Critical conditions for co-workership in healthcare organizations

A workplace health promotion perspective

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Till min älskade mamma ❤

Tackord

Nu har doktorandresan börjat närma sig ett slut. Under resans gång så är det många personer som har bidragit med sin tid, kunskap, omtanke och kärlek. Er vill jag nu tillägna ett tack.

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Abstract

The workplace is well-established as one of the priority settings for promoting health in a large population. To achieve a good work environment, cooperation between managers and employees is essential. However, there is a large discrepancy between the amount of management and leadership research that has been performed and the amount of research investigating the impact of important factors of co-workership. Thus, the overall aim of this thesis was to increase knowledge about critical conditions for co-workership in healthcare organizations from the employee's point of view. This thesis has also a practical aim of providing information that can be used and applied in establishing a holistic and sustainable health-promoting workplace. A qualitatively-driven mixed-methods approach was applied, combining different qualitative methods to gather and analyze data. Study I used data collected through observations, interviews, focus group interviews, and feedback seminars, analyzed with content analysis and descriptive statistics. Study II used data collected from twelve focus group interviews with 68 employees, analyzed with phenomenography. The results from Study I show that the communication flow and organization of the observed meetings varied in terms of physical setting, frequency, time allocated, and duration. The topics for the workplace meetings were mainly functional with a focus on clinical processes. Overall, the meetings were viewed not only as an opportunity to communicate information from the top downwards, but also as a means by which employees could influence decision-making and development at the workplace. The results from Study II show that the phenomenon of co-workership was experienced as a collective process, which included colleagues but not did explicitly include managers. Five categories emerged, representing different conceptions of co-workership: group coherence and striving toward a common goal, cooperation over professional and organizational boundaries, work experience and trusting each other's competence, social climate and sense of community, and participation and influence. The conclusion of this thesis is that conditions such as participation and influence, social support, and communication were mostly related to the employees' everyday work, especially the clinical work, and were not seen in relation to the overall organization. Workplace meetings seemed to be a well-functioning setting for conditions of importance for co-workership, although the outcomes of these meetings varied to a large extent. This knowledge provided in this thesis can be of importance for future strategies to develop health-promoting workplaces.

Keywords: co-workership, communication, workplace meetings, healthcare organization, qualitative methods, workplace health promotion, salutogenesis

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Sammanfattning

Bakgrund

Arbetsplatsen är den plats där de flesta förvärvsarbetande människor tillbringar den största delen av sin vardag och har därför stor betydelse för att främja en god hälsa i hela befolkningen. För att uppnå en god arbetsmiljö är samarbetet mellan chef och medarbetare av stor betydelse. Trots detta är det i dagsläget stor skillnad mellan den mängd ledarskapsforskning som hittills har producerats och den mängd forskning som finns tillgänglig kring t.ex. organisatoriska förutsättningar för medarbetarskap. Denna avhandling har därför som övergripande syfte att öka kunskapen om vilka förutsättningar som är betydelsefulla för att utveckla ett medarbetarskap utifrån ett medarbetarperspektiv. Avhandlingens fokus ligger på att utforska dessa förutsättningar inom hälso- och sjukvården i Västra Götalandsregionen. Avhandlingen har även ett praktiskt syfte genom att tillhandahålla ny och direkt användbar kunskap inom områdena medarbetarskap och hälsofrämjande arbetsplatser.

Metod

Resultaten från de två ingående studierna i avhandlingen har tagits fram genom en kvalitativt mixad metoddesign där data samlades in via ett flertal olika kvalitativa metoder: observationer på arbetsplatsträffar, fokusgruppsintervjuer med medarbetare, intervjuer med chefer och feedbackseminarium. Data har analyserats med innehållsanalys, deskriptiv statistik och fenomenografi.

Resultat

Resultaten från Studie I visar på att riktningen i kommunikationsflödet, den fysiska miljön för mötena, hur ofta dessa möten hölls samt hur lång tid som var avsatt, varierade stort mellan de olika avdelningarna. Det samtalsämnet som upptog mesta delen av mötestiden var relaterat till det kliniska arbetet. Arbetsplatsträffarna upplevdes inte bara som ett forum för chefen att nå ut med information till medarbetarna utan även som en möjlighet för den enskilde medarbetaren att ha inflytande över beslut och utvecklingen av arbetsplatsen. Resultatet från Studie II visar att medarbetarna uppfattade begreppet medarbetarskap som en kollektiv process, där andra kollegor var inkluderade men inte chefen. I resultatet utkristalliseras fem kategorier som representerar olika uppfattningar om förutsättningar för medarbetarskap: grupptillhörighet och strävan mot gemensamma mål, samarbete över professionella och organisatoriska gränser, arbetslivserfarenhet och tillit till varandras kompetens, socialt klimat och känsla av gemenskap, delaktighet och inflytande.

Slutsats

Slutsatsen från denna avhandling är att förutsättningar såsom delaktighet och inflytande, socialt stöd och kommunikation var mestadels relaterat till medarbetarnas vardagsarbete, särskilt det kliniska arbetet, och inte i någon större omfattning till organisationen i sin helhet. Trots att innehållet och utformningen av de olika mötena varierade verkar arbetsplatsträffar vara ett välfungerande forum för att främja ett utvecklat medarbetarskap.

List of papers

This licentiate thesis is based on the following studies, referred to in the text by their Roman numerals.

I. Bergman C, Dellve L, Skagert K. Exploring communication processes in workplace meetings: A mixed methods study in a Swedish healthcare organization. *WORK: A Journal of Prevention, Assessment & Rehabilitation.* 2016; 54: 533-541.

II. Bergman C, Löve J, Hultberg A, Skagert K. Employees' Conceptions of Coworkership in a Swedish Health Care Organization. *Nordic Journal of Working Life Studies*. 2017; 7:91-107.

Content

Introduction

To achieve the Sustainable Development Goals established by the United Nations (1), it is necessary to focus on the settings of people's everyday lives (2). One such setting is the workplace. Conditions connected to work-related factors are thus established as one of the priority settings for promoting health in a large population (2-4). The workplace has also been emphasized in Sweden's national public health policy (5) as one of the eleven public health objective domains targeted in order to improve health in the general population. The prioritization of the workplace setting is linked not only to the fact that the work environment can directly affect employees' health, but also to the well-established fact that the productivity and efficiency of organizations are linked to the health and living conditions for all people in a society (6, 7). Thus, carrying out health promotion in settings where people work is considered an effective way to reach the Sustainable Development Goals.

There is robust evidence-based knowledge about the most important factors and conditions in promoting employees' health within workplaces (8-12). For instance, the importance of willingness to change on an individual level has received a great deal of attention (13, 14). This despite successful integration of workplace health promotion in practice requires a holistic system theoretical approach with a combination of top-down and bottom-up approaches (4, 8, 15). Moreover, cooperation between managers and employees is essential in achieving an overall good work environment. In Sweden, workplace meetings are regulated by a collective labor agreement in order to encourage communication between managers and employees about issues such as the work environment (16). The structure of these meetings has been assessed in several settings, although at the time of writing little attention has been paid to the outcome of these meetings in terms of the communication processes. This is despite the fact that communication is a critical condition for creating a health-promoting workplace as well as a foundation for the development of co-workership (17-19).

Good communication will strengthen the opportunities for employees to influence and participate in the discussion concerning working conditions (17, 20, 21). However, there is a great discrepancy between the amount of leadership research that has been performed and the amount of research investigating the impact of important factors of co-workership from the employee's point of view. This thesis identifies and further explores some of these knowledge gaps, with a special focus on the practical operationalization of workplace meetings and the communication process during these meetings.

Background

Health and salutogenesis

Having access to resources to achieve health is regarded as a fundamental human right (22). Health can be developed through the interactions between genetic, cultural, structural, and social conditions in combination with the individual's own choices in life (23). However, the definition of health is rather complex, partly because health is to a great extent subjectively perceived and dependent on the individual's own life circumstances. Rival theories about what health is also exist, for instance, the often-used biomedical theory of health perceives health as the absence of disease, while holistic theories of health see health as a function of a person's ability to achieve various goals related to health. In this way, health is not necessarily incompatible with the presence of disease. From a public health point of view, both perspectives of health are significant for health development (23). In this thesis, health is considered as a resource in people's everyday life, in accordance with theories on health promotion (2), and the concepts of health and disease are not seen as mutually exclusive to each other, but rather as two endpoints on a continuum.

According to Antonovsky's theory of salutogenesis, an individual's state of health varies in a continuum between ease and dis-ease during a lifetime, and can therefore be seen as a lifelong process rather than a state or a dichotomy of health or ill health (24-26). To strengthen the individual's position on the continuum, salutogenic factors called generalized resistance resources (GRR) are critical (24). These resources can be of biological, material, or psychosocial nature. Examples of GRR include personal traits, access to financial resources, and social support. To cope with life stressors, poor health, and difficult situations in general, each individual makes use of the combinations of GRR that are appropriate and accessible to them.

Antonovsky introduced the theory of sense of coherence to explain how individuals make sense of a certain situation and how they deal with stressors via the GRR (26). This theory has three components: comprehensibility, manageability, and meaningfulness. Comprehensibility includes the cognitive ability to understand and analyze different situations in a reflective way, while manageability focuses on resources and strategies that are available to meet different situations in a constructive way. Meaningfulness deals with the emotional considerations which determine the extent to which the individual finds it worth investing energy and commitment in the actual problem or situation. Improvements of each individual's sense of coherence could be

obtained in various settings, including the workplace. Given the right conditions, the workplace might enhance individual resources and thus contribute to an increased sense of coherence for the employees (27).

