AFTER OUTSOURCING: WORKING COLLABORATIVELY TO DELIVER PATIENT CARE?

by

Niknaz Kahnamoui
Bachelor of Business Administration, Simon Fraser University, 2000

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

In the
Faculty of Arts and Social Sciences
under
Special Arrangements

© Niknaz Kahnamoui 2005

SIMON FRASER UNIVERSITY

Summer 2005

APPROVAL

Name: **Niknaz Kahnamoui**

Degree: **MA**

Title of Thesis: **After outsourcing: Working collaboratively to deliver patient care?**

Examining Committee:

         Chair: **Dr. Jonathan C. Driver**

Dr. Marjorie Griffin Cohen
Senior Supervisor
Professor, Women's Studies and Political Science

Dr. Ellen Balka
Supervisor
Professor, Communication

Dr. Pat Armstrong
External Examiner
Professor, Sociology
York University

Date Defended/Approved: June 10, 2005

SIMON FRASER UNIVERSITY

PARTIAL COPYRIGHT LICENCE

Simon Fraser University

Ethics Approval

The author, whose name appears on the title page of this work, has obtained human research ethics approval from the Simon Fraser University Office of Research Ethics for the research described in this work, or has conducted the research as a member of a project or course approved by the Ethics Office.

A copy of the approval letter has been filed at the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for ethics approval and letter of approval is filed with the Office of Research Ethics. Inquiries may be directed to that Office.

<div align="right">

Bennett Library
Simon Fraser University
Burnaby, BC, Canada

</div>

ABSTRACT

Undermining the value of cleaning work and its contribution to patient care has led to the creation of an artificial divide between cleaning and care, which is used as a justification for outsourcing. Outsourcing fragments the system of care, where each part works separately towards the attainment of its own objectives. This qualitative research is an exploration of organizational arrangements after the outsourcing of cleaning services at Vancouver General Hospital that affect the gendered work of cleaning, and act as an impediment to the integration of workers and the smooth flow of work practice. Using feminist methodology within a systems thinking framework, this study argues that hospital cleaning and care work are highly integrated and for the delivery of patient care, a considerable amount of coordination between the different groups of workers is required. The artificial fragmentation of the system of care prevents from the attainment of efficiencies for the whole system and has ramifications for patient care.

DEDICATION

To my loving parents, Jaleh and Massoud, without whose encouragement, unconditional support and love, I would not have been able to write this thesis.

And to Laurie, thank you for challenging me and helping me recognize the questions that were important to be asked. I am deeply grateful for your love and support of many years.

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

LIST OF FIGURES

GLOSSARY

Asset Specificity
Asset specificity is one of the cost determinants of contracting out (Vining & Globerman, 1999). Domberger (1998) defines asset specificity as characteristics of an asset that make it valuable only in the context of a very specific business need. Hence, if the asset were to be removed from that business, there would not be a significant value attached to it.

Contracting-out
Contracting out is the term which was previously used to refer to outsourcing arrangements.

Information Asymmetry
Information asymmetry is when one of the parties to a contract has information that the other party does not have. This could be due to task complexity or specialized knowledge, and it enables the more informed party to behave opportunistically, which could result in higher costs.

Methicillin-Resistant Staphylococus Aureus (MRSA)
MRSA is a type of bacteria that is resistant to certain antibiotics and it is a very common type of hospital-acquired infection.

Nosocomial Infections
Infections that are acquired in a hospital or hospital-like setting.

Task Complexity
Task complexity is one of the determinants of contracting out that describes the degree of difficulty in specifying and monitoring the outsourced tasks. The higher the task complexity, the higher the contract costs.

Transaction Costs
The costs of using markets and contractors (Sclar, 2000).

LIST OF ACRONYMS

BCNU   British Columbia Nurses Union

CCT   Compulsury Competitive Tendering

HEU   Hospital Employees Union

IMF   International Monetary Fund

LPN   Licensed Practical Nurse

MRSA   Methicillin-Resistant Staphylococus Aureus

NHS   National Health Services

PHSA   Provincial Health Services Authority

PSC   Patient Services Coordinator

PSM   Patient Services Manager

RFA   Request for Proposal

RHA   Regional Health Authority

RN   Registered Nurse

VCH   Vancouver Coastal Health

VGH   Vancouver General Hospital

WTO   World Trade Organization

CHAPTER 1
INTRODUCTION

Outsourcing, viewed as an organizational restructuring strategy that is intended to reduce costs, gained momentum in British Columbia's (B.C.) healthcare sector after the election of the provincial Liberal government in 2001. The first phase of healthcare restructuring began in December 2001 when the B.C. provincial government announced the amalgamation of the 52 existing health authorities into 5 Regional Health Authorities (RHA) and the creation of a Provincial Health Services Authority (PHSA). Each RHA was required to sign performance contracts with the Ministry of Health, holding it accountable for the delivery of budgeted plans and patient care (British Columbia Ministry of Health Planning, 2002). One of the new RHA's is Vancouver Coastal Health (VCH), which houses Vancouver General Hospital (VGH).

Around the same time that this accountability model was implemented, the provincial government introduced Bill 29, thereby eliminating certain union contract provisions, such as protection against contracting out. With labour costs absorbing a very high percentage of the healthcare budget, and the belief that contracting out would result in significant cost savings, Bill 29 was basically a green flag to the health authorities to compensate for their budget shortfalls by contracting out their ancillary services (non-clinical services) to the private sector.

Health Authorities argued that their core competency was the delivery of patient care, and classified the different services that they offered in relation to this core competency. As a result, services such as housekeeping, laundry, and food services were categorized as ancillary services (not directly related to patient care) and were placed on tender. Subsequently, within various RHA's, external for-profit companies replaced many of the in-house departments offering these ancillary services. In VCH, housekeeping was one of the first departments affected by these restructuring strategies. VCH signed an agreement with Compass Group Canada in November 2002, for the delivery of housekeeping services in nine non-clinical VCH buildings (Vancouver Coastal Health Authority, 2002c). Following this, in July 2003, VCH entered another contract with Aramark for the delivery of cleaning services in VCH acute and residential care facilities, including VGH (Vancouver Coastal Health Authority, 2003b). This study is an exploration of how after the

outsourcing of cleaning services at VGH to Aramark, hospital employees (especially nurses, care aids, and unit clerks) work with Aramark cleaning staff to ensure the delivery of patient care.

1.1 Overview of study

Since the outsourcing of cleaning services in hospitals, there has been considerable media coverage about the risks associated with privatisation of hospitals' cleaning services and the associated risks for patients. Quality assurance reports produced by VCH indicate a dip in standards during the transition period to Aramark, which have gradually improved. However, some areas, such as patient rooms in the Jim Pattison tower in VGH still remain below the desired target scores[1] (Vancouver Coastal Health Authority, 2005). On the other hand, studies conducted by the British Columbia Nurses Union (BCNU) and the Hospital Employees Union (HEU) show a drop in cleaning standards, where for example bodily fluid has been left on equipment and on privacy curtains between stretchers (British Columbia Nurses' Union, Hospital Employees' Union & Health Sciences Association, 2004).

In this thesis, taking into account the absence of studies on intergroup and interpersonal analysis of organizations undergoing change (Gardner, Paulsen, Gallois, Callan & Monaghan, 2001), I approach outsourcing from a meso or organizational level of analysis. Using data collected through observations and interviews on a clinical unit[2] at VGH, and by applying a feminist methodology and systems thinking framework, *I argue that outsourcing of cleaning services in a hospital fragments the system of care, and has ramifications for patient care. Within a hospital setting, cleaning and care are highly integrated, and for the delivery of patient care a considerable amount of coordination between cleaners and care workers is required.* This thesis is an analysis of different groups of workers, working along the new organizational divide created by outsourcing, and how they are negotiating and redefining the new boundaries resulting from contracting out.

