshaped by workers in rehabilitative homecare work.2 Through this lens, the following research question is explored in this article: How do the discursive and material techniques that flourish within rehabilitation reshape the articulations and practices of stigmatized homecare work, and what implications does this have and for whom?

7.7 Method

The data for this article were collected exploring the work at five publicly funded homecare organizations as part of the research project ReKoHver over an eight-month period in 2012 (Albertsen et al., 2014). As in other western countries, Danish homecare organizations provide domestic, personal and nursing care in people's homes (England and Dyck, 2011; Knijn and Verhagen, 2007). However, Danish publicly funded homecare organizations are distinctive in the sense that they are government regulated, and workers are publicly employed. In addition, all citizens can receive homecare provi- sion without paying a user's fee if they are considered incapable of independently performing homecare tasks (Nielsen and Andersen, 2006). In line with other western countries, the recipients are typically infirm people of an advanced age. Accordingly, 133,000 of the 158,000 Danish homecare recipients are over 65 years old, with an average age of 81.7 years old. Statistical data from 2009 suggested that 25 per cent of these recipients suffered from mental and/or neurological disorders and 66 per cent of the Danish population over 75 years old suffer from a chronic disease (Hjemmehjælpskommissionen, 2013).

As part of a larger national and international trend towards introducing rehabilitation policies to encourage ageing recipients to relearn self-care skills and to reduce their need for (longer-term) support, at the time of data collection the homecare organizations had recently adopted a new rehabilitation policy. Following the apparent success of the first Danish homecare organization that implemented rehabilitation, rehabilitation became a popular solution for expected demographic changes and the potential for increased numbers of homecare recipients (the so-called 'age burden') in Denmark in the 2000s. The results from this organization indicated that rehabilitation could improve recipients' quality of life and could reduce the cost of care and improve workers' safety in their work- ing environment (Kjellberg et al., 2011).

7.7.1 Focus groups and observations

To explore the implications of rehabilitation for homecare work, I collected in collaboration with four other scholars – Karen Albertsen, Inger-Marie Wiegman, Hans Jørgen Limborg and Flemming Pedersen data at five homecare organizations, including focus groups and observations.

In each organization, two types of focus groups were conducted (ten in total). In the first type of focus group all the employees were involved in daily rehabilitation work; typically a nurse, two occupational therapists, a medical officer and four care aides, were invited. In the second type of focus group eight top or middle managers were invited, many of whom were nurses. This division between the two types of focus groups sought to ensure a safe environment in which the participants felt comfortable enough to express their opinions without fear of sanctions (Liamputtong, 2011). Eight participants, around the number recommended by Morgan (1996), were thereby invited to each focus group; however, due to cancellations, the number varied between four and eight participants. Thus, 64 respondents participated in the interviews (28 managers, 26 women and two men and 36 lower level employees, all women). Each focus group lasted two hours, with two moderators (A and B) participating in each interview. Moderator A introduced the topic — rehabilitation in homecare — and assisted the participants in discussing it based on a semi-structured focus group guide identify- ing three broad sub-topics: (a) the target group, (b) the care workers' skills and roles and (c) the tasks and techniques involved in the context of rehabilitation. In addition, moderator A asked supplemen- tary questions, such as 'Do you have other examples?' and 'Did you experience that in the same way?', to encourage interaction (Liamputtong, 2011; Morgan, 1996). Moderator B recorded and took notes during the interview.

The focus groups explored how participants articulate, censure, negotiate and make their stigma- tized work meaningful in each other's company (Dahl, 2009; Liamputtong, 2011). The fact that partic- ipants queried each other and explained themselves to each other in the focus groups (Morgan, 1996) made me 'sensitive to people's own vocabularies concerning the framing of their work task, technol- ogies and objects of care' (Wilkinson, 1998: 117). Focus groups are also an effective way to give voice to a marginalized group with regard to their work (Morgan, 1996). As feminist literature argues, focus groups may be less 'intimidating' or 'scary' than face-to-face interactions with a researcher (Liamputtong, 2011: 6; Wilkinson, 1998).

Focus groups' ability to reveal the ways in which homecare workers translate their work into words is both a strength and a weakness in that this translation may 'bleach out' the 'corporeal' nature of the practice (Twigg et al., 2011: 5). As a result, the focus groups were supplemented with observations of the homecare providers' actual rehabilitation work. These observations were conducted on approximately four full working days with each of the five organizations. More specif- ically, homecare workers were observed at two different locations considered the most central to the introduction of rehabilitation: (a) the homes of the recipients, where rehabilitation programmes were planned and executed and (b) occupational supervision meetings at the care organization office, where progress with the programmes was discussed. The approach involved shadowing (Bruni et al., 2004) a therapist's or a care aide's 'work day' (typically driving from house to house and back to the office). Ten observations were performed at occupational meetings and 13 in the homes of the recipients. The observations lasted between 30 minutes and two hours. During the observations, field notes were compiled regarding the concrete sensory details of actions and speech to avoid our own generalization and interpretations (Emerson, 1995).

7.7.2 Data analysis

To analyse the data, the entire collection of transcripts and field notes were analysed using grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1998). First, I coded all the mundane ways the daily work in rehabilitative homecare was articulated and practised, such as mentions of 'the recipi- ents' resources', 'keeping hands at a distance' or 'care workers care-gene', a notion I discuss below. This coding was performed in tandem with the exploration of various theories. As I re-viewed, re- theorized and re-coded the data in Nvivo on an ongoing basis, the dirty and body work literature

emerged as particularly helpful. The use of this literature helped to group collections of codes of similar content into three broad concepts that were closely related to three core aspects of homecare work, and vital in terms of analysing stigma: (1) ageing bodies, (2) care workers' bodies and (3) the tools and practices to undertake intimate body work.

Second, I added two thematic categories — 'Rehabilitation' and 'Nurturing' — under which the codes were regrouped. I did this because a recurring topic across the coded material (grouped under the three concepts; ageing bodies, care workers' bodies and tools and practices) concerned how actors distinguished between two ways of framing and practising the homecare work, namely rehabilitation and something that was not rehabilitation (which I labelled nurturing). Subsequently, I developed a list of the ways in which rehabilitation and nurturing (non-rehabilitation) were related to the codes under the three aforementioned concepts. For instance, under the concept 'ageing bodies' I found that some codes, such as the recipients' resources, were related to rehabilitation while others, such as the recipients' decline, were related to nurturing. During this process, I began to approach rehabilitation and nurturing as two distinct yet coexisting ways or techniques to discursively and materially shape the core aspects of homecare work that risks stigmatization. As a result, I ultimately labelled the two categories 'Rehabilitation techniques' and 'Nurturing techniques' (see Table 6).

	Core aspects of work that risk stigmatization	Rehabilitation techniques	Nurturing techniques
Material techniques*	Intimate body work - tools and practices	Keep hands at a distance, frame the body functionality, and introduce aides to replace hands.	Hands on helping, touch and compensating by, e.g., rinsing off shampoo.
Discursive techniques**	Ageing bodies — focus and framing	(Hidden) resources, potentials.	Old, declining, frail, infirm.
	Care workers bodies — focus and framing	Thinking, training, professional, trainer, consultant, tough.	Kind, nurturing, female, emotions, sensitivity, a big heart, a nurture gene.

Notes: Table 1 gives an overview of the result of the coding process. It shows how rehabilitation and nurturing techniques (columns) were related to two discursively and materially competing ways to shape three core aspects of homecare work (rows).
* Table category inspired by Twigg et al. (2011) and Wolkowitz (2006).
** Table category inspired by Ashforth and Kreiner (1999) and Johnston and Hodge (2014).

Table 6. Compeling techniques to shape stigmatized aspects of work.

The categorization of ‘Rehabilitation techniques’ and ‘Nurturing techniques’ emerged in tandem with a re-examination of the coexistence of the techniques in the dataset. In this process, the observa- tions and focus groups allowed for different analytical insights. The observations showed the situated ways in which the introduction of rehabilitation by higher status therapists to lower status care aides and older people lead to disagreement over the approach, which should guide and shape aspect of homecare work associated with stigma; care aides and older people emphasised nurturing, that conflicted with rehabilitation approaches. Hence, the observations were useful to identify how rehabilitation and nurturing techniques coexisted and continually generated dynamic negotiation over the roles, means and outcomes of homecare providing among the actors. In contrast, the focus groups were helpful, because they showed how workers shared their more abstract and general thoughts, reflections and feelings concerning the observed practice and disagreements. Hence, the focus groups were useful in identifying the ways in which higher status workers (occupational therapists and nurses) seemed to systematically value and promote rehabilitation techniques at the expense of nurturing techniques to resolve and justify the observed disagreements, and the ramifications for care aides.

7.8 Shaping the stigma of women’s ‘dirty’ body work

The results of the analysis presented below illustrate how the homecare workers’ practice and negotiation of rehabilitation shaped responses to the stigma associated with homecare work and the corresponding implications for the work and workers. First, I will begin the analysis by sharing an ethnographic narrative about Ella. The narrative makes visible some of the dynamic status-related and situated negotiations over the value of stigmatized aspects of work that emerged when high- status therapists introduced rehabilitation to care aides and older people. Second, I will draw on a larger set of data to outline the implications of rehabilitation by elaborating on the ways in which the higher status workers, imposition of the value of rehabilitation over nurture risks reinforced the work and workers’ associated stigma.

7.9 The Ella narrative

Ella was a mentally sound 80-year-old woman with no chronic diseases; in other words, she is less marked by her age than most other recipients are. In addition, and in comparison to other recipients, she appeared relatively positive and receptive to rehabilitation. I was invited into Ella’s home to observe

how a rehabilitation programme was conducted. Those present in the home besides Ella and myself were Anne, the therapist, and Karen, the care aide.

I arrive at Ella's detached house in a rural residential neighbourhood with Anne, an occupa- tional therapist. When the care aide Karen arrives, we ring the bell. We stand there for a while until Ella finally opens the door. She has white ruffled hair and is wearing a dressing gown. She is leaning on a walker. 'You are a big crowd,' she says and looks a little overwhelmed and confused. Anne explains that they talked about the visit on the phone. We all sit down in her living room. Anne begins by summarizing Ella's situation: 'So Ella, you recently fell off your bike and cracked your pelvis. You have also undergone two knee replacements and one hip replacement, but before the incident you did not get any help?' Ella nods. Anne continues, 'The aim of this meeting is to make you independent of your walker again, as we talked about on the phone.' Ella smiles: 'I would love to be able to walk in my garden again.' Anne finds two sheets of paper in her bag, one sheet that says 'work plan' and another with a circle: 'a citizen wheel', she explains. It consists of squares with categories such as 'Bathing' and 'Bedding'. Anne starts to go through it, filling out the categories step by step.

First, Anne asks Ella about her bathing routine. Ella does most of the bathing herself; as she says, 'Karen helps me rinse my hair after I shampoo it because the soap makes me feel inse- cure.' Anne replies, 'This is something that we have to work on. We will put up a grip in the shower.' 'Yes, because otherwise it's a little bit difficult to wash your behind — right?' Karen explains with a smile. Ella nods. Second, Anne asks about dressing. 'Ella, I can tell you get help putting on your tights; why is that?' Ella explains, 'It's the silly toes that are causing trouble.' Anne and Karen discuss what aids they can use to overcome this problem. 'I don't think I can use such things [aids],' Ella says with a concerned voice. Karen replies, 'No, but that's what we're going to work on.' Anne continues, 'Karen, you can also try with the shoes. You have to remember to keep your hands behind your back, right?' Karen looks at Ella and replies, 'Yes, we have to think a little before we act.' The third topic is vacuuming and mopping. Anne tells Karen that she is surprised how mobile Ella is despite her walker and her prosthesis. They discuss whether they can train Ella to do the tasks. Ella asks with a worried voice, 'What are you talking about?' Anne smiles: 'I have incredibly good experience with training people to do the vacuuming again.' 'Will you come by and control me then?' Ella asks. Anne replies, 'Karen will help you, but I prefer the word collaboration over control, right?' Ella nods. Bedding is the fourth

topic. Anne and Karen discuss whether Ella might be able to make the bed, change the duvet cover and put on the sheet herself; despite her walker, 'Nothing is wrong with her arms,' as one of them notes. Ella says, 'However, Karen has been nice enough to help me with the bedding.' 'Yes, but you can learn that fast, right Ella?' Anne says with an encouraging voice. Ella replies, 'If somebody is standing next to me, I will try.'

In the end, Karen and Anne discuss how many minutes Karen needs to train Ella in each task. Karen continuously argues that she needs more time than Anne suggests. 'Alright, you still have to do some cleaning, so I'll give you more time,' Anne says. Karen replies, 'Ella will most likely never be able to wash the toilet on the sides.' Anne says: 'Well, Ella can wash the toilet on the sides if she sits on the toilet.' Karen looks sceptical: 'Yes, I guess so.' Anne shows Ella the coloured citizen wheel: 'It describes your function levels concerning your everyday tasks.' Ella nods in a disinterested way.

This narrative illustrates the ambiguous ways stigma is reshaped as Anne introduces rehabilitation and disrupts Ella's and, to some extent, Karen's alternative nurturing approach to the work. As a result, we see that rehabilitation and nurturing techniques emerge as two competing ways to discur- sively and materially (Ashforth and Kreiner, 1999; Wolkowitz, 2006) shape similar aspects of the work. As demonstrated above, Anne in a sense avoids focusing on bodily vulnerability, drawing on rehabilitation techniques that focus on Ella's (hidden) physical potential and urging Karen to 'think', 'train' and use hands-off tools such as ability aids. In contrast, Ella draws on nurturing techniques that centre on her declining, insecure and infirm body (parts) and her need for Karen's nurturing and physical contact (for an generalized overview of these two techniques, see Table 6). Finally, we see that Karen, inconsistently and dynamically, draws on both techniques. The competing techniques, and Karen's indecisive use of them, show that techniques to shape stigma are not stable, undisputable or stratified (Twigg et al., 2011; Wainwright et al., 2011). Lower-status recipients and care aides draw on nurturing techniques to challenge self-care rehabilitation techniques. For example, Ella highlights that she not only needs Karen's help due to her physical decline but also values her 'nice' behaviour.

Although the narrative demonstrates that the introduction of rehabilitation has stimulated disagreement about the appropriate motivations and outcomes guiding eldercare, it also shows that they are associated with the actors' status-differentiated use of techniques. As with other higher status actors

with formal decision-making power, we see Anne attempting to make rehabilitation the dominant technique by patronising Ella and ignoring Ella's (and Karen's) points of view or by indicating that to obtain her acknowledgement, they had to dispense with their nurturing approach and adopt rehabilitation. In the next three sections, I will elaborate on the implications of these ambiguous ways of shaping stigma for the three core aspects of work that risk stigmatization (ageing bodies, tools and practices to undertake intimate work and care workers' bodies; see Table 6). I will show the ways in which higher status nurses and therapists attempt to promote and entrench rehabilitation techniques at the expense of nurturing techniques.

7.10 Shaping the stigma of frail ageing bodies by redefining them as self-care potential

As demonstrated in the Ella narrative, the introduction of rehabilitation by higher status occupational therapists and nurses seeks to reframe recipients' and some care aides' nurturing approaches to age- ing bodies by 'infusing' these bodies with new, more positive meanings (Ashforth and Kreiner, 1999). In the focus groups higher status workers seemed to recognise that advanced chronological age, sick- ness and illness were present in the work context on a bodily level (Twigg, 2004). However, similar to butchers' emphasis on 'valuable' meat as opposed to the smell, blood and carcasses of meat (Meara, 1974), the higher status nurses and therapists indicated that they deliberately attempted to shift the focus from traces of old age and mental and physical dysfunction towards the recipients' more 'uplifting' resources, potentials, motivations and functionality (Ashforth and Kreiner, 1999).

> *Christa (Therapist): As colleagues, we have discussed that chronological age is not an issue regardless of whether you are 70 or 95 years old. This [age] should not influence your participation [in rehabilitation]. It's very much an individual question as to whether and to what extent they [the recipients] are motivated and also whether they have some resource we can cultivate.*

As demonstrated, higher status workers such as Christa continuously encourage their colleagues' denial or negation of aspects of the recipients' bodies that could be associated with stigma or a 'victim' status (Ashforth and Kreiner, 1999), such as advanced age. Conversely, the recipients were framed as 'normal' by referring to them as 'individuals' and 'citizens' with resources and potential to be

cultivated. The focus groups showed that this cycle of normalization and denial was justified as an attempt to emancipate and improve the wellbeing of ageing recipients' bodies, as exemplified by Henning:

> *Henning (Nurse): The dilemma might be that the citizen is sick and feeling ill. They have back pain, COPD, and bad lung function, but in the last couple of years [with rehabilitation], we have started to focus on, whether that means they need help doing their everyday activities. Is it not a good thing that you use your physical capabilities when you are suffering from that kind of illness?'*

As we see in Henning's quote and in the case of Ella, higher status professional workers encourage their colleagues to focus deliberately on tolerating and overlooking recipients' pain, concerns and illness, justifying this approach as a mean to ensure the recipients' (assumed) recovery. In fact, 'help' given to sick and ill recipients was portrayed as counter-productive for their recovery.

Higher status workers were well aware that this approach was disputed by 'outsiders' to the organization, both recipients and their families. However, they insisted on the superiority of their approach, based on celebration of their status and knowledge as professionals (as found in other research, for instance by Ashforth and Kreiner, 1999 and Johnston and Hodge, 2014).