The workplace setting

The workplace setting has the potential to affect workers' individual health, for example via hazardous exposures in terms of poor physical and/or psychosocial working conditions (28). The physical and psychosocial work environment are interlinked, which means that physical aspects of the working environment can have consequences for the psychosocial work environment and vice-versa. There is evidence showing that psychosocial working conditions are one of the main contributing factors to an increased prevalence of sick leave due to mental ill-health (12, 28, 29). Moreover, work-related diseases, especially mental health problems due to organizational and social conditions, comprise the main reasons for occupational disorders and high frequencies of sick leave (12). This can cause problems not only for the individual and the organization, but for the whole of society.

In Sweden, employers have statutory obligations regarding the work environment. According to the Swedish Work Environment Authority, a continuous systematic work environment management control is mandatory and should cover all physical, organizational, and social working conditions of importance for the work environment (30). A systematic work environment management is defined as *"the work done by the employer to investigate, carry out and follow up activities in such a way that ill-health and accidents at work are prevented and a satisfactory working environment is achieved"* (AFS, 2001:1, page 5). The dominant focus in the work environment regulation is still on risks for poor health and accidents. A review of research on the psychosocial work environment concluded that much is now known about psychosocial work environmental factors leading to stress, but knowledge is still needed about organizational work conditions, preferably with a positive focus (9). So, although occupational health and safety activities are still required, the systematic work environment management in practice needs to be complemented with both a focus on the organizational and social work environment related to the practice of co-workership, and the strategy of workplace health promotion.

To support employers in their work to achieve this, clearer regulations focusing on organizational and social working conditions as a part of the systematic

work environment management have recently been established by the Swedish Work Environment Authority (2015: 16). These regulations are aimed at helping the employer to control and improve the psychosocial work environment on an organizational level, instead of the more traditional way where the focus is on individuals' experiences and responses to a given working situation.

According to the new regulations, the organizational work environment includes the conditions and prerequisites for work such as management and governance, communication, participation and room for action, allocation for work tasks, and demands, resources, and responsibilities, while the social work environment is about interactions between people, collaboration, and social support from managers and colleagues (31). Although several of these conditions have been identified in earlier literature as important for the development of co-workership (18, 19, 32, 33), few studies until now have had a major focus on employees' perceptions of how managers succeed in the practical organizing in their attempts to achieve the aim of this regulation.

Workplace health promotion

Workplace health promotion has been defined by the European Network for Workplace Health Promotion as: "*the combined efforts of employers, employees and society to improve the health and well-being of people at work"* (34). To achieve this, the Network suggests a particular focus on improving the work organization and the work environment. This include increasing employees' participation in influencing the work environment, and encouraging an ongoing personal development of the employees (35). In organizational research, as well as in public health, researchers have argued that it is time to go beyond the existing focus on work injuries, illness, and organizational dysfunction (9, 36). Future health development interventions should therefore complement the traditional pathogenic perspective with a more salutogenic approach that emphasizes resources for the promotion of health (23). This thesis has a particular focus on psychosocial work factors, such as communication, which might act as work resources that could support employees and managers in their endeavor to maintain and improve the work environment.

Workplace health promotion aims at both preventing ill-health and enhancing health-promoting potentials (34), and is often related to two approaches or strategies. The first of these is the individual approach, where lifestyle factors and individual responsibilities are in focus. The second is the holistic and

system theoretical approach, which focuses on how work is organized and employees' ability to influence workplace factors (37).

In the majority of workplace health promotion interventions, the most commonly used strategy for enhancing health among the employees is the individual approach (13, 14), even though this approach has been shown to be difficult to integrate with a more holistic strategy (15, 38). Moreover, a recent study suggests that the individual workplace health-promotion approach plays only a minor role in job satisfaction, while the psychosocial work factors included in the holistic approach, such as social support from superiors and colleagues, can significantly influence job satisfaction (39). Thus, it can be concluded that the interactions between individual, group, and organizational factors often have a stronger impact than single factors in the workplace (40, 41).

System theoretical approach

In the field of public health, the ecological system theoretical approach has long been used to analyze and understand people's interactions in and with particular contexts (42, 43). According to this theory, a person's health is developed within a larger context where biological, psychosocial, sociocultural, and physical environmental factors interact. However, this conception of health alongside a holistic model is missing from earlier studies of workplace health promotion, and did not appear in the literature until recently, when Bone (2015) applied the bioecological model of Bronfenbrenner (1999) to occupational health in order to support a broadened view of workplace wellbeing. Dellve and Eriksson (2017) further developed Bone's bioecological model with a practical perspective on managerial work and organizing, and applied the model to focus on health-promoting and sustainable leadership (44). They argue that a theoretical framework which takes a more holistic perspective can help in developing a more comprehensive understanding of health-promotive working conditions. Thus, the systems approaches exemplified by these models address various determinants of health along with political and cultural dimensions that are influential to an individual's health. The layers of the system theoretical model are presented in Figure 1 and described further below.

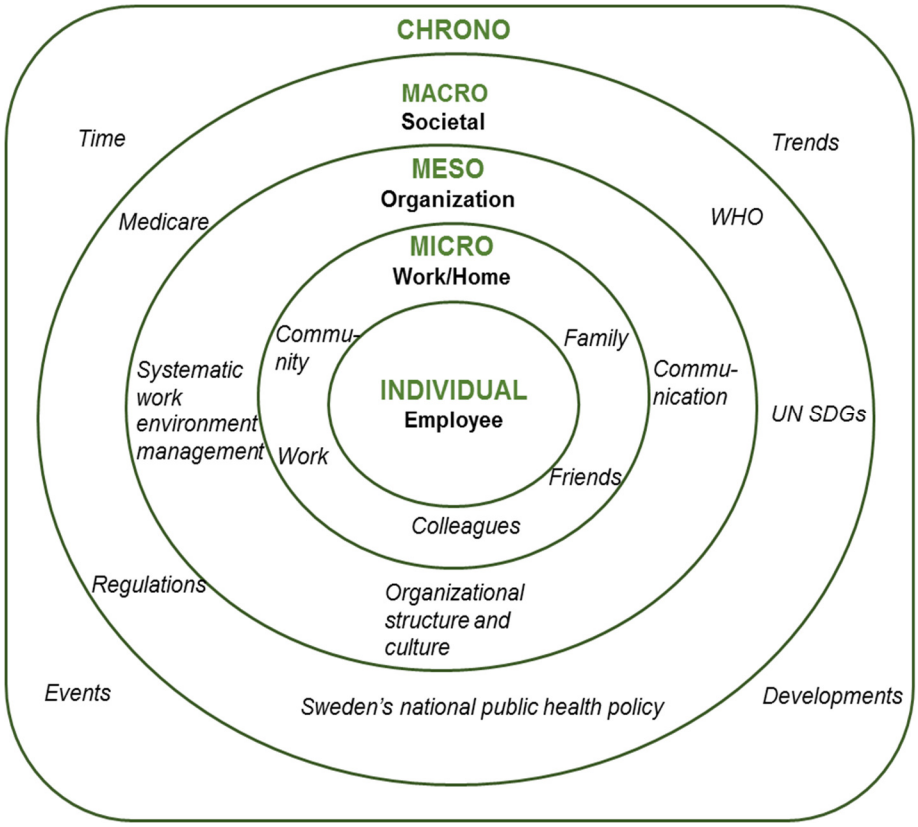

Figure 1. System theoretical approach adapted from the models created by Bronfenbrenner (1999), Bone (2015), and Dellve (2017).

The individual is at the center in this model, positioned as active rather than passive. According to Bone (2015), this is linked to the fact that the employee can impact their environment as much as the environment can influence the individual (45). The *micro level* includes interpersonal relationships and settings, for example the workplace and the home. The workplace setting includes conditions and factors in the work environment which are directly experienced by the individual, often on a daily basis. Psychosocial work conditions at the micro level that are related to co-workership and team, such as social support, social climate, social capital, and sense of coherence, have been identified as important for handling work challenges (29, 46-48).

The *meso level* contains the interrelations among two or more settings in which the employee actively participates. One example is that the work and family domains can be overlapping and interrelated in an employee's life. Within the workplace setting, the meso-level system can be the organizational structures and culture (44). An example of such structural conditions, given by Dellve (2015), is the systematic work environment management with activities and goals from health-promotive, preventive, and rehabilitation perspectives that have importance for promoting employees' health and a good work environment. Another condition at the meso level is communication that can flow over different system levels, thus allowing information around work processes and important decisions to be shared.

The *macro level* comprises the cultural and social context, which includes public policy and politics that can have an impact on work and living conditions. Although the individual employee in the workplace setting may not be directly involved at this level, policies such as the regulation of organizational and social work environment (AFS 2015:4) and the Work Environment Act can interact with the work environment in the micro level.

Bone (2015) complemented the original model of Bronfenbrenner (1999) with the *chronosystem level*, which focuses on time aspects. This level includes developments or events over time that may start at one level but have implications for all levels. An example of events given by Bone (2015) is that it would be less effective if an individual employee was engaged in only one health activity in a year than if the employee was engaged in the activity many times per week over several years.

