

**“WE’RE NOT SUPPOSED TO WORK WITH ICT—  
WE’RE SUPPOSED TO WORK WITH THE CLIENTS”:  
HOME HEALTH AIDES IN SWEDEN USING  
LOYALTY AS RESISTANCE**

**MARIE HJALMARSSON**

*University West, Sweden*

**ABSTRACT**

The purpose of this article is to shed light on informal resistance among home health aides in Sweden. Although they endure stressful working conditions, down-sizing, and management-initiated changes that are in some cases considered irrelevant and even stupid, surprisingly few formal resistance actions are carried out by home health workers in Sweden. This doesn't mean that they (and other workers too) are passive victims of management power, nor does it mean that they are free riders acting only according to their self-interest. Their resistance strategies are characterized by divided loyalties and competing interests rather than conscious and rational choice. The results of this study show that the home health aides do not engage in formal resistance even though they are unionized and have the opportunity of collective action; instead they engage in informal resistance. The main reason for their informal resistance, I argue, is the loyal attitude and loyal way of thinking and acting that is embedded in their professional identity. It holds them back and hinders them from expressing resistance in a loud manner. At the same time, their loyalty can also be considered as a form of resistance when they use it in a selective manner as a way of creating scope for action.

**UNDERSTANDING RESISTANCE**

There is a challenge for researchers with an interest in the relationship between power and resistance in organizations and how it is expressed in everyday work situations. Even though there is interesting research concerning the exercise of

management power and/or employee actions as planned and formally performed resistance, there are gaps to fill. Employee resistance of a more informal character, with its local and cultural variations in both form and content, is a field of organizational research with a never ending need for more studies. It is, however, problematic to clearly define resistance; there is no set definition (and perhaps there shouldn't be one). The problem area is multifaceted and complex, and there are at least three disputable aspects (Edwards, Collinson, & Della Rocca, 1995). First, who owns the preferential right of interpretation to define employee actions as resistance? Which actions, conditions, and consequences should be considered in studies of employee resistance? Employees may not define their own actions and responses at work as resistance, even if through scientific analyses their actions and responses can be identified and presented as resistance. Furthermore, employees may consider their actions as resistance but for an outsider their actions may seem rather by some other intention. Second, expressions of resistance take specific local and cultural forms. Expressions of resistance may be hard to discover in the everyday complexity and dynamic of workplaces. Therefore, studying expressions of resistance requires a lot of time, good access to cases to study, and researchers prepared to get involved. Third, it is problematic to carry out comparative analyses due to the above mentioned factors as well as because of the conceptual variety. Some studies have the explicit aim of studying resistance (see Huzell, 2005), while others do in fact carry out resistance studies, but without using the concept of resistance (see Furåker, 2009). There are various models of explanation. Either employee actions and responses *or* management control is declared to be the primary research interest. Bearing in mind the points mentioned above, it is of great interest to shed light on and acknowledge every possible form of resistance, especially forms of informal character such as unorganized, unplanned, and, on the surface, unintentional manifestations. The home health aides' identity formation and interpretation of meaning as well as their striving for autonomy are, in this article, seen as intertwined with their display of resistance. Instead of asking why they don't engage in formal resistance, I ask: What do they do to preserve their (professional) identity, self-respect, and dignity? How do they interpret their scope for action and create autonomy? How do they act when they are dissatisfied with management initiatives and the intentions behind these initiatives? How can we understand this kind of silent and almost invisible everyday resistance (Scott, 1985)?

The exit, voice, and loyalty framework of Hirschman (1970) presents useful concepts to help us to understand informal resistance (although the framework is presented as a theory of how employees *respond* to unsatisfactory conditions, not specifically a theory of *resistance*). Exit (choosing to leave the job when dissatisfied) is a rare form of resistance. It is a difficult decision to make, especially among unqualified workers considering the current unemployment figures (almost 8% in February 2011 according to Statistics Sweden [2011]). Voice, on the other hand, encompasses employee activities of formal resistance such as

expressions of dissatisfaction and discontent. Both exit and voice represent overt and explicit forms of resistance, while loyalty can be described as a subtle and hidden form. It is embedded in the activities of daily work, often manifested in increased levels of performance and stronger commitment to the organization (Sverke & Hellgren, 2001). In the case of home health services, levels of performance and commitment are already as high as they can be. Previous research concerning work performance and dedication to tasks in caring professions in general and in home health services in particular presents the same picture. Employees in these professions perform more than they are asked to do, due to loyalty toward their clients rather than loyalty to the organization (e.g., Hjalmarsson, 2009a). Farrell (1983) in his elaboration of the EVLN model (Exit, Voice, Loyalty, and Neglect) establishes that further elaboration of the loyalty construct in particular is necessary for a deeper understanding of employee behavior.

### **A Few Words on Power**

Power in this article is, in line with Foucault (1991), considered as something that has to be repeated and exercised in order to exist. In line with the concept of discipline, power is understood as being integrated in a society through being in alliance with the financial and productive purposes of institutions and organizations of that society. Disciplinary power is productive, which means that it produces opportunities to exercise power. Even if representatives of management are present, it is not these individuals that “have power”; it is the machinery itself that produces and distributes power. It is self-reproductive, and it is discreet, sometimes so discreet that it seems invisible in contrast to traditional power.