> *Rie (Nurse): We have also had some [recipients] where the big challenge has been that they don't really understand it [the rehabilitation approach], and then the family won't buy into it either. Then, we have these sad children [relatives] who call us: 'But I don't understand it, my mom has paid taxes for 80 years, and now she can't even get help when she really needs it?' . . . because they [the relatives and the older people] haven't watched the movies [about rehabilitation] or received the training ..., so explaining to them why we can't help their mom is a huge challenge.*
>
> *Mette (Nurse): We often talk about how we should get in contact with the relatives to explain to them that they should not feel sorry for their mom just because she has to put on her own bra or socks.*

We see here how Rie and Mette, each in a different focus group, describe the emotional reactions of members of elders' families to the ageing body — 'feeling sorry for them' and expecting the care

workers to spare them from (unnecessary) suffering. However, as with other higher status workers, Rie and Mette patronisingly maintain that (as professionals) it is their obligation to 'explain' to out- siders the shortcomings of the nurturing approach and the insufficient knowledge on which it is based. As I will discuss later, this was also a lesson for care aides such as Karen.

Unlike the gynaecological nurses studied by Bolton (2005), higher status workers, mostly women, did not draw on their stereotypical feminine 'natural' instinct to minimize patients' pain as a source of professional pride. On the contrary, by emphasizing their ability to tolerate pain and to be tough and emotionally detached, the female workers employed stereotypes of masculinity. This approach represents an attempt to differentiate themselves from family members and, as such, to delineate their own professionalism.

With the introduction of rehabilitation, higher status workers attempt to render the object of care, the ageing body, more attractive by reframing it as potential rather than focusing on its infirmity and decline, thereby promoting discursive rehabilitation techniques to shape the ageing body at the expense of nurturing techniques (Ashforth and Kreiner, 1999). We see in accordance with previous studies (Bolton, 2005; Johnston and Hodge, 2014) that this effort to inscribe new discursive value onto stigmatized bodies is gendered. Unexpectedly, I found that predominantly female higher status workers drew professional pride from negating the negativities of the body and from celebrating masculine stereotypes of toughness. However, I found that this attempt to reshape ageing bodies as having self-care potential did not really challenge the stigma of having (or working with) a deteriorating body. On the contrary, the stigma associated with deteriorating bodies — the decline, illness and pain that, as exemplified in the Ella narrative, remained on a bodily level (Twigg, 2004) — was reproduced. Hence, in trying to avoid talking about the deteriorating aspects of the ageing body this maintains the idea that these aspects are stigmatized and something to be avoided. In the next section, I will elaborate on how this reinforcement of stigma is supported by the introduction of new material tools.

7.11 Shaping the stigma of intimate body work by generating distance

In an effort to strengthen the new image of older people's self-care potential, new material 'distance techniques' (Twigg et al., 2011), such as measurement tools, aids and hands-behind-the-back techniques, have been introduced in rehabilitative homecare work, as illustrated in the Ella narrative.

The significance of these techniques lies in their intention to make the recipient independent by physically distancing the homecare provider from both the recipients' bodies and the recipients' bodily waste. As Mette explains,

> *Mette (Nurse): The key element when I think about rehabilitation is that we do training instead of nurturing; we change the manner in which we encounter the citizen [recipient]. We do not take over and do the [everyday] tasks for them; rather, we stand with our hands behind our backs.*

The distance techniques were, however, unequally distributed among homecare workers in a way that, as suggested by Twigg et al. (2011), paralleled their position in the occupational hierarchy. The therapist with the highest status, as shown in the Ella narrative, used a citizen wheel3 as a measurement tool to plan a programme targeted at the recipient's potential for physical self-reliance. This assessment tool was used to 'closely frame' (Twigg et al., 2011) and analyse the recipient's physical functionality. The therapists explained that the tool was intended to be an emancipating 'eye-opener' for recipients that would give them an overview of their physical functionality, on the one hand, and would involve and commit them to the improvement of such functionalities, on the other.

> *Anne (Therapist): It [the measurement tool] is an eye opener, also for the citizen: 'Well, yes, actually I can perform these things myself.' It gives a quick overview [of body functionality], so one could say that it also makes it more tangible for the citizen, so they can see that this is what it's all about.*

The tool implies that the assessment process is based on a pre-structured hypothetical 'body talk' (Måseide, 2011) regarding physical functions and potential (related to public expenditures), which actively de-emphasizes the demeaning aspects and negativities of ageing bodies. For example, in the Ella narrative, Anne (the therapist) addressed the more abstract aspects of Ella's bathing situation and her potential to learn rather than Ella's particular difficulties, such as washing her 'behind' (as Karen framed it) or her specific wish to walk in the garden. Furthermore, the tool transfers the respon- sibility for the intimate body work that remains to the care aides, who are encouraged to 'work on' enabling the self-reliance of older people. Accordingly, the therapists only engaged in body work to the extent

that the 'potentially demeaning aspects' of the body were 'bracket[ed] off' 'symbolically' and 'transferred (...) to a lesser status ancillary' (Twigg et al., 2011: 5).

In the day-to-day training situations in which care aides were expected to conduct rehabilitation, they continually reiterated that the most important rehabilitation technique they had learned was to stand with their hands behind their backs (see also Kofod, 2012). For example, in quotes taken from two different focus groups, Karoline and Helene explain how the new technique involved a direct attempt to increase their distance from ageing bodies by concealing and limiting the availability of their own hands and bodies:

> *Karoline (Care aide): We also have a schizophrenic woman. She is afraid of taking a bath, but here we try with a grip and a bathing bench to adjust [her body] and withdraw more and more [from the situation] to make her feel more secure doing it herself. Then, you will have to wait and see: 'Does she actually get to shower [on her own]?' So you will try to check up and see whether it works.*
>
> *Helene (Care aide): You can also kind of pretend that you're busy with cleaning up the sink instead of standing there [next to the citizen] helping when they need to put on their trousers. It's like being there and then [pretending] that you aren't really aware of what's going on. And then [the senior citizen will think], 'Hmm, I need to put on my trousers now. Then, I'll just do it myself.'*

Similar to the ways in which massage students are taught to avoid intimacy and wear uniforms to appear professional (Sullivan, 2012; Wainwright et al., 2011), care aides were asked to avoid bodily contact by replacing their hands with stocking aids, grips, shower stools and bathmats.

Through rehabilitation, higher status workers attempt to materially manage the stigma associated with intimate body work by replacing 'hands-on' help with new material distancing techniques, thereby promoting material rehabilitation techniques at the expense of nurturing techniques. Yet, paradoxically, this attempt to manage stigma by trying to avoid touching or being intimate with age- ing bodies maintains the idea that needing or providing hands-on help is something to be avoided, and thereby seems to reshape and redistribute the stigma rather than negating it. Thus, similarly to previous body work studies (Twigg et al., 2011; Wainwright et al., 2011), I found that workers' use of distancing

techniques (and the sophistication of the tool) delineated their status while continuing to transfer the (remaining) demeaning aspects of the body down the occupational hierarchy – a phenomenon that has been argued to reaffirm the gendered privileging of masculine stereotypes of separation in the hierarchy (Davies, 1995). In addition, we see that when lower-status workers, who perform most of the embodied work, are also encouraged to use distancing techniques, the responsibility for dealing with bodily waste is no longer simply transferred down the occupational hierarchy (Twigg et al., 2011), but extends beyond the occupational chain and is transferred onto [back to] the older people themselves. This in effect maintains the idea that bodily care is something people should do themselves, for themselves, and they are stigmatized (along with the carer) if they cannot do this. Hence, the stigma associated with bodily care is reinforced rather than challenged. Moreover, this does not really enhance workers' interests in another sense. The analysis suggests that when care aides transfer tasks to recipients, they risk reducing their own work. At the very least, the analysis indicates that through the introduction of rehabilitation and the encompassing cutbacks in the care aide staff group, all five organizations were able to incur short-term savings.

7.12 Shaping the stigma of being a female body worker by redefining workers as 'macho' trainers

Through the introduction of rehabilitation, nurses and therapists generally attempted to shift the care aides' focus away from the role of a nurturing body worker towards so-called consultant and trainer roles. As illustrated in the Ella narrative, Anne prompted Karen to act out this trainer role by encouraging her to think and train Ella by maintaining physical and emotional distance from her rather than nurturing her or being kind and intimate with her. This attempt to shift care aides' framing and understanding of their own bodies and roles was generally accompanied by the reproduction of traditional, gendered distinctions between 'altruism and nurturance,' on the one hand, and 'choice and skills', on the other (Lee-Treweek, 1997).

Accordingly, higher status workers generally attempted to teach care aides to distinguish between two roles. The first, the now disparaged 'traditional' nurturing role, is associated with women who are at the whims of people's 'demands', and who practice 'maid' and 'service organ' roles due to their 'big hearts', emotions and 'care genes' (emotional work). In contrast, the second, the new 'trainer' role,

which is associated with more prestigious-sounding occupational skills, such as 'reflection', 'supervision', 'coaching' and making a difference in older people's lives (mind work).

Karen's indecisive and conflicting use of nurturing and rehabilitation techniques indicated the ambivalence and difficulty surrounding this distinction. On the one hand, higher status workers introduced care aides to new and prestigious-sounding trainer and consultant roles that appeared more socially acceptable and uplifting. The focus groups showed that care aides were inclined to reframe their role in these more professional-sounding ways, just as exotic dancers are inclined to normalize their work by associating it with therapeutic and educational services (Ashforth and Kreiner, 1999). As Leila explains:

> *Leila (Care aide): This way of thinking [about rehabilitation] that the citizens are capable of doing something on their own also means that we don't need to be an organ of service [anymore].*

In contrast, the new, prestigious-sounding roles were, as exemplified by Leila, associated with an attempt to avoid the nurturing, service roles that higher status workers stigmatized. This constituted an unpleasant lesson for those care aides who questioned or found it difficult to employ rehabilitation and the trainer role universally across all situations. In particular, these care aides risked stigmatiza- tion and even sanctions by their (superior) colleagues for being incapable of setting limits to their help and being unable to keep their emotions and so-called feminine sentiments in check for professional purposes (Sullivan, 2012; Wainwright et al., 2011).

For example, recall how higher status workers scorned relatives (who felt sorry for their parents) for lacking rehabilitation knowledge, and see below how care aides are portrayed in similar ways, namely, as incapable of keeping their emotions in check and tolerating pain.

> *Helle (Therapist): I know some care aides who have had a difficult time [with the introduction of rehabilitation] because they feel sorry for the citizen; somehow it's difficult to ask a 90-year- old woman with back pain to do it [the task] herself.*

Furthermore, as exemplified in the focus group dialogue below, care aides who did not keep their hands behind their backs associated this behaviour with guilt, stupidity and their failure to keep their feminine sentiments and so-called 'care genes' in check.

> *Julie (Care aide): I've also felt a bit ashamed because, frankly, you have nursed [the recip- ient] more than you should have; then you can stand there and get totally barrrhhh, it's actually not okay that I didn't stand with my hands behind my back if you are then told afterwards, 'She [the recipient] could have done that herself.' Oh yes, stupid me [gently knocks herself in the head]. Then I stand there and get completely embarrassed. I want to help, but I realize that she [the recipient] could have done that herself, but now I was just kind enough to do it [people laughing], not that it was based on any bad intentions.*
>
> *Lily (Care aide): Many of us can get in conflict with our nursing gene. Julie: It's quite difficult to take that away from us.*
>
> *Lily: We are women!*
>
> *Julie: At least it requires some work.*
>
> *Karen: (Care aide): However, I think in the period where we have worked with rehabilitation, there are many workers who have changed their approach; they're thinking differently.*

Similar to Johnston and Hodge's (2014: 552) finding that female security guards who did not live up 'to the masculine standards of the job' were emotionally distressed because they feared sanctions from their male colleagues, we see here how care aides expressed feelings of 'stupidity' and 'embarrassment' if they did not live up to the trainer role expectations. They related this to their 'nursing gene' and the fact that they were women.

With the introduction of rehabilitation, higher status workers attempted to render the body worker role more socially acceptable and uplifting by reframing it in terms of prestigious and professional-sounding 'macho' trainer roles. Thereby distinguishing the role from kindly female maid roles and care 'genes', thus promoting discursive rehabilitation techniques to frame the body workers at the expense

of nurturing techniques. Yet, paradoxically, we see how this effort to reshape the meaning of the body worker role through rehabilitation seems to reproduce gendered stereotypes that are associated with professionalism and to cause emotional distress among care aides (Davies, 1995; Johnston and Hodge, 2014; Twigg, 1999). The evocation of the professional 'macho' trainer role worked to reinforce associations of professionalism with masculine stereotypes and caring with feminine ones (Lee-Treweek, 1997; Tronto, 1993). In this process, 'necessary aspects' of care work, such as empathy and 'emotional sensitivity and expressivity' (Twigg et al., 2011: 16), were actively gendered as feminine and non-professional, thereby reinforcing the stigma associated with the tradi- tional work of female body workers. The process was a painful and stressful experience for some care aides, especially those who found it difficult to apply the trainer role in all situations. Their critical voices were typically reduced to nothing more than an issue of their own low-status female bodies and 'genes', whereby their potentially crucial voices, based on their ongoing situated body work, were devalued and neglected as non-professional and even 'stupid'.

7.13 Concluding discussion

This article has examined the dynamic and ambiguous ways rehabilitation is currently practised and negotiated in Danish homecare work, a type of work that is often stigmatized due to its association with 'dirty' work and the women workers at the bottom of the care ladder who undertake body work in older people's homes. The analysis illustrates that as homecare organization staff with a higher status took action to practise discursive and material rehabilitation techniques, this put lower-status care aides into an ambivalent position. The latter were introduced to a new set of techniques celebrated as a way to successfully manage their risk of stigma. However, these techniques seemed, paradoxically, to reshape and reinforce the very stigma associated with their work, so that pride in the caring skills that previously might have elevated body work — were now stigmatized too.

This article contributes theoretically and empirically to the study and conceptualization of gen- dered stigma management in four respects. First, by reviewing and combining the dirty work and body work literature, the article develops an analytical lens to explore the ambiguous ways the stigma of women's 'dirty' body work is being reshaped in eldercare. As an alternative to most studies of stigma management, this approach directs our attention to the ways stigmatized aspects of the work are reshaped and reinforced through attempts to manage it. Although previous studies have addressed the

ambiguous gendered implications of stigma management (Bolton, 2005; Chiappetta- Swanson, 2005; Johnston and Hodge, 2014; Sullivan, 2012; Twigg et al., 2011; Wainwright et al., 2011), the continued use of the term 'management' and the focus on workers' inclination to secure dignity and a positive sense of self perpetuates the assumption that workers can successfully manage stigma. Furthermore, previous studies suggest that workers' techniques to successfully manage the outsider's tendency to stigmatize them emerges from 'internal' occupational ideologies and/or distance tools gained during their education, yet they fail to connect the techniques to 'external' political changes and neoliberal trends, such as in the public sector (Dean, 2006; Katz, 2000). This study, however, provides a new analytical lens to study stigma management by situating the sources of and techniques to manage stigma within the politically changing context of eldercare: a focus on situated change that allows us to explore the multiple ongoing ways stigma is reshaped and negoti- ated. This focus breaks with dualistic approaches to stigma management (dignity) and stigma reinforcement (suffering).

Second, the 'Ella narrative' empirically demonstrates that no stable, singular, stratified, or coherent technique to manage stigma exists in homecare. Rather, I find that stigmatized aspects of work are dynamically negotiated and ambiguously reshaped because multiple discursive and material techniques coexist. We see in the narrative that the introduction of rehabilitation disrupts an alternative nurturing way to articulate and practice homecare work and deal with stigma. The coexisting techniques make it possible to negotiate whether (a) Ella was old and in decline or had potential and capabilities; (b) Ella needed hands-on help or self-care training and hands-off aids; and (c) whether Ella's care aide Karen was her nurturing caretaker or her 'macho' trainer. That is, we see a dynamic ambiguous situation emerge from the coexistence of conflicting discursive and material techniques. This can be attributed to the fact that individuals exploit the contradictions of the techniques (Thomas and Davies, 2005: 700) to negotiate and reshape matters of stigma and dignity. Moreover, I show that the individuals who embody these negotiations — Ella, Karen and the therapist Anne — draw on techniques in a status-related way (Lee-Treweek, 1997; Twigg et al., 2011). However, I expand on previous studies by illustrating that individuals' utilization of these techniques is neither coherent nor determined in advance. Whereas Ella and Anne adhered to the competing nurturing and rehabil- itation techniques, respectively, Karen drew on both techniques in a processual and dynamic manner. Despite

these disagreements, I nevertheless found that Anne, similar to other higher status-workers, was more successful in enforcing rehabilitation.

Third, by drawing on a larger set of data, the analysis expands beyond previous studies. It does this by showing the ways in which rehabilitation as a technique to successfully manage stigma in eldercare, ambiguously seems to reinforce the stigma it intends to manage. I find that higher status workers' promoted the idea that rehabilitation is a solution to stigma because it transforms frail ageing bodies in individuals capable of self-care and at the same time offers female body workers new and more prestigious-sounding work-roles, roles that are distant from intimate and polluted work. However, I show how this promotion in fact reinforced stigma associated with bodily care, because the promotion maintains that bodily care is something that (even older and infirm) people should be able to do for themselves. This resulted in stigmatizing 'female' care workers who seek to help recipients rather than retrain them.