While there has been a major development of Bronfenbrenner's ecological model applied to workplace health promotion focusing on employees' health and managerial work (44, 45), there is still little knowledge about how critical conditions of importance for co-workership are bridged across system levels from the employees' point of view.

Co-workership

Cooperation between managers and employees is essential in achieving an overall good work environment. Despite this, there is still a discrepancy between the amount of management and leadership research that has been performed and the amount of research investigating the impact of important

factors of co-workership. Co-workership is not a new phenomenon, but has evolved from a long working life tradition within the Nordic countries (18, 19, 33). Employers began to use co-workership as a concept in policies and documents in the 1990s, as part of efforts to increase efficiency and handle organizational changes (18). During this time, organizations were characterized by relatively flat organizational structure and few managers. This led to individualization of responsibility and the role of the employees becoming more active and responsible (33), which still seems to be the main core of co-workership as it is applied in research and practical contexts.

Definitions of co-workership are rather diffuse and complex. Co-workership as a concept is used and interpreted differently according to context, as well as according to who is using it and for what purpose. Nevertheless, the most frequently used definition of co-workership has been described by Hällstén and Tengblad (2006) as the practices and attitudes that employees develop in relation to their managers, colleagues, and employer (the organization as a whole) (18). Consequently, co-workership is about people's relationships in organizations and practices in these relationships. However, the interpretation of co-workership in practice seems to differ both between organizations and between different levels within the same organization (32). Employees' conceptions of co-workership are concerned with the work group and how it is functioning, while on the organizational level the interpretation of co-workership focuses on individual responsibility. Since the understanding of co-workership and how it should be developed is often normative in terms of "good co-workership" and seen from a leader's perspective (49), there is a growing need to take the employee's point of view of the phenomenon into consideration.

Hällstén and Tengblad (2006) described a normative model including important and necessary conditions for co-workership, such as trust and openness, community spirit and cooperation, engagement and meaningfulness, and responsibility and initiative (18). These conditions are not solely critical for the employees, but are relevant to managers too, since co-workership is a relationship in which both parties, managers and employees, take responsibility for their actions, their attitudes, and the relationship as a whole. In this normative way, a well-functioning co-workership is dependent on contextual factors such as how work is organized and other specific conditions in an organization. One of these conditions that is of importance for the development of co-workership is the communication climate (19).

Communication climate

An earlier theory described communication as a linear model in which a message passes from a sender through a medium to a receiver (50). However, this model can be seen as one-sided and merely a way of conveying information. Communication that functions as a process, on the other hand, focuses on sharing and exchanging information between two or more people in order to solve problems and explore new ways of working (51). In this way, communication includes complex and creative processes where the content is constructed and interpreted through interaction between people. Such communication is often characterized as dialogue (52, 53).

Dialogue requires unrestricted, honest, and mutual interaction (52, 53), for people to understand each other better. In this way, dialogue can be seen as relational and focusing on interactions between people. The unique part of dialogue is not the content but rather the process (54). One important goal of dialogue is to enable a group of people to reach a higher level of consciousness and creativity through a "common" thinking process (55). Active listening plays a major role in this process, but is not the central focus or purpose since feelings and other dimensions of communication can also be important in the thinking process. The process may not result in solutions to the problems identified, but rather in a relational resolution that develops from understanding each other's interests, values, emotions, and positions. Dialogue thus seems to have the potential to go beyond specific problem resolution and become a way of achieving social harmony (54). However, most of the theories of dialogue often describe dialogue uncritically as a panacea without questioning, for example, its potential to disguise covert agendas or power relations. This means that although dialogue is often seen as an important element of social existence, the context in which it occurs must be taken into account.

In the context of the workplace, communication characterized by dialogue gives employees the opportunity to speak up and provide critical feedback that can be important in decision-making processes (21). Such a communication climate can be seen as health-promoting, as it strengthens the conditions for employee influence and participation (17). This is also linked to the fact that employees taking responsibility through participative decision making is of importance for the development of co-workership (18). Hence, employee participation needs well-functioning structures, such as time and arenas, and processes including meaningful communication where people interact.

In organizations, communication flows in different directions, either vertically or horizontally in the organizational hierarchy (56), or free-flowing, with all

the members of the organization communicating with each other (57). An upward communication flow is the process of conveying information from the lower levels to the upper levels in the organization. However, an earlier study pointed out that positive information is more likely to flow upwards than negative information, which could result in potential problems at lower levels in the organizations failing to reach the top management (21). It is thus necessary to bring into existence a communication process that includes both upward, downward, and multi-way flow; not only the ability to listen and learn from each other, but also structural conditions. One example of such structural conditions is regular organized meetings where employees and managers can communicate with each other (16).

Workplace meetings

In an international context, a workplace meeting has been defined as three or more people coming together to discuss a work-related issue (58). These meetings are typically scheduled in advance, last between thirty and sixty minutes, and are conducted face-to-face. In Sweden, workplace meetings are a meeting arena regulated by a collective labor agreement that was established by the Swedish Association of Local Authorities and Regions in order to encourage collaboration at workplaces in municipalities, county councils, and regions (16). This collaboration is a process-oriented approach which is based on employees' and managers' participation and involvement in the process to manage improvements of the workplace and work environment.

The workplace meeting is an arena for employees and managers to use dialogue to address work environment issues, such as organizational and social conditions, that can be of importance for systematic work environment management. This can be supported by having the work environment as an item on the agenda. According to Leach et al. (2009), a written agenda prepared in advance appears to be associated with perceived effectiveness (59). However, there might be obstacles to adding the work environment as an obligatory and regular item on the meeting's agenda. A project performed in a healthcare organization identified obstacles such as difficulty in realizing that the work environment and business organization cannot be distinguished, and lack of time for prioritizing the work environment issue due to a business full of daily production to run (60). This indicates the need for development of workplace meetings in healthcare organizations in order to strengthen the opportunity for collaboration on work environment issues.

Collaboration through workplace meetings means a right for the employees to have influence (16). However, this requires that employees attend the meetings and are active and involved during the meetings. In this way, employees play a major role in the outcome of these meetings. On the other hand, workplace meetings can also be seen as a structural condition for development of co-workership, where dialogue can promote conditions of importance for co-workership (18, 19). If both employees and manager take responsibility for their actions, their attitudes, and the relationship as a whole, this might strengthen the opportunities for collaboration between both parties at the workplace meetings. However, the format and structure of workplace meetings are usually decided by management, often with regard to how the business runs. To date, little is known how these meetings function in practice in terms of communication processes, structural conditions, and opportunities for employee participation. This is especially the case in healthcare organizations, where the complexity of these organizations can affect the outcomes of these meetings.

Complexity in healthcare organizations

Healthcare organizations are among the most complex types of organization (61). One way to understand the complexity in healthcare organizations is to shed light on Glouberman and Mintzberg's illustration of the hospital as an organization divided into four separate and different worlds (mindsets): community (public or private owners/politicians), control (managers), cure (physicians), and care (registered nurses and other care professionals) (Figure 2). Consequently, each of these separate worlds represents a different understanding of the organizational reality (61). Moreover, the primary focus in professional bureaucracies such as hospitals is on the operating core and specific conditions of strong professions, and the identity of nurses and physicians is often closely associated with their own profession rather than with their role as an employee or with the organization itself (62, 63). According to Andersson (2013), co-workership in strongly professional organizations such as hospitals is usually based on a strong relationship to the team and the group members' profession (64).

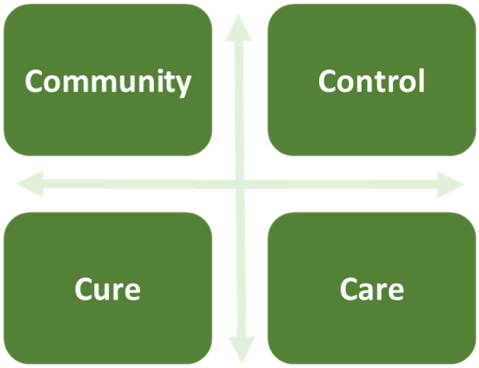

Figure 2. Mintzberg's model. Adapted from Glouberman and Mintzberg (2001).

Given this limitation, co-workership in healthcare organizations can be compared to the concept of team and teamwork, which has been defined as a group of people who work together toward a common goal that could not be achieved by individuals working alone (65). Consequently, this can result in an undeveloped relationship with the employer and indirectly with their manager (64). This can form a barrier, since co-workership considers a broader set of relationships, both horizontally between employees with different professions, and vertically between different levels in the overall organization. There is, therefore, a demonstrable need to strengthen conditions in healthcare organizations in order to develop co-workership over professional and organizational boundaries. However, there are still very few explorative empirical studies of co-workership in the specific context of healthcare organization. This is especially the case when it comes to employee's perceptions and understanding of the phenomenon and conditions of importance for co-workership from their own point of view.

Rationale of the thesis

Throughout this introduction, it has been shown that the most important factors and conditions for promoting employees' health within workplaces have already been investigated. However, there is a need to apply a holistic and system theoretical approach to workplace health promotion, rather than solely focusing on health-promoting and preventive behavior change on the individual level. This thesis is based on the fact that there is a need for knowledge about the organization of the work and employees' ability to exert influence at work, as well as a need to go beyond the total focus on risk perspective and prevention, and rather complement this approach with the principle of salutogenesis.