McKenzie (2001) presents the concept of performance as a way of understanding how the exercise of power is transforming from a disciplinary exercise into one of performance. In working life it is expressed as an idea in which a creative and self-regulating employee is preferred and is considered a source of high performance rather than an obstacle. Traditional forms of discipline through standardization of work and lack of opportunities for employees to take initiatives of their own is accompanied by innovation, creativity, and increasing possibilities for employees’ own initiatives. This means, admittedly, that the ways of governing employees are changing, but it does not mean that the motives are. Models and discourses such as those of human relations, learning organization, and new public management contain different ways to optimize work performance, but they still have one thing in common, which is the basic principle of performance: “The challenge of efficiency, the imperative to maximize outputs and to minimize inputs” (McKenzie, 2001: 82).

McKenzie (2001: 247) calls the power of performance “nomadic.” Its ruling and controlling systems are widespread, and it generates a network of opportunities and financial means of pressure. This pressure is in place not only in order

to shape employees to adapt, but also to enable them to subscribe, to resist, and to stretch the boundaries of the controlling systems. This complexity makes the power of performance almost paradoxical, but also relevant to the understanding of complex and contradictory structures of power. How can we then study resistance, if resistance itself is approved and embedded in the nomadic power of performance? I suggest we rather ask what exercises of power we can identify by studying resistance. If our conceptualization of resistance involves taking into consideration its complexity and contradictions, it is also possible to identify and criticize contradictory structures of power: “To resist something also means to reify it, by privileging it as a meaningful area for political contest” (Thomas & Davies, 2005: 687).

In my study of home health services in Sweden, the overall purpose was to gain further understanding of how employees interpret and make use of their possibilities of acting. The point of departure is then to highlight a struggle for autonomy: how the employees in everyday work try to do things their own way, to preserve their dignity and to create an identity of their own. In short (a more detailed description will follow), the study takes place in a situation where the employees are expected to exercise self-control through a kind of performance monitoring (see also Ball & Wilson, 2000), in this case involving handheld computers. I was, at the beginning of my long-term visits to the home health service providers, expecting formal resistance that could be characterized as collective, conscious, and planned. But I didn’t find it. The lack of such activities puzzled me until I realized that I was experiencing resistance in a more subtle form. There was a constant struggle for autonomy, but not necessarily a protest against someone or something. The home health aides were acting to create scope for action and to gain and maintain self-respect along with a professional identity of their own.

### **ETHNOGRAPHY— A WAY TO GRASP EVERYDAY RESISTANCE**

When your research questions deal with stories linked together and chains of events that need to be traced over time, the case study as a method is appropriate (Yin, 2003). This is a case study with an ethnographic approach, with the (limited but still existing) potential to answer the how and why questions that arose from the situation in home health services. A case study renders possible a relatively long-term relationship with people in their own contexts, and through this it is possible to gain a deeper understanding of their ideas, values, actions, and driving forces (Hammersley, 1992). The fieldwork lasted 18 months in total, from autumn 2003 to the end of spring 2005. It started with an opening period of familiarization followed by a period of observation of selected sites, contexts, and events. The familiarization period focused on, apart from “getting my feet wet” (Taylor & Bogdan, 1984), understanding the work performance and its routines. The

choice of sample was theoretically informed by sensitizing concepts (Marshall & Rossman, 2006) from a review of the literature on caring labor, emotional labor, power and resistance, gender and technology, and so on. A part of the initial plan was to study the process of learning how to use the handheld computers, as well as the actual use of them. This could not be done, because the computers weren't functioning as they were supposed to, due to severe and frequent technical problems. The focus shifted to trying to achieve an understanding of the information and communication technologies (ICT) project as a process. The ICT project continued despite the technical problems, and this puzzled me. Later on, interactions among the home health aides and between the home health aides and management became of special interest. To obtain a rich collection of material, I followed the home health aides during their entire workday: at the clients' homes, at meetings, at lunch, during smoking breaks, and so on. I was also studying documents such as the application for funding to run the ICT project, formal regulations for carrying out home health services, work schemes and more informal to-do lists (e.g., yellow post-it notes), and the home health aides' lists of problems related to the ICT project. Reports from the national board of health and welfare also served as empirical material.

To summarize, the empirical material is based on a combination of participant observation, interviews, and document analysis. The interviews with the home health aides were conducted as thematic conversations with the aim of capturing their descriptions of work routines and work performance, their skills and knowledge as well as their opinions of the computers and their intended use. The themes were work performance, the meaning and content of the work, and the skills and knowledge connected to the work in home health services. I also asked the home health aides to talk about their possibilities and limitations at work and their professionalism. One obvious theme of the interviews was the use of the handheld computers and the home health aides' participation in the ICT project. Interviews were also conducted with management, the two leaders of the ICT project, a consultant from one of three software companies involved in the project, a representative from the union, and one of the local councilors. The interviews with the management representatives (three persons) had two purposes: to gain an understanding of the organization and to get a picture of the history and intentions behind the ICT project.