Finally, the article clarifies the practical implications of rehabilitation and the ambiguous way stigma is reshaped for both recipients and care aides. We see that for older and/or infirm recipients such as Ella, decline, illness and pain were still present on a bodily level (Twigg, 2004) despite higher status workers' attempts to refocus (Ashforth and Kreiner, 1999) and physically distance themselves from it. I thereby expand on the existing literature by suggesting that when older people are 'eman- cipated' from the help they generally seem to value, responsibility for bodily waste is no longer simply transferred down the occupational hierarchy (Twigg et al., 2011) but rather is placed upon the older people themselves. Moreover, we see that rehabilitation provides an unpleasant lesson for care aides, such as Karen, who do not live up to rehabilitation expectations or who question such expectations by evoking the alternative nurturing approach. These care aides risk being stigmatized as women with 'care genes' and 'maid' roles who are 'stupid' and non-reflexive individuals (Lee-Treweek, 1997; Twigg, 2004; Wainwright et al., 2011). To be acknowledged as 'good' and 'profes- sional' workers, care aides were required to enact the prestigious-sounding trainer role and corre- sponding masculine stereotypes of separation and toughness. Thereby, crucial aspects of the work, such as sensitivity and empathy, were devalued as non-professional through associations with female stereotypes. In addition, care aides' critical (nurturing)-voices based on their ongoing situated embodied knowledge were reduced to a failure associated with their female bodies. Additionally, although care aides received new titles and

tools to ‘distance’ themselves from body work, this has not led to salary increases. On the contrary, the tools resulted in lay-offs in the staff group and reduced aspects of the job that both they and the older people valued. From this perspective, the ‘genderfication’ of the work that rehabilitation enforced did not appear to be a powerful strategy to manage the stigma of care work (Lee-Treweek, 1997; Tronto, 1993).

This article has limitations. First, I acknowledge that the article presents a rather critical account of rehabilitation (which is undeniably successful in some cases). However, the article points to the ambivalent implications of rehabilitative eldercare, which are often overlooked in public debates in which rehabilitation is celebrated as an indisputable win-win policy that generates both dignity and cost reduction. Second, the character of the data limited the generalizability of the findings. How- ever, the article’s focus on how rehabilitation policy is closely related to professional status battles and what I term the ‘genderfication’ of work is an overlooked topic that may interest both governance and work scholars. In particular, this focus seems broadly relevant because the rehabilitation of older peo- ple is expanding in western countries (Kjellberg et al., 2011; Social Care Institute for Excellence, 2010). Overall, the findings point to the importance of situating stigma and its sources in a political context and future research should investigate the broader scope and macro-relationships among political change, status-related stigma shaping and women’s ‘dirty’ body work in public service provision.

Notes

1. In Denmark, for instance, 94.8 per cent of organized care aides are women. Only 8 per cent of publicly employed Danish care aides are non-skilled (92 per cent have one year of formal training or more). However, other occupational groups within homecare such as occupational therapists and nurses receive longer formal training (minimum 3.5 years). In addition, compared to other permanent public employed workers, care aides receive the fourth-lowest salary in the state (www.krl.dk; FOA, 2014).

2. A similar distinction between managing and shaping is mentioned by Strauss et al. (1997) in their seminal book Social Organization of Medical Work.

3. The methodology varied across the organizations but was inspired by international instruments such as the Activity of Daily Living (ADL), Canadian Occupational Performance Measure (COMP) and/?or the International Classification of Functioning, Disability and Health (ICF).

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CHAPTER 8:

CONCLUDING DISCUSSION

8.1 Towards an understanding of professionalization and marginalizaton

This dissertation has inquired into the often neglected work-related complexities and marginalization processes that arise with attempts to center professionalization of public home care work on the concept of rehabilitation. This focus is particularly pertinent today, when rehabilitation is proliferating in public (home care) organizations, and generally is framed as a new appealing professionalization opportunity in public debates. The opportunity is said to reconfigure home care work in ways that result in improved working conditions, better quality of services, and cost savings. Rehabilitation is, however, only the most recent example of an ongoing range of new reforms and demands that have focused on professionalizing home care work by imposing new professional structures, qualifications or status on the workers. And, yet, despite these ongoing attempts to professionalize the work, home care work is still a type of work that continues to have a marginalized status in society.

This paradox has increasingly encouraged particular feminist-inspired academics (e.g., Sullivan, 2006; Hearn, 1982; Davies, 1996; Cheney and Ashcraft, 2007) to question whether we have sufficiently understood the complexities and particularities of how professionalization processes are constituted and function at work. Their studies indicate that home care workers' historical struggles over professionalization are closely related to what I in this dissertation have referred to as "boundaries of professionalization". That is, discursive and more material divisions and differences at work that operates to priviledge what is understood as "the professional" (actors, techniques, labels and positions) at the expense of the "others", who risk social, technical and economical marginalization. More specifically, the studies (Ibid.) suggest that it is difficult to change care workers' marginalized position by means of professionalization because such boundaries historically have functioned to (re-)marginalize and stigmatize the personal attributes, tasks and areas of work that care workers tend to embody, symbolize and perform. The contrast between the appealing positive rhetoric about rehabilitation as a professionalization opportunity in home care policy and these studies' portrayals of professionalization as a complex matter for home care workers gave rise to a puzzle about how the introduction of rehabilitation had silenced or avoided marginalization processes in rehabilitative home care organizations. And thus, this dissertation set out to inquire into the various layers of complexity and potentially hidden dilemmas, challenges and marginalization processes that home care workers

faced when they were confronted with the "opportunity" to be professionalized in rehabilitative home care organizations.

To study how rehabilitation as a professionalization opportunity influenced the home care workers and their fight to escape their marginalized position at work, the dissertation empirically relied on an eight-month ethnography-inspired study of five home care organizations that had recently implemented rehabilitation. Following the feminist-inspired academics, it has delved into and sought to deconstruct the complex and particular ways the professionalization processes intersected with marginalization processes in rehabilitative home care organizations. More specifically, I found that the professionalization processes in rehabilitative home care organizations were constituted through three different means in particular: new experts, new team meetings and new working tools. And thus, the dissertation has used these means as a stepping point to explore how the professionalization processes (and by implication the marginalization processes) became: 1) *regulated* with the introduction of new experts in rehabilitative home care organizations (in article 1); 2) *negotiated* at the newly established team meetings in rehabilitative in home care organizations (in article 2); and 3) *practiced* with the introduction of various new techniques and tools in rehabilitative home care organizations (in article 3). This exploration has, in order to ensure a complex understanding of the intersecting professionalization and marginalization processes, been shaped and guided by an attention to co-emerging discursive and material constitutive processes. More specifically, the dissertation has experimented with combining theoretical building blocks from both critical discursive-oriented and material-oriented studies on professionalization in order to make the often-silent ways the boundaries of professionalization are regulated, negotiated and practiced at work salient. This empirical and theoretical framework has served two aims.

The practical and empirical aim of the dissertation has been to nuance the dominating optimistic public ideas about rehabilitation as an appealing professionalization opportunity by providing an empirical window to capture the particular dilemmas and challenges home care workers face at work in professionalization processes, and their ongoing risks of being socially, economically and technically (re-)marginalized at work. The theoretical aim of the dissertation has been to use rehabilitation as a case to experiment with combining theoretical building blocks from both material-oriented and discursive-oriented studies. This was done to advance a more complex and practical understanding of

how processes of professionalization become regulated, negotiated and practiced at contemporary workplaces in ways that, paradoxically, not only constitute boundaries of professionalization, but also function to silence how such boundaries were drawn. To guide these aims the dissertation raised the following research question: *How are the boundaries of professionalization regulated, negotiated and practiced at work in rehabilitative home care organizations, and with what implications for the home care workers and their risks of being socially, economically and technically (re-)marginalized?*

The reminder of this chapter is devoted to giving a conclusive answer to the research question and to discussing the contributions and limitations of the dissertation. For this purpose the chapter is divided into three sections. First, I address the practical aim of the dissertation by presenting the empirical findings that may add to a more nuanced dialogue about rehabilitation and its implications within home care policy and practice. More specifically, I present three central dilemmas home care workers face at work with the introduction of rehabilitation, and discuss what implications rehabilitation has for their risk of being socially, technically and economically (re-)marginalized. Second, I turn to the theoretical aim of the dissertation by elaborating on how the experiment of combining theoretical building blocks may have advanced our knowledge about how boundaries of professionalization are constituted and function at work. More specifically, the presentation centers around the development of what I call three "professionalization mechanisms of silence," that show how boundaries of professionalization were regulated, negotiated and practiced in co-emerging discursive and material ways at work, but also how such boundaries ambiguously functioned to silence the way they "worked". Third, I reflect back on how the methodological framework I have constructed, referred to as a 'workography,' has influenced my knowledge production about the relationship between professionalization and marginalization "at work", and on how far my conclusions may be extended, and what advice my dissertation may offer to future studies.

8.2 Empirical findings: Dilemmas surrounding professionalization intentions at the margin

This section presents the empirical findings of the dissertation. Reflecting the critical stance I apply to the research, the aim is to provide the reader with a window that make the "too easy gestures" about the value of professionalizing home care workers in rehabilitative home care organizations "difficult" (Foucault, 1981: 34). For this purpose, it is centered on providing the reader with a situated and

empirically grounded lens into the particular and practical dilemmas and challenges that the introduction of rehabilitation instituted for home care workers. A window that may be particular and situated enough to surprise, and provoke actors within home care policy and practice, and would thus allow them to see themselves and their practices through new or different eyes (Ybema et al., 2009; Cunliffe, 2010).

The section is structured around a presentation of the dilemmas and marginalization processes that arise with the three central means to professionalize home care workers (i.e., care aides) and their areas of work in rehabilitative home care organizations. The presentation is thereby also closely tied to the three different articles I have presented in the analytical body of the dissertation, but also weaves a red thread through them. First I address the implications it has for the professionalization of home care workers (and by implication their marginalized position) that these processes in rehabilitative organizations are regulated by means of introducing new experts (the occupational therapists) who are supposed to upskill the home care workers. Second, I elaborate on the implications it has for the professionalization of home care workers (and by implication their marginalized position) that their professional negotiation of their work with rehabilitation becomes "underpinned" by means of introducing team meetings. And third, I elaborate on the implications it has for the professionalization of home care workers (and by implication their marginalized position) that their practices are reshaped with the introduction of new techniques and tools in rehabilitative home care organisation. These three 'practical' dilemmas make it possible to address what implications rehabilitative home care organizations have for home care workers and their risks of being socially, economically and technically (re-)marginalized at work.

8.2.1 Empirical finding 1: The dilemma of introducing new experts to upskill workers

To provide a window into the implications the professionalization processes in rehabilitative home care organizations have for home care workers, I began by focusing on how the introduction of the new rehabilitation experts - the occupational therapists - influenced home care workers' marginalized position at work (see article 1). In rehabilitative home care organizations the therapists were introduced as so-called "drivers" of rehabilitation and as a means to upskill the care aides in the field of rehabilitation expertise (see also Kjellberg et al., 2011a). This role reconfigured the work, because the work division was altered with the introduction of the new therapists. Thus, in their new roles as

working experts, the therapists were supposed, like the nurse managers, to teach the care aides about rehabilitation at a distance from the frontline, i.e. from the office (e.g. through team meetings) or at training courses. However, in addition, the therapists were also positioned directly on the frontlines. In this position they went out with the care aides to the recipients' homes in order to plan the rehabilitation programs and underpin the care aides execution of the programs (see articles 1 and 3).

The dissertation shows that in their new positions, the therapists did indeed emerge as 'drivers' of rehabilitation and as sources to mobilize the care aides to adapt the new rehabilitation expertise, as intended. In particular, in their capacity as working experts on rehabilitation they not only (often in tandem with the nurses) mobilized the care aides to adopt the new rehabilitation expertise by presenting it as a new professionalization opportunity, they also (in contrast to the nurses) personified and performed rehabilitation themselves side-by-side with the care aides in the homes. For instance, by zooming in on how the therapist Henriette and the care aide Mette appear in the home of Laila (in article 1) and the relationship between Anne, the therapist, and Karen, the care aide, in the home of Ella (article 3), the dissertation shows that the therapists in this role seek to mobilize care aides to adopt the new expertise. More specifically, we learn from these examples that the therapists become a powerful source of regulation and cultivate the ideal that a "professional" persona is a worker who restores older people by being 'tough' and 'entrepreneurial'. Yet, the question remains as to what implication this promotion of this professional persona had for the marginalized position of home care workers at work?

Article 1 indicates that the therapists' role as working experts not only promoted a new professional ideal and persona. Rather, it shows that their presence also marginalized and suppressed an alternative form of expertise, nurturing, with which (some) home care workers were associated. Nurturing was associated with attributes of traditional, soft, manual, and female workers, and thereby a non-professional care approach. For instance, we have seen how the therapist Anne tries to "cultivate" the care aide Karen to 'de-learn' her nurturing skills by teaching her that Ella is not incapable of washing the toilet on the sides, because she can sit on the toilet and do it (article 3). This presence of therapists came with some challenges. For instance one of the core challenges care aides faced was that they clearly wanted to avoid being (re-)marginalized as non-professionals, but on the other hand it was difficult for them to live up to the new ideals in practice. This happened either because they found that

the recipients resisted their new role (or more specifically valorized the nurturing role), or due to what they called their own 'personal' barriers (i.e. ongoing identification with the nurturing role).

Thus, ironically we have seen how the introduction of the therapists indeed poses a dilemma to the home care workers. On the one hand the presence of the therapists did offer care aides an opportunity to gain new skills, expertise and attributes, especially in terms of being more entrepreneurial and tough at work, skills that are often considered more 'professional' than being soft and nurturing in the west (Davies, 1995, 1996). On the other hand, the presence of the therapist taught the home care workers that they were not experts on their own work and that they in principle had performed non-professional work before the entry of the therapists, and thus needed to de-learn their former expertise. In other words, the introduction of the rehabilitation expertise did not upskill the care aides' skills (as a new layer of knowledge); rather, care aides' risk of marginalization was reinforced in the sense that they were asked to DE-skill themselves from their previous knowledge and roles, in order to re-learn and transform into a new (externally defined) professional role. Thus we have seen that the regulation of professionalization through the introduction of the working expert seems to sustain the care aides' position at the margin, because the introduction of the working expert sets them back as a type of workers who need 'higher-qualified' experts to teach them how to conduct their work 'more professionally'. And in addition, the dissertation shows (article 1, 2, 3) that care aides who struggled to adapt to this new professional persona risk being blamed for being a bad colleague or for having a non-professional attitude. Overall, figure 7 (Chapter 2, p. 39) also adds to this dilemma by implying that the introduction (and cost of hiring) the therapists was one reason why layoffs were made in that care aides' group.

8.2.2 Empirical finding 2: The dilemma of introducing team meetings to underpin negotiation

Below I will focus on how the introduction of the team meeting as a means to underpin professional dialogue influenced home care workers' marginalized position at work (see article 2) in order to provide another situated window into the implications the professionalization processes in rehabilitative home care organizations had for the home care workers. The introduction of the team meetings reconfigured the work, because the team meetings became a new forum where the home care workers could discuss their work with rehabilitating recipients. In contrast to their 'ordinary meetings' where only administrative things had been discussed, the new team meetings were introduced as a

means to increase and underpin the professional and cross-occupational dialogue about work at work[31]. Yet, by looking at how the care aides shared their stories at the meetings and how the meetings were supervised and orchestrated by the therapists, we learn (in article 2) that this was not quite what happened. Rather, article 2 shows that the team meetings seemed to streamline the dialogue about the professional outcome of care rather than openly negotiating the care aides' often complex and unpredictable work with rehabilitating the care recipients. This had primarily to do with how norms and ideas about successful - and not so successful – work outcomes were established at the meetings.

The team meetings streamlined the negotiations about professionalism because certain stories with a particular plot were promoted as 'success stories' at the meetings. These stories were characterized by a particular storyline that underpinned the vision about rehabilitation. The success stories often concerned: 1) recipients who were happy because they had become more self-reliant, 2) an indication that the home care recipients received less service, and 3) a care aide storyteller who was proud of her 'entrepreneurial' results. Some therapists directly mentioned that they promoted and labeled such stories as success stories, as a means to acknowledge and reward the work of the care aides. Yet, at the team meetings we saw that other stories flourished. These stories were not associated with success and rewards, but rather seemed to evoke tension and frustration. In addition, these stories did not mirror the rehabilitation vision. They articulated that some recipients were not motivated to become rehabilitated or were incapable (mentally, physically or socially) of being 'restored'. These reflections, in particular plots that focused on 'incapable' recipients, were not rewarded at the team meetings. Rather, while the lack of motivation plot about the recipients was accepted at the meetings (because they did not deny a future potential to restore the recipient), the plot about the incapable recipient was challenged by especially the therapists, who tried to redirect the care aides' attention towards the recipients' rehabilitation potential.

The reconfiguration of work into the team meeting arrangement where the care aides' stories about their work were shared and valorized (as successful or non-successful) had implications for the workers' risk of marginalization. Thus at the meeting we saw how the flow of stories established a

[31] This idea that teamwork (including team meetings), in contrast to more bureaucratic and Taylorized work arrangements, better underpin and optimize professional dialogue and performance is described in article 2 and widely assumed in the healthcare management literature (see e.g. Ferlie and Shortell 2001; Denvir 2015; Mezey et al. 2002; Gittell et al. 2010)

sanction and reward system where the care aides could expect that some of their stories would be welcomed and rewarded, while they risked sanctions by bringing alternative stories about their work with recipients to the table. Thereby the meetings gave rise to a dilemma for the aides. On the one hand, the meetings became a new opportunity for them, in the sense that they got a new forum where they could share their work experiences and get rewards and recognition from their colleagues (if they lived up to the expectations defined by higher-status workers). On the other hand, in the very same forum they also increased their risk of experiencing marginalization and sanctions if they could not live up to the rehabilitation norms and agenda. Thus although the meetings were intended to offer the care aides a new opportunity to discuss and share knowledge about their work (rather than administrative things), the meetings also became a source to streamline discussion rather than open up for negotiations about the complex work. In particular, due to the asymmetrical power relation, the limited time frame, the shadow of the rehabilitation ideology, and the allocation of sanctions that caracterised the meetings.