Although there is robust evidence-based knowledge about the role of leadership in promoting employees' health and a good work environment, there is far less research investing the impact of important factors of co-workership in relation to workplace health promotion. This thesis puts co-workership in the limelight, and investigates critical conditions that are required for development of co-workership from the employee's point of view.

Such knowledge is important for future strategies to develop holistic and sustainable health-promoting workplaces where top-down and bottom-up approaches are combined and integrated into employees' work practice. This knowledge is especially critical in healthcare organizations, where the work environment not only affects the health of employees directly but also organizational outcomes that in turn affect the health and living conditions for all people in a society.

Aim

The overall aim of this licentiate thesis was to increase knowledge about critical conditions for co-workership in healthcare organizations from the employee's point of view. This thesis has also a practical aim of providing information that can be used and applied in establishing a holistic and sustainable health-promoting workplace.

The aims of the studies included in this thesis were:

- To explore communication processes in workplace meetings in a Swedish healthcare organization (Paper I).

- To explore and describe conceptions of co-workership among employees with different professions in a Swedish healthcare organization (Paper II).

Methods

Design

This thesis used a qualitatively-driven mixed-methods explorative design (66) involving several different qualitative data collection methods. The reason for using this design was that investigating the research questions from different perspectives would give a comprehensive picture and deeper understanding of the study area as a whole. Qualitative methods were used both to investigate phenomena that had not been sufficiently explored in earlier scientific literature (67) and when a deeper understanding of the content and meaning of a phenomenon was needed in order to answer the research questions (68). The different study designs and data collection methods used in this thesis created a triangulation, which strengthens the findings by combining methods that illuminate the results from different angles (67). An overview of the studies' research designs is presented in Table 1.

Table 1. Overview of the study designs.

Study	Design	Data collection	Data analysis
Study I	Mixed methods	Observations, interviews, focus group interviews, feedback seminars	Content analysis and descriptive statistics
Study II	Qualitative design	Focus group interviews	Phenomenography

Setting

The two studies were carried out as part of a research project aimed to investigate the implementation process of workplace health promotion into practice in the context of a healthcare organization in the Region Västra Götaland. The initiative of this implementation process was decided on in the steering board of union and employer representatives in Västra Götaland. The main motivation for initiation grew out of experiences from an earlier project in this county council that focused on health-promoting behavior changes at

the individual level. Although the health-promoting approach was not successfully integrated in the organizations, one hospital was identified as being ready to take further steps towards implementing a holistic perspective of workplace health promotion. A project organization with an externally recruited project leader was placed in the human resources department at the hospital. A written implementation process plan with overall goals and activities was created, focusing on health promotion at three levels: the organizational level, the workplace level, and the individual level. The implementation process is fully described elsewhere (60).

The setting was a medium-sized hospital that provided acute, planned, and psychiatric care, with approximately 800 beds and around 140 wards. The hospital had 4,500 employees and was a multi-professional organization with around 50% employees with professional background as nurse or assistant nurse, more than 10% physicians, less than 10% medical secretaries, and 3-4% physiotherapists.

Data collection and sample selection

Observations

Observations were conducted in Study I in order to explore the communication processes in formal workplace meetings. The rationale underlying the use of this method was to understand the communication in terms of how employees and managers talked during the meetings and what they talked about. Observations were considered a suitable method, as they are often used to understand the complexities of situations that can be difficult to obtain verbally through interviews or in written form through survey responses (67).

A strategic selection of medical and surgical wards was used, with the intention of choosing those wards that are most common in healthcare organizations. The ward managers within the selected wards were contacted via an email sent by the human resources department, which provided them with information about the study and an invitation to participate. Nine managers (seven female and two men) chose to participate, and dates for observations and interviews were decided via telephone contact.

The observations were conducted from November 2010 to February 2011. Nine workplace meetings in nine different wards were observed in their natural settings. The observer did not participate in the meetings, but also was not

completely separated from the setting. Patton (2002) has described the extent of participation as a continuum that varies between full participation in the setting being studied and complete separation (67). During the observations at the workplace meetings, the role of the observer was in between these two end points. The observations were semi-structured using a computerized observation scheme with predefined categories based on the labor agreement (16) and experiences in the researcher team (Table 2). Unstructured field notes were also used. This observation scheme was considered suitable to collect quantitative data in terms of registered time in minutes for each of the predefined categories. A similar observation scheme with other predefined categories has been used in other research studies to observe managers' use of time (69, 70).

Table 2. The predefined categories in the observation scheme.

Topic	Communication flow
Physical work environment	One-way communication flow downwards
Psychosocial work environment	One-way communication flow upwards
Structural organizational changes	Two-way/multi-way communication flow
Economy	
Clinical work	
Quality and organizational development	
Planning and organization of meetings	
Employment, staffing, schedules	
Health and illness among employees	
Competence development	
Cooperation	
Technology	

Interviews

In connection with the observations of workplace meetings in Study I, interviews were conducted with each of the ward managers (n=9) responsible for the observed meetings. Interviews were considered a suitable way to obtain information about the way the workplace meetings were organized, as this could not be observed directly (67).

A semi-structured interview guide was used, with questions such as: “How often do the meetings occur?”, “Who usually attends the meetings and who usually does not participate?”, and “Do you usually have an agenda at the meeting, and if so, do you send it out before the meeting?”. The interviews lasted approximately 15-30 minutes each and were conducted in a location near where the workplace meetings took place. Notes were taken during the interviews.

Focus group interviews

Interviews with employees were carried out in focus groups to obtain their conceptions of the workplace as a health-promoting arena focusing on two phenomena: communication processes at workplace meetings (Study I) and co-workership (Study II). Employees’ practice of and approaches to these phenomena may be unspoken or taken for granted, which could make them difficult to articulate in a normal interview situation. Focus group interviews were therefore chosen as an appropriate method since the focus of the method is the process of sharing and comparing among the participants as well as eliciting their opinions without the goal of reaching an agreement (71).

Employees were strategically selected to obtain a variation in profession. Managers from 44 different clinical units (psychiatric, medical, and surgical) were contacted via email and telephone with information about the study and a request to select or ask one to three employees to participate in focus group interviews. The total sample consisted of 68 employees, with professions including nurse (n=29), assistant nurse (n=21), medical secretary (n=8), occupational therapist (n=2), physiotherapist (n=3), and physician (n=5). The participants varied in length of employment, gender, and age (Table 3).

Table 3. Characteristics of the focus groups.

Focus group	**Partici-pants (*n*)**	**Profession**	**Length of employment (*years*)**	**Gender *(female/ male)***	**Age**
1	5	Nurse	6–42	5/0	30–62
2	8	Assistant nurse	10–34	8/0	41–55
3	7	Nurse	3.5–37	7/0	35–58
4	4	Nurse	7–35	4/0	35–60
5	8	Medical secretary	5–36	8/0	26–58
6	5	Occupational therapist and physiotherapist	0.5–11	5/0	25–52
7	5	Assistant nurse	3–38	4/1	38–59
8	6	Nurse	5–31	4/2	28–57
9	8	Assistant nurse	5–38	7/1	29–59
10	7	Nurse	1–36	6/1	28–59
11	3	Physician	3–35	2/1	29–60
12	2	Physician	3–10	1/1	36–40

Twelve focus group interviews were carried out from November 2011 to January 2012. They were held in conference rooms at the hospital where the participants worked, and lasted approximately one hour each. Employees with the same profession but from different wards were placed in the same focus group in order to enable descriptions of differences in how employees with different professional backgrounds experienced the two phenomena. Another reason was to prevent potential verbal dominance among the different professions (72). The number of employees per focus group ranged from two to eight.

The focus group interviews started with reiterated information about the aim of the study and the ethical aspects of the interview situation. A moderator led the interviews and a co-moderator took field notes. The moderator used an interview guide with one main open question: “What does co-workership mean to you?”. Follow-up questions were asked in order to elicit concrete examples from the participants’ everyday work. For example, when they talked about opportunities to have influence, they were asked the follow-up question: “How do you experience workplace meetings as a formal arena for influence?”. All interviews were audio-recorded and then transcribed verbatim by an experienced transcriber. To ascertain the validity of the transcription, the moderator read through the transcript material while listening to the audio recordings.

Feedback seminars

Feedback seminars were arranged in order to present preliminary findings from the observations, the interviews with managers, and the focus group interviews with employees.

The preliminary results from the observations and interviews were presented to the ward managers responsible for the workplace meetings. Seven ward managers attended the seminar, which was conducted in a venue at the studied hospital. Field notes were taken during the seminar.

A similar feedback seminar was conducted for the employees who had participated in the focus group interviews. Twenty employees participated in the seminar. The preliminary findings were first presented to the employees and thereafter discussed in three different groups with one of the researchers in each group. Field notes were taken during the discussions.

Data analysis

Qualitative data

The qualitative data analysis used in this thesis had an explorative and inductive approach, meaning that findings such as patterns, themes and categories emerged out of the data (67). The inductive approach is called "bottom-up" because the analysis goes from the empirical data to a general level in order to answer the research questions (68). Inductive analysis is well-suitable when there is limited knowledge of a phenomenon (73). Two methods were used to analyze the qualitative data in Studies I and II: *content analysis* and *phenomenography*. The analytical process for each of the studies is briefly described below.