In line with Delamont (2004), I acted as a participant observer, but that does not mean that I fully participated in whatever the home health aides did. Instead, I saw things being done rather than doing them myself. There were, however, a few situations in which I temporarily assisted the home health aides when unexpected things happened at the homes of clients, in order to avoid accidents or other difficulties. This shadowing requires both presence and distance: presence in both time and space to enable one to be an intense observer, and enough distance to maintain an awareness of the fact that one's presence has an impact on people's actions and on the course of events in question (Tedlock, 2000). My choice was

to avoid interfering actively in the work-related tasks of the home health aides such as caring, meetings, planning, and organizing. But in more informal situations such as breaks, car rides, walks, and everyday discussions about cooking, celebrities, or political matters as well as jokes and small talk, I was participating in the right sense of the word. I too was making small talk, laughing, joking, and grumbling. It was in these situations that I had the opportunity to build confidence. At the same time, when it comes to personal relations, it is easy to lose one's balance and become unable to keep the appropriate distance. From time to time it was emotionally tough to become involved in the home health aides' frustration over some of the clients' life situations as well as over their own stressful and demanding work situation.

The next section presents a brief account of the history of the reorganization of home health services in Sweden and discusses the ICT project as a contemporary example.

### **HOME HEALTH SERVICES IN SWEDEN**

The municipal home health services in Sweden provide health care and home care for people who are living in their own homes and who have difficulties managing their daily lives. The services are publicly funded, financed by taxes, and organized by local councils. Private and for-profit agencies are a growing industry in Sweden, but the municipal responsibility for home health and home care still dominates. The people in need of home health services include, for example, elderly people, physically or mentally disabled people, and people with a combination of mental health and drug problems. The tasks performed by the staff consist of help with clients' daily hygiene and household duties, such as washing dishes, doing their laundry, cleaning, and supervising the delivery of prepared food. The tasks also include providing health care, for example, changing dressings and distributing medicine, as well as providing clients with social support. The time allocated to each of these tasks is regulated in accordance with each individual person's assistance entitlement. These entitlements form the basis of the fee that the clients pay to the local council for the subsidized services they receive.

The home health services in Sweden have gone through radical changes since the 1950s, from informal, unpaid work performed by women to paid work formally organized by local councils but still performed mostly by women. In 2007, 93% of the members of the municipal home health services workforce were women (Sveriges kommuner och landsting, 2007). The changes were introduced in the 1970s and escalated in the 1980s with rationalization and division of labor as landmarks in their development. The former model for organizing home help was based on mutual agreements between the caregiver and the client on what to be done. The new model for organizing home help is based on tasks

planned and regulated in detail, and the planning is now performed by a supervisor who distributes the tasks to the home health aides.

### **Similarities between the United States and Sweden**

Working conditions for home health aides in Sweden are very similar to those in the United States. Markkanen et al. (2007) present the results from a study of work experience and work hazards in the United States. The experience of heavy patient lifting, violence or threats of violence in the homes of clients, and last but not least high productivity demands are similar to the Swedish experience. The advantages of working in home health care are identified as flexibility in time and space, independence, and autonomy, as in Sweden (e.g., Hjalmarsson, 2009a, 2009b). Meaningful relationships are considered an overall advantage within the profession, in Sweden (Hjalmarsson, 2009a) as well as in the United States (Lopez, 2006; Markkanen et al., 2007; Piercy, 2000). It can nevertheless be difficult to set boundaries for keeping a healthy distance in professional relationships, for example, deciding how much and what to do at work (Hjalmarsson, 2009a; Lopez, 2006; Piercy, 2000). The “climate of blame” mentioned by Markkanen et al. (2007) as an explanation for not reporting injuries offers an example of how close relationships can be unhealthy for employees. Stacey (2005) provides a nuanced analysis of how home care workers negotiate meaning at work and finds that they place great value on the nonmaterial aspects of their work, for example, on relationships with emotional bonds and finding dignity in doing “dirty work.” In Sweden, however, the workforce in home care and home health is unionized to a greater extent than in the United States.

### **THE ICT PROJECT**

The specific ICT project discussed in this article is an example of the general, ongoing rationalization of home health services in Sweden. ICT has been introduced in order to change the ways of working and organizing within home health services (e.g., Hjalmarsson, 2009b; Vuokko, 2008). This specific project displays a touch of old taylorism, but with the help of a new tool: handheld computers. The purpose of the handheld computers is to register what happens during the working time of the home health aides in order to obtain documentation of what they do at work and how long it takes. The main reason for introducing the handheld computers is to make work performance visible to management by transforming it into text. Work performance has indeed been visible even before this, for the aides and for the clients, but as action rather than text. As Zuboff (1988) points out, access to systemic electronic text makes work performance visible in a different way than before, though not necessarily more visible.

The dominant part of aides' working time is spent at a client's home and is called "client time". The remaining part of working time is called "indefinable time." It consists of activities including telephone contacts with relatives, nurses, and doctors; lunches; picking up medicine from a pharmacy; travel time; meetings and planning; and lots of unplanned actions. This indefinable time was, when the project started, estimated by the management as 37% of working time. This is considered to be a problem of efficiency, by management in this specific local council as well as by the national board of health and welfare (e.g., Socialstyrelsen, 2004, 2005). Management decides to make use of new technology in the hope of causing fundamental organizational changes to happen. It is doing things the easy way, and according to Zuboff (1988: 392) there is a risk that nothing will happen: "Technology developments, in the absence of organizational innovation, will be assimilated into the status quo."