8.2.3 Empirical finding 3: The dilemma of introducing new (distancing) techniques and practices

I will now turn to the implications for the professionalization of home care workers (and by implication their marginalized position) of having their practices reshaped by the introduction of new techniques and tools in rehabilitative home care organizations (see article 3). With the introduction of rehabilitation, the care aides were given new working tools as a means to practice their work more professionally, and thus these working tools reconfigured the work by altering work practices. The working tools included both a new vocabulary and a new bodily approach and material tools (such as ability aids) that were supposed to be used to practice and perform rehabilitative home care work. But, it's questionable whether these working tools minimized the workers' risk of marginalization. The dissertation has shown that the workers, by using the new working tools and practices, generated a distance from aspects of work that traditionally have been stigmatized. More specifically, by looking at how these working tools were practiced by the care aides and therapists in, for example, the home of Ella and Laila (article 1 and 3), and how the managers tried to promote them in the organizations (article 3), we have seen that the working tools generated a distance from stigmatized aspects of the work in three ways. First, the tools were used to focus on older people's potentials and resources rather than their decline and pain. Second, the tools generated a bodily distance from the former (dirty) hands-

on work. And third, the tools were used to underpin the move away from the 'female' nurturing role and towards the more 'tough' entrepreneurial trainer role. And thus, clearly the working tools did offer a 'potential' to distance oneself from the core aspects of care work, that often risk stigmatization.

The dissertation also shows, however, that these three ways of generating distance from stigmatized aspects of work were not unproblematic. Rather, the new working tools and practices gave rise to a dilemma. On the one hand, the working tools did indeed provide workers with an opportunity to both rhetorically and physically distance themselves from the aspects of work that are most often stigmatized in the West. On the other hand, however, this requirement to distance oneself from these particular aspects of work seemed to re-stigmatize female workers who perform 'dirty' work for older people who need nurture and intimacy. Thus the dissertation indicates that the distance did not change the work context, which still was populated by weak – even dying, aged and 'dirty' people – who needed help in their homes, and females who provided care. Thus we have seen that the distance implied that recipients such as Ella and Laila were now asked to be responsible for their own dirt and pain. In addition, the care aides still risked being sanctioned as 'non-professional' females if they did not practice the physical and rhetorical distance at work. Furthermore, we have seen how the division of labour was sustained. Care aides did not move 'up' the occupational latter due to their new tools and practices (in fact it seemed that a new layer of superiors were added). Rather, due to the new distances they made from the recipients, they cut down their own tasks in the homes, thereby adding to layoffs in the care aides' occupational group. Thus although the tools did provide an option to distance oneself from the stigmatized aspects of work, this distance did not change the care aides' risk of stigmatization.

8.2.4 Summing up: Dilemmas at the margin

Above I have given an empirically grounded description of how the means to professionalize home care workers with the introduction of rehabilitation gave rise to a range of dilemmas for these workers, because the means to professionalize them was regulated, negotiated and practiced in ways that interacted with (re-)marginalizing processes. Together the empirical findings show that the means to professionalize home care work (the new experts, team meetings and working tools) indeed reconfigured the work division, qualifications of the workers, the work arrangements, and the practices at work, yet these reconfigurations did not quite "work" as intended, but instead generated new dilemmas.

One the one hand, we can conclude that the means to professionalize home care workers indeed appeared as positive opportunities. Perhaps, because the initiatives did give the care aides an option to gain new expertise, an option to get a new forum where they could discuss and reward each other for their accomplishments, and an option to practice their work through new working tools, that did build distance from what is commonly understood as stigmatized aspects of home care work. Or perhaps because the initiatives in many ways mirrored the qualifications, work arrangements and work practices that often are naturalized as 'professional' (associated with professionalism) in Western societies, and thus indeed appeared as an option to include care workers within the boundaries of professionalisation.

On the other hand, a source of complexity was that situated in the specific home care context, each professionalization option seemed to be united with a risk of (re-)marginalizing home care workers and their area of work. To sum up: a) although the care aides got new qualifications with the introduction of the therapists, the regulation of their work was increased and they were taught that they were not experts on their own work and that they had to de-learn their nurturing skills to avoid marginalization; b) although the care aides got a new forum to discuss their work and get rewards for their accomplishments at work with the introduction of team meetings, the very same forum seemed to streamline the discussions about the complex work and gave raise to sanctions as well; and c) although the care aides got new working tools to technically distance themselves from the stigmatized aspects of their work, it did not make these aspects disappear. There were still older people, dirty homes and female employees at work – but now these aspects of work were re-stigmatized.

The way I have presented these dilemmas are closely related to the three means to professionalize home care work in rehabilitative home care organizations and the three articles I present in the dissertation. However, the way I have explored these dilemmas in the analytical body of the dissertation also makes it possible to provide a more cross-cutting conclusive answer to what implications the professionalization processes (and by implication boundaries of professionalization) in rehabilitative home care organizations had for the home care workers' risk of being socially, economically and technically (re-)marginalized at work.

Home care workers' risk of being socially, economically and technically (re-)marginalized

Economically, the findings have shown that there were indeed investments in the means to upskill the home care workers with the introduction of rehabilitation; however, the dissertation shows that with the introduction of rehabilitation home care workers' risk of being laid off was increased,[32] because it was through layoffs in the care aides' staff group (and cutting down on the services in the homes) that the investments (to e.g. the hiring of therapists and making training courses) were to be financed, and the overall savings on making recipients self-reliant as such.

Technically, we have seen that although the home care workers were offered new distancing techniques and working tools with rehabilitation (that did generate a distance from older 'dirty' people's bodies), home care workers still worked in the same spaces with the same bodies. In addition, their new tools (and the therapists' new presence in the homes) did not change the unequal distribution of distance techniques between workers with different statuses in home care organizations (i.e., the care aids did not move up the occupational latter). Rather, we have seen how a new (and additional) technical hierarchy was established in the homes, where the therapists used measurement tools to assess the older bodies in the homes, while the home care workers primarily new distance technique concerned to keep 'their hands on the backs' (cf. article 3). In fact, as mentioned, home care workers' hands-on techniques and expertise as such were re-marginalized as incompatible with rehabilitation, and they learned to keep their own bodies in check.

Socially, the findings show that some home care workers did indeed receive more social rewards and recognition for their 'professional' work in the homes with rehabilitation, i.e. when they lived up to the rehabilitation ideal or showed that they were champions of rehabilitation. However, rehabilitation also generated identity struggles and sanctions among the care aides, especially for those who due to the unpredictability of work could not live up to the expectations associated with the rehabilitation ideal, or for those who tried to voice critiques of this ideal (see also Rasmussen, 2004). These workers risked being characterized as 'unprofessional' women. And thus these findings point in the direction that if home care workers wanted to be socially accepted, they not only had to act as champions of rehabilitation but also as 'social men' (Davies and Thomas, 2002), 'tough' and 'entrepreneurial' rather

[32] In addition, no evidence suggests that their salaries increased.

than ‘soft’ and ‘nurturing’. Overall, the dissertation thereby suggests that rehabilitation did not radically break with home care workers’ risk of being socially, technically or economically marginalized at work, but rather risked reinforcing their marginalization.

Censorship at the margin

A necessary question that remains is then why we have not heard about these re-marginalization processes and dilemmas in the public debates? The dissertation indicates that some kind of censorship may exist in rehabilitative home care organizations. In chapter 1 I referred to a recent quantitative study that suggests that up to one-third of the workers in eldercare censor themselves because they fear retaliations from their managers if they speak up about critical conditions at work (Pedersen and Jespersen, 2017). This high amount of censorship, together with the findings of this dissertation, clearly indicates that the reason why we have not heard about the re-marginalization processes in eldercare may be that the workers are censoring or silencing themselves and each other. While the quantitative study shows how widespread the censorship is, the data of this dissertation specify the ways this censorship may be cultivated at work, at least in rehabilitative home care organizations. As already implied, the dissertation asserts that the introduction of rehabilitation and its associated promises of professionalization generated a climate among the home care workers, were it was risky for the employees not to align with the rehabilitation vision (aka the professionalization opportunities). Namely, the dissertation shows that if the care aides voiced a critique of the savings, or their behavior signaled a preference for nurturing (even if this was only addressed in relation to a particular recipient), or if they critiqued an ‘over-focus’ on the rehabilitation opportunity (at the expense of nurturing) they risked being blamed and/or sanctioned as ‘traditional’ non-professional, stupid persons, and/or a bad colleague by higher-status staff. As workers who were incapable of seeing the opportunities and resources of older people, but also their own opportunities to escape their marginalized positions as workers. Censorship was not only problematic for the ‘critical’ workers. In tandem, this censorship, may seem particularly problematic considering the character of the work: work with primarily older

recipients who often suffer from a social, mental and/or physical condition, and thus may not be in a position to speak up for themselves[33].

In this section I have delved into the practical and empirical findings of this dissertation. However, clearly the identification of the dilemmas has been guided by the theoretical building blocks I have applied and experimentally combined in the dissertation. Thus I will now turn to evaluate the theoretical aim of the dissertation: that rehabilitative home care organizations could serve as an apt case to experiment with combining theoretical building blocks from both material-oriented and discursive-oriented studies to advance a more complex understanding of how boundaries of professionalization become regulated, negotiated and practiced at contemporary workplaces in ways that both constitute such boundaries and function to silence them.

8.3 Theoretical contributions: Mechanisms of silence at the margin

The aim of this section is to present and reflect on the theoretical insights and contributions the attempt to answer the overall research question has generated. In the introduction of the dissertation I have - inspired by feminist scholars - developed the notion of boundaries of professionalization as an analytical guideline to inquire into the complex - both material and discursive – constitutive processes whereby professionalization and marginalization processes may intersect at work in rehabilitative home care organizations. Yet to conceptualize how boundaries of professionalization more specifically were constituted and functioned at work in rehabilitative home care organizations, I have experimented with combining different theoretical building blocks from what I have called the discursive-oriented and material-oriented studies on professionalization.

The discursive-oriented studies have helped me to explore the symbolic, discursive and regulative nature of how boundaries of professionalization were constituted at work, or more specifically how discursive activities differentiated "the professional" from "the non-professional" at work, often times by a seductive language of opportunities. In contrast, the material-oriented studies on professionalization have helped me to study the more silent and material nature of how boundaries of

[33] A problem here might also be (as shown in paper 2) that a common assumption in home care organizations seems to be that in order to obtain the 'success results', it may require some 'fights' and conflicts with the care recipients (fights that are legitimized by the fact that recipients are expected to be grateful in the longer run).

professionalization were embedded, embodied and mark-up in the socio-technical arrangements at work, in the division of labour, in the relations, in the division of tasks, in the task trajectories, in the human bodies, in the diagnosis processes, and in the working tools. The experiment with combining these two types of studies in a situated study of rehabilitative home care organizations was, as mentioned, ultimately aimed at advancing a more complex understanding of how boundaries of professionalization become regulated, negotiated and practiced at contemporary workplaces in ways that not only constitute boundaries of professionalization but also, paradoxically, function to silence them. It is, however, important to emphasize that this theoretical experiment first and foremost has been centred around an abductive processes where I have moved back and forth between the theoretical building blocks and the empirical data, and thus in this sense it was the empirical data that 'called' for these experiments.

To address the theoretical contribution of the dissertation, the section is structured around a presentation of what I call three professionalization mechanisms of silence that I propose may advance our ideas about how boundaries of professionalization respectively are regulated, negotiated and practiced at the margins. These three mechanisms can also be seen as mechanism of silence, because they are mechanisms that simultaneously constitute boundaries of professionalization (differences and divisions) by means of specific modes of regulation, negotiation orders and practices at work, but also seem to 'work' at work by silencing and denying such boundaries. The three professionalization mechanisms of silence are developed on the basis of each of the three articles that comprise the analytical body of the dissertation. First, I introduce what I call an identity regulation mechanism (cf. article 1). Second, I introduce what I call a negotiation mechanism (cf. article 2). And third, I present what I call a practice distance mechanism (cf. article 3).

8.3.1 Identity regulation mechanisms

Article 1 in this dissertation has tried to advance our understanding of how boundaries of professionalization are *regulated* at work by experimenting with combining theoretical building blocks from discursive-oriented critical management studies and performative theory. This combination was made in the endeavor to understand how the introduction of the therapists as a means to upskill home care workers influenced both the discursive and more material ways boundaries of professionalization were regulated at work in rehabilitative home care organizations (see article 1).

Discursive-oriented critical management studies (CMS) (e.g., Alvesson and Willmott, 2002; du Gay, 2008; Ashforth, 2007; Davies and Thomas, 2002) hold that new contemporary organizational policies such as rehabilitation regulate workers by means of defining and transforming their identities. This regulation, which they call 'identity-regulation' (Alvesson and Willmott, 2002: 627) mobilizes workers to pursue organizational targets (e.g. efficiency purposes) not by means of explicit rules but by means of seductive language that offers the workers new meaning and more 'positive' identities, e.g. promises of a professional identity. They also indicate that this meaning is not priceless for the workers. For example, they show that new policies such as NPM are often affiliated with gendered discourses that affiliate the "positive" professional identities with associations of masculine stereotypes (e.g., of autonomy, rationality, individuality and competitiveness), and thus that in particular women who find it difficult to adapt to the managerial-defined identities risk becoming marginalized as non-professional "women" - associated with feminine stereotypes (e.g., of empathy, supportiveness and nurturing) (Davies and Thomas, 2002; Rasmussen, 2004; Dahl, 2009). The studies thereby indicate that the managerially produced identity regulation may provoke various struggles of incorporating or resisting these discourses among the employees (Sveningsson and Alvesson, 2003; Alvesson, 2010). The CMS studies thereby provided a crucial theoretical lens through which to understand how the therapists (as new experts and drivers of rehabilitation) and the manager nurses discursively constituted boundaries of professionalization in rehabilitative home care organizations through their utterances about rehabilitation at work.

The discursive-oriented CMS studies could, however, not fully explain the regulative role the therapists seemed to play in rehabilitative home care organizations. And thus, to understand how the presence and authorization of the therapists and their behavior at the frontline – not only as a new human actor or manager at work, but as a working expert – influenced the regulation of professionalization in more 'material' ways, CMS studies were combined with STS-inspired performativity theory (see Cabantous et al., 2016). This theory provided building blocks to open the analysis of the performative ways therapists regulated boundaries of professionalization at work. Figure 18, presented in article 1 (p.137), summarizes the result of this experiment.

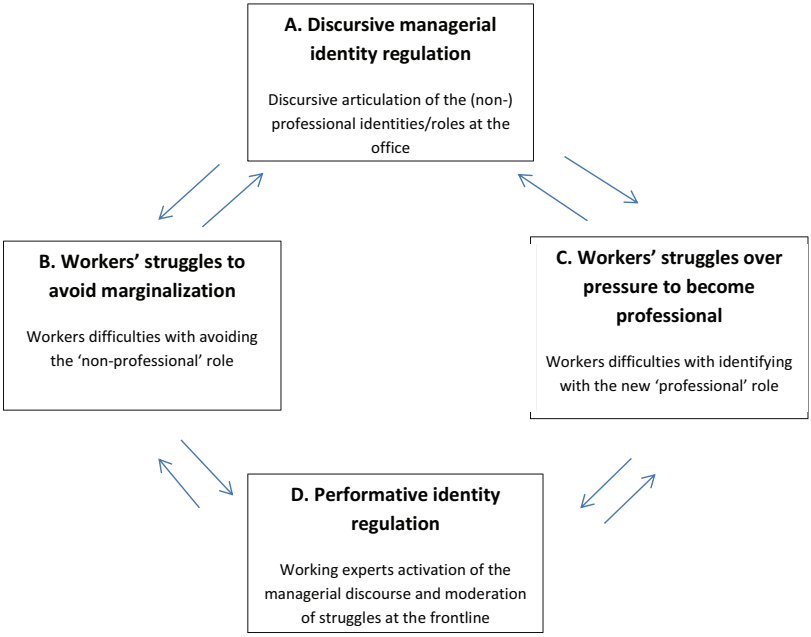

Figure 17. The relationships and interactions between the discursive and performative identity regulation and struggles over professional identities.

To the study of professionalization at the margins, the findings summarized in figure 18, offer a model that may be used as a guideline to understand the *regulative identity mechanisms* whereby boundaries of professionalization, and in particular distinctions between non-professional and professional identities, are constituted and function at work in contemporary welfare organizations.

Constituting discursive and material regulative identity mechanisms at work

The dissertation has contributed to the literature by showing how home care workers in rehabilitative home care organizations were mobilized to transform into a new 'entrepreneurial' and 'tough' 'professional' identity through the *co-emergence* of discursive identity regulation (Boks A, figure 18) and what I refer to as 'performative identity regulation' (Boks B, figure 18). Through discursive

identity regulation (Alvesson and Willmott, 2002), nurses and therapists in tandem sought to mobilized the home care workers to transform into the new 'professional' identity by rhetorically crafting a rather abstract and symbolic identity hierarchy between what was defined as the tough and entrepreneurial 'professional' persona and a marginalized non-professional 'soft' nurturing persona (which the home care workers were expected to dis-identify with). The dissertation shows, however, that the discursive identity regulation was supplemented by 'performative identity regulation,' i.e. the therapists' performative 'professional' utterances and their 'doing' of exemplary 'professional' practices at the frontline. A performativity, whereby the therapists and their task accomplishment became a living example of how this 'professional' persona would act, talk and feel in front of the recipients, that was perhaps easier to relate to than the abstract voiced ideals for the care aides.