Suzanne Young (2000), who has researched the outsourcing of public services in Australia, discusses how outsourcing affects contract workers as well as workers employed by the contracting organization, and that issues of trust, communication, commitment, morale and safety arise between the different groups of workers. These issues could provide a challenge for

---

[1] The targeted quality score is 85% for all VCH facilities. More information on how this figure is measured is provided in Chapter 3.
[2] To ensure the confidentiality of research participants I have removed all identifiers that could breach their anonymity, including the clinical unit in which the research was conducted, name of research participants, and their respective roles within the organization. I will further elaborate on this issue later in this chapter.

workers in performing their daily work and as a result could impact organizational outcomes. In an internal bulletin released by VCH prior to transitioning housekeeping services to Aramark, VCH management alludes to these challenges: "This initiative will mean some employees will be working with new, private sector partners, which may mean building new working relationships and in some cases doing things differently" (Vancouver Coastal Health Authority, 2003a, p. 2).

With outsourcing, patient care is approached from a mechanistic perspective. This approach towards healthcare organizations assumes that a component within the system can be removed and replaced with another part, and that the whole machine would still be fully functional. There are social dimensions to organizations though, and patient care is not merely a combination of parts. For the successful realization of hospital objectives, that of patient care, the components within the organizational system need to be integrated to work towards this common objective. With outsourcing, each organization is ultimately pursing its own objective. The hospital's main objective is to deliver patient care at the lowest cost, while the private company aims to provide cleaning services at lowest costs, to attain the highest possible profit margins for its shareholders. Both organizations aim to achieve higher efficiency, maximizing the level of output in relation to a given input, or "achieving an objective for the lowest cost" (Stone, 2002, p. 61), but their intended objectives are not congruent. As hospital administrators no longer view cleaning as a direct component of care, strategies undertaken for the attainment of efficiencies in providing cleaning services do not necessarily translate into realization of efficiencies for the whole system of care (including cleaning). One of the understandings in systems thinking is that the optimization of one part of a system does not necessarily lead to the optimization of the whole system, but rather it might result in consequences elsewhere in the system that are damaging to the whole (Jackson, 2003). For example, one of the human resource business practices implemented by Aramark was offering workers a $300 bonus as an incentive for not taking any sick days in a period of three months. A business practice such as this fails to acknowledge that cleaners work in an environment where patients are present. Encouraging sick employees to work could have ramifications for the overall objective of the system, that of patient safety and care.

1.2 The story of VGH

The whirlwind of healthcare reform in B.C. was triggered by the total freeze on federal healthcare funding transfers to provinces in 1990. In 1995 there was a further reduction to the amount of the transfers, when the Liberal government announced that it would combine transfer funding for healthcare, secondary education and welfare services as a lump sum amount, thereby, allowing

3

provinces to allocate the funds based on their own discretion, as long as they met certain conditions. With the election of the Liberal government in B.C. in 2001, healthcare reform remained part of the government's agenda. The public was constantly reminded that the health system, taking up 40% of the provincial budget, was no longer sustainable as it was and that changes had to be made. With hospitals consuming much of this share, the Liberal government reforms focused on hospital spending.

One of the issues raised by the right wing Fraser Institute in terms of high costs of running hospitals was the proportion of hospital budgets spent on labour costs. As a general rule, hospital employees' wages and benefits account for approximately 75 percent of hospital expenditures (Government of British Columbia, 1991). According to the data retrieved by the Fraser Institute from Vancouver Hospital, 80% of their budget in 1995 was spent on employees' salary and benefits (McArthur, Ramsay & Walker, 1996). The authors suggested an average of $35,500 spending per employee, and claimed that such a high salary was not competitive with the private sector (McArthur et al., 1996). This focus on non-competitive wages was directed at the unionized and mostly female labour force that was finally starting to rightfully receive pay equity gains.[3] Unionized hospital support workers are compared with hotel workers, in order to illustrate the similarity in the jobs performed, and to argue for lower salaries for hospital support workers (Esmail, 2002). The argument is built on the assumption that hospital support workers are non-medical staff, and do not require any specialized or medical training for performing their work. As such, they should receive wages that are competitive with similar positions in the private sector (Esmail, 2002). The Liberal government, evidently concerned with the 'astronomical'[4] salaries paid in the health sector, addressed the problem of labour costs by introducing Bill 29 (The Health and Social Services Delivery Improvement Act) on January 28, 2002. This bill eliminated long-standing collective agreements, and included provisions such as contracting out of non-clinical services, affecting tens of thousands of unionized healthcare workers.

Contracting out, or outsourcing, has become a huge industry and is positioned as one of the ways public organizations could increase their efficiency while decreasing their costs (Domberger & Jensen, 1997). With the passage of Bill 29, VCH began redesigning its structure based on a model of division of work between clinical and non-clinical areas. In an internal communication bulletin with employees, it was stated that the redesign was part of a larger plan to eliminate duplication, enhance efficiencies and reduce non-patient care expenditures through shared

---

[3] The Hospital Employees' Union (HEU) is one of the main unions representing hospital workers. Out of the 46,000 members of HEU, 85% are women (Cohen, 2004).

[4] "Astronomical wages in B.C.," was the terminology used by Health Services Minister Colin Hansen in regard to the salaries received by unionized cleaners working in hospitals (Dix, 2003).

services (Vancouver Coastal Health Authority, 2002b, 1). The justification was that by outsourcing, the different facilities and entities in the VCH region could share services. Thirty-two different service areas were considered for this shared services model, and it was decided to focus on those service areas that provided the largest return, required the least amount of capital investment, and were not directly related to patient care. Service areas that were considered for assessment included: Plant Operations, Food services, Housekeeping, Laundry, Logistics, and Security.

Within VCH, a new working group was developed called the Value Improvement Network, referred to as the ValueIN team. The objective of this group, as is explicit in its name, is to ensure that VCH is maximizing the delivery of patient care for each dollar spent in the region. To this end, their mandate has been to realize savings amounting to at least $40 million over the course of three years (Vancouver Coastal Health Authority, 2003a). For this purpose, one of the foci of the group has been to find ways to reduce labour costs. As a first assignment, they undertook a comparison of labour expenditure across healthcare sectors in Canada. In an internal Bulletin released by VCH, the hourly wages of workers in housekeeping were compared against those of other provinces, showing that B.C. paid the highest wages to cleaning workers at $17.77 an hour, while in Alberta the hourly wage for a cleaning worker is estimated to be $11.99 (Vancouver Coastal Health Authority, 2003a).

In November 2002, VCH in conjunction with Providence Health Care[5] released a request for proposals for cleaning services on clinical units within the VCH region. In the summer, following a process of negotiations, Aramark was selected to provide housekeeping services at acute care hospitals and a few residential facilities within the VCH region. Aramark is a multinational company whose business spans from food services delivery to building maintenance, and housekeeping services, in industries ranging from businesses, prisons, healthcare facilities, and colleges. Aramark's main office is located in Philadelphia and it owes its growth to mergers and acquisitions. The five-year contract between Aramark and VCH is worth $100 million (Vancouver Coastal Health Authority, 2003b) and it is estimated that $13 million annual savings will be realized as a result of this contract (Vancouver Coastal Health Authority, 2003b). This arrangement affected the work of 850 unionized housekeeping employees. Currently, it is estimated that the hourly wage for the average non-unionized Aramark cleaner is approximately

---

[5] A faith-based and non-profit healthcare provider, operating a number of hospitals and residential care facilities, such as St. Paul's hospital, in Vancouver, BC.

$10.00.[6] These low wages place the purchasing power of workers at what it was in 1968 (Cohen, 2004).

1.3 Significance of study

While outsourcing is becoming a more common model for the delivery of ancillary services in the health sector, recently there has been much media coverage in B.C. about the standards of cleanliness at hospitals that have outsourced their cleaning services. For example, recently Melba Carlsen, a patient who had gone for successive visits to the emergency department at Royal Columbian Hospital, which has also outsourced its cleaning services to a private company, filed a complaint with the Medical Director of the hospital regarding her experience and the unsanitary conditions of the hospital (Lau, 2004). While Carlsen's story gained media coverage, Lau (2004) reports that there have been other incidences at the Royal Columbian where other patients have complained about the cleanliness of the hospital. In mid November 2004, there was another complaint by a Delta area woman who says that she nearly died from an infection after giving birth at the Surrey Memorial Hospital. She was not alone in this experience, as eight other women who had also given birth at the hospital had developed infections. The common complaint among these women was the lack of cleanliness at the hospital.