The home help team in the study consisted of 12 women of various ages; 10 of them were from Sweden and two were immigrants, from Russia and Croatia. The project started in the spring of 2003 with the aim of developing new ways of working by registering and documenting the tasks performed by the home health aides. Each aide was given a handheld computer containing information about the aide's clients and the help that they require. These computers are connected to a large internal server in the municipal offices, and the aides are expected to be able to quickly get the information they need and at the same time register each completed task. Every action they perform during working hours is supposed to be registered. These actions include morning meetings and other scheduled meetings, time for planning, every single action performed in clients' homes, such as health care, personal hygiene, and cleaning, and the time spent talking to clients' relatives, nursing staff, and doctors. Software for measuring work performances has to be as complex and detailed as the work performance in the profession in question. The software in this particular ICT project was not fully developed. It was replaced three times during the study, and still it was difficult to achieve proper functioning and use of the handheld computers due to the lack of fully developed software and other technical problems. During my stay with the team, never once were all of the handheld computers in use at the same time; there was always something that wasn't working. The aides' general opinion was that it was impossible to measure every single activity during the day, but they tried, even with malfunctioning software:

We are outside a client's home and Pia takes her handheld computer out of her handbag and clicks on the menu in order to find this specific client. She finds what she is looking for and then she looks at her yellow post-it note [not at the computer, as the information there is not updated properly] to find out what to do for the client. She clicks on *start action* and enters the apartment. The aides often wait in the stairway until they are ready with the computers. Pia says that she doesn't want to answer questions from the clients about the computers. Today's activities are to help this woman take



her medicine and to help her put on compression stockings. Both of these actions are, in the menu, categorized as *delivering medicine 15 minutes*. This particular visit takes 30 minutes because Pia couldn't find the stockings anywhere in the apartment. When she finds them at last and starts trying to convince the client to put them on, she fails. Pia says to me after the visit that she knows that this particular client doesn't want to have them on. The visit ends with Pia surrendering, and the stockings remain in the drawer where she found them. The visit takes longer than expected. When we have left the apartment, Pia registers, after arguing with herself for a while, in two predetermined categories: *delivering medicine 15 minutes* and *daily attendance 10 minutes*. She says in a troubled voice: "I still didn't have it right. It took 30 minutes and I registered 10+15 and that's 25 minutes." She stops the timer and a text message shows up on the display: *mission completed*.

The home health aides are willing to try to make the handheld computers function properly and the ICT project run smoothly, but it doesn't. And even if it has nothing to do with their motivation or ICT competence, they feel ashamed and worried about their reputation as professionals: "It is so embarrassing, the whole project, you don't want to tell anyone about it."

One might have expected loud protests from the home health aides against the computers and even refusal to use them, but they didn't explicitly express formal and collective protests; instead they acted with loyalty and consent. *Their loyalty is selective*: some rules and norms are followed and some are not. Before introducing the selective loyalty of the home health aides, let me present some additional examples of their everyday resistance.

### Unorganized Disturbance

The home health aides disturb the order in various ways, such as joking, using irony, and committing mild forms of sabotage. This is especially apparent in interactions with their nearest manager, which is not particularly surprising. Their nearest manager is the person from management who has frequent contact with the team, and they feel familiar with her. It also seems that this way of acting is both expected and accepted by management. It could be a part of management's strategy. By letting the home health aides act *as if* they were engaging in resistance, management creates an impression of the aides as employees with a high degree of autonomy at work.

In this section, I present a shortened version of my field notes on a situation in which the home health aides acted with consent, irony, and mild sabotage. It is a workplace meeting, and the home health aides have informed me that they are going to bring up the complications with the handheld computers and make a stand, and they have specifically asked me to attend. They have given me the impression that my presence is important, maybe because I am interested in them and their work. They haven't informed the manager in advance about their

plans, and the manager has in turn intended to treat them to sandwich layer cake.<sup>1</sup> The home health aides do not act according to their plans, to my surprise, but they act in other ways to create autonomy. Thirteen people participate in the meeting: 11 of 12 home health aides, the nearest manager, and me. It is a meeting without an explicit agenda, but there is a hidden one (or two):

I arrive at 12.30 at the house where the team spend their lunches, have their daily planning sessions, workplace meetings, and so on. The table in the kitchen is laid with coffee mugs, plates, and cutlery. One of the home health aides is coming up the stairs with a sandwich layer cake in a box. I ask her why there is going to be cake today. She tells me with a snort that it is the manager that has made the order and that she has been asked to fetch the ordered cake on her way to the workplace meeting.

It starts getting crowded around the table. Some of the home health aides are fiddling with their handheld computers. They are taking photos of each other while yelling and laughing. Some are on the internet looking for nice backgrounds for their computers. Two of them discuss how they are going to register the forthcoming meeting; they wonder how it is categorized in the menu on the display. I ask the one sitting next to me how she has managed with the computer today. She tells me that she has been “thrown out of the system” again and hasn’t been able to use the computer today. To be “thrown out of the system” means that the handheld computer is logged out from the central system of the municipal office. Usually when the computer is restarted, all the information that was previously registered is lost.

One of the home health aides puts a mug and a plate in front of me and says: “Marie also needs a plate.” I politely say no, thank you, adding that I have just had lunch. Haven’t you? I ask them. They laugh and say: “No!” I understand that they are hungry and that they knew about the sandwich layer cake in advance.