Content analysis (Study I)

The overall aim of content analysis is to interpret the content of qualitative data through a systematic organization process of coding and categorization in order to identify themes or patterns (74). In Study I, the data from observations, interviews, focus group interviews, and feedback seminars were analyzed in line with conventional content analysis (75). The focus of the analysis process

was on both the manifest and descriptive content as well as the latent and interpreted content (74).

The data analysis was performed in the following steps. First, comments made in the observation scheme were analyzed to identify content that could complement and further describe the predefined categories. Second, the field notes made during the observations, the individual interviews, and the feedback seminars with the managers were analyzed by highlighting words from the notes that appeared to capture the key information about the organization of the meetings. The highlighted text was labeled with codes, and the codes that were similar to each other were then merged into categories. Third, to get a comprehensive picture of the workplace meetings including both managers' and employees' perspectives, field notes made during the interviews with the managers and transcribed material from eight of the focus group interviews with the employees were analyzed. The material was initially read and re-read to get a sense of the overall content. Next, relevant content was labeled with codes, and codes that were similar were clustered into emerging categories such as communication of information, opportunity for employee influence and decision-making, sharing knowledge and development of competence, and attendance opportunities and motives.

Study I did not use material from all of the focus group interviews with employees, but instead looked only at the eight groups comprising nurses or assistant nurses. The reason for this was that those were the professions that usually attended the workplace meetings (especially the meetings that were observed), while the other professions, such as physicians, did not. However, there was no requirement for the employees who participated in the focus group interviews to have attended the observed workplace meetings.

Phenomenographic analysis (Study II)

The aim of phenomenography is to describe the qualitatively different ways in which a group of people experience and understand a phenomenon in their surrounding world (76). In Study II, phenomenography was used to describe how employees with different professional backgrounds experienced the phenomenon of co-workership in a healthcare organization. In the light of Glouberman and Mintzberg's illustration of the hospital as being divided into four different and separate worlds, where each of the four worlds represents different understandings of the organizational reality (61), phenomenography was considered to be a suitable approach since it assumes that people have

different conceptions of phenomena in the world due to their different relationships to the world (77).

The phenomenographic analysis in Study II was performed in line with Alexandersson's four steps (77). First, the transcribed material from the focus group interviews was read through to get an overall impression of the material. The material from the feedback seminar with the employees was seen as a complement in this first step, but was not further used in the analytical process. Second, conceptions about co-workership were highlighted in the material from the focus group interviews, and similarities and differences between the professions were noted. Third, conceptions that seemed to belong together were grouped into descriptive categories, from which a theme emerged. Finally, the underlying structure of the categorization system was examined. This allowed the outcome space in terms of the main result to form the basis for a more systematic analysis of how conceptions were related to each other.

Quantitative data

Descriptive statistics (Study I)

Quantitative data in Study I were collected during the observations by using the computerized observation scheme, which allowed the observer to register time in minutes for each of the predefined categories (Table 2). The registered times obtained from the FileMaker data file were analyzed in the computer program Microsoft Excel 2010 to obtain the proportion of the total observation time for each of the predefined categories. The aim of this analysis was to identify how much time in the workplace meetings was devoted to the different topics and communication flows.

Ethical considerations

Ethical guidelines for human and social research have been considered throughout the two studies in this thesis (78). Both studies were conducted according to the ethical principles of the Declaration of Helsinki (79). The studies were carried out as part of a larger research project that was approved

by the Regional Ethical Review Board in Gothenburg, Sweden (ref. no. 433-10).

Permission to observe the communication processes during workplace meetings was given by the manager of each unit participating in the study. The managers were responsible for informing the employees in advance about the aim of the study and the observations. Information about issues including confidentiality and the voluntary nature of participation was also given by the observer at the beginning of each observation. One observation of a meeting was cancelled spontaneously by a manager due to a secrecy-related topic that they needed to discuss without being observed; this observation was postponed to a later date.

Information about the aim of the focus group interviews, the voluntary nature of participation, and confidentiality was given to the employees at the beginning of each focus group interview. Although complete confidentiality can be difficult during focus group interviews, since participants from the same organization may know each other, the moderator emphasized the importance of not sharing other group members' opinions outside the group afterwards. Written informed consent was obtained from all the employees who participated in the focus group interviews.

Results

Communication processes and organization of workplace meetings (Study I)

Formal workplace meetings are regulated by a collective labor agreement that was established to encourage communication at workplaces. However, little is known about how these meetings is functioning in practice, especially when it comes to the outcome in terms of the communication processes and how these meetings are organized.

The results from the observations in study I shows how the communication processes during the workplace meetings was performed in practice. The workplace meetings were mainly an opportunity for downward, one-way communication flow characterized as information from the managers, but they also permitted upward communication flow characterized as information from the employees, and two-way and multi-way communication in terms of dialogue and discussions (Figure3). This relatively equally distributed communication flow indicates that the employees could have opportunities to exert influence, for example in potential decisions being made. However, due to the results from the observations, there were only three vague decisions being made during the observed meetings. Moreover, it was particularly clear that the actual influence was associated with the employees' everyday work, which was not only described by the interviewed employees but also observed in terms of that the topic *clinical work* was one of the most communicated topic during the workplace meetings.

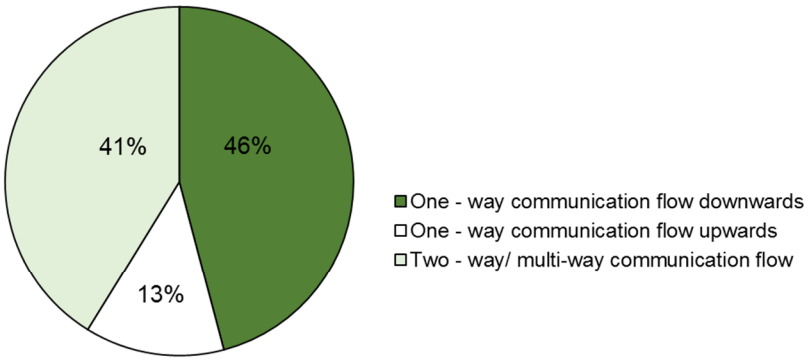

Figure 3. Communication flow for all the observed workplace meetings. The total observation time for all the workplace meetings was approximately eight hours.

Variation in communication flow and organization of workplace meetings (Study I)

Communication flow

Although the results in Study I showed that the total communication flow for all the observed meetings was relatively equally distributed between vertical and horizontal communication flow, there was considerable variation in how the communication flow was performed between the different workplace meetings (Figure 4). For example, one meeting was characterized by one-way downward communication flow that took up 87% of the time (WM2), while another was dominated by two-way or multi-way communication flow that took up 75% of the time (WM7).

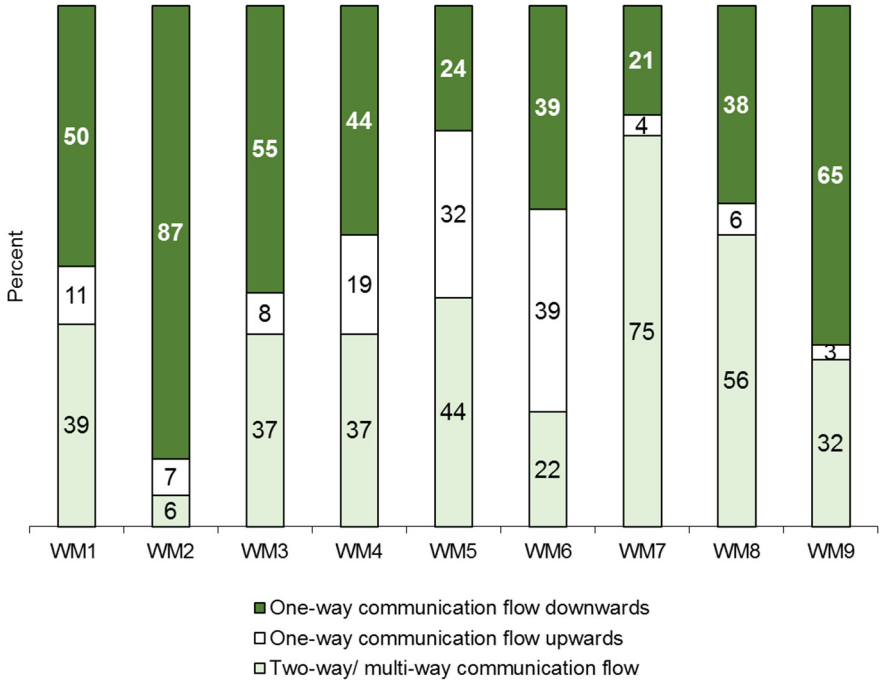

Figure 4. Variation in communication flow between the meetings.

Table 4. Organization of the observed workplace meetings (WM).

	WM1	WM2	WM3	WM4	WM5	WM6	WM7	WM8	WM9
Clinical setting	Medicine	Surgery	Medicine	Medicine	Medicine	Medicine	Medicine	Surgery	Medicine
Venue	Break room	Break room	Break room	Break room	Conference room	Conference room	Office	Break room	Break room
Time of day	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon	Morning	Afternoon	Afternoon
Scheduled duration	01:15	00:45	01:30	00:30	01:00	01:00	01:00	02:30	00:30
Actual duration	01:16	00:38	01:05	00:26	00:45	00:42	00:37	01:41	00:34
Frequency	Once a month	Every two weeks	Once a month	Once a week	Once a month	Once a week	Once a week	Once a month	Once a month
Participants[1]	9 (18%)	23 (38%)	15 (50%)	15 (30%)	12 (30-34%)	9 (36%)	3 (-)	11 (29%)	11 (14%)

[1]Approximate number of participating employees (percentage of all employees who worked in the wards).