In addition to media reports about individual cases, experiences in the UK also reveal that outsourcing of cleaning services is not always in the best interest of the public. Contracting out gained momentum in the UK during the Thatcher government, based on the belief that the private sector and market mechanisms were able to produce efficiencies far beyond the capabilities of the public sector. Legislation in the UK in 1988 required local authorities to put six of their key services, such as "refuse collection" and "school cleaning", to competitive tender (Thomas, 1988). The Local Government Act that enacted Compulsory Competitive Tendering (CCT) for a range of municipal services was based on research that showed considerable financial savings resulting from this practice (Domberger, 1998). This type of reform gradually permeated the UK's National Health Services (NHS), where health trusts were required to place their support services to tender, with domestic work being part of these service areas. By the mid 90's and after extensive consultations with the public, the NHS found that patients were dissatisfied with the level of cleanliness in hospitals and many blamed the deterioration in standards on CCT. According to Harriet Sergeant (2003), each year five thousand people die from hospital-acquired

---

[6] In January 2005 Aramark employees voted 84% in favour of joining the Hospital Employees Union. Bargaining dates are scheduled for April 2005 to negotiate the first collective agreement between Aramark and HEU to cover approximately 700 housekeeping workers servicing the VCH facilities (Hospital Employees' Union, 2005).

6

infections, which costs the NHS more than £ 1 million. The NHS finally discontinued CCT and in July 2000 announced a £ 32 million clean up initiative. As the UK experience shows, the outsourcing of cleaning services has not only not contributed to direct cost savings but has also resulted in dirtier hospitals, increasing the chances of patients acquiring infections during their stay at hospitals (nonsocomial infections). This in turn translates into patients returning to hospitals or having their stay extended beyond what had been initially required, which results in additional long-term costs.

The NHS clean-up initiative included the return of ward sisters or matrons, also known as head nurses. One of the main roles of the matron is to ensure integration of the work of different groups of workers. In addition to being strong clinical leaders, matrons are now also given the authority to resolve cleanliness issues, and to influence decisions about cleanliness specifications and standards. The NHS also introduced cleanliness standards and linked these to hospitals' performances. This kind of linkage highlights the connection between cleanliness and patient well-being, where cleanliness becomes a fundamental component of care. In a report produced by the NHS outlining the standards of cleanliness (NHS Estates, 2001), the importance of the role of cleaning staff is emphasized:

> The cleanliness of any hospital environment is important for infection control and patient well-being. Cleaning-staff play an important role in quality improvement, in the confidence the public has in hospitals and in reducing infection-related risks. This role should be recognized and supported by management.

Solutions implemented by the NHS are rooted in the understanding that cleanliness happens within the context of care. Cleanliness is now taken into account as part of the overall performance of UK hospitals, and the role of the matron has been re-developed to ensure the integration of cleanliness and care. The UK experience reveals the importance of examining organizational arrangements when addressing problems ensuing from outsourcing. It also recognizes the importance of cleaners and the contribution this group of workers make in ensuring patient care. By bringing cleaners to the forefront, the NHS is acknowledging that cleaners and cleaning work is not peripheral to patient care, but rather directly related to it. Finally, with many people blaming the falling cleaning standards in UK hospitals on the introduction of CCT, and on the private contracting companies who have little understanding of the clinical importance of cleanliness and its contribution to patient care, (Gulland, 2001), the NHS has discontinued CCT and hospitals are now permitted to return their cleaning services in-house.

At a time where in B.C. frequently more hospital services and departments are being categorized as ancillary services and are considered for outsourcing, it is important to understand how the organizational boundaries that are created as a result of outsourcing could lead to problems in the integration of workers. While "boundary busting is endemic in the current wave of healthcare system change," there is also the awareness of the need for integration and mutual interdependence (Denis, Lamothe, Langley & Valette, 1999, p. 106). Hence, this thesis will help in identifying the organizational arrangements and approaches that are built on the notion that cleaning is separate from care, as well as how these arrangements impede the work practice on clinical units and lead to difficulties in the attainment of the overall objective of patient care. This study also reveals how the separation of cleaning from care work has led to significant decreases in cleaners' (mostly women workers) wages and working conditions, contributing to the further devaluation of cleaning work, which has ramifications for patient care.

It took many years of hard work by various groups and individuals to ensure pay equity gains in the health sector, which not only helped raise the wages of women workers, but also "affirmed the value, skill and responsibility involved in the work they perform" (Cohen, 2003, p. 2). When pay equity gains are rolled back as a result of outsourcing, the gendered work of cleaning is once again undermined. "The links between women's paid and unpaid work in social reproduction help explain why this work is so undervalued and so easily defined out of healthcare" (Armstrong & Laxer, in press, p. 3). While this has social repercussions, it also contributes to an environment where ensuring patient safety and care is placed at risk.

This interdisciplinary research is part of my broader interests in the critical analysis of organizational strategies and practices, specifically as they pertain to women and women's work. Through this study I hope to contribute to the body of knowledge that highlights the areas within which women's work is devalued. This research shifts the focus to women's work and emphasizes the importance of the invisible-work women perform in providing patient care. Employing this perspective is particularly important in a time period where practices that have historically undermined women's work are resurfacing and contributing to the further undermining of the achievements made in gaining recognition for the value of women's work.

1.4 Research design and justification

In this research, I will use some of the important concepts of modern systems thinking, which I will discuss further within subsequent chapters, as guiding principles that provide insight into the study. Within a systems thinking framework organizations are viewed as social systems (Ackoff,

1999a), where the "overall performance [of an organization] depends on the interactions among its parts and its environment, rather than being determined by the specific actions of the parts themselves" (Lewis, 2002, p. 25). Viewing organizations as social systems and applying a systems thinking perspective to this study allows for a holistic approach to patient care, where the interaction between the components making the system gains importance. Systems thinking is commonly used in management (Kim, 1999), and is gaining more popularity in the health sector (Checkland, 1999). It allows for reflections on boundaries between system components, which is the focal point of my study.

Most systems thinking approaches begin with a problem identification phase and lead into some form of intervention. Individual stakeholders bring their own perception of the problem into discussions. Problem identification means bringing forth these different perceptions, which brings to light the problem situation. Checkland (1999) proposes obtaining feedback from different groups in order to improve the picture of the problem situation. In this study, through observations and interviews the experience of various stakeholders will be brought to light. Midgley (2000) views observations as a form of intervention, defining intervention as a form of purposeful action by an agent to create change. While my hope is that as a result of this thesis changes will occur (for the improvement of organization of work and patient care and safety), the focus of the thesis is not on intervention, but rather on problem definition. My intention in pursuing this study is to provide another lens through which to view the issues that are arising from outsourcing practices. In this process, I will be using feminist methodology and methods to collect and analyze data.

It is an oversimplification to assume that there is a universal feminist approach to research, stemming from universal feminist values. Feminist methodology does not prescribe a single way of doing research, but rather it is reflective of the diversity in the women's movement itself. While recognizing that there is no one way of doing feminist research or a "woman's way of knowing" (Belenky, Clinchy, Goldberger, & Tarule, 1986), it is important to recognize that feminist methodology grew out of a critique of the invisibility of women (Gorelick, 1996). As such, it would be safe to assume that all feminist research is ultimately built on the awareness of the role that gender plays in society. "One shared radical tenet underlying feminist research is that women's lives are important" (Reinharz, 1992, p. 241). Feminist research poses questions that are organized around the "centrality of gender in shaping our consciousness, skills and institutions as well as in the distribution of power and privilege" (Lather, 1988, p. 571). As a feminist scholar, my research stems from a recognition of women's work as a large component of women's lives. The work women perform as part of the labour force cannot be seen in isolation

from the work women have historically performed in the domestic sphere. Women's work is embedded in a wider gendered political economy. Thus, it is important "to connect the everyday moments of women's lives back to the structural level of capitalism" (Riordan, 2002,p. 4). The way women's work is perceived and the value attributed to the work women perform is very much rooted in societal relations of inequality and domination. Thus, I cannot divorce a study on the outsourcing of an occupation predominantly occupied by women, from the societal context within which it is taking place.