The manager arrives and opens the meeting. Information about a couple of routine matters is dealt with. The manager speaks and the team listens without saying anything. Meanwhile the home health aides start to dig into the sandwich layer cake. The manager stops her information and says with a tone that makes you unsure if she is joking or being serious: “I bought a sandwich layer cake so that you will continue to cope with the handheld computers. It is a kind of lubricant if I may say so.” Some of the home health aides are smiling, and one of them is looking really bothered. Suddenly one of the home health aides points at the handheld computer belonging to the colleague sitting next to her. She turns to her colleague but speaks out so loudly that everyone around the table can hear: “Have you registered ‘sandwich layer cake’ yet?” She jokes about the fact that the time it takes to

<sup>1</sup> In Sweden, sandwich layer cake is common at affirmation parties, christenings, and other family occasions. It has, however, a symbolic meaning when it is offered to employees by a manager; it is sometimes seen as a kind of a bribe. I myself have participated in making jokes and ironic comments about this kind of cake and its symbolism in several of my previous workplaces, when managers offered it. Nevertheless, it tastes delicious!

eat the cake should be registered, like everything else during working hours, in the handheld computer. Laughter breaks out around the table and the eating goes on.

After some more routine information, the manager suddenly says: "Shall we talk about the handheld computers?" To my surprise, one of the home health aides asks where to keep the computers when they are off duty. An engaged discussion goes on for about 15 minutes on how to keep the handheld computers in a safe place. After that discussion, the meeting seems to have changed character; minor chaos breaks out. Some of the home health aides go outside for a smoke, some go to the sink and start washing up, and some speak over the head of the manager, who is still trying to make herself heard. It is probably only the ones sitting next to her that can hear what she says. When the smoking and dishwashing are over, another discussion begins, this time about new furniture for the office. Almost everyone is engaged in this matter. Once again the manager tries to talk about the handheld computers. This time the home health aide who has extra responsibility in the team for the introduction of the computers says in a firm voice: "The whole project is very badly planned." She seems irritated and tired. None of the others are giving her support. The manager doesn't seem to take notice of what she is saying. Instead, some of the home health aides are taking photos of the manager with their handheld computers while giggling. Some of the home health aides are still discussing furniture for the office. "If there isn't anything else, we'll end this meeting" says the manager, and the meeting ends. Afterward I walk up to the manager to talk to her. She sighs and tells me that the team shows a large degree of resistance toward the handheld computers. She says: "Sandwich layer cake is sometimes needed; this wasn't the first time."

This meeting raises many questions: Why didn't they express their protests? Is talking about engaging in resistance actually a way of engaging in resistance? What can be interpreted as resistance during this meeting? And last but not least: What is the meaning of the sandwich layer cake in this situation? In the following section I try to answer these questions by analyzing the home health aides' way of acting at the meeting as resistance.

### **Consent but not Cooperation**

The home health aides display a form of organizational misbehavior (Ackroyd & Thompson, 1999) that I speak of as "consent." To act with consent means to be (or even look as if you are) engaged but not so engaged that you fully cooperate and take initiatives. The home health aides show up at the meeting; they refrain from having lunch and they eat the sandwich layer cake with good appetite; they engage in choosing new furniture for the office; and they discuss how the computers should be kept safely. They talk about the handheld computers when the manager asks them to. But they talk about them without referring to how to solve the complications related to them or the project as a whole. They use the

handheld computers but in their own way: they treat them as items suitable to play with. The home health aides know the rules of the game, and they play their part with just about enough effort. This seems to be a tactic à la de Certeau (1984). Tactics are short term: they are actions and responses that are practiced by those who have to follow the rules of the game, those who are in no position to have powerful influence on their situation. Their reactions are conditioned by someone else's strategies. It is a kind of routine consent; it is calculating and they do it without considering other alternatives. Maybe it is a way to conform to the stereotypical picture of them as loyal home health aides, not only for the sake of being seen as loyal but also for the advantages such a reputation can bring (Scott, 1985). It is a calculating and at the same time self-protective way of acting.

### **Irony**

Irony is effective for highlighting situations or conditions that are experienced as irrelevant, illogical, or just silly. It also prevents the sender from being personally exposed (Johansson & Woodilla, 2005). This is what happens when one of the home health aides asks her colleague if she has registered "sandwich layer cake" on the computer. The question isn't meant to be answered, but it effectively points out the absurdity of the detailed registrations on the computers. The joke hits home, the home health aides laugh, and the situation strengthens the social bonds within the team. Because it is only a joke, the aide in question can't be held responsible for her utterance. The sandwich layer cake has a symbolic meaning as an encouragement (or even a bribe) for the home health aides to continue to be patient with the complications around the handheld computers. It is also a symbol of the exercise of power. The manager is aware of it, and the home health aides are as well, but they all act as if they don't know; the manager offers and the home health aides eat. But with the help of irony, the home health aides disturb the balance of power and put themselves in a superior position. They use verbal irony to comment on the irony in the situation (e.g., Johansson & Woodilla, 2005). Of course, irony has its limitations. It is balanced between having subversive effects and preserving effects (Johansson & Woodilla, 2005; Wahl, Holgersson, & Höök, 2005; Wasson, 2005). In this situation, irony has a subversive effect even if it doesn't change the formal positions of power. When the aide uses irony she puts herself in a superior position with regard to the object joked about. This prevents feelings of degradation and subordination by turning the tables. By allowing an alternative understanding of the situation that is opposite to the officially accepted one, she can turn the emotional hierarchy on its head.