The silencing function of regulative identity mechanisms at work

The dissertation has also shown how the regulative identity mechanisms, in particular the performative identity regulation that emerged in rehabilitative home care organizations, functioned at work to not only generate identity struggles among the workers but also to moderate the resistant nature of such struggles. More specifically, article 1 has shown how the home care workers both struggled to avoid marginalization (the nurturing persona) and to become 'professionals' (the entrepreneurial persona) in rehabilitative home care organizations as a result of the discursive and performative identity regulation (see boks B, C, figure 18). However, these struggles were never formulated as a workers corps kicking back against the managerial discourse. Rather, the dissertation indicates that they tended to happen in 'silence', i.e. the home care workers blamed themselves (and their personal difficulties) or the recipients for their struggles over identities, and thereby seemed to express both an affirmation of and resistance to the managerial discourses at the same time (see Egan-Wyer et al. forthcoming; Thomas and Davies, 2005 for other analyses of the omnipotence of resistance). This silent or moderate form of resistance might be closely tied to the performative regulation performed by the therapists which the majority of the care aides did not associate with a managerial attempt to control or regulate them (but rather as a co-worker colleague who performed certain tasks with them). In this way, performative regulation was more easily accepted by the care aides; it worked better as a more 'silent' control

mechanism regulating their identities at the frontline[34]. The notion of performative regulation, therefore, seems important to further our understanding of how regulation is not only discursive and cultural, but also material, embodied and thus performative at work.

8.3.2 Negotiation mechanisms

In article 2 we advance our understanding of how boundaries of professionalization are negotiated at work by experimenting with combining theoretical building blocks from critical studies on team organizing with classic theories on the nature of health care work. This combination was made to understand how the introduction of new team meetings as a means to ensure more professional dialogue at work influenced both the discursive and more material ways boundaries of professionalization were negotiated at work in rehabilitative home care organizations (see article 2).

The discursive-oriented critical studies on team organizing (Barker 1993; Boltanski and Chiapello 2005; Ekman 2010; du Gay and Morgan 2013) were a valuable lens through which to critically understand the negotiation consensus and peer control that emerge when team organizing is introduced in professionalization processes[35]. Of particular importance, Barker (1993) argues that team norms, that are established on the basis of a managerial vision in teams, become crucial in the collective peer evaluation processes, where the norms are used as a template to draw discursive boundaries between those colleagues who respectively are rewarded or sanctioned due to their behavioral and attitudinal (mis)alignment with the team's norms. Thus critical studies on team organizing provide important building blocks to understand how negotiated orders and norms in teams are discursively constituted, and how such orders tend to draw boundaries between colleagues who are rewarded or sanctioned due to their work outcomes. Yet, I argue that the limitations of these studies are that they tend to generate rather 'generic' analyses that focus more on the abstract concepts such as norms, rather than the contexts and type of work where these norms are constituted (see also Vikkelsø, 2015). And thus, to ensure a lens on how these team norms are shaped by, and have implications for the work and workers,

[34] According to Lipsky (1980), frontline workers such as home care workers normally have discretion at the frontline (because they often times work out of sight of the managers); however, with the entrance of the therapists at the frontline, this space was clearly narrowed down.

[35] In contrast to this literature, more mainstream health care management literature on team organizing tends to celebrate team organizing as a means to underpin and optimize professional dialogue and performance (see e.g. Ferlie and Shortell 2001; Denvir 2015; Mezey et al. 2002; Gittell et al. 2010).

I suggested to combine the critical studies on team organizing with classic theories on the nature of health care work, which according to these theories is unpredictable and complex due to the work with weak and often sick human beings (Strauss et al. 1997; Hughes 1958). The matrix (Table 7) presented in article 2, summarizes the results of this attempt to apply the two different building blocks and a narrative analytical lens (Boje, 1991; Downing, 1997; Orr, 1998: 62; Humle og Pedersen, 2010) to understand what happens at team meetings in rehabilitative home care organization.

	3 ideal typical everyday stories			
Narrator	'Success story'	Non-success story: Buffer story	Non-success story: Push story	**Analytical point**
Care aide's main plot regarding the care recipient	The receipient is motivated. He/she has become more self-reliant and their need for aid has been reduced.	The recipient is mentally, physically or socially unstable and is not capable of becoming self-reliant.	The recipient is not motivated and expects a more luxury service.	Ideal types which all together express the complexity in the rehabilitation work (even though each narrative stabilizes the complexity).
The feedback and narrative techniques of the therapists	Is emphasized and promoted as a 'success'. Followed up by acknowledgement and praise.	Active attempt to retell the story of the recipient by focusing on the ressources of the individual. Lack of praise and acknowledgement.	Hesitant – supports and prioritizes the plot. From time to time praise for the 'entrepreneurial spirit'.	Ideal types which altogether show how different 'plots' are received, and how they create different kinds of sanctions or rewards in the group.
Self-perception of the care aide	Express that they feel pride.	Express that they feel worried and nervous.	Express that they feel anger and flexibility.	Shows the consequences of the reward-and-sanction system
Example	Jørgen	Anne	Inge and Agnes	

Table 7. Analytical results.

To the study of professionalization at the margin the findings, summarized in Table 7, offer a model that may be used as a guideline to understand the negation mechanisms whereby boundaries of professionalization, and in particular distinctions between non-professional and professional outcomes and accomplishments at work, are constituted and function in contemporary welfare organizations.

Constituting discursive and material negotiation mechanisms at work

The dissertation contributes to the literature by showing how a negotiation order that differentiated between workers' (non-)professional accomplishments and outcomes at team meetings in rehabilitative home care organizations were constituted through a co-emergence of on the one hand discursive plots and success and failure labels, and on the other hand more material (asymmetrical) relations in the team. Alla Barker's (1993), the dissertation shows that this negotiation order was discursively underpinned by means of a reward-and-sanction system. However, the dissertation provides a more particular account of how this reward-and-sanction system was underpinned by a narrative network of stories that allocated discursive labels that framed some workers' stories about their work as a 'success story', while labeling other stories (buffer and push-stories) as non-successes. In addition, I extent Barker's (1993) notion of negotiatied consensus in teams by foregrounding how these discursive constitutive processes that differentiated workers' (non-)professional accomplishments and outcomes at work were closely affiliated with more material aspects of work. Namely, the asymmetrical relations at the team meetings (between the present care aides and therapists) and the situated complex content of work that individual workers faced (due to the different and complex rehabilitation cases). There was a 'material' difference between the multiple cases that could not be entirely bleached out or reshaped by the discursive constitutive processes, although attempts indeed were made to do so.

The silencing function of negotiation mechanisms at work

The dissertation has also shown how the ways boundaries of professionalization that were negotiated at work, seemed to function at work. Namely, it suggests that the negotiation mechanisms seemed to streamline the professional dialogue in ways that silenced the failures of the rehabilitation vision by over-focusing on the successes. The dissertation points in the direction that although the workers' stories at the meetings clearly indicated that the workers in some cases found it difficult to apply the abstract rehabilitation vision on the often old and infirm care recipients, these difficulties were seldom

discussed as a 'failure' of the rehabilitation vision. Rather, the roots of this misalignment between the vision and the recipients were framed as products of the failure of some recipients or some workers (as we also see in article 1). By evoking a push-plot and blaming the recipients for having a motivation problem, the workers could legitimize that although they had to present a non-success story at the meetings, they were champions of and intended to pursue the rehabilitation vision (i.e., they could assure their colleagues at the team meetings that they had observed a restorative potential, but the recipient refused to be rehabilitated). In contrast, workers who focused on a potential misalignment between the vision and a recipient's lack of mental, social or physical restoring potential (the push-stories) risked being blamed and sanctioned for being unwilling to see and/or pursue such a restorative potential and thus for being non-professional and even a disloyal colleague. Thereby the push-stories also expand our knowledge about the boundaries of professionalization because it clearly illustrates that such boundaries are not so simple as strict binaries, e.g. between success or failure outcomes. Workers may be seen as 'professional' although they have produced a failure, if they can legitimize that they have the right 'spirit' in the team.

8.3.3 Practice distance mechanisms

Finally, the dissertation has tried to advance understanding of how boundaries of professionalization are practiced at work by experimenting with combining dirty work and body work studies. This combination was made to understand how the introduction of new working tools and techniques as a means to professionalize the performance of home care workers influenced both the discursive and more material ways boundaries of professionalization were practiced in rehabilitative home care organizations (see article 3).

Dirty work studies highlight how workers at the margin deploy discursive practices to reframe their work in more attractive or more honourable ways (Meara, 1974; Ashforth et al., 2007; Ashforth and Kreiner, 1999: 424), ultimately as a means to manage their risk of stigma. And thus, I found that these studies could provide important building blocks to understanding the discursive practices that the working tools were affiliated with in rehabilitative home care organizations. Yet, I argued that these discursive practices could not alone explain the practices I observed at work. Thus, to understand the more material aspects of the practices that emerged with the introduction of new working tools in rehabilitative home care organizations, I also relied on building blocks from body work studies. The

body work studies (Wolkowitz, 2006: 13; Sullivan, 2012; Twigg et al., 2011: 5) focus on workers' more material practices and particularly what they refer to as workers' 'distancing techniques.' Distancing techniques they propose are used by workers not only to remain physically clean but also to de-emphasize the bodily character of work that cannot be discursively fixed.

Thus while body work and dirty work studies share an attention to how workers try to manage their potential risk of stigma through specific practices at work, they focus on respectively the discursive and material aspects of these practices. In addition both dirty and body work studies argue that respectively, material and discursive practices that are used to manage stigma at work often are gendered at the margin, but from different angles. The body work studies focus on how the occupational hierarchy as such is gendered because professional status often is associated with masculine stereotypes (for example, the disembodied and the tough) but also privileged men within the organizational hierarchy (Davies, 1995; Martin-Matthews, 2007; Palmer and Eveline, 2012; Rasmussen, 2004; Sullivan, 2012; Twigg, 2004; Twigg et al., 2011; Wainwright et al., 2011). In contrast, the dirty work studies argue that workers who risk stigmatization celebrate stereotypical notions of their essential gender identities as an integrated part of their attempts to discursively manage stigma and ensure a positive sense of self (Bolton, 2005; Chiappetta-Swanson, 2005; Jervis, 2001; Johnston and Hodge, 2014; Meara, 1974).

The applications of these theoretical building blocks to the study of rehabilitative home care work made it possible to pin out the ways professionalization was practiced in both discursive and material ways when rehabilitation were introduced by higher-status workers to replace the nurturing approach (see Table 8, presented in article 3)

	Core aspects of work that risk stigmatization	Rehabilitation techniques	Nurturing techniques
Material techniques*	Intimate body work - tools and practices	Keep hands at a distance, frame the body functionality, and introduce aides to replace hands.	Hands on helping, touch and compensating by, e.g., rinsing off shampoo.
Discursive techniques**	Ageing bodies — focus and framing	(Hidden) resources, potentials.	Old, declining, frail, infirm.
	Care workers bodies — focus and framing	Thinking, training, professional, trainer, consultant, tough.	Kind, nurturing, female, emotions, sensitivity, a big heart, a nurture gene.

Notes: Table 1 gives an overview of the result of the coding process. It shows how rehabilitation and nurturing techniques (columns) were related to two discursively and materially competing ways to shape three core aspects of homecare work (rows).
* Table category inspired by Twigg et al. (2011) and Wolkowitz (2006).
** Table category inspired by Ashforth and Kreiner (1999) and Johnston and Hodge (2014).

Table 8. Competing techniques to shape stigmatized aspects of work.

Table 8 shows that different material practices (ways to undertake the work) and discursive practices (ways of framing the objects of care and the working bodies) were affiliated with rehabilitation and nurturing, respectively. For the study of professionalization at the margin these findings may offer a model that can be used as a guideline to understand the *practice distance mechanisms* whereby boundaries of professionalization, and in particular distinctions between non-professional practices (nurturing) and professional practices (rehabilitation) at work, are constituted and function in contemporary welfare organizations.

Constituting discursive and material practice mechanisms at work

The dissertation extends the literature by showing how boundaries of professionalization were constituted at work by the co-emerging rhetorical and material ways "the professionals" and their rehabilitative distance practices were differentiated from "the non-professional" and their intimate, hands-on practices. In particular, the dissertations' contribution is showing how the changing political context of eldercare (the introduction of rehabilitation) exposed the home care workers, in particular the care aides, to a contradicting yet co-existing set of approaches – rehabilitation and nurturing. An ambivalent context where the care aides practices were not pre-determined by their occupational affiliation or ideology as often anticipated in the literature (see for example Twigg et al., 2011; Ashforth and Kreiner, 1999). Rather, the care aides seemed to draw on both the rehabilitation and the nurturing approaches in a processual manner. Yet, I propose that therapists indeed tended to stick to

rehabilitation, and that they were more successful in constituting the rehabilitation approach and practices as *the* professional approach.

The silencing function of practice mechanisms at work

In article 3 the dissertation also put forth the notion of "stigma shaping" to describe how the ways professional boundaries were practiced at worked, seemed to function. Following Strauss et al. (1997), I propose to use this notion instead of stigma management, that is often used (especially within dirty work studies) to describe how workers try to manage their potential risk of stigma through specific discursive/material practices at work (or even how managers try to shelter their employees from this stigma via those practices). Yet, I propose that the notion of stigma management may 'hide' the function of the practices because it perpetuates the assumption that stigmatized aspects of work can be managed or negated through them, e.g. that the problem of dirt disappears if we do not focus (rhetorically) on it. In contrast, I propose that the notion of stigma shaping may help us to direct our awareness to how stigmatized aspects of work may not be negated but potentially get a "new shape" through these practices at work. For instance, older people (who lack their legs) may no longer be framed as 'old' (or lacking their legs) by care workers, but as a resource (who has arms), but this new 'shape' of the person, does not necessarily mean that old age or the lack of legs *is* managed for all parties (these disabilities might still be very present at a bodily level for the recipient)[36]. Finally, article 3 also holds that the practice distance mechanism functioned by enforcing what I call a 'genderfication' of work. By this I mean that in my case rehabilitation practices seemed to enforce a masculinification of the work at a female-dominated workplace, i.e. in the process masculine stereotypes were valued as professional skills, while skills associated with classic female stereotypes were devalued as non-professional. This shows that the issue of gender is still a crucial aspect of how boundaries of professionalization are constructed at work, but again that the boundaries are not so simple as strict binaries allow, e.g. between women/men, female/male and professional/non-professional, since it was women (i.e., not men) who forced other women to become "social men" (Davies and Thomas, 2002: 390).

[36] An interesting aspect of this notion is also that different 'shapes' of the body have different prices. For instance, a body with two arms is less expensive for the service provider than a body without two legs.

8.3.4 Summing up: Making silent mechanisms of professionalization salient

In this dissertation, I have studied professional processes in rehabilitative home care organizations as involving not only one, but several heterogeneous initiatives and means to professionalize home care workers and their area of work (i.e. the introduction of new working experts, the team meetings and the new working tools). I have shown that these initiatives encompassed new human beings (with new expertise and tasks), new social and relational practices, new modes of organizing the work and new technologies and devices, that were merged into the already existing socio-technical/discursive-material arrangements at work in home care organizations (Callon, 2008).

While the initiatives indeed were heterogeneous, the dissertation has shown that they shared a similar aim to professionalize home care workers and their area of work, and by following these initiatives, the dissertation has shown that, at least in rehabilitative home care organizations, professionalization is not a concept that makes people strive for consensus. Rather, the professionalization processes in rehabilitative home care organizations were constituted around binary distinctions between rehabilitation and nurturing approaches to home care provision, or more specifically boundaries of professionalization that prioritized the privileged professional rehabilitation approach at the expense of the now-marginalized non-professional nurturing approach (see Table 9). Or put differently, rehabilitation became particularly powerful by means of constituting its own contrast. The non-professional nurturing approach provided this contract, because without it rehabilitation would not be a privileged professional approach or something to strive for.

Mechanisms	**Boundaries of professionalization**	
	Nurturing (marginalized)	**Rehabilitation (priviledged)**
Identity regulation mechanisms	A waiter/housewife	Entreprenur/developer
	Traditional	New thinking
	Soft	Tough
	Female	Masculine
Practice 'distance' mechanisms	Intimate	Distance (hands on the back)
	Dirty	Clean
	Focus on the "old"/"disabled"	Focus on "resources"/"restorable"
Negotiation mechanisms	Not a success story	A success outcome/story
	Sanctions	Rewards

Table 9. The marginalized versus the privileged 'professionals'

More specifically, by inquiring into the multiple and complex layers of how professionalization processes were discursively and materially constituted at work in rehabilitative home care

organizations, the dissertation has identified three mechanisms whereby boundaries of professionalization are regulated, negotiated and practiced at the margin. To sum up:

- a identity regulation mechanisms whereby a professional persona (and by implications a non-professional persona) are materially and discursively constituted and regulated through (a working experts') performative 'professional' utterances and the 'doing' of exemplary 'professional' practices at the frontline;
- a negotiation mechanism that through rewarding and sanctioning plots and asymmetrical power relations at team meetings include and label some outcomes of work as a professional success, and marginalize other outcomes as non-professional (failures); and
- a practice distance mechanism that include the performance of rhetorical and bodily distancing practices as professional and marginalize intimate practices that pay attention to dirt and disability as non-professional.

The description of these mechanisms clearly shows that in order to understand how boundaries of professionalization are regulated, negotiated and practiced at work, it was not sufficient to study either the material or discursive aspects of professionalization processes. Rather, it was necessary to delve into the co-emerging discursive and material processes in order to understand the complex mechanisms of professionalization and how they "worked" at work. In addition, the findings of the dissertation also indicate that these professionalization mechanisms did not work independently. Rather the dissertation points toward how the three mechanisms seemed to "work" in the same direction (towards rehabilitation and 'professionalization') by different means, and thereby to reinforce the power of each other, and the overall change from nurturing to rehabilitation (as Figure 19 illustrates).

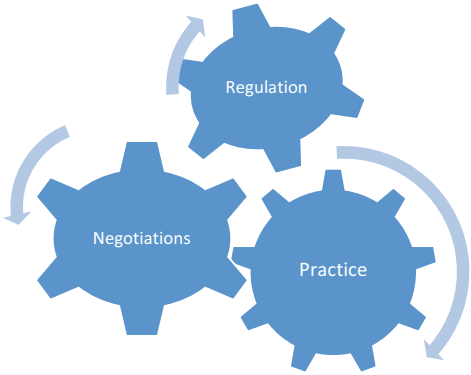

Figure 18. Reinforcing mechanisms of professionalization.