While the focus of this study is the work of cleaners and cleaning as one of the components of patient safety and ultimately patient care, the cleaners' voice, as the knowers and doers, for the most part, remains absent from this study. This omission has not been intentional. In order to gain access to the field site, I had to obtain the approval of the ValueIN group at VCH and for the purpose of interviewing cleaners, I required Aramark's approval of my research. However, Aramark, having found the usage of the words 'patient care' and 'collaboration' in my research problematic, and deeming certain questions unnecessary and of no concern to VCH, did not consent to having its employees (cleaners) participate in this study. Having to modify my research design due to restrictions in access is what is referred to as the "strategic dilemma of feminist practice" (Adamson, Briskin & McPhail, 1988, p. 179). That is, feminist practice while confronting and critiquing the institutions and structures that are contributing to the oppression of women, must at the same time relate to and use these very institutions and structures (Adamson et al., 1988).

The absence of the cleaners' voices in this study further exemplifies the invisibility to which I would like to draw attention, which is also an illustration of one of the characteristics of privatization of public services. Starr (1988) defines this as the withdrawal from a space with open access and visibility. By pursuing this research with the awareness that the cleaners' voice is absent from the discourse, and my disclosure of intent for the inclusion of cleaners voices, I am in many ways raising awareness about the institutional arrangements that maintain dominant-subordinate relationships. One might even argue, that had I, in response to Aramark's objection with my study, changed my research question in its entirety, I, too, would have contributed to the invisibility of cleaners.

1.4.1 Boundary of study

Golden and Martin (2004) suggest that all systems are nested. Building on this notion, in this study the hospital is viewed as a subsystem embedded within the health region, which is itself a

subsystem embedded in the provincial healthcare structure. Within the hospital, the clinical unit in which I have conducted my research is yet another subsystem. The clinical unit itself also contains programs and different components that could be taken as smaller subsystems. The idea of nested systems draws our attention to the concept of boundaries of research. Boundaries, according to Churchman, are "social or personal constructs that define the limits of the knowledge that is to be taken as pertinent in an analysis and also the people who generate that knowledge" (Midgely, 2000, p. 35). The boundary concept lies at the heart of systems thinking. A holistic approach, while recognizing that everything is directly or indirectly connected to everything else, is also the first to acknowledge that for any inquiry to take place the parameters of inquiry have to be determined.

The complex interweaving of the diverse roles and responsibilities in a hospital setting makes the process of boundary creation for the purposes of inquiry rather complicated. On the other hand, the functional division of the hospital into clinical units, which also guides the process for obtaining ethical approval for the research, helps in the shaping of the boundaries of this study. VCH ethics board requires the approval of the manager of each clinical unit where studies are to be conducted. Initially, my intention was to conduct research on units that had been identified as problem areas due to higher staff reporting of hazardous incidences, higher infection rates, or lower quality measures. However, prior to the hospital being able to release any of this information to me, I had to obtain the approval of the manager of the clinical unit on which I wanted to conduct the study. This ethics restriction prevented me from being able to choose a clinical unit that was already reporting higher problems with cleaning services. I recognized that a problem area was not necessarily what I was seeking, for the intention of my study was not highlighting problems in cleaning, but rather the examination of work practices and workers' interactions. Having conducted research at the hospital prior to this study, I was familiar with the organization of work on different clinical units at the hospital. Having encountered a unit that worked cohesively as a team, headed by a supportive manager, I decided to focus on this particular unit.

This clinical unit is spread out on two different physical spaces on the same floor. Each section is referred to as a pod: Pod A and Pod B. The visitors' elevators and staff elevators, which are located on each side of the pods, separate the physical space of the unit. On each shift, other than the night shifts, a dedicated unit clerk works in each pod and is only responsible for maintaining the records of patients who are staying in that area. On a daily shift, the regular staff members only work in one of the pods, while physicians move between the different areas.

11

1.4.2 Research methods

The study attempts to answer questions of "how" work in the hospital setting is constituted and "why." Mason (2002) suggests that qualitative research is best for supporting arguments "that focus on how social phenomena and processes operate" (p. 175). Her justification is that most qualitative research is a rich, contextual, local explanation and interpretation of messy contexts (Mason, 2002). Qualitative research allows for focus on context and particulars (Mason, 2002), which was important in bringing together the voice of various stakeholders. In this study, multiple qualitative research methods have been used for data collection, each selected to ensure it was the most appropriate for addressing the related research question and sub-question. Literature reviews and textual analysis were conducted in order to determine the context and background of the study, complemented by interviews and passive observations.

Interviews were tailored towards the individuals, depending on their position in the hospital (a sample of interview questions is included in the Appendix). The realities of the research participants are based on their role and the position they occupy in the hospital. Therefore, by interviewing a range of people, from management of the ValueIN group, management of the clinical unit, nurses, float staff, unit clerks and infection control officers, I was able to piece together the different realities and thereby develop a better understanding of the issues.

Two different approaches were used for interviewing staff. Interviews conducted with administrative staff members (i.e. management of the ValueIN group) were all taped and transcribed. A formal consent form was obtained from each research participant. A total of eight formal semi-structured interviews were conducted, each approximately an hour in length. Participants for these interviews were selected based on their position in the hospital and their responsibilities as administrators in relation to the outsourcing of cleaning services. Interviews conducted on the clinical unit with ward staff were not taped, as the work arrangement of staff prevented them from committing to a certain duration of time and the setting was also not conducive for a taped interview. Verbal consent was obtained from staff prior to conducting these interviews and notes were taken during the interview process. As a gesture of appreciation for the time hospital staff set aside for these interviews, a $10.00 honorarium (store gift certificate) was given to each staff member after the completion of the interview. A total of nine informal semi-structured interviews were conducted, each approximately half an hour to forty-five minutes long. Research participants for these interviews were selected based on their availability and their curiosity about the research. In addition, two interviews were conducted with patients and two

informal interviews were conducted with cleaners.[7] These interviews however, only serve to complement the existing data, as these two groups were not included as part of the research design.

To ensure the confidentiality and anonymity of research participants, people interviewed will be referred to as either administrative management (ValueIN employees, Infection Control officers) or ward staff (nurses, unit clerks, care aides). Certain roles that lie in between the two, such as the manager of the clinical unit, or the clinician of the unit, who fulfil administrative responsibilities as well as being closely tied to the daily operations of the unit will be referred to as ward administrators. Revealing the positions of research participant would allow for the cross referencing of the position to an individual. The clinical unit has also not been identified, because by doing so, I would have not been able to ensure the anonymity of research participants.

Prior to conducting this study, I obtained official ethics approval from Simon Fraser University and VCH ethics boards. On my first day on site to conduct passive observations, I personally introduced myself to the unit clerk. As a way to introduce myself to the rest of the staff on the unit, I placed a bag of candy with a note attached to it in the space where staff gather for updating patients' charts. In the note, I introduced myself and provided a brief overview of the research I was conducting, and also thanked the staff for allowing me to share their space. I also asked for those who were interested and who had time, to feel free to come and talk to me. This approach did yield a few research participants for my interviews. Following the first day of conducting passive observations on site, at each subsequent visit, I would introduce myself to the unit clerk (if I had not already done so) and would let them know the reason for my being in their space. I attempted to stay out of the way, while at the same time providing staff with the opportunity to talk to me at their will by making regular eye contact with them.

In conducting observations, I was selective. I did focus my gaze on the work of cleaners, their interaction with staff members and the work of the unit clerk who for the most part acted as the intermediary between the Aramark call centre and staff members' requests. I took note of the conversations I heard, the work practices, the layout of the unit, the appearance of the unit, and other sensory aspects, such as the noise and the smells. Mason (2002) maintains that,

---

[7] Approval was obtained from Simon Fraser University ethics board to interview cleaners, with the condition that cleaners were informed that their employer, Aramark, had not approved the study. I was, however, informally informed by hospital staff that in prior occasions Aramark cleaners had been reprimanded for participating in research and speaking with the media without their employer's approval. Consequently, I chose not to formally involve cleaners in the study. The two informal interviews were conducted with cleaners with whom over the course of data collection I developed a closer relationship, and who voluntarily expressed that they did not have a problem with my using their shared experiences in my study.