### **Mild Sabotage**

I use Ackroyd and Thompson's (1999) term "sabotage" to describe the home health aides' activity at the workplace meeting. I also add the adjective "mild," because it is not at all violent or causing physical damage but is a subtle and

disciplined disruption. Examples of such sabotage occur when the home health aides turn their backs to the manager while she is speaking or when they leave the room for a smoking break as well as to do the washing up. They also acquire time during the meeting for a birthday celebration. It is traditional, with singing, a gift, and a tasty cake. One of the aides clears her throat to get our attention and she proposes that we all sing and say hurray for Irina to celebrate her birthday. After the singing, Irina gets a birthday gift from her colleagues, a pair of candle holders, and everyone is watching excitedly when she struggles with the wrapping. While we are all admiring the gift, two of the aides open the fridge, take out a birthday cake, and put it on the table in front of the celebrant. It was obvious that the manager didn't know of this celebration in advance, but the home health aides did: they had paid for the gift and the cake from their private means. It is a social event that is carried out with neither the manager's knowledge nor her permission, and it has disrupting effects.

Another particularly delicate form of mild sabotage occurs when the home health aides choose, at several times during the meeting, to talk about the clients instead of the manager's issues. This particular kind of sabotage is very subtle and effective; the manager can't criticize it because the home health aides are just doing their job: trying to care for the elderly as well as possible. The extensive technical problems with the handheld computers are embraced by the home health aides and often expressed as the main reason for not using them. One of the home health aides has been trying all morning to log on to her computer and has failed. She is not sorry for this and expresses her relief: "They never work and that's good!"

The home health aides also use other ways of resisting, for example, symbolic sanctions such as slander. But these kinds of symbolic sanctions are often used offstage and they are implicitly directed to whatever person is at hand, not to anyone with actual power over the issue. One such event took place in an educational setting apart from the usual work situation. The home health aides were participating in an instruction session regarding some new software for the handheld computers. It was the third version of the software that was being tested, and only a few of the computers functioned as they were supposed to do. The patience of the home health aides was running out. They told me before the instruction session started that they were discontented with being required to learn more about something that was already a failure. The home health aides made fun of the software consultant. They made comments about his looks and giggled behind his back. Such insults behind someone's back are an example of a kind of offstage symbolic sanction. I understand these kinds of situations as, in the words of Scott (1985: 284), "character assassination"; not of this particular consultant but of the ICT project. Of course it is possible that the consultant *felt* assassinated, but I don't think he noticed the insults. The home health aides' choice in this situation is about both convenience and strategy. It is convenient to bother the person at hand and not have to deal with the person(s) in a position

to affect the situation (i.e., management). The strategy (de Certeau, 1984; Scott, 1985) here is to focus on the specific (human) agents that are reasonable targets within the aides' space of action. In this particular situation, the agent was the software consultant. It is unimaginable to directly address the organizational structures that made the situation possible. There were, however, opportunities for the home health aides to confront the management and they did, but in a loyal, indirect, and contradictory way rather than being direct and pushy.

The next section is about the loyalty permeating the home health aides' thinking and acting, toward the clients, of course, but also toward management, the organization, and their colleagues. This loyal way of acting raises questions about resistance: Does it affect the home health aides' resistance strategies? If it does, in what ways? Can the loyalty in itself be considered as a way of engaging in resistance?

### LOYAL THINKING AND ACTING

The actions of the home health aides in everyday work situations as well as in relation to the ICT project are characterized by loyalty. They think and act according to basic values such as adaptability, responsibility, and reliability. They act as persons who can be trusted, and they show a constant readiness to help and to put things in order, whatever and whomever it concerns. The home health aides act with emotional as well as cognitive flexibility in order to make themselves adaptable and helpful. This loyalty appears above all in relation to the clients, but it also spreads to other situations and contexts. It can also appear in relation to colleagues or to management. The loyalty often results in a conflict for the carer, and one way of solving it is to let the relationship with the client overrule other matters. Self-exploitation is at risk here; employers let this happen and seem content to have employees save money for the organization (Himmelveit, 1999). I argue that the loyal thinking and acting of the aides is part of the explanation for the absence of protests and other collective actions against the ICT project. I will also show how the strong relationship with the clients is used by the workers to influence the management-worker relationship (cf. Jones, 2001). The aides make use of, in a more or less conscious way, their loyalty toward the clients as a resistance strategy.

It is a (value) rational way of acting where adaptability, responsibility, and reliability permeate the thoughts and actions of the home health aides. It functions as a premise for their interpretation of their possibilities of acting. One of the fundamental premises for how the home health aides think and act is expressed like this by one of the aides: "that you make things work, whatever it is."