Together, the three mechanisms became powerful because they ensured that rehabilitation did not stick to the management level of the organization. Rather, the mechanisms seemed to infiltrate the workplace all the way to the frontline, because they operated in ways that affected for instance how home care work were organized, how the workers accomplished their work, the devices the workers drew on, the feelings they showed in their relations with the recipients, how they thought about themselves, and how they interacted with each other.

A crucial aim of the dissertation has been to make salient the ways these professionalization mechanisms and boundaries of professionalization are constituted and function at work. However, as mentioned I found that the professionalization mechanisms often worked rather 'silently' at work. In particular, throughout the dissertation I have shown that although rehabilitation generated tensions, problems, dilemmas and renewed re-marginalization processes (for both the workers and the recipients), this complexity was often silenced at work. This was first and foremost because the multifaceted ways rehabilitation "worked" at work by (at least rhetorically) offering the workers a professionalization opportunity, seemed to be a forceful way to silence those who critiqued this opportunitity (i.e. for being incapable of realizing their own and the recipients' 'potential' success). More specifically the three aforementioned mechanism function to silence the marginalization processes in three ways:

- The regulative identity mechanism made the marginalization processes it generated silent because the new modes of regulation that were introduced with the working expert did not appear as explicit control voiced from a managerial position at the office, but rather as 'positive' help to solve the tasks provided by a co-worker.
- The negotiation mechanism made the marginalization processes it generated silent because it generated a reward–and-sanction system where the workers' failures were marked up by highlighting and rewarding the successful workers.
- The practice distance mechanism made the marginalization processes it generated silent because it worked at work by 'offering' the workers a more 'positive' way to talk about and perform their areas of work; an 'offer', however, that simultaneously re-enforced Western ideas that associate stigma with dirty and intimate body work.

Thus overall, rehabilitation seemed to narrow down the understanding of professionalization in home care organizations, although it often appeared at work as doing the reverse. In the table below I have summarized both the discursive and material ways professionalization mechanisms were constituted in rehabilitative home care work and how they were silenced.

Mechanism	Discursive and material constitution of boundaries of professionalization	Silencing function of boundaries of professionalization
Identity regulation mechanism	Regulative constitutive processes that differentiates the "professional personas" and non-professional persona, by means of a *working experts* performative 'professional' utterances and the 'doing' of exemplary 'professional' practices at the frontline.	The differentiation processes (and by implication the marginalization processes) that the new modes of regulation generate are silenced because the regulation does not appear as explicit control voiced from a managerial position at the office, but rather is experienced as 'positive' help to solve the tasks.
Negotiation order mechanism	Negotiated 'orders' that differentiate some workers' 'successful' accomplishments and outcomes at work from others' non-professional and failing outcomes, by means of success and failure plots and asymmetrical relations at team meetings	The differentiation processes (and by implication the marginalization processes) that the new modes of negotiation generated are silenced, because a reward-and-sanction system is constituted where the failures at work are marked up by highlighting the successes.
Practice distance mechanism	Rhetorical and bodily practices that constitute differences between the 'clean' 'distant' professional practices and the marginalized intimate, bodily and dirty practices	The differentiation processes (and by implication the marginalization processes) that the new mode of practices generated are silenced, because workers are 'offered' a more 'positive' way to talk about and perform their areas of work; an 'offer', however, that simultaneously re-enforced Western ideas that associate stigma with dirty and intimate bodywork.

Table 10.

8.4 Methodological contribution and reflections: the workography approach

In the method section in the dissertation, I argued that the methodological framework and design I have constructed and refer to as a workography has mattered for the final product of the dissertation, and ultimately my understanding and approach to the study of professionalization and professional boundaries at the margin. As mentioned I have not used the workography notion to introduce a new type of ethnographic tradition. Rather, with this notion I have tried to specify up front what level of analysis I am operating on. Below, I will make some final reflections about how this research approach, and more specifically my study of professionalization and marginalization at work, and how it may add to future studies on similar topics. The reflections also involve addressing how far my conclusion may be extended and what we still have left to learn.

8.4.1 How we study professionalization processes and concepts at work matters

In this dissertation I have studied professionalization processes in a particular way, and in a particular setting, and clearly this has had implications for not only the conclusions I have made but also how far the conclusions may be extended. Below I will make some reflections about who might benefit from my research.

Relevance for other workplaces that have implemented/intend to implement rehabilitation

The professionalization processes I have studied in this dissertation have been closely affiliated with the notion of rehabilitation, and thus I believe that other public organizations that intend to or already have implemented rehabilitation as a way to professionalize their workers may draw on my conclusion. As already explained rehabilitation (also labeled 'reablement' and 'restorative care') is not restricted to Danish home care organizations (see e.g. Gustafsson et al., 2010; Social Care Institute for Excellence, 2010), nor is rehabilitation restricted to home care organizations (see e.g. God praksis I den rehabiliterings indsats, 2011; Vejledning om kommunal rehabilitering, 2011). Rather, rehabilitation is a concept that both nationally and internationally has proliferated as a solution to treat unemployed people, cancer patients and psychiatric patients in welfare organizations, among others. Thus it is not only in Danish home care organizations were rehabilitation is portrayed and celebrated as a win-win solution.

The dissertations findings may, however, be used to disrupt and nuance the simplistic public ideas about rehabilitation as a clear-cut win-win solution. The dissertation has shown that at least in home care organization rehabilitation is way more encompassing and complex than what is often presumed. To begin with, the dissertation suggests that rehabilitation is not only a new approach to the recipients. Rather, with Mol's (2008: 8) words rehabilitation seems to bring 'a whole world with it.' It is a world that may change how the work is organized, how the workers perform and practice their work, and how workers understand themselves and the recipients and the outcome of their work. It is a concept that not only aims at restoring the recipients but also the workers' reputation and the financial situation of the organization. And, in home care organizations, rehabilitation builds up and legitimizes this world, and in particular the savings that follow rehabilitation by highlighting the win-win stories.

Yet, by focusing on the particular and complex everyday work situations in rehabilitative home care organizations, the dissertation has nuanced the outcomes rehabilitation generates. Thus, we have seen that both the workers and the recipients may experience that they lose with rehabilitation. In particular, it seems that there are cases where efficiency purposes 'win' over the social- and quality-oriented purposes of care. It all seems to depend on the individual recipient-case in question. Should other workplaces in the public sector then avoid implementing rehabilitation? Not necessarily, but what this dissertation suggests is that due to the complexity of work in public organizations, complex care approach*es* may be required in the public sector. Or in other words, the dissertation points in the direction that a key problem in rehabilitative home care is the strong focus on how rehabilitation is supposed to replace rather than supplement nurturing care (see also Hauge, 2017). There is a focus on replacement that other workplaces may be able to avoid, or at least critically discuss, for example by raising questions such as: Is it possible to restore all kinds of citizens with all kinds of problems (e.g. at some point people will die)? Is it desirable? For whom? And is it efficient, in the short AND long run, in all cases[37]?

Relevance for studies on (and workplaces that has implemented) proliferating 'promising' concepts

The dissertation focuses on how professionalization processes are affiliated with the notion of rehabilitation, and the way I have tried to study this concept and its function at work, may also be relevant for other studies of, or other workplaces that have implemented, new promising concepts. What rehabilitation seems to share with other contemporary proliferating concepts such as LEAN and NPM is the focus on dual efficiency and quality effects, and also fuzziness. As Power (1997) have explained it is the fuzziness and the seductive promises that such concepts come with that make it possible for these concepts to travel from sector to sector, and to commit the employees for its purposes (because efficiency purposes cannot in and of themselves mobilize workers). Studies of NPM have however been critiqued for studying NPM as a 'homogenous' 'catch it all term' or discourse that attends to societal transformations rather than the lived experiences of the workers (Ashworth et al., 2013, Thomas and Davies, 2005, Dahl, 2009).

[37] As an example, in article 2, one of my respondents indicate that if help is taken away from lonely or physical vulnerable persons there is a risk that they will "fall down" and e.g. need hospitalization, whereby rehabilitation in the long run might generate more costs than savings

This dissertation has followed another path, namely to study how rehabilitation was affixed at work and the implication it had for the workers. This has not only made it possible to attend to how new proliferating concepts may be affiliated with heterogeneous initiatives, but also how these initiatives share a sameness in the sense that they from different angles and by different constitutive processes (both material and discursive) reinforce each other to "work" in the same direction (cf. Figure 19, p. 236). Thus the dissertation points in the direction that the heterogeneous means to professionalize the home care workers seemed to be united in some kind of network or what Callon (2008) might have called a socio-technical agencement at work. However, it is up to future studies to explore the potential relevance of this notion for studies on professionalization in detail. In addition, by following how these initiatives were affixed at work the dissertation has, as mentioned, also shown that rehabilitation (or the socio-technical agencement) did not "work" in similar ways for all actors. Rather, some actors (recipients and workers alike) seemed to benefit from rehabilitation, while others suffered (see also Davies and Thomas, 2002; Dahl, 2009). Finally, what the dissertation might bring to these studies is the emphasis on how contemporary concepts do not only work in seductive ways by giving workers a new hope. Rather, at least in home care organizations, rehabilitation also worked at work by generating fear or risk of being re-marginalized as "the other": the non-professional worker.

Relevance for other marginalized workplaces

Finally, I have studied professionalization processes in a particular work setting at the 'margin.' That is, in a work setting where a legitimate professional identity is not uniformly available to all the workers, and in particular not to the dominating occupational group – the care aides who historically have fought to be recognized as professionals. Due to historical, social, economic, cultural and geographic influences, home care workers are, however, not the only group of workers who due to several markers such as level of education and training, certifications, race, class, gender, sexuality, and embodied attributes are kept 'on the margins' in Western societies (Sullivan, 2007; Ashforth and Kreiner, 1999; Ashforth et al., 2007). And thus for these workers the findings of this dissertation might be of particular importance. The dissertation has in particular described some of the challenges and dilemmas workers at the margin may face in professionalization processes and the mechanisms whereby they sustain their marginalized position, and these may be extended to other workplaces at the margin.

For instance it is not unlikely that other care workers at the margin will be introduced to team meetings, new experts and/or new practices and working tools as a means to professionalize them, since these initiatives cannot be reduced to the notion of rehabilitation. And thus although other work settings may not implement the whole package of rehabilitation, one or more of the professionalization mechanisms I have described in the dissertation may be relevant and "work" in similar ways at other workplaces at the margin, depending on whether it is team meetings, new experts and/or new practices and working tools that are being introduced. Thus although the table and figures I have presented in the three articles are context dependent, and suggest that it is crucial to attend to the specific content of the work, they may also be generic enough to say something about how boundaries of professionalization emerge at other workplaces. That is, how boundaries of professionalization can be identified, how they becomes regulated, negotiated and practiced in both material and discursive ways at work, and how they may be silenced in other work settings.

8.4.2 How we make "windows" into work matters – selecting the grain in the sand

As it should be clear now, this dissertation is based on data collected in five home care organizations that have recently introduced rehabilitation. Yet a limitation of my study is that I don't compare the organizations directly. Clearly, there are differences between the five organizations that may influence the relationship between professionalization and marginalization.[38] Yet, as mentioned my intention has not been to write a story about "the five organizations" and how they differ (or are similar). Rather, the intention has been to tell a story about the attempts to professionalize the work and workers in rehabilitative home care organization*s*. As I have argued in the methods section, I chose this focus on work, not only based on theoretical reasons, but also because I sometimes felt more like I was within the same organization when I observed similar events, e.g. an occupational meeting within two distinct organizations, than when I moved from one type of work event/situation within one organizations to the next over the course of a day (see also Glerup, 2015). It is clear to me now, that the diversity and tension I observed at work in relation to the professionalization process, i.e. the boundary drawing between the (non-)professional persona, the (non-)professional accomplishments and the (non-

[38] For example, evidence suggests that the financial situation in public home care organizations differs a lot across the country (https://www.foa.dk/Afdelinger/PMF-Afd-4/Nyheder/Nyheder?newsid=187BDB86-D070-4F17-9322-E4B796DD05D1)

)professional practices at work, seemed much bigger and more important to describe than the diversity between the five organizations. Yet the dissertation, gives rise to some reflections about how it is possible to write up stories that provide the reader with a window (Ybema, 2009, Cunliffe, 2010) into the work and workers, and more specifically how it is possible to describe how professionalization and marginalization intersect at multiple worksites. This dissertation has contributed two suggestions in this regard.

First, in order to understand and describe to 'outsiders' how professionalization and marginalization intersected at multiple work sites at the margin, I have found it crucial to rely on ethnography-inspired methods that had 'work' as the core level of analysis and to make triangulations between focus group transcripts and field notes. The focus groups have been a crucial source to investigate how workers express, reflect upon, negotiate and give meaning to their work (in each other's company) (Dahl, 2009; Liamputtong, 2011, Morgan, 1996), and more specifically how these sense-making processes are informed by - and reinforce - boundaries between "the professional (actors, technologies, outcomes etc.)", and the "non-professional" at work. Compared with the observations, the focus groups also became a crucial source to show how the informants (especially the higher-status workers) had a tendency to bleach out corporal aspects of work under the label of professionalization/rehabilitation (namely, those aspects of work which risk stigmatization – old age, dirt, intimacy, etc.). These rhetorical ways to bleach out the corporal aspects of the work (see also Twigg et al., 2011), that I would never have been able to understand or describe if I had not had the field notes, showed the clash between these rhetorical attempt to "(re)shape " the work and the corporal nature of the work. In fact, I remember that the first observation I made – the one in the home of "Ella" (article 3) – took me by surprise. The day before the visit I had just finished the focus groups with the managers and employees, and I went out (in all my naivety) to Ella's home with the idea that Ella would happily receive us. And thus, when she opened the door confused, dressed in her dressing grown with white ruffled hair and leaning on a walker I got a so-called "reality check": I realized that sickness, pain, dirt and deep age was still "there" in the recipient's private sphere – their home. And yet, had I only made the observations, I would not have gotten insight into how the workers reflected on how this 'clash' between the rehabilitation vision and the corporal nature of work was experienced by – and influenced them as - workers.

Second, I have found it useful to select a case in each article to demonstrate to 'outsiders' how professionalization and marginalization intersected at work, or more specifically to exemplify how boundaries of professionalization emerge through interactions between specific actors at work and the specific context they work in. I think this has been crucial for the purpose of the dissertation, namely because rehabilitative home care organizations were characterized by the above-mentioned clash between the rhetoric about the work (what was said in the focus groups) and the corporal nature of the work (what I observed at work). And, thus with the cases I wanted to give the reader the same "reality check" as I had experienced myself by conducting the observations. Yet, clearly the way I chose these cases deserves some more reflections. As such there is nothing controversial about using a case to provide the reader with a 'window' into the field. As Ybema et al. (2009: 6) has highlighted, ethnographic work seeks to understand "the world in a grain of sand." Yet, when I chose for instance the Ella case (article 3), the Laila case (article 1), and for that sake the excerpts from the team meetings (article 2), I wanted to illustrate a specific "grain" or "world". Namely, based on my critical stance to 'denaturalize' common understandings of rehabilitations professionalization opportunities, I was interested in showing the complexity the centering of professionalization on the concept of rehabilitation gave rise to at work, yet I chose different windows/cases in this endeavor. In article 2, I chose three different case-excerpts, in order to demonstrate, in ideal typically ways, how rehabilitation gave rise to different types of case stories at work (through the push-stories, buffer stories and success stories), and thereby complexity, and how the actors at the team meetings sought to handle this complexity. In articles 1 and 3, however, I chose one case, respectively the Laila and Ella cases, to zoom in on a complex case that could show how boundaries of professionalization emerged at work through the actors' "work" in the homes. Thus the Laila and Ella cases did not fully reflect the complexity we found at work (for example, a success case would have provided another window). However, nor were they extreme cases; the resistance we saw Laila and Ella express towards rehabilitation, and the workers' resulting negotiations with the recipients, was more the rule than the exception (Flyvbjerg, 2010). Rather, the Leila and Ella cases were chosen as what Flyvbjerg (2010) calls a paradigmatic case, that is, they function as a prototype of how boundaries of professionalization "worked" at work in rehabilitative home care organizations.

Thus, since I have critiqued the public debate for being too focused on the success example, I think a reasonable critique of my own work would be that I, due to the critical stance I apply in the dissertation, might have been too critical and focused too narrowly on complexity, rather than the success. Yet, what I hope to have shown with my choice of cases is that success at work was based on very narrow success criteria in rehabilitative home care organizations. A narrow success criterion which unavoidably generates tensions and negotiations in a context like home care work because it is a type of work that per definition is complex and unpredictable, and where plural actors tends to have different success criteria (Strauss et al., 1997; Hughes, 1958). And that is exactly what I hope I have shown with my choice of cases. Yet, as I have mentioned in the method chapter and will elaborate further on below, there are some risks and ethical dilemmas in making these 'windows,' because they rely on sensitive empirical extracts, which may give raise to anonymity issues, in particular in a context like rehabilitative home care work where 'unpopular' voices risked being stigmatized and often were silenced (thus making it easier to identify those who actually spoke up).

8.4.3 How we write about (marginalized) work(ers) matters

As I have already mentioned in the methods section, studying marginalized work and workers prompts several ethical considerations and dilemmas both during the data collection and in the writing-up phase. Yet, here I want to put forth a final remark about the dilemmas that may arise in the writing-up phase, because it may be crucial to consider in future research on the topic. During my effort to write up the dissertation a very challenging concern came up: namely I realized that I, through my own writing, risked re-stigmatizing the home care workers I wrote about. Thus at a point in the writing phase I faced a dilemma: how to write about stigmatization and marginalization work and workers without reproducing this very stigma. This issue became particularly clear to me during my review process for *Gender, Work & Organization* (where article 3 is published). Here the editor in chief raised a warning about the first draft of my article:

"I agree with the others [reviewers] that there is a tendency to disparage (or at least to replicate the disparagement shown by senior workers towards) the dependency of elderly citizens. I also felt there was an implicit, but problematic tendency to reproduce the scorn which the more qualified staff displayed towards lower level staff, and therefore also to reproduce the stigma rather than challenge it. All the reviewers say this in different ways."