"observation allows the generation of multidimensional data on social interaction in specific contexts as it occurs" (p. 86). This type of data is a good complement to the interviews I was conducting. Interviews provided people's retrospective accounts of the work processes, and observations provided me another lens through which to learn about the work processes. I took notes on a template I had created, logging the date, location, and time of each incident. I also had a column, within which I noted my interpretations of the incidences. Using a reference number for each entry, I was able to link back incidences that were related to each other and which did not necessarily happen in an uninterrupted timeline. I spent a total of 30 hours conducting observations on the clinical units.

As I was wearing a VCH staff i.d., staff for the most part did not appear too curious about why I was on their unit. The badge made me appear to be an insider. However, at the same time the fact that I was not part of the team was evident and that made me an outsider. For example, on a few different occasions staff members anxiously asked me whether I was monitoring their work performance. On such occasions, I would provide a brief explanation of the study to staff, ensuring them that their work was not being monitored as part of any performance measures. I would then ask them whether they had time and were willing to participate in the study. If hospital staff were concerned that their work was being monitored for quality performance, I had no reason to believe that cleaners were not feeling as anxious. Therefore, in observing the work of cleaners, I also found myself struggling with the ethical dilemma of informing them about my work to prevent from adding to their stress load at work. On the second day of conducting observations, I approached the cleaners who seemed to be regulars on the two pods of the clinical unit, and introduced myself to them and reassured them that their employer was not monitoring their work, and that I would ensure anonymity of all participants in my study. In time, as the staff got to know me and my reasons for spending time on their unit, I assumed more of an insider role, and they began informing me of incidences that had occurred during the times I was not present on the unit. I established a closer relationship with one of the ward staff, who provided me access to the issue log their unit had created on housekeeping matters. I was informed that the log was used every time a call was placed to Aramark, to enable staff to track the requests and to follow up if required. Staff would also approach me with new issues or concerns they had regarding housekeeping services. During one of my observations, a staff member who I had already interviewed approached me and asked: "Is this going to make a difference in the way things are around here?"

1.4.3 Thesis outline

This thesis is composed of six chapters. This chapter serves as a brief introduction to the thesis and provides background information about how outsourcing was adopted at VCH as a restructuring strategy. In this chapter, I also discuss the research methods used for conducting the study. In chapter two, I will provide a brief explanation of outsourcing as a business strategy and an overview of the theoretical framework that has informed my study. The next three chapters each focus on a thematic area informed by Flood's (1999) version of the ideal type categorization employed by Critical Systems Thinking/Total Systems Intervention. Flood breaks down issues within organizations into four different categories: systems of structure (Chapter three), of process (Chapter four), of meaning, and of knowledge-power (Chapter five).

In chapter three, I question: "What is management's role in ensuring hospital cleanliness and patient care after outsourcing?" Using data generated from observations and semi-structured interviews with people in the health authority and with hospital staff, I argue that the management strategies employed in the process of outsourcing cleaning services were initially based on a mechanistic approach towards the organization, which failed to recognize the connection between cleaning work and patient care. As this approach is not congruent with the systems oriented approach employed at the work practice level on clinical units, the organization has gone through a painful learning process where management is gradually making adjustments that are more conducive to work practice requirements.

Chapter four poses the question of: "How does the work of housekeeping fit into the work performed by staff?" Relying mostly on data generated through observations and semi-structured interviews that were conducted with hospital staff, I demonstrate the requirement for the integration of different workers and tasks for the purpose of delivering patient care on clinical units. Here I argue that performing highly integrated tasks requires a team environment where collaboration is encouraged.

Chapter five examines the possible affects of management strategies and the organizational hierarchy on cleaners. In this chapter, using data generated from a combination of textual analysis, semi-structured interviews and observations, I argue that management strategies and professional boundaries between cleaners and hospital staff could lead to the marginalization of cleaners and the trivialization of cleaning work. This leads to the decontextualization of cleaning from care. Cleaning becomes an end in itself rather that part of the bigger picture, that of cleaning to ensure patient safety, and as such could have negative ramifications for patients.

15

Chapter six is a synthesis of material already discussed. It summarizes the problems ensuing from outsourcing of cleaning services in a healthcare setting. Based on the findings of this study, I will provide recommendations on organizational arrangements that could help alleviate some of the pains and risks associated with outsourcing of cleaning services.

CHAPTER 2
CONTRACTING OUT HOUSEKEEPING
IN HEALTH CARE: A WOMEN'S ISSUE

In the emerging discourses and changes in the health system and structure in Canada, there seems to be a dominance of processes of boundary redefinition (Denis et al., 1999), where the boundaries delineating existing health care structures and organizations are reconsidered and shifted. For example, the current focus on population health and health promotion are indicative of the recognition that the historical boundaries of the healthcare structure need to be redefined and traversed (Hayes & Dunn, 1998). At the organizational level, outsourcing is a form of boundary shifting.

The explanation that is provided for outsourcing housekeeping services to the private sector is to make the public system of patient care more efficient (Vancouver Coastal Health Authority, 2002a). To this end, VCH has positioned itself as being in the business of patients. Hospital administrators state that their core competency is patient care and that housekeeping is peripheral to this care (Personal interview, 15). However, there seems to be an inherent contradiction in this position, as cleaning has been an integral part of care, ever since Florence Nightingale recognized the importance of cleaning to patient care. Work that is currently being categorized as not directly related to healthcare was previously performed by nurses, whose role has always been patient care (Armstrong & Armstrong, 2003).

In this chapter, I argue that it is the gendered nature of housekeeping work that leads to its devaluation and renders its intricacies in the health sector as invisible, making it a prime target for outsourcing. I will provide a brief explanation of outsourcing and the way in which cost savings could be realized from contracting out housekeeping services, which as I will argue, serves in the further devaluation of this work. Through outsourcing, the health sector is reinforcing the medical model and is approaching healthcare from a mechanistic position. To conclude this chapter, I will present a contrary approach to this mechanistic approach towards healthcare organizations. This approach is based on systems thinking, where the interrelationship between components of a system are brought to the forefront in order to ensure the realization of the emergent properties of the system (patient care).

2.1 Housekeeping: A gendered occupation

Hirsch and Osborn (2000) argue that housekeeping work performed in public sector organizations is invisible from the public and as a result contracting out this service would elicit far less public resistance than those with which the public directly interacts. I also believe that it is the gendered nature of these occupations, due to their association with chores performed by women in the private domain of the home that has led to the undermining of the importance of cleaning work. This work, while vitally important for the functioning of society, has historically been devalued and rendered invisible. Related to this is the medical model dominating the healthcare sector with its focus on cure, which has historically undermined those activities associated with care, as they too are gendered activities. Many of these gendered occupations are categorized as ancillary services by hospitals and not related to patient care. Distancing these tasks from the core functions of the health sector and trivializing their importance in regards to patient care makes them the most viable options for outsourcing.

A medical model of care dominates the health sector. This model approaches the body as a combination of parts, similar to a machine. Treatment of each part is relegated to a specialist, who has obtained extensive training and education on a specific component and is thereby viewed as the objective expert on that part. This model is reflective of a mechanistic paradigm, where it is assumed that the reality of something can be understood by reducing it to ultimate indivisible elements. Underlying this viewpoint is the assumption that a complete understanding of the world and reality is possible, which is inherent in the prevalent scientific method. Once each element is understood, the relationship between the elements is seen as a simple cause-effect interaction (Ackoff, 1999a).

Underestimation of women's work is further exacerbated within a health sector that is dominated by a medical model of care. Within this model, the physicians who have been able to afford the higher education required for entering these speciality positions are for the most part white males (Armstrong et al., 2003). As the prevalent assumption is that those occupying these positions posses the superior knowledge for fixing the problem areas of the body, they are at the top of the health care hierarchy. Contrarily, women are generally relegated to tasks that are more aligned with their perceived instinctive nature, in roles perceived to be an extension of the work they perform in the domestic sphere.