Organization of workplace meetings

The results from Study I indicated that format and implementation of the formal requirements according to the collective labor agreement varied in practice between the observed meetings. This variation was related to frequency, scheduled duration, different venues, and number of participants (Table 4).

The frequency of the meetings varied from once a week to once a month. Most of the observed meetings were scheduled for afternoons, to enable employees on both day and night shifts to attend. The scheduled duration of the meetings varied from half an hour to two and a half hours. However, according to the observations, most of the meetings lasted approximately one hour.

The meetings were held in different venues such as break rooms, conference rooms, and offices, and the different venues offered different opportunities for physical arrangements. At one of the meetings (WM1), for example, the participants sat face to face so that they could see each other. The communication flow during this meeting was equally distributed between downward, upward, and two/multiway communication flow. Moreover, the item on the agenda that gave employees an opportunity to speak up was prioritized at both the beginning and the end of the meeting, which strengthened the possibility of upward communication flow. At another meeting (WM2), some of the employees and the manager sat with their backs to each other. This meeting was dominated by a downward communication flow of information from the

manager. The item on the agenda that gave employees an opportunity to speak up was at the end of the meeting, and was limited due to lack of time, since the actual duration of the meeting was only 38 minutes. These two examples indicate that the outcome in terms of the communication processes might be sensitive to how these meetings are organized.

A major difference between the observed workplace meetings was the number of employees who attended (range: 3–23) and the proportion of all the ward's employees who worked in the wards (range: 14%–50%). The most common professions of meeting attendees were nurses and assistant nurses. According to the interviewed employees, scheduling and ongoing patient care during the meetings were perceived as factors that prevented employees from attending.

Employees' conceptions of co-workership (Study II)

Co-workership is well-established and used as a top-down communication strategy in most Swedish organizations, but the relevance and understanding of co-workership from the employee's point of view is still largely unexplored.

The results from Study II show that the employees' conceptions of co-workership in the healthcare organization were mainly expressed as a collective process, indirectly or directly formed around the patient. This collective process included colleagues but not explicitly managers, even though the manager could contribute to the process. The employees' conceptions formed one theme and five categories representing different conceptions of co-workership (Table 5).

Table 5. Overview of the theme and categories.

Theme: Co-workership as a collective process					
Categories	Group coherence and striving toward a common goal	Cooperation over professional and organizational boundaries	Work experience and trusting each other's competence	Social climate and sense of community	Participation and influence

Group coherence and striving toward a common goal. Co-workership was mainly associated with working together and taking responsibility for the work as a group, rather than working alone and taking individual responsibility. Working together toward the common goal and ensuring that the goal was clear were perceived as preconditions for group coherence. The role of the manager was to ensure that everyone worked toward the common goal.

Cooperation over professional and organizational boundaries. The employees described cooperation as a central aspect of co-workership. Cooperation often included several employees with different professional backgrounds, and could be over unit boundaries. This kind of cooperation, comparable to teamwork, was perceived as promoting understandings between colleagues and could contribute to a well-functioning workplace as a whole, not only for the unit team.

Work experience and trusting each other's competence. Co-workership was perceived as depending on mutual trust in each other's competence. Trusting relations between colleagues were about reliance and confidence, and could be seen as complement to work experience and knowledge. According to the employees, a climate of trust could promote dialogue as well as being important for their work with patients. Trusting relations between employees and managers relied on the manager being able to promote a culture of transparency, security, and trust at the workplace.

Social climate and sense of community. Normative statements of what characterized "good co-workership" were not only restricted to group coherence and working together with patients, but also covered supporting and helping each other and maintaining a positive climate and a familiar atmosphere. Respect between colleagues was perceived as promoting a social climate which led to sustainability among the employees. In promoting a social climate and sense of community, the role of the manager was to listen, to be engaged, and to acknowledge the employees.

Participation and influence. The employees' conceptions of participation and influence were mainly concerned with aspects of their work with patients. There were also conceptions of opportunities for exerting influence related to organizational issues, but the employees questioned how much influence they actually had in the overall organization. A good communication climate in terms of allowing people to speak up was pointed out as a condition for exerting influence.

Different conceptions of co-workership between the different professions (Study II)

Study II also included an analysis of how employees with different professional backgrounds experienced co-workership. The results indicate that conceptions of co-workership differed between the professions in terms of who was included in co-workership, what obstacles existed to cooperation, and what opportunities existed for exerting influence.

Who was included in co-workership? Some of the physicians worked at several units and included only physicians in their view of co-workership, while nurses and physicians who worked within a single unit included all the professions they worked with.

What were the obstacles to cooperation? According to the medical secretaries, different work routines and the different terminologies used by the physicians could be obstacles to cooperation over unit boundaries, while the physicians pointed out that conflicts of interest in terms of prioritizing different patient groups could also be an obstacle.

What opportunities were there to exert influence? The physicians could exert influence in their clinical work, while the other professions had less influence on their working day and their own schedules. The assistant nurses and the nurses had found that they had less influence when physicians were present, for example during workplace meetings, and so they organized meetings together without the physicians.

Discussion

Reflections on the findings

The focus of this thesis has been on putting co-workership in the limelight and increasing knowledge about critical conditions for co-workership in healthcare organizations from the employees' point of view. The rationale was to obtain a comprehensive picture and deeper understanding of this area, which has not previously been sufficiently explored in the literature. The results in this thesis reveal that the phenomenon of co-workership was perceived by the employees as a collective process that took place at the bottom of the organizational hierarchy. Conditions such as participation and influence, social support, and communication were mostly related to the employees' everyday work and their clinical work in particular, rather than to the overall organization. Workplace meetings seemed to be a well-functioning organizational prerequisite for several conditions important to co-workership, although the outcomes in terms of communication processes varied between different workplace meetings.

The phenomenon of co-workership in healthcare organizations

The employees described co-workership in the healthcare context as a collective process, indirectly or directly shaped around the patient. This collective process included colleagues but not explicitly managers. This is in line with results from a recent study where co-workership from the employees' point of view was primarily associated with group coherence and how the group worked together, while the focus from upper levels in the organization was on the individualistic responsibility of employees (32). The finding of co-workership as a collective process can be comparable to other phenomena, for example team and teamwork, which in earlier research has been defined as a group of people working together toward a common goal that could not be achieved by individuals working alone (65).

As described by Hällstén and Tengblad (2006), a hallmark of co-workership is the relationship employees have with their manager, colleagues, and the organization as a whole (18). In a normative way, co-workership in healthcare organizations can be considered as rather undeveloped, since it seems to only include relationships with colleagues. In relation to this, the research in this thesis identified some frictions, both horizontal and vertical. The horizontal frictions occurred between employees with different professional backgrounds

and were related to different opportunities to exert influence and belonging to a group with other professions, but also prioritization of different patient groups. The vertical friction concerned the sense of not being a part of the overall organization. These frictions are rather common in healthcare organizations (61-64, 72). One way to understand this is via Glouberman and Mintzberg's illustration of the hospital as an organization divided into four separate and different worlds (mindsets): community (public or private owners/politicians), control (managers), cure (physicians), and care (registered nurses and other care professionals). Each of these worlds represents different understandings of the organizational reality (61). Based on the employees' conceptions of co-workership, the "care" and "cure" worlds dominated the organizational dimensions, whereas "control" and "community" were weak. Given this limitation, there is a demonstrable need for strengthening conditions in healthcare organizations for development of co-workership over professional and organizational boundaries.

Critical conditions for co-workership

The employees' conceptions revealed certain conditions they considered important for co-workership: *participation and influence*, *social support*, and *communication climate*. These are in congruence with conditions described in earlier research about co-workership (18, 19). However, this affirmative result from Study II contributes important knowledge about co-workership from the employee's point of view in a healthcare organization, which might be useful both in promoting efficiency, quality, and a good work environment within such organizations, and in further research focusing on these kinds of questions.

Participation and influence were mainly related to the employees' everyday work with the patients, but also in a sense to overall organizational issues. This finding is comparable to task-based participation, which allows workers to influence their immediate job and work environment, rather than participation at higher levels that allows influence over business policy and management strategy (80). Such participation can be considered weak in the sense that it gives employees less influence over the final decisions. By emphasizing opportunities for taking responsibility through participative decision making, health-promoting work conditions might be obtained (81). Moreover, as described by Mikkelsen (1999), a high decision authority together with a high degree of social support can function as a resource in demanding work situations (82).

Social support was described in terms of supporting and helping each other when needed, both emotionally and practically. This was also related to promoting a social climate and sense of community. To achieve this, the role of the manager was to listen, to be engaged, and to acknowledge the employees. These findings seem to be related to the definition of social support. As described by Pejtersen (2010), social support at work can be defined as access to help and support each other, listen to problems, and get feedback from managers and colleagues (83). According to this definition, communication seems essential when providing social support. This is especially important in healthcare organizations, where lack of social support can lead to mistakes related to organizational performance and patient safety (84, 85). According to one of the studies conducted by Eklöf and colleagues (2014), social support was needed when individuals were emotionally upset by stress, which in turn could lead to mistakes such as incorrect medicine doses (84).