This warning came as quite a shock to me. Clearly my intention had not been to reproduce the scorn or the stigma I had observed, but rather the opposite. Then why did the reviewers and the editor interpret my writing in that way? I think some of the explanation lies in the difficulties in translating concepts about work from Danish to English. It is not always easy to know as a Danish writer which words are 'loaded words' in English. But it is also something bigger than that. It concerns matters of how we can address a problem like marginalization without reinforcing marginalization and stigma, and how we can write for instance about 'the more or less qualified staff' without again contributing to the idea that some staff members are more highly qualified (and some may assume, therefore know better than the lower qualified), without contributing to re-stigmatizing the workers who have received less formal training and thereby formally have lower qualifications. At its core this poses a dilemma to us as scholars. On the one hand, a crucial obligation of scholars is, from my point of view, that we should address marginalization processes in society. On the other hand, however, the vocabulary we have to address such concerns as researchers may not be beneficial to solving these problems – or even reinforce problems of marginalization. Again, just as higher-status workers in home care who intends to solve the stigma problem with rehabilitation seem to re-stigmatize the workers (the lower-qualified care aides), we also risk as academic who write about marginalized work, unintendedly reproducing assertions that this work *is* marginalized. One way I have tried to handle this 'problem' is for example, by trying to avoid characterizing the work and workers as marginalized, but instead as a type of work and workers that RISK marginalization. Yet, clearly future research has to focus on better ways to handle this 'problem,' and one source that properly could help us tackle these dilemmas could be to study how the disability or black movements have tackled similar challenges.

8.4.4 What we study matters for whom we are: Being a 'dirty scholar' in a clean academic world

Another challenge I faced during my PhD process concerned my own role as a young (female and non-established) scholar (or PhD "student") who studies professionalization at the margin – and more specifically home care work (that risks stigmatization). It is well known within ethnographic work that there is a close relationship between the researcher role and the object of research (see e.g. Cunliffe, 2010), but it took me some time to realize how much this relationship influenced my own research process. As already mentioned, when I entered academia as a PhD Fellow, my first inclination was,

although I had data from five home care organizations, to move the focus away from home care and instead focus on the 'popular' and 'interesting' proliferating concept of rehabilitation. In fact, at my first evaluation seminar (WIP 1) I was told that I was ahistorical and encouraged to make a genealogy of rehabilitation, in order to familiarize myself with this concept. In addition, it was questioned whether I could rely on the literature on the profession, since home care workers were "only" an occupation. Similarly, when I presented a first draft of a article to one of my mentors (in this case a "star" within his field of studies), he told me that "to be frankly" my case was not "exactly sexy" and that I consequently should keep in mind to treat it as a case (about rehabilitation/NPM). Furthermore, in a review process for publication in *Strategic Organizations* my article was rejected after the first round, primarily because I "failed to systematically compare my five organizations," and instead focused on the work. And, finally at my last evaluation seminar (WIP 2) I was told to focus on the therapist (instead of the work) because they seemed to be something "new" (in relation to NPM) and as an "interesting" take on my work.

These are only a few examples of how I within the academic world have continually been guided away from my final focus in the dissertation: home care work and workers. I am highlighting this to generate awareness of the fact that research on home care work is a marginalized and perhaps underexplored topic within academia. Thus reflecting back on my process, I realize that it involves some of the same marginalization processes (and risks) I have studied myself, being a scholar who studies home care work in academia. Namely, just as workers who undertake stigmatized tasks risk 'the perceived taint of the dirty work' being projected onto them "so that they are seen to personify the dirt" or stigma (Ashforth and Kreiner, 1999: 415), scholars who study this work risk the same kind of stigmatization in academia (if we don't adjust to the dominating understanding of "interesting" research). At times I have even felt embarrassed about my topic. I have felt that I had to justify and legitimize, both within and outside academia, why I had chosen such a 'borrowing' and 'dusty' case, just like home care workers might feel they have to justify their choice of work in society. These reflections all started when I read Twiggs' (2004) publication "The body, gender, and age: Feminist insights in social gerontology." Here she describes how especially deep age is underexplored within academia (due to the associations of stigma), and in addition that "It is notable that the subject of the aged body within gerontology has been taken forward particularly by women" (Twiggs, 2004: 62) – women who already

are a minority within academia. This article helped me find comfort in the fact that the struggles I faced in my role as a new scholar in academia did not (only) reflect my poor skills as an academic, but also my choice of case. And I started to find comfort and even to be proud of the fact that the focus of my dissertation could be seen as part of a feminist project. In other words, who I was as a person mattered for what I studied.

Overall, however, I hope that this project will not only serve as my own feminist endeavor. After all, compared to the struggles workers at the margin face, my personal struggles are slight. And thus, I hope that the dissertation may add to the small but growing number of scholars who increasingly bring into question the common assumption that it is valuable to professionalize workers at the margin through what Sullivan (2007) has called "defensive" professionalization strategies. These are professionalization strategies that mirror the actors, techniques, work arrangements, etc. that are already privileged as 'professional' in the west. Thus, it seems that to break with and move beyond the reproduction of boundaries of professionalization in the west, other more progressive strategies are needed to ensure care workers the dignity and recognition they deserve at work.

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ENGLISH SUMMARY

Within the last decade, rehabilitation has been promoted as a new professionalization opportunity within home care policy and practice in both Denmark and across Europe. Rehabilitation is said to reconfigure home care work in ways that result in improved working conditions, better quality of services, and cost savings. Rehabilitation is, however, only the most recent example of an ongoing range of new reforms and demands that have focused on professionalizing home care workers and their areas of work by imposing new professional structures, qualifications or status on the workers. And, yet, despite these ongoing processes of professionalization, home care workers, and care workers as such, continue to be socially, technically and economically marginalized at work.

This paradox has increasingly encouraged in particular feminist-inspired academics (e.g., Sullivan, 2007; Cheney and Ashcraft, 2007) to question whether we have sufficiently understood the complexities and particularities of how professionalization processes are constituted and function at work. Their studies indicate that both definitions of "professionals" and the more material modes of organizing and doing "professional" work in the west tend to privilege some workers (i.e., white, white-collar, heterosexual males) and marginalize others, especially female workers who perform "dirty", private household services for the aging or disabled, such as home care workers. Following these studies I take a critical stance against the so-called professionalization opportunities that are offered to home care workers with the introduction of rehabilitation in home care organizations. I ask what happens to the home care workers' area of work and their risk of being socially, economically and technically marginalized, when they are confronted with the new opportunities to professionalize in rehabilitative home care organizations.

The dissertation draws on an ethnography-inspired study of five publicly funded rehabilitative home care organizations. These organizations provide domestic and personal care in predominantly older people's homes. At the point of inquiry, all five organisations had recently implemented rehabilitation. Although there were differences across these organizations (in e.g. size, geographical span, budgets), there were clear similarities and parallels in the ways they had implemented rehabilitation. For instance, with rehabilitation they had all introduced three means of professionalizing home care workers: a) a new occupation (therapists) who were introduced to advance the home care workers' rehabilitation skills, b) new cross-occupational team meetings which were initiated to 'professionally'

advance the workers' negotiations about rehabilitation, and c) new tools which were introduced to bolster the workers' rehabilitation practices. This dissertation follows these three means of professionalizing home care work and workers and their implications by interviewing the managers and employees about their experiences with rehabilitation, and by observing their work with rehabilitation.

Inspired by feminist-inspired academics (e.g., Hearn and Parkin, 2001; Davies, 1996), I review both critical discursive-oriented and material-oriented studies on professionalization to analyse these three means of professionalizing, and the potential ways they intersects with processes of marginalization in rehabilitative home care organizations. I find that the critical discursive-oriented studies on professionalization (e.g., Alvesson and Willmott, 2002; Rasmussen, 2004; Dahl, 2009) provide valuable perspectives and concepts to explore the symbolic, discursive and regulative activities whereby liberating and empowering "professional" identities are cultivated and promoted with the new professionalization processes at work - often times by differentiating the "professional" identities from the marginalized "others" (i.e. "non-professional" identities). I argue, however, that these studies did not, for the purpose of this dissertation, pay sufficient attention to the more material and enduring aspects of professionalization processes. And thus, in the search for optics and concepts to address this blind spot, the dissertation turns to review "material-oriented" studies on professionalization. These studies comprise both classical and more recent literature. They hold that processes that privilege the professional (and by implication tend to marginalize the "other") at work are embedded and embodied in the actual doing of the work. Thereby they provide crucial concepts to explore how the privilege of some "professional" bodies, techniques, and tasks in ongoing professionalization processes are differentiated from the marginalizing of "others" at work, e.g. by the division of labour and the division of tasks. Based on these reviews, the dissertation lays out the groundwork for analysis by suggesting different ways to experiment with combining building blocks and concepts from the two groups of studies in order to inquire into the complex layers – both discursive and material – of professionalization processes in rehabilitative home care organizations.

The analytical body of the dissertation is comprised of three articles that analyse how each of the three new means to professionalize home care workers in rehabilitative home care organizations (the introduction of the therapists, team meetings and new working tools) reconfigured home care work and the implications this had for home care workers' marginalized position at work. The first article is titled

"Performative identity regulation: An empirical analysis of how co-working 'experts' legitimize managerial ideology and moderate resistance." This article puts forth the notion of "performative identity regulation" to discuss how the introduction of therapists at work regulates home care workers' ability to adapt a new identity and role in two interrelated ways. It shows that the therapists' presence promotes a discursive cultivation of a new "tough", "entrepreneurial" and "professional" rehabilitative persona, that is contrasted with the home care workers' 'traditional' (now marginalized) "soft" and nurturing persona. In addition, it shows how the therapists embody this new ideal in their own performance at work. The article proposes that both types of regulation affect the home care workers' behaviour, and ambiguously generate identity struggles among the care workers, while simultaneously moderating and silencing such struggles.

The second article (in Danish) is called "Teammøder i rehabilitativ hjemmepleje – effektiv ensretning eller nuanceret faglig dialog?". This article explores how (non-)professional efforts and outcomes are negotiated with the introduction of new team meetings at work. The article shows that care aides at the new meetings shared stories about their complex rehabilitative work with the therapists who orchestrated the meetings. These stories were not equally received by the therapists, who celebrated and labelled some of them as "success stories," while others were received with less enthusiasm. The article suggests that the collectively negotiated storytelling that emerged at the meetings allocated social rewards to some workers and sanctioned others in a way that seemed to narrow down, rather than expand, ideas and discussions about what it means to work professionally in a home care context.

The last article is called "Gender stereotypes and the reshaping of stigma in rehabilitative eldercare". This article explores how, in conjunction with the introduction of rehabilitation, home care workers are offered new discursive and material practices and techniques for managing and negating areas of their work that are often stigmatized (i.e., their "dirty" body work with aging bodies). To guide this investigation, I put forth the notion of "stigma shaping", which I use to discuss how the workers' new practices and tools seem to reshape their approaches to work in ways that create a distance from the often-stigmatized aspects of their work (Twigg et al., 2011). For instance, through these practices, the workers became capable of refocusing on the resources (rather than the decline) of older people and of physically distancing themselves from the older people's ("dirty") bodies. However, the findings indicate that this professional distance emerged at work by reinforcing the idea that it is stigmatizing

and non-professional to have a dirty, declining body or to work with such bodies, and that such work should be avoided, silenced or reshaped instead of being socially and economically rewarded.

The conclusion argues that the professionalization opportunities in rehabilitative home care organizations (the introduction of the experts, team meetings and working tools) are not as valuable as suggested within home care policy. Rather, the particular and complex empirical findings suggest that home care workers face three dilemmas in rehabilitative home care organizations. First, although the therapists provided care aides with new skills, the presence of the therapists also taught the care aides that they were not experts on their own work and needed to de-learn their former expertise to avoid (re-)marginalization. Second, although the team meetings provided the care aides with a new forum to discuss their work and get rewards for their accomplishments, the very same forum seemed to streamline and suppress discussions about the complex work in sanctioning ways. Third, although the care aides learned new working tools to technically distance themselves from the aspects of their work most often associated with stigma, it did not make these aspects of work disappear, and the responsibility for ”dirt,” pain and sickness was redistributed. Nevertheless, the dissertation suggests that the professionalization processes in rehabilitative home care organizations were regulated, negotiated and practiced in ways that often times silence these dilemmas, and the struggles, pain, and critiques they give rise to. By making the silent intersection between professionalization and marginalization processes salient, the dissertation thereby contributes to a more complex understanding of how professionalization opportunities are constituted and function in the context of contemporary policy.

DANSK RESUME

Rehabilitering har bredt sig som en steppebrand i den danske hjemmepleje. I hjemmeplejen promoveres rehabilitering som en positiv mulighed og middel til at professionalisere, hvad ofte omtales som traditionel kompenserende hjemmepleje (Kjellberg et al., 2011a). En professionaliseringsmulighed, der både indbefatter at medarbejderne søges opkvalificeret, og at deres arbejde reorganiseres på en såkaldt mere 'professionel' måde. Rehabilitering kan imidlertid, set i et historisk lys, kun betragtes som det seneste forsøg ud af mange på at professionalisere både medarbejderne, arbejdet og/eller organisering i hjemmeplejen. På trods af disse vedblivende forsøg på at professionalisere området har forskningen imidlertid igen og igen demonstreret, hvordan medarbejderne inden for omsorgsområdet, og særligt hjemmeplejeområdet, vedbliver med at være socialt, teknisk og økonomisk marginaliserede på arbejdsmarkedet. I afhandlingen arbejdes der dermed med en antagelse om, at det positive fokus på rehabiliteringens professionaliseringsmuligheder må ses i forhold til hjemmeplejefagets og arbejdets historiske tendens til at blive stigmatiseret og marginaliseret som et lav-status og lavtlønnet 'kvinde' arbejde. Samtidigt forholder afhandlingen sig dog, netop pga. denne historik, der illustrerer, at det er svært at ændre hjemmehjælpernes marginaliserede position via professionaliseringsstrategier, sig undren overfor, hvordan rehabilitering ofte promoveres som problemløs, og en win-win løsning, i den offentlige debat. Med afsæt i denne undren undersøger jeg i afhandlingen, hvad der sker med medarbejderne og deres ofte marginaliserede arbejde, når de konfronteres med muligheden (- eller presset for) at 'opkvalificere' sig og udøve deres arbejde mere 'professionelt' i den rehabiliterende hjemmepleje. Mere konkret belyses interessen for grænsefladerne mellem professionaliserings- og marginaliserings processer i hjemmeplejearbejde ved at rejse følgende spørgsmål i afhandlingen: hvordan bliver grænseflader mellem det (ikke-)professionelle reguleret, diskuteret og praktiseret i den rehabilitative hjemmepleje, og hvilke konsekvenser får disse grænseflader for medarbejdernes risiko for at blive socialt, teknisk og økonomisk marginaliseret. Et problemfelt og spørgsmål der udfoldes i afhandlingens Kapitel 1.

Kapitel 2 beskriver casen – rehabilitative hjemmeplejeorganisationer. I kapitlet fremhæver jeg, at jeg har undersøgt fem rehabiliterende hjemmeplejeorganisationer, og at min tilgang til dem - inspireret af arbejdssociologien (Strauss et al., 1997; Hughes, 1958) – har været at anse dem som bestående af multiple aktører, opgaver, rum, teknologier og måder at organisere arbejdet på. Et perspektiv på

organisationer, der har indebåret, at jeg ikke har lavet en systematisk komparativ analyse af de fem organisationer, men snarere har undersøgt, hvad der karakteriserer arbejdet i rehabiliterende hjemmeplejeorganisationer (set i forhold til 'ordinære' hjemmeplejeorganisationer). Jeg fremhæver mere specifikt at, rehabilitering på tværs af de fem organisationer bliver associeret med implementeringen af tre kilder til professionalisering. Nemlig: a) ansættelsen af en ny profession – ergo- og fysioterapeuter som anses som middel til at opkvalificere medarbejderne i den nødvendige rehabiliterende ekspertise, b) indførelsen af tværfaglige teams, der omtales som et middel til at højne den tværfaglige dialog og c) indførelsen af nye mere 'professionelle' rehabiliteringsteknikker til at udføre arbejdet med borgerne.

Kapitel 3 præsenterer afhandlingens teoretiske framework. I kapitlet argumenterer jeg for, at jeg - inspireret af feministiske studier af professionaliseringsprocesser - har kombineret teoretiske "byggeklodser" fra kritiske, diskursive ledelsesstudier og praksisorienterede arbejdsstudier for at undersøge, hvordan grænsefladerne mellem det (ikke-)professionelle bliver reguleret, diskuteret og praktiseret i rehabilitativ hjemmepleje, særligt ved introduktionen af de tre nye kilder til professionalisering. Disse studier peger nemlig på, at den måde grænsefladerne mellem det (ikke-)professionelle bliver etableret på i organisatoriske sammenhænge både har en diskursiv og mere materiel karakter. På baggrund af denne viden, og med afsæt i min empiri, inddrager jeg kritiske, diskursive ledelsesstudier for at sikre et begrebsapparat, der gør det muligt at undersøge, hvordan de diskursive processer, der introduceres med nye politikker eller ledelsesmodeller, såsom rehabilitering, påvirker og potentielt ændre den måde den (ikke-)professionelle bliver defineret på i hjemmeplejearbejdet. Ligeledes inddrager jeg kritiske praksisorienterede arbejdsstudier for at sikre et begrebsapparat, der også har blik for de mere materielle og praksisorienterede måder, hvorpå introduktionen af rehabilitering påvirker den måde det (ikke-)professionelle er indlejret i den måde arbejdet udføres og organiseres på.