This model of health care became dominant because of the power doctors possessed in relation to their class and sex. As a way to maintain this sexual division of labour, they ensured that

women's work continued to be defined in relation to the work they performed (Armstrong et al., 2003). Underlying this system is a patriarchal model of work organization, where men are in charge and focus on 'cure', while women who are in subordinate roles are responsible for 'care'. "Emphasis on cure in our modern health-care system can largely be explained in terms of the power of medical men, and the invisibility of care can be understood primarily as a reflection of women's position and power as caregivers" (Armstrong et al., 2003, p. 96).

When defining the health sector's core mission, although the discussions revolve around delivering patient care, this is for the most part confined to those activities that concentrate on cure, not care. Fragmentation of health into cure and care, with more emphasis and focus on the former, and the further fragmentation of care into narrowly defined tasks, has removed many important services that directly affect the health of patients from the domain of health. Care requires the integration of a variety of tasks and is not just the accumulation of these tasks. Care within a health framework involves "bathing, feeding, turning, injecting, teaching, recording, cleaning, bandaging, and examining" (Armstrong et al., 2003, p. 107). Separation of these tasks, however, disassociates them from care, whereby they become categorized as peripheral to health. For example, housekeeping services, which are critical for hygiene and infection control, are now being defined as hotel services rather than health services. "Because cleaning has no part in curing disease in hospitals, but only in keeping it from spreading, the function is low on the totem pole" (Messing, 1998, p. 178). Defining cleaning as a service that is peripheral to patients' health creates an artificial divide between cleaning and care, and leads to the further devaluation of cleaning work. It decontextualizes cleaning work from patient care, and as a consequence could ultimately affect patient care.

In the health sector, through various unions, women have been able to gain some recognition in the value of the work they perform and to improve their working conditions. Pay equity gains have provided housekeeping workers some recognition in the value of the work they perform. However, this very success is one of the reasons for the drive to distinguish between direct and indirect patient care services (Cohen, 2004). By making this distinction, employers are able to contract out indirect services, thereby reducing the costs of labour that had been gradually increased to reflect the value of the work that was performed.

2.2 Outsourcing

Contracting out or outsourcing is "the act of transferring some of a company's recurring internal activities and decision rights to outside providers, as set forth in a contract" (Greaver, 1999, p.3).

Two key terms in this definition are "transferring" and "recurring". The transfer of activities makes outsourcing different from when contracts are signed with consultants. Emphasis on recurring activities distinguishes outsourcing from spot or occasional purchases. In defining outsourcing, Young (2000) places additional emphasis on two notions: that prior to the transference of services to a third party, the services had to have been performed in house, and that the same employment relations governing the organization's employees do not govern the third party. Both of these definitions take the existence of organizational boundaries as a given and outsourcing is the process whereby boundaries of the organization are shifted.

Scholars remind us that despite the recent upsurge of contracting out, this strategy is not a new phenomenon (Kakabadse & Kakabadse, 2002; Domberger, 1998). Outsourcing which used to be referred to as contracting out has been around since the eighteenth century. With the industrial revolution, contractual relationships became even more common and took on a variety of forms. It was the twentieth century that gave rise to the popularity of large enterprises, and vertical integration was adopted across different industries. According to Domberger (1998), during this time "the internalization of transactions within organizations was the dominant trend" (9). The argument for the creation of large enterprises was that they "yielded efficiencies in terms of economies of scale and corporate synergies" (Domberger, 1998, p. 16). By the mid 1980s and into the 1990s, the large enterprises of the past were no longer viewed as being responsive enough to market forces. In all industrial societies, social and economic changes required organizations to be more flexible in their production and employment processes (Kalleberg, 2003). The current popular belief is that "large enterprises are neither responsive enough nor necessarily more efficient than the more fragmented but cooperative networks of enterprises" (Domberger, 1998, p. 9). Desire for more flexibility and cost savings has reversed the vertical integration trend that became dominant in the twentieth century and has once again given rise to outsourcing.

The argument for the fragmentation of large organizations is the extent of efficiencies that can be realized by focusing on the core business. It is a strategy used to mitigate the increased costs of 'in-house' production by concentrating on those activities in which the organization is relatively more specialized and efficient (Domberger, 1998). The notion of specialization is connected with demonstrable economic benefits. Organizations specialize in different components of manufacturing and service provisions, and through contractual relationships they form networks, which are referred to as hybrid organizations (Domberger, 1998). Each organization focuses on its core competency, which is performed by regular and permanent workers, and all other activities peripheral to this core are externalised by means of transactional contracts to part-time,

and temporary workers. Segmentation of the organization's workforce into fixed and variable components allows the organization to achieve cost effectiveness, as contingent workers provide the organization the flexibility required to adjust to market conditions.

2.2.1 Theoretical underpinning justifying outsourcing

In questioning the boundaries of an organization in terms of core and peripheral activities, one of the most common theoretical frameworks that is used is transaction cost economics. This theoretical context is used to explain the conditions within which it would be more beneficial for an organization to replace its internal structures with market structures or vice versa. That is, to make a decision as to whether to "organize labour and capital to directly produce the desired output" or to invest its resources in obtaining the desired output from the market (Sclar, 2000, p. 96). This "make" or "buy" decision shifts the boundaries of the organization.

Organizations and firms exist because the use of markets and contracts is costly. Significant time and resources have to be spent to obtain and process information necessary for engaging in market transactions. These costs are referred to as transaction costs, and are often higher than the costs of maintaining the activity within the organization (Sclar, 2000). Information required for an organization to engage in a transaction is not always easily available or accessible. Since information is not uniformly distributed among organizations and individuals, those who are in the position of having better access to information can act opportunistically. This information asymmetry affects transaction costs. However, at the same time, it is believed that there is a point where it is more costly to perform the function internally than it is to rely on the market (Domberger, 1998). This is due to diseconomies of scale, resulting from inefficiencies with large size organizations.

Building on Ronald Coase's (1937) work on the boundaries of firms, Oliver Williamson (1979) expanded the modern theory of transaction cost economics and suggested that by determining the three key dimensions of transactions, that of frequency, asset specificity and uncertainty, every transaction could be mapped out to such extent that it would result in the most efficient organizational arrangement. This arrangement would signify the boundaries of the organization. According to Williamson's theory, the attributes of transactions determine the governance structure that should be implemented to minimize the costs of managing transactions (McKinley & Mone, 2003).

Vining and Globerman (1999) suggest task complexity, contestability and asset specificity as the three dimensions that impact the boundaries of organizations. Task complexity determines the degree of difficulty in defining the required tasks, outlining the task characteristics and evaluation criteria. If the task involves specialized knowledge and information on the product or service, and the contractor has the required knowledge, it could act opportunistically. The higher the task complexity, the higher the outsourcing costs. Contestability of an outsourcing contract involves the number of competitors that would be available to bid on the tender. The higher the contestability, the lower the costs of outsourcing. Asset specificity determines the extent of specialized assets required for performing outsourced tasks, and whether those assets could have alternative usage. When high capital cost assets are required that are specific to a certain client, the outsourcing contract will be more expensive than if the assets are more general and could be employed for different clients.

2.2.2 Outsourcing in the public sector

During the last two decades outsourcing has become quite prevalent in the public sector and is one of the major strategies used in public sector reform. According to Flynn and Williams (1997), governments in most industrialized countries, facing fiscal crises and rising public expenditures, have resorted to this strategy to contain costs and to also make the public sector more accountable to the public. Outsourcing fragments the many layers of the vertically integrated large public bureaucracy (Kakabadse et al., 2002), with the idea that by introducing elements of the private sector in the public sector, the cash strapped public sector can deliver higher quality services with less available resources.