This loyalty is reproduced in daily work by the home health aides as well as by management. The conception of loyal home health aides appears in different situations and is reproduced by various actors. However, it has a different meaning depending on by whom and in what situation it is expressed. The home

health aides present themselves as, and place great value on, directing their loyalty toward their clients. Loyalty toward colleagues or toward the organization as a whole as well as toward specific representatives of management is also considered valuable. The concept of loyal home health aides is also reproduced by management. It is, however, contradictory; management expresses a view of the home health aides as both loyal and unreliable. The loyalty the home health aides show toward their clients is considered an asset by the management at the same time as it is questioned. This becomes evident when one of the managers talks about the intentions behind the ICT project:

There is some sort of truth about what the aides do when they aren't at the clients', shopping for themselves and so on . . . so I would like to have it in black and white: our staff is professional, they use every minute and they don't sit around with folded arms. This [the handheld computers] is a way for me to prove this. It is important for us to be trustworthy [to be proved by the statistics that are supposed to be the result of using the computers]. And the aides find this "truth" insulting. But my god, it is not just here; it is all over the nation when it comes to home health and home care. Because you can't see and control what they do as they don't work in one specific building like nurses and aides do in an old people's home. (Manager at the local council)

On the one hand it is desirable to have an aide who is loyal toward the clients, because it ensures a certain level of quality of caring. It often results in aides staying longer than the scheduled time at the homes of the clients. On the other hand, someone who is loyal toward the organization and its financial and above all its bureaucratic demands is convenient from a management perspective. To keep precisely to the schedule is from this perspective considered professional and the proper thing to do.

The home health aides also use their loyalty as a way of creating autonomy, meaning, and a definition of a professional identity of their own.

### **Selective Loyalty**

The home health aides are, to a certain extent, aware of their loyalty, and they sometimes use it in a conscious way. Their loyalty can be aimed in different directions. Who or what they are loyal to is considered, more or less consciously, in work situations. They sometimes make judgments of how strong their loyalty toward the client should be. Their loyalty can be affected by whether the response from the client is good or poor or by the home helps' own preferences concerning what they like to do. Pleasant and grateful clients receive more attention and help than ungrateful or grumpy ones:

It's rewarding to work with elderly, it really is. You get a lot back and I think that most of our clients are very nice. You feel appreciated. It is only a few that make you feel like you're not appreciated for what you do, like it is

taken for granted. But from most of them you get a lot back. You feel needed and you almost become like one of the family.

Another point is that sometimes the home health aides act according to their own norms of caring and household duties and sometimes even according to their own preferences for what they find pleasure in doing. Some of them put more energy into cleaning than caring and vice versa, and this affects how they interpret the needs of the clients:

Anna is cleaning at a client's home. She is dusting and says that she is doing more than she is supposed to do according to the rules. She says that it is sloppy in the apartment and that she now has to do extra tidying. . . . She explains that the extra tidying is as much for her own and her colleagues' sake as for the clients. She likes tidying up when it is really filthy because you can actually see that something has been done.

To act loyally toward the clients often means breaking the organizational rules of performing time-regulated and (economically) effective home help:

There are norms and rules; you don't do window cleaning, you don't cook, there are certain things that you're not supposed to do [according to the rules], but you always evade them. You feel pity for her [the client]; she hasn't had a home-cooked meal for such a long time. It's not the whole world if I boil a couple of potatoes and fry a sausage while I do the vacuuming. But this is considered unprofessional, I know.

The home health aides also express the contradiction between acting according to the formal rules for performing home health services and being compassionate and emotionally flexible. Following the formal rules of the work is often considered as complicating the performance of care. One of the home health aides talks about what she sees as good work performance:

I don't mean that they should work so much more and give the person so much more. I mean that they should open up a little bit and give some warmth; not everyone does. It depends on their personality; some have a more difficult time than others . . . and some find it easier to deal with people than others. I definitely think that it is complicated [to work in home health services] if you think that everything has to follow the rules to the point. You have to be a little handy, solve problems, and work things out as they come.

From a resistance perspective, the selective loyalty of aides can be considered a way of creating scope for action as well as an alternative definition of professionalism.

The home health aides appear to consent when it comes to participating in the ICT project, but that does not mean that they are fully cooperating. They collectively agreed to participate in using the hand held computers but only one of them was really engaged and tried to work things out and solve problems. The majority of the aides showed only limited interest. This reluctance to engage in the



project was defended by the home health aides through explanations related to the clients. Sometimes they use their loyalty toward the clients as a more explicit way of expressing resistance. The home health aides often express the view that responsibility toward the clients and caring for them is limited by the use of computers. This is often argued when expressing discontent in relation to the handheld computers:

It feels like they are going to monitor that we are doing our job properly. I can't see it [using handheld computers] as an improvement. We're not supposed to work with ICT; we're supposed to work with the clients.

The aides point out that the use of the handheld computers is not supposed to interfere with caring for the clients. The presentation of this argument has, from a resistance perspective, two consequences. First, by using the good of the clients as an argument, they avoid taking a stance on whether they should formally protest against the time-consuming and complicated ICT project. This provides a way for the aides to deal with their frustration over the extra workload that is involved in trying to use the nonfunctional handheld computers. And second, it is, through this argument, possible to maintain self-respect and dignity. When aides use the good of the clients as an argument for not using the handheld computers, they can avoid the confrontation involved in engaging in formal resistance with their self-respect and dignity intact. It is a situation in which the home health aides act as if they give consent, but the consent is conditioned by the good of the clients. Their self-respect and dignity is maintained by their reference to something that can't be questioned, namely, the good of the clients. They are, however, aware of the fact that they should act more collectively and powerfully. They explain their nonresistance partly as gender specific:

We are too nice and wimpy, accepting this [participating in the ICT project]. I mean to accept that much extra work without getting paid. We develop software for this company that they can make profit on. A male working team would never have accepted this.