I kapitel 4 præsenterer jeg afhandlingens metodiske tilgang – som jeg med en samlebetegnelse kalder en 'workography'. Jeg starter med at beskrive at min eksplorative forskningsproces. I kapitlet beskriver jeg, hvordan jeg fandt "min vej" i afhandlingen, da jeg begyndte at tage min empiriske kontekst – hjemmeplejeorganisationen og hjemmeplejearbejdet 'alvorligt' og forlod et mere abstrakt fokus på 'rehabilitering.' På den baggrund opridser jeg, hvordan jeg har indsamlet forskelligt kvalitativ data, der

belyser det rehabiliterende arbejde i fem hjemmeplejeorganisationer fra forskellige vinkler. Jeg beskriver, hvordan jeg har analyseret og kodet mine data, og hvordan denne kodning i skrivefasen krystalliserede sig i afhandlingens tre artikler, der hver især zoomer ind på, hvordan hver af de tre tidligere omtalte såkaldte kilder til professionalisering (introduktionen af terapeuter, teamsamarbejde og nye rehabiliteringsprakssiser) påvirker medarbejderne og deres arbejde. Endelig reflekterer jeg kritisk over de etiske, sociale og repræsentative overvejelser, jeg har gjort mig i forbindelse med udarbejdelsen af min workografi.

Kapitel 5 udgør afhandlingens første artikel, der har titlen: Performative identity regulation: An empirical analysis of how co-working 'experts' legitimize managerial ideology and moderate resistance. Artiklen (der er skerevet i samarbejde med Sara Louise Muhr) zoomer ind på hvordan professionelle grænsedragninger bliver reguleret i rehabilitativ hjemmepleje ved at fokusere på introduktionen af ergo- og fysioterapeuter. Artiklen viser, hvordan introduktionen af terapeuter som en ny professionel 'ekspert' er med til at regulere og legitimere, hvad der opfattes som en (ikke-)'professionel' persona og (ikke-) professionel ekspertise/tilgang i hjemmeplejen. Terapeuterne får ikke kun denne regulerende rolle på f.eks. træningseminarer, hvor de mobiliserer medarbejderne til at identificere sig med den rehabiliterende persona ved at italesætte denne som 'professionel' og afgrænse den fra den traditionelle kompenserende plejerolle, der står tilbage som 'uprofessionel'. Terapeuterne regulerer også potentiel modstand (resistance) mod denne konstruktion af den professionelle persona i kræft af deres mere 'materielle' placering direkte på frontlinen i den rehabiliterende hjemmepleje, hvor de i samarbejde med hjemmehjælperne (sosu'erne) skal rehabilitere de enkelte borgere i deres hjem. Denne tilstedeværelse i hjemmene betyder nemlig at terapeuterne ikke kun italesætter, men også performer den professionelle 'persona' foran medarbejderne. I hjemmene kan de (foran hjemmehjælperne) fremvise, hvilken fremtoning, tanker, følelser, handlinger og ordvalg det involverer at 'være' professionel og håndtere de problemer, der kan opstå i forbindelse med, at man indtager denne rolle. Det sker eksempelvis, når borgeren hellere vil kompenseres end rehabiliteres. Særligt at man som professionel bør være 'hård', snarere end omsorgsfuld og kompenserende. Med dette fokus på introduktionen af terapeuterne ønsker jeg at fremhæve at regulering af, hvad det vil sige at være en (ikke-)professionel persona i hjemmeplejen bliver særlig effektfuld i rehabiliterende hjemmepleje, fordi terapeuterne ved deres tilstedeværelse både italesætter og udfører (performer) det professionelle ideal.

Ligeledes ønsker jeg også at vise noget af den modstand, der både opstår og 'modereres', når hjemmehjælperne mobiliseres til at identificere sig med det ny ideal.

I Kapitel 6 præsenteres afhandlingens anden artikel. Artiklen zoomer ind på hvordan en professional tilgang til arbejdet bliver debatteret i rehabilitativ hjemmepleje ved at fokusere på introduktionen af tværfaglige teammøder i rehabilitativ hjemmepleje. Artiklen viser, hvordan introduktionen af teammøder er en vigtig kilde til at forme diskussionerne af, hvad der er en professionel og (ikke-)professionel tilgang til borgeren i rehabilitativ hjemmepleje. Teammødestrukturen skaber nemlig et særligt rum der består af asymmetriske relationer, hvor terapeuter skal supervisere hjemmehjælperne i forhold til deres daglige arbejde med at rehabilitere borgerne. Denne supervision foregår på en måde hvor hjemmehjælpernes historier, om deres rehabiliteringsarbejde, modtages og bearbejdes forskelligt i det asymmetriske rum. Artiklen fremhæver således hvordan møderne er iscenesat på en måde, hvor nogle historier udpeges som 'succeshistorier', og derved resulterer i anerkendelse, mens andre historier giver anledning til frustration og sanktioner på møderne. En central pointe er, at det forum hvor det 'professionelle' rehabiliterende arbejde kunne være bragt til diskussion, snarere ser ud til at ensrette dialogen fremfor at åbne op for dialogen om faglighed i arbejdet. Det skyldes bl.a. at udveksling af historier på møderne etablerer et sanktions- og belønningssystem, der er baseret på én dominerende vision om, hvordan arbejdet optimeres og håndteres 'professionelt', og at supervisionen dermed er baseret på grænsedragninger mellem det professionelle (succeserne) og det potentielt ikke-professionelle. I tråd med kapitel 5 (artikel 1) viser analysen, at terapeuternes tilstedeværelse på frontlinen har en afgørende betydning for reguleringen af professionalisme. Med artiklen ønsker jeg imidlertid at vise hvordan grænsedragninger mellem det professionelle og ikke-professionelle kultiveres og formes gennem historieudveksling og gruppedynamikker på teammøderne.

Kapitel 7 præsenterer afhandlingens tredje artikel. Artiklen zoomer ind på, hvordan professionalisme bliver praktiseret og udført i rehabilitativ hjemmepleje ved at fokusere på de arbejdsteknikker, som indføres i rehabilitativ hjemmepleje. Artiklen viser, hvordan de praksisser og teknikker hjemmehjælperne bliver opfordret til at benytte i udførelsen af rehabiliteringsarbejdet i høj grad er præget af grænsedragninger mellem professionelle og ikke-professionelle praksisser. Medarbejderne lærer at 'professionelle' rehabiliterende praksisser og teknikker indebærer både en sproglig og mere kropslig distancering fra de aspekter af arbejdet, der traditionelt har været forbundet med stigma: det at

være en kvinde med en lav uddannelse, der udfører manuelt arbejde i ældre – ofte beskidte – menneskers hjem. Det er praksisser og teknikker, der involverer at medarbejderne skal a) fokusere på ældres potentialer og muligheder, snarere end deres forfald og smerte; b) bruge redskaber, der skaber afstand til det beskidte tidligere hands-on arbejde; og c) erstatte deres 'kvindelige' omsorgsrolle med en trænerrolle. I artiklen argumenterer jeg for, at indførelsen af disse praksisser og teknikker, snarere end at udgøre den re-professionaliseringsmulighed de promoveres som, risikerer at re-stigmatisere det at have et 'kvindejob' og arbejde med og yde omsorg for 'beskidte' mennesker, der har brug for hjælp og tæt kropslig kontakt. Artiklen peger ligeledes på, at udførelsen af det rehabiliterende arbejde får konsekvenser for borgerne, fordi de nu skal tage ansvar for deres egen smerte/sårbarhed eller 'skidt' og for medarbejderne der konstant skal være på vagt for om de nu fremstår professionelle. I tillæg betyder professionaliseringen ikke, at hjemmehjælperne stiger i løn, snarere betyder rehabilitering at hjemmehjælperne i flere kommuner fyres, når borgerne gøres uafhængige af hjælp. Ved at flytte fokus til selve praktiseringen og udførelsen af arbejdet, ønsker jeg at vise, hvordan de grænsedragninger, der trækkes mellem de professionelle og stigmatiserede arbejdspraksisser og teknikker i kølvandet på rehabilitering, indirekte opfordrer medarbejderne til at distancere sig fra kerneaspekter af arbejdet og i stedet efterligne mere accepterede professioners arbejde, såsom lægernes.

Kapitel 8 udgør afhandlingens diskuterende konklusion. Kapitlet tager udgangspunkt i afhandlingens forsøg på at bidrage med en kompleks og situeret forståelse af hvordan (ikke-)professionelle grænseflader søges reguleret, diskuteret og praktiseret/udført i rehabilitativ hjemmepleje, og hvilke konsekvenser disse grænseflader får for medarbejdernes risiko for marginalisering. I konklusionen argumenterer jeg for, at forsøget på at professionalisere hjemmeplejen gennem introduktionen af rehabilitering ændrer det retoriske, relationelle og fysiske rum hvori hjemmeplejearbejde bliver reguleret, diskuteret og praktiseret. Særligt de nye eksperter, teammøder og nye arbejdsteknikker understøtter nemlig, både materielt og diskursivt, at der skabes en klar grænsedragning mellem en 'professionel' rehabiliterede tilgang og en nu marginaliseret 'uprofessionel' omsorgs- og plejeorienteret tilgang i hjemmeplejen, der får reelle effekter for arbejdet og medarbejderne. Grænsedragning giver nemlig anledning til en række dilemmaer for særlig sosu-medarbejderne: A) introduktionen af terapeuterne giver sosu-medarbejderne mulighed for at opkvalificere sig og identificere sig med en ny professionel (entreprenørisk og hård) persona, men samtidigt lærer de også, at de ikke selv er eksperter

på deres arbejde og skal 'aflære' deres viden om omsorg og pleje for ikke at fremstå som (uprofessionelle) kvinder, der fokuserer på borgerens problemer og sårbarhed; B) teammøderne giver sosu-medarbejderne mulighed for at dele viden om deres arbejde og belønne hinanden for de nye 'succeser', der skabes i det rehabiliterende arbejde, samtidigt skaber teammøderne imidlertid en meget snæver forståelse af, hvad en professionel succes er i arbejdet med ældre mennesker, hvilket betyder at medarbejdere, der ikke lever op til idealerne eller sætter spørgsmålstegn ved dem risikerer sanktioner som en gammeldags (og dermed uprofessionel) omsorgsperson; C) selvom sosu-medarbejderne med deres nye arbejdsteknikker får mulighed for fysisk og følelsesmæssigt at distancere sig fra de aspekter af arbejdet, der ofte er associeret med stigma, får det ikke disse aspekter til at forsvinde – der er stadig ofte sårbare ældre, der efterspørger og har brug for omsorg. Afhandlingen argumenterer dermed overordnet for, at sosu-medarbejdernes sociale, økonomiske eller tekniske marginalisering ikke har ændret sig markant med rehabilitering, men endog potentielt er blevet forværret. Afhandlingen peger dog på, at denne (re-)marginalisering – og dermed de uintenderede effekter af rehabilitering - ofte undertrykkes og censureres, fordi kritikere risikerer at blive anset for at skabe barrierer for at realisere deres egen, deres kollegaers og borgernes 'skjulte' muligheder og potentialer.

APPENDIX 1

De fokusgrupper vi udførte var beskrevet semi-strukturerede. Derfor varrierede interviewsguiderne fra gang til gang. Spørgsmålene til lederne og medarbejderne blev også tilpassede. Der var dog en række generelle spørgsmål vi forsøgte at få belyst. Derfor er de nedenstående interviewguide (fra hhv. en leder og medarbejder fokusgruppe) også angivet som et eksempeler (for en uddybelse se http://teamarbejdsliv.dk/wp-content/uploads/Bilagsrapport-ReKoHver-projektet.pdf).

Eksempel på interviewguide til ledere

Deltagere (Navn, uddannelse, funktion, anciennitet i kommunen/funktionen, hvor længe I har været involveret i eller berørt af [betegnelse for kommunens indsats]?)

Baggrund for implementeringen af hverdagsrehabilitering Motivation, forventninger og rationale
Hvad var kommunens motivation/rationale for at påbegynde hverdagsrehabilitering?

Hvilke erfaringer trak/trækker I på/ hvor hentede I inspirationen fra?
Hvilke perspektiver ser I i hverdagsrehabiliteringstanken?

Hvordan var opbakningen til tankegangen i forskellige dele af kommunen/forvaltningen?

Udformning og forberedelse
Hvem har været involveret i udviklingen eller udformningen af den model for hverdagsrehabilitering, som [betegnelse for kommunens indsats] i Kolding kommune er udtryk for?

Hvordan blev de ledere, som ikke var involveret i processen informeret?
Hvordan og af hvem blev [betegnelse for kommunens indsats]-medarbejdere udvalgt?

Hvilken uddannelse har de forskellige medarbejdergrupper fået?

Hvilke ressourcer er der blevet afsat?

Ydelsen og organiseringen
Hvad er grundpillerne i hverdagsrehabilitering/ [betegnelse for kommunens indsats]i dag?

Hvordan og af hvem planlægges et forløb?

Oplever I at der i dag er klarhed over, hvilke borgere, der er omfattet og hvordan indsatsen er organiseret?

Hvordan har jeres funktion og rolle ændret sig som følge af [betegnelse for kommunens indsats]?

Hvordan har jeres medarbejderes funktion og rolle ændret sig som følge af [betegnelse for kommunens indsats]?

Det tværfaglige samarbejde (den relationelle koordinering)

Hvordan oplever I det tværfaglige samarbejde i dag?

Hvordan sikres videndeling og kommunikation på tværs?

Hvad kan der opstå uenigheder om?
 Hvordan håndteres uenigheder eller konflikter?

Er kompetencer til samarbejde noget der betyder noget, når I rekrutterer nye medarbejdere?

 På alle niveauer?

 Har I nogen former for belønningssystemer ift specielle medarbejderindsatser?

Udfordringer og perspektiver

Hvad er de vigtigste resultater, der er opnået med [betegnelse for kommunens indsats]?

Hvordan oplever I opbakningen til hverdagsrehabilitering i dag blandt borgere, medarbejdere og ledere?

 Hvad er der kritik af? Og ros?

Hvilke udfordringer ser I i dag i forhold til hverdagsrehabilitering/[betegnelse for kommunens indsats]?

Hvad er de vigtigste ændringer eller nye tiltag det næste år?

Hvad vil I anbefale til andre kommuner, som skal i gang med eller ønsker at videreudvikle deres "hjælp til selvhjælp"?

Eksempel på interviewguide medarbejdere

Deltagere (præsentation: navn, uddannelse, funktion, anciennitet i funktionen/kommunen, område/enhed – hvor længe har I været med i/berørt af [betegnelse for kommunens indsats]: 1 eller 2 runder:

Baggrund for implementeringen af hverdagsrehabilitering Motivation, forventninger og rationale

Hvad var baggrunden/motivation for at påbegynde [betegnelse for kommunens indsats]?

Har I været inddraget i udviklingen af modellen/konceptet?

Hvad anser i som grundelementerne i den ny tankegang

Hvordan adskiller den sig fra tankegangen i den traditionelle hjemmepleje

Hvordan har I oplevet opbakning til skiftet fra forskellige grupper af ledere og medarbejdere?

Udformning og forberedelse

Hvem har været involveret i udviklingen af [betegnelse for kommunens indsats] i Holbæk kommune?

Har I været involveret i processen? Eller orienteret?

Hvilken uddannelse har de forskellige medarbejdergrupper fået? Hvordan er Jeres vurdering af det kursusforløb I har været igennem?

Ydelsen og organiseringen

Kan I beskrive, hvordan et typisk forløb med en borger som visiteres til [betegnelse for kommunens indsats] ser ud? Og et typisk forløb for en borger, der ikke visiteres til [betegnelse for kommunens indsats]?

Hvad er afgørende for, om borgeren visiteres til [betegnelse for kommunens indsats]?

Hvordan adskiller ydelsen sig fra den ydelse, der gives andre borgere? Omfatter den alene de fysiske funktioner eller også de psykiske, sociale og fx ernæring?

På hvilke måder inddrages borgerens ønsker i forløbet – mere end normalt?

Hvordan og af hvem planlægges et forløb?

Hvordan har jeres funktion og rolle ændret sig som følge af [betegnelse for kommunens indsats]?

Hvordan har organiseringen ændret sig? Er der sket ændringer i Jeres møder, hvem der deltager og hvor ofte de holdes?

Det tværfaglige samarbejde (den relationelle koordinering)

Hvordan oplever I det tværfaglige samarbejde i dag? Er det vigtigt?

Bliver alle faggrupper inddraget og hørt? Er der gensidig respekt grupperne imellem?

Kender I hinandens kompetencer? Ved I hvornår og hvordan I kan trække på hinanden?

Hvad kan der opstå uenigheder om? Hvordan håndteres de?

Hvordan sikres videndeling og kommunikation på tværs? (Care-systemet, PDA'erne Kvalitetshåndbogen)

Får I de oplysninger fra I har brug for på det tidspunkt I har brug for dem?

Er der belønnings- eller kvalitetssikringssystemer, som understøtter det tværfaglige samarbejde?

Udfordringer og perspektiver

Hvad er de vigtigste resultater, der er opnået med [betegnelse for kommunens indsats]?

Hvordan oplever I opbakningen til hverdagsrehabilitering i dag blandt borgere, medarbejdere og ledere?

Hvilke udfordringer ser I i dag i forhold til hverdagsrehabilitering/ [betegnelse for kommunens indsats]?

Hvad er de vigtigste ændringer eller nye tiltag det næste år?

Hvad vil I anbefale til andre kommuner, som skal i gang med eller ønsker at videreudvikle deres ”hjælp til selvhjælp”?

Co-author statement

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