Many reasons are provided for the rise in privatization and the outsourcing of public services: The collapse of communism in 1989 (Feigenbaum & Henig, 1997), the right wing political ideologies of the Thatcher and Reagan administration in the 80s, (Samson, 1994), the ideological drive for shrinking government (Sclar, 2000), the subsequent spread of neo liberal ideologies and its permeation in the public sector (Foster & Braddon, 1996; Hodge, 2000), the internationalization of markets (Ostry, 2001), the separation of distribution and production markets (Cohen, 1997), the funding requirements for capital intensive sectors that outstrip the capacity of the state (Hodge, 2000) and the policies of the World Trade Organization (WTO) and International Monetary Fund (IMF) (Price, Pollack, & Shaoul, 1999; Starr, 1997). At times, privatization is also quite simply implemented based on imitation (Starr, 1997; Feigenbaum et al., 1997). Outsourcing is often times viewed as a strategy that can enable governments facing fiscal crisis to lower costs and increase the efficiency of delivering public services (Young, 2000). Trade unions within

public organization are viewed to have developed into 'in-house' monopolies that apply restrictive labour practices and have low productivity (Young, 2000). Outsourcing leads to the weakening of trade unions and introduces cost control measures and competition in the public sector (Hartley, 1990). Through outsourcing, organizational structures are transformed into administrative control agencies that focus on their core competitive advantages, and are thereby able to overcome human resource problems such as turnover and compensation (Young, 2000). Access to funding to continue provision of public services without having to increase the public sector borrowing ratio is also another reason that helps explain the drive towards outsourcing (Hodge, 2000).

While some of these reasons are also incentives for outsourcing in the private sector, they are mostly specific to the public sector. What distinguishes outsourcing in the private sector from that of the public sector is the ethos underlying public services. There are differences in the values, goals, standards, responsibilities and accountability of the public sector and the market (Gross-Stein, 2001, p.86). Values underlying public services are "equity, responsiveness to need and social justice, which are not wholly compatible with market approaches (Foster et al., 1996, p. 294). According to Sclar (2000), "when a product [or service] creates significant external benefits or costs, society (in the guise of government) intervenes to ensure that more of the beneficial goods [or services] are produced and that the goods responsible for negative impacts are produced less frequently or not at all" (p. 25). Society values public services because the benefits derived from their expanded consumption outweigh the costs of producing them (Sclar, 2000). This includes public education, transportation, healthcare, fire protection, defence, street cleaning, refuse collection, utilities, etc. When outsourcing is viewed as a form of privatisation, the transformations in the arrangements for delivering public services through elements of the market is believed to lead to the obscuring of the locus of power (Samson, 1997) and as a threat to public services.

2.2.3 Cost savings at an expense to labour

Following the outsourcing model, in an attempt to contain costs, many health authorities have segmented their workforce and functions performed in hospitals into core and periphery in relation to patient care. As a significant percentage of hospital expenses are comprised of labour costs, by externalizing the workforce, health authorities are able to circumvent unionized labour protections (such as higher wages, job security, sick days, benefits) that prevail in their organizations and thereby save on labour costs.

Sclar (2000) describes the real economy as:

> a mountain terrain that includes several high peaks from which well-endowed corporate and individual warriors swoop down to seize targets of opportunity. Among these high peaks are some flat areas where market battles akin to the competitive ones described by the standard market model do occur. But the players are not always equal as the model assumes, and these comparatively level plateaus are seldom where the real economic action takes place. (p. 9)

Health authorities act as large monopolies within an economic environment that is composed of several large corporations and organizations, with various areas in between that are composed of smaller organizations and firms who compete for the work of the large organizations. Through contracting out, the health authorities shift part of their work to the competitive sector. Companies operating within the competitive sector maintain lower labour costs, which is appealing to organizations within the monopoly. According to Harrison (1994), larger firms within the monopoly sector attain flexibility by depending on contingent labour (part-time, temporary, contract) working within the competitive sector. As Kallberg (2003) notes, "segmenting the organization's workforce into fixed and variable components is assumed to achieve cost effectiveness, as the numerically flexible, non-standard, peripheral workers are used to buffer or protect the regular, core labour force from fluctuations in demand" (p. 157).

The phenomenon where the labour market appears to be separated into a primary and secondary market is further explained by the "dual labour market" concept, which was originally developed by Doeringer and Piore (1971). This dualism is a result of the variability and uncertainty inherent to modern, industrial economies (Berger & Piore, 1980). The structure of the market is a "response to the conflict between the inherent insecurity in the economic activity and pressures (either narrowly economic or of a broader social and political character) for protection and security" (Berger et al., 1980, p. 27). The primary market offers jobs with relatively high wages, good working conditions, employment stability, job security, and opportunities for promotion. Compared to the primary market, the secondary market companies operate at lower margins and in a more competitive environment. As such, in order to maintain their profit margins they place downward pressure on wages and working conditions of labour.

Housekeeping, which is viewed as an activity with low task complexity, high contestability and low asset specificity, is commonly contracted out to the lowest bidder, operating within the secondary market. In this market, jobs are low status, offer lower wages, little job security and virtually no promotion or training opportunities. These jobs tend to be filled by women, ethnic minorities and people from disadvantaged backgrounds (Berger et al., 1980). Jobs in this market

are likely to be "governed by the logic of Fordist employment relations, which sees them as disposable" (Kallberg, 2003, p. 160). Workers are also closely supervised and monitored. As labour costs are estimated to make up at least 85% of an environmental services department's[8] overall operating costs (Death, 2003), maintaining the lowest possible figure will significantly impact the private contractor's profit margins.

The effect of outsourcing on labours' wages and benefits is one of the reasons unions are opposed to outsourcing strategies. Unions have played a significant role in improving the working conditions and pay of supporting health care workers. Contracting out of services eradicates all the advances unions have been able to make on behalf of their members over the past thirty years (Cohen, 2003). This decrease in wages is also indicative of the low value attributed to cleaning work and undermines pay equity gains that had been attained for this work. Under the new contracts with private companies, the wages for housekeepers decreased by 48% from what was offered to workers under the HEU union contracts (Cohen, 2003). This is a significant decline, especially when we consider the high cost of living in B.C.

Characteristics of the secondary labour market and the Fordist employment relations that seemingly govern organizations within this market are symptomatic of a mechanistic approach towards organizations, in which the social dimension of an organization is undermined. Through outsourcing, the health sector is reinforcing this mechanistic approach and along with that, the medical model of care. In contrast to the mechanistic approach, the holistic approach focuses on the interactions required between the different groups of workers and tasks is brought to the forefront. This approach is referred to as systems thinking.

2.3 Systems thinking

Defining certain services as core and others as support, and outsourcing the support functions could lead to fragmentation of the organization and could have subsequent implications for an organization's objectives. Kallberg (2003) maintains that the polarization of the workforce into different groups could lead to divided loyalties and diminished cooperation between different groups of workers. The problem is that, within a healthcare setting that requires the integration of the complementary skills of a range of workers (Armstrong et al., in press), outsourcing could lead to the weakening of the critical interactions required between the components making up

---

[8] Environmental services departments or vendors are used by some companies and within some of the literature to refer to companies that provide housekeeping, waste management as well as laundry and linen services to health care facilities.

the whole system. Patient care has the potential of being compromised when cleaning is segregated to the periphery. Systems thinking provides a framework in which the interaction and the integration of the components that make up the system become the focus of attention. The objective is to ensure that the components, while functioning individually, are also related together properly in order to ensure the attainment of the objectives of the overall system (Jackson, 2003).

The core of systems thinking is that a complex whole has properties which are meaningless if only the individual parts are considered. The properties of the whole emerge as a result of the interdependence and interaction between the different components within the system. A system in itself is "any group of interacting, interrelated, or interdependent parts that form a complex and unified whole that has a specific purpose" (Kim, 1999, p. 2). System thinking hence, is a perspective, a way of seeing and talking about reality. It developed as a response to the inadequacies of reductionism inherent in the classically conceived scientific method. Within reductionism, knowledge is generated by breaking down phenomenon into small parts, analysing the individual components and examining the relationship between the individual parts based on a cause and effect relationship. One of the problems with this approach is that the whole has characteristics that cannot be described by the characteristics of the parts. According to Peter Senge (1994), by learning to break complex tasks into smaller parts in order to deal with them, we lose sight of the bigger picture and the sense of connection to a larger whole, and as a result are not able to see how the consequences of our actions impact the bigger picture.