Communication climate was described in positive terms of allowing people to speak up and promoting a climate of trust. In turn, a climate of trust could also provide dialogue, which was perceived as important for the work with the patients. According to earlier research, a good communication climate seems to be crucial to building organizational climate, trust, and an overall good work environment (86), which in turn can improve not only employees' health but also patients' safety (84, 87). The results from the research in this thesis show that a good communication climate gave the employees opportunity to speak up and provide critical feedback. Such a communication climate is important in decision-making processes (21), and can also be seen as health-promoting due to the strengthened conditions for employee influence and participation (17). According to Hiede and Simonsson (2011), one requirement for co-workership is a good communication climate, including the existence of a communication platform that makes it possible to develop relationships among coworkers (88). One such communication platform at workplaces in municipalities, county councils, and regions is the workplace meeting, which as previously mentioned is regulated by a collective labor agreement in order to encourage communication (16).

Workplace meetings – an essential forum for communication

The findings in Study I, suggest that workplace meetings can offer a forum for vertical and horizontal communication flow. The results are thus in line with the aim behind the collective labor agreement (16), which recognizes work-

place meetings as an essential part of the concept of workplace health promotion (34, 35). Although the findings indicate that the communication flow was primarily a one-way downwards flow of information from the manager, upward, two-way, and multi-way communication flow was also allowed (and observed) in the study. This gave the employees opportunities to speak up and provide critical feedback that could be of importance for decision-making processes (21). However, since the structure and format of these meetings has not been explored to any great extent, there remains, as pointed out by Tschannen (2012), the foundational step of understanding the environment before implementing any strategies aimed at improving communication (89). The findings from this thesis highlight several factors concerning workplace meetings that need to be discussed.

Study I revealed a low attendance of employees during the observed workplace meetings in relation to the number of people employed within these units. Difficulty in attending meetings was mostly related to scheduling and to ongoing patient care. This is in congruence with an earlier finding that the difficulty of attending workplace meetings was related to scheduling and operative work, particularly for physicians (62). However, the findings in Study II indicate that physicians hindered other employees with less education from having influence during the meetings. Consequently, the nurses and assistant nurses arranged their own workplace meetings which excluded the physicians. According to Thylefors (2012), such verbal dominance during meetings can be linked to a hierarchy related to profession (72). Furthermore, this type of power and status differential can cause people to censor expressions of their views more generally (20).

Another factor that can influence the communication process in a group is the size of the group. An earlier study showed that the communication in a small group with five members was characterized as dialogue, while the communication in a larger group of ten members was more like monologue (90). Since the workplace meetings observed in the present thesis were attended by up to 23 people, this indicates that it might be fruitful to occasionally split up such larger groups into smaller groups in order to promote dialogue.

As described by Svennevig (2012), meetings are generally held in designated rooms where the architecture, furniture, and technological equipment are specially constructed for the activities associated with meetings (91). However, this was not the case when it came to the meetings observed in this thesis. Several of the meetings were held in break rooms that were not dedicated to meetings, and only two of nine were performed in conference rooms. The meetings were arranged in rooms available within the wards in order to make

it possible for more employees to participate. This was linked to the constant flow of patients, and the employees' need to be present in ways that differed from the outpatient departments. Thus, the workplace meetings were adapted to the reality of the wards, which aligns well with the collective labor agreement (16).

The physical characteristics of a meeting, such as the surrounding and the environment, seem to be crucial (92). According to Leach (2009), a lack of optimal physical facilities in terms of suitable table arrangements can impede the meeting processes (59). One unexpected result in Study I was related to physical facilities; specifically, how the attendees sat during the workplace meetings. This was especially the case when it came to one of the meetings where the employees and the manager sat in different arrangements, and consequently had their backs to each other. This might have affected the communication process, since the observation showed that there was an overload of information from the manager and hence little time for the employees to speak.

Although the results in this thesis showed a fairly equal communication flow when the meetings were considered as a whole, the variation between the meetings indicated a redundancy of one-way downwards communication flow during some of the workplace meetings. Employees did perceive the information shared by the manager as important, but only if it was related to their own unit and/or profession. Similar results were found in another study, where employees enjoyed meetings when the meetings had a clear objective and when important relevant information was shared (93). However, the findings from Study I show that the managers found it difficult to prioritize among the flow of information. As described by Simonsson (2002), who studied communication between department managers and employees in meetings within the motor industry, it seems that managers to a large extent are caught in an informative and distributive communication role (94). In this role, managers might use strategies of filtering and/or hiding problems upwards and downwards, with motivations which include preventing unnecessary worry and stress among employees as well as protecting themselves from negative consequences (95).

An overload of one-way communication flow can be a potential obstacle to a dialogically oriented form of communication. However, the two-way and multi-way communication flow in Study I indicated that dialogue occurred between employees and managers during the workplace meetings. Dialogue at work is often positively valued, but in reality is often absent (94, 96-98). A study conducted by Grill (2011) concluded that although first-line managers in

the healthcare context valued dialogue positively, this valuation was not always manifest in practical action (97). In addition, Schein (2009) has claimed that dialogue has little space in organizations, because organizations focus on results and efficiency, whereas dialogue does not focus on immediate results but rather on increased employee participation, which could actually clash with productivity (99).

The workplace meeting is a suitable arena for employees and managers to use dialogue to address work environment issues, and together identify potential risk factors that can be of importance for the systematic work environment management (16). However, there was a surprising lack of this type of communication during the workplace meetings observed in Study I, indicating that workplace meetings need to be further developed in order to have space on the agenda for topics related to the work environment. One policy that supports this development is the new work environment regulation that aims to provide employees with support in taking up organizational and social work environment issues in the workplace to a greater extent (31).

Focusing on co-workership in implementations of workplace health promotion in healthcare organizations

To achieve a successful integration of workplace health promotion into practice, it is crucial to take a holistic approach with a combination of top-down and bottom-up strategies (4, 8, 15). Such a theoretical framework based on the system theory suggests the holistic consideration of conditions, factors, and relationships between individual challenges in the context of the workplace (*micro level*), within the systems, rules, values, and norms of the organization (*meso level*), and with regard to impacts from society (*macro level*) (42, 44, 45). From the perspective of this theoretical standpoint, the aim of the overall research project within which the studies in this thesis were carried out was to investigate the implementation of a holistic workplace health promotion perspective in a healthcare organization. One of the conclusions from this project was that the focus of co-workership in the implementation process was limited and the actual implementation project was based on a decision taken from above. Thus, the employees were not involved in the actual planning of the project, and the health-promoting activities were not clearly adapted to the daily clinical work (60). Neither the employees' own work situation nor the context on the micro level had been taken into account. The individual employee's conceptions were in focus in this thesis, but the analyses and the results were performed with a focus on the micro level. Moreover, the

results indicate that the individual aspects of co-workership defined in closely related concepts of co-workership such as employeeship (33) might not commonly occur in practice. This seems to particularly be the case in the context of healthcare organizations. Although individualistic responsibility was illustrated in terms of giving patients treatment based on professional knowledge and competence, it was mostly the collective aspects of co-workership that were dominant.

According to the system theoretical model, the collective process was related to the micro-level and took place within the clinical base of the hospital organizational hierarchy. In relation to this, it is clear that health-promoting activities should be linked to the collective process of co-workership in terms of employees' everyday work with the patients. Employees' actual influence was associated with their everyday work; this was not only described by the interviewed employees but also observed during the workplace meetings, where clinical work was one of the most communicated topics. As several other studies have pointed out that employee participation is critical for a comprehensive health promotion approach (100-103), it is time to put co-workership at the center of developing holistic and sustainable health-promoting workplaces.

Methodological considerations

To explore and describe the critical conditions for co-workership, a qualitative mixed-methods research approach was required. One strength of the mixed-methods design used in this thesis was that the research questions of each study were investigated from different perspectives, which led to a comprehensive picture and deeper understanding of the study area as a whole. However, a disadvantage of this design was that the data collection and data analysis were time-consuming, especially in Study I where the data were collected stepwise with several data collection methods. On the other hand, the use of different methods was necessary in order to investigate a phenomenon that had not sufficiently been explored in earlier scientific literature. Overall, the use of a mixed-method design was predominately positive. The following section describes some methodological considerations in relation to the two studies in this thesis.

Quality in qualitative research

Quality in qualitative research can be described in terms of trustworthiness, which can be considered as comprising four closely related criteria: credibility, dependability, confirmability, and transferability (104).

Credibility refers to confidence in the "truth" of the study findings (104). The credibility of the findings in this thesis was established by triangulation, and the probability of being able to verify the data was improved by the use of multiple data sources. However, the aim of the triangulation was primarily to increase the understanding of complex phenomenon, rather than to reach agreement between the different sources.

To enhance the credibility of the results from the focus group interviews, the interactions between the participants were followed up with probing questions to verify their statements. Another way of verifying the statements made by the participants was to present the preliminary findings to them at a feedback seminar. The findings seemed to make sense to the participants, which strengthens the credibility of the findings (104).

The majority of the focus group interviews were conducted by the same researcher, with only two of twelve being conducted by another researcher. Both of the moderators were involved in every phase of the study, and the possible impact on the findings was discussed together with the co-moderator, which again strengthens the credibility of the findings.