A male team is presumed to engage in active resistance in a similar situation, which is considered as suitable behavior by the home health aides. Their own way of acting is considered inadequate and is positioned in relation to the way a male working team would have acted. It seems that the home health aides see it as desirable, but not normal or expected, for them to engage in formal resistance.

## CONCLUSION

The home health aides engage in informal everyday resistance (Scott, 1985). This takes little or no coordination. It takes place through implied assumptions and informal networks. It makes it possible to avoid confrontation with authorities, and it is a kind of informal self-help. The aides engage in this informal resistance

by using humor and particularly irony to enable them to understand and deal with the paradoxical situation of being the object of controlling their own work performances (e.g., Johansson & Woodilla, 2005). They joke about the handheld computers and the absurdity of trying to split up their daily performances into measurable units. Irony is also a way of keeping the social bonds in the work group strong and of introducing an alternative interpretation of the situation as opposed to the one presented by management. The aides also engage in a degree of mild sabotage, a subtle and disciplined form of disturbance. It happens, for example, at workplace meetings. They talked during the meeting I attended and did problem solving related to clients while their nearest manager was trying to run the meeting according to her agenda. This mild sabotage disturbed the power balance between the group and their nearest manager. The home health aides created opportunities to acquire time and social space for an alternative agenda. They also used slander as a way of gaining at least some control over a situation they had been ordered to participate in.

Perhaps the most subtle form resistance out of them all is the way the home health aides use their loyalty in a selective manner. Their loyalty has the potential to function as both limiting resistance and productive of it. The actions of the home health aides are about both consent to and denial of the management's directives. The denial appears when the home health aides, in their daily work, interpret and make judgments regarding the rules, regulations, and norms that management and the organization lay down. The aides act to create the most reasonable scope for autonomy in work situations, and this struggle is often related to caring for the clients. The maintenance, above all, of caring relations is an aspect of their work that is of great importance. The home health aides make sure to point out their loyalty toward the clients in many different situations. This is a form of autonomy and a form of freedom of action embedded in the position of being a (loyal) employee. Stacey (2005: 845) uses the concept of "practical autonomy" to describe "a way that workers create and manage their own environments within certain constraints." Despite control and discipline, the home health aides make this freedom of action available to them. Management and the organization reply by introducing a tool, handheld computers, for managing what they consider to be time wasting and limitation of work.

Despite the limited and informal character of the resistance of the home health aides, it can be considered subversive. It has the possibility of undermining the exercise of power, and it creates a professional identity alternative to the one offered by management. The resistance of the home health aides is a creative and productive process as it generates critical engagement in their identity formation and workplace relationships. This line of thought presupposes a view of identities as well as workplace relationships as constantly moving.

The home health aides' way of interpreting and selecting how to use their loyalty—when to be cooperative and to whom or what, and above all how to perform their work—is an empirical example of a constant struggle for autonomy

at work. It is not “just” about coping with daily difficulties at work; it is more complex than that. This article suggests that exploring resistance at a micro-political level involves taking processes of identity formation and construction of meaning into consideration. These processes are dynamic and open to constant reinterpretation.

How then can the rights of these workers be improved? My answer is by actual and not just rhetorical employee participation; by recognizing the workers as active and competent subjects who are both willing and able to take responsibility for their own work performance. Instead of increasing the opportunities for the employees to participate in their own situation at work, the implementation of ICT as a means to improve effectiveness and quality in home health services gave them no opportunities for such participation. It could have been a success, first, *if* the aides had been the ones to decide how to take advantage of the huge number of ICT devices on the market. In my interviews, I asked them what they would do with the handheld computers if they were the ones to decide. They came up with several serious suggestions regarding how to use them to organize their work for improved performance. Second, it could have been a success *if* there had been a serious discussion about whether effectiveness and quality in home health services depends only on speed and quantitative measurement. And finally, it could have been a success *if* the aides had had the opportunity to participate in this discussion as equal participants.

I strongly agree with Stacey (2005) when she points out the difficulties in unionizing this category of workers (and in making it worthwhile for them to continue as union members) only by addressing their material interests. As home health workers put great value on the nonmaterial aspects of their work, such as relationships with emotional bonds, the union must consider these aspects as professionalism, which it is important to protect from misguided productivity demands. Full recognition of the emotional and cognitive flexibility (Hjalmarsson, 2009a) that the home health aides possess and constantly develop at work as important competences is a fundamental issue for the union to consider. My study shows that the home health aides are acting for their right to do a good job and for their right to be recognized as competent professionals. The union should accentuate the competencies that the home health aides possess and, perhaps more important, emphasize resisting any attempt to regard home health aides as less qualified or even unskilled workers. In doing this (salary negotiations are a specific and rewarding example of a situation in which it can be done), there is a possibility of improving the status of work in home health care and of preserving the workers' dignity.

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Direct reprint requests to:

Marie Hjalmarsson  
 Division of Health, Culture and Educational Sciences  
 University West  
 S-46186 Trollhättan, Sweden  
 e-mail: [marie.hjalmarsson@hv.se](mailto:marie.hjalmarsson@hv.se)