To enhance the credibility of the observational results, the observation scheme was validated in order to check its relevance for observing communication processes during workplace meetings. After the first three observations were conducted, the data were interpreted by the research team to check the relevance of the predefined categories. This procedure resulted in a high level of agreement and addition of a new category.

In qualitative inquiry the researcher is the instrument, and therefore some information about the researcher should be reported (67). The researcher (PhD student) had no previous experiences of the healthcare organization before the data were collected, but did have substantial knowledge in the area of public health and workplace health promotion. The semi-structured observation scheme with the predefined categories was helpful in allowing extraction of the most relevant information for the purpose of the study. The presence of the observer affected the participants at the workplace meetings, in terms of creating curiosity among them. This curiosity was reduced after information about the observer was presented and the purpose of the observations was

explained. The rigorous data collection and the triangulation validated the data and minimized the potential observer biases. On the other hand, it should be remembered that data from and about humans represent some degree of perspective rather than absolute truth (67).

Peer debriefing was used during the data collection processes in order to establish credibility of the data (104). This was considered a suitable way to explore aspects and test hypotheses that might otherwise have remained only implicit within the inquirer's mind. After each of the observations in Study I, the observer debriefed with one of the other researchers in the research team via telephone contact, thereby allowing them to clear their mind of emotions and feelings. Similarly, after each of the focus group interviews peer debriefing took place between the moderator and the co-moderator. After all the observations and focus group interviews had been conducted, the researcher debriefed again in meetings with the research team, which gave opportunities to probe the observer's biases, explore the meanings of the data, and clarify the basis for interpretations of the data (104). Another way of strengthening credibility was the use of this multidisciplinary team of researchers to interpret the data during the analytical process. Each of the researchers analyzed some parts of the material separately, and the interpretation was then discussed in the group. This way of considering multiple interpretations of an empirical material could be called research group triangulation (67).

Credibility in phenomenographic studies, as well as in studies using content analysis, is about the relationship between the empirical data and the categories describing ways of experiencing a certain phenomenon (74, 105). The credibility of the findings in Studies I and II was established by exemplifying the categories with illustrative quotations, thus allowing the reader to consider the relevance of the categories.

Dependability refers to the consistency and repeatability of the findings (104). However, it is difficult to accomplish consistency in qualitative studies, because the contexts are changeable and it may be difficult to repeat this type of study. Although the economic crisis seemed to affect the studied hospital in terms of personnel downsizing (60), there were no obvious changes that affected the research in this thesis. To establish dependability, the logic of the selection of participants, the data collection methods, and the context were clearly described in each of the studies. Furthermore, according to Lincoln and Guba (1985), there is no credibility without dependability; in line with this consideration, it seems that the demonstration of credibility in this thesis is sufficient to establish dependability.

Confirmability refers to the degree of neutrality in regard to a phenomenon under study, or the extent to which the findings are shaped by the respondents rather than by the researcher's motivation or interest (104). To achieve confirmability, the findings need to reflect the respondents' voices (67). The qualitative data analysis in this thesis was conducted inductively, which means that the findings emerged from the data and no specific theory was chosen to organize the text. However, according to Malterud (2001), the notions used in interpretation of qualitative data are always derived from a theory of some sort. It is therefore important to clarify the standpoints of the researcher, in order to enhance intersubjectivity (106). The PhD student's preconceptions can be related to the area of public health and workplace health promotion, with an interest in the perspective of employees, which might have influenced the direction of the data collection and interpretation and could have hindered the data from representing the respondents' voices. However, the multidisciplinary team of researchers was involved in every phase of conducting Studies I and II, particularly in the interpretation of the data, in order to reduce the subjectivity and thus enhance the confirmability. In addition, the participants' recognition of the preliminary findings presented at the feedback seminars can also be an aspect of confirmability (74).

Transferability refers to the extent to which the findings can be applied to other groups or settings (104). Findings from qualitative inquiry are not intended to be valid for population groups in general, but can be applicable within a specified setting (106). The authors can give suggestions about such transferability, but it is the reader who decides whether or not the findings are transferable to another context. The context, participants, data collection, and analysis have been clearly described for each of the studies in this thesis as a way to support readers in drawing their own conclusions about which of the findings are transferable to other settings.

The findings about the communication processes and the organization of the meetings in Study I could probably be applied to other healthcare organizations as well as other settings where workplace meetings exist. In Study II, the most common professions in healthcare organizations were chosen to participate in focus group interviews about the phenomenon of co-workership. This strengthens the probability of being able to apply the findings of employees' conceptions of co-workership to other healthcare organizations in Sweden, as well as to those in the other Nordic countries where co-workership has evolved from a long working life tradition.

Conclusions

The research in this licentiate thesis shows that:

- The phenomenon of co-workership in a healthcare organization was experienced by the employees as a collective process, indirectly or directly shaped around the patient. This collective process included colleagues but not explicitly managers. In contrast to earlier research about co-workership, this view of co-workership can be seen as rather undeveloped, since it does not include the employees' relationship to their manager, employer, or the organization as a whole. Consequently, co-workership in healthcare organizations can be comparable to other phenomena in this type of organization, for example team and teamwork.

- There is a demonstrable need to strengthen the conditions in healthcare organizations that facilitate development of co-workership over professional and organizational boundaries. The employees who participated in the present research described several conditions for this: *participation and influence* due to the employees' work with the patients, *social support* in terms of helping each other when needed, both emotionally and practically, and *communication climate* in terms of allowing people to speak up.

- Workplace meetings are an organizational prerequisite that seems to have the potential to promote critical conditions of importance for co-workership. This is especially the case when it comes to the communication process. However, some obstacles were identified: difficulty in ensuring attendance of all employees, the redundancy of one-way downwards communication flow of information from the manager, lack of tools for promoting dialogue, and the physical arrangement of the meetings. Given these limitations, there is a demonstrable need to develop these meetings in order to strengthen the opportunity for employees to influence decisions and for employees and managers to collaborate together on work environment issues.

- To integrate workplace health promotion into practice with both top-down and bottom-up approaches, a particular focus of co-workership is needed. This means that in healthcare organizations, health-promoting activities should be linked to the collective process of co-workership in terms of employees' everyday work with the patients.

Future perspectives

Implications for practice

The research in this thesis contributes increased knowledge about critical conditions for co-workership, with a special focus on the practical operationalization of workplace meetings and the communication process during these meetings. While the thesis focuses on the healthcare context, the following recommendations will likely be useful in developing workplace meetings in other organizations with similar challenges.

Adjust information to the target group. Workplace meetings are an opportunity for managers to inform employees verbally. However, it is important to filter and prioritize the information that should be communicated. To determine if the information is relevant, a good question to ask is: "How does this information concern our work, unit, or patient/customer group?"

Inform through other channels. Besides workplace meetings, there are several other ways to inform employees: emailing the information to the participants before the meeting, displaying the information on a billboard, distributing the information in a weekly newsletter, or dedicating a specific meeting to only the provision of information and then using workplace meetings for dialogue and discussions about predetermined topics.

Promote dialogue during workplace meetings. There are also several ways to promote dialogue within meetings. Paired conversation ("bikupesamtal"), that is, a conversation between two people, can be implemented during a workplace meeting through inviting participants to talk with the person sitting next to them. Similarly, group conversation can be used to split up a large group into smaller groups of 3-5 persons. Round-table conversation ("laget runt"), in which everyone in turn is given a few minutes to speak, is another option. Finally, to promote engagement among the participants, themes with related questions can be used, such as "What does health mean in our workplace?", "What can we do to develop/maintain health in our workplace?", and "How can we together create a good work environment that promotes health?".

Observe the physical environment. The venues and furniture used for meetings can differ depending on the context. However, it is important that all participants can see and hear each other. There are a few things to consider: whether the room fits the purpose, whether there is access to the necessary

resources (e.g. computer, whiteboard, post-it notes), and whether the furniture invites participation.

Promote competence development. Workplace meetings aim to provide the conditions for personal and professional development. This can be achieved, for example, by the employees or an external speaker giving a lecture about a desirable topic, or by showing sequences of a film/documentary followed by discussion of important issues related to the business. Another possibility is to invite employees to share different work situations which are then discussed in groups. Finally, there is the option of organizing a study circle in which every participant reads, for example, a scientific article or a book chapter, and then discusses interesting issues at the next workplace meeting.

Implications for future research

The research in this thesis contributes knowledge about conditions of importance for co-workership from the employee's point of view. A further interesting question is whether the conditions identified in this work, such as influence and participation, communication climate, and social support, are associated with efficiency and quality of care in healthcare organizations. Such knowledge could be useful both in promoting organizational outcomes and a health-promoting work environment within healthcare organizations, and in further research focusing on such questions.

Another important issue for future research is to investigate communication processes in workplace meetings in a longitudinal perspective. To achieve this, a workplace meeting within a ward should be studied over time in order to identify a pattern in the communication flow. In addition, interviews should be conducted with both the manager and the employees who participated in the observed meeting, to obtain their views about the communication processes. This would give a broader perspective of workplace meetings from different perspectives. However, one observer may not be sufficient to cover the whole communication process. To study both verbal and non-verbal communication, for example, two observers could be needed to cover each aspect of the communication process. Hopefully, the research in this thesis will encourage such future studies in this field to be carried out.

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