Initially used in biology and explained by Von Bertalanffy (1949), systems thinking has expanded to different disciplines, and in recent years has become very popular in management decision making. Kim (1999) goes as far as stating that system thinking has been defined as one of the key management competencies for the 21st century and is used in tackling and resolving a wide variety of complex organizational and managerial problem situations. Systems thinking views organizations as complex open systems that interact with their environment to achieve their stated objectives (Checkland, 1999). Organizations are studied as a whole rather than a collection of their parts, and while systems thinking ensures the proper functioning of each part of the organization, it is primarily concerned with the way in which the parts interact and interrelate such to serve the purpose of the whole system. It is not the performance of each part relative to its own objective that determines the overall performance of the system. Thus, the whole system exhibits properties that are more than the sum of its parts. For example, a hospital is a system with the objective of patient care. It is clear that patient care cannot be delivered by any one of the parts of the hospital alone. It is the interaction between the many different

components within the hospital that lead to the realization of patient care. Insight into the whole system is obtained by understanding the linkages, interactions and processes between the elements that comprise the whole system (Jackson, 2003).

Since its first applications in managerial problem solving during the Second World War, a wide variety of systems thinking approaches have been developed to respond to diverse and complex problem situations. While these different application methods all have a holistic character, the way in which they use systems ideas is dependent upon the purposes they want to serve (Jackson, 2003). Traditional approaches of systems thinking are very much rooted in the natural sciences and are aligned with functionalist thinking. Other, more modern approaches are not positivist or functionalist, and more open to individual interpretations (Jackson, 1991).

The traditional approaches regard system models as actual representations of reality, and fail to take into account human beings within social systems as individuals with their own motivations and goals, assuming that people can be manipulated as part of the larger system (Midgley, 2000). The notion of an observer creating a representation of reality is indicative of the belief in a subject/object dualism that underlies reductionism, and leads to the belief of perfect objectivity. Grint (1991) sees the traditional systems approaches as "not only technocratic[9] in its denial of conflicting ideologies and material interests but also deterministic[10] in its pursuit of the correct prediction of behaviour through an analysis of organizational rules" (p. 137). There are also similarities between traditional approaches of systems thinking and functionalism. For example, the work of Talcott Parsons, one of the proponents of functionalism in North America in the 50's and 60's, was very much geared towards the development of abstract, generalizing concepts that would describe the social system (Marshall, 1998). Parsons conceptualised society as a collection of systems within systems. He presupposed a personality system that was embedded within a cultural system, which was embedded within the physical environment (Parsons, 1951).

Along with all the criticisms raised against functionalism in the 60's, because it was unable to explain a wide variety of issues, such as poverty, social change and inequality, feminists have also been vocal about their critique of functionalist thinking. Feminists reject one of the notions central to functional theory that assumes a shared value system is equally beneficial to everyone. Functionalism provides a justification for male privilege and leads to the segregation of society

---

[9] By technocratic, Grint (1991) is referring to pragmatic approaches that are tools for improving organizational efficiency, without regards to the impact of the approaches on organizational members.
[10] Deterministic approaches, according to Grint (1991) are those which stress the scientific and objective ways in understanding organizations.

and jobs based on gender, further contributing to the oppression of women. While functionalists might argue that labour market segmentation ultimately serves a number of purposes that are required for the functioning of society, such as ensuring the existence of a variable labour supply, feminists would argue that the result of this segregation is the relegation of women into job ghettos, that are for the most part market extensions of home work (Phillips & Philips, 2000).

Ontological and epistemological differences between feminism and traditional systems thinking, prevents these two paradigms from finding any common ground, or even complementing each other's strengths and weaknesses. Criticisms to systems thinking has led to significant changes, and as a result new systems thinking approaches have been developed. These new approaches no longer view systems as objective representations of the real world, but rather as constructs that are intended to help in the understanding of real world issues. Emphasis of the modern approaches to systems thinking is "on dialogue, mutual appreciation and the inter-subjective construction of realities" (Midgley, 2000, p. 193). Total Systems Intervention, which is one of the most recent strands of systems thinking, acknowledges the "diversity in the issues and dilemmas that confront decision makers" (Flood, 2001, p. 140), and suggests that the intention for applying systems thinking to organizational problem solving should be about stimulating debate, generating insights, and enhancing learning (Flood, 2001). These are significant changes from the functionalism of Parsons, and they highlight the move away from structures of objectivity to the subjectivity of individuals.

Criticisms are also raised about the new approaches in systems thinking, mainly regarding their inability to acknowledge power relationships between individuals within an organization. This could lead to systems thinking promoting and reinforcing the vision of those in positions of authority. These approaches fail to challenge the larger political and economic relationships within the system's environment. Consequently, "participants are encouraged to adapt their organizations to these relationships instead of challenging them" (Midgley, 2000, p. 204), which defeats the purpose of applying systems thinking to organizational problem solving. Changes to systems thinking, despite the new criticisms raised against them, create the space for feminist thinking to enter into a constructive dialogue with systems thinking. Harding (1987) suggests that research should reveal and examine "the privileged identities and the unequal power relations that facilitate the collusion of research in the perpetuation of conditions of domination, oppression, and privilege" (p. 22). Here, feminism can complement the shortcomings of systems thinking and address the existing power relationships within organizations and contextualize the organization within the larger political and economical environment.

2.4 Conclusion

From a business perspective, it is the low asset specificity and task complexity and the high contestability of housekeeping that creates the conception that its outsourcing would yield more efficiencies. However, the decision to outsource is also rooted in a historical context that helps in shaping societal perceptions on the value of cleaning work. Housekeeping is gendered work and is an extension of domestic work performed by women in the household, which has historically been devalued. Mechanistic models of management predominant in the secondary labour market to which housekeeping work is contracted out, lead to the further devaluation of this work. These models fragment the system of care, leading to potential negative ramifications for patients. Since the delivery of patient care requires the interaction of many different components, as an alternative to these mechanistic models, I will use a systems thinking framework for this study. A systems thinking perspective considers organizations as open systems where the interconnection and interaction between components within the system allow for the realization of emergent properties of the system.

CHAPTER 3
THE GAP BETWEEN
MANAGEMENT STRATEGIES AND
WORK PRACTICE REQUIREMENTS

In *Images of Organizations*, Morgan (1986) identifies eight metaphors that are commonly used for studying and understanding organizations. These metaphors describe organizations: as machines, organisms, brains, cultures, political systems, psychic prisons, flux, and transformation. Depending on the metaphor used to describe an organization, a different set of underlying assumptions guides the decision-making processes and activities within the organization and influences how management intervenes in organizational change. Frequently managers become too focused on one particular mindset and this affects the way they manage and implement organizational change (Jackson, 2003). It could be argued that staff at different levels within the organizational hierarchy, depending on their position within the organization, their responsibilities and work activities, would describe the organization using different metaphors. As a result of this disjunction between those directing change and the recipients who must adopt and adapt to the implemented changes, a great deal of tension can arise (Knox & Irving, 1997), which can ultimately affect the performance of the overall organization, regardless of the employed metaphor directing the change.

In this chapter, I will examine management's[11] role at VCH in ensuring hospital cleanliness and patient care after the outsourcing of cleaning services to Aramark. I will argue that failing to recognize the intricacies of the gendered work of cleaning performed at the low end of the organizational hierarchy, the structured organizational boundaries constructed by management at upper levels within VCH following the contracting out of services reflect a clear divide between housekeeping and care work. Management at VCH has employed strategies that are based on a mechanistic view of organizations, which are not congruent with the systems oriented paradigm common at the clinical unit level. As a result, the structured boundaries have acted as impediments to work practice and smooth workflow on clinical units. This has led to a slow and painful learning process of making change at the clinical unit level, which could have been

---

[11] Management is a reference to VCH employees involved in the administrative decisions regarding outsourcing.

avoided had management been more cognisant of the work performed by cleaners and the requirement for its integration with care work.

3.1 The case of Bill 29

On January 28, 2002, the Liberal government in B.C. enacted Bill 29, the Health and Social Services Delivery Improvement Act. This act applies to non-clinical services that are performed by healthcare workers and voids certain provisions within collective agreements that were negotiated between unions and healthcare employers. One of the outcomes of this act, as it pertains to this study, is that a health sector employer can contract out certain services that were previously performed by unionized workers, and were formerly protected from contracting out. Bill 29 removes any language restricting health sector employer's ability in contracting out non-clinical services from collective agreements and emphasizes that collective agreements should not contain any provisions that would include such restrictions.

Bill 29 paved the way for private companies to assume the responsibility for the delivery of healthcare support services, such as housekeeping, security, food services and laundry in hospitals and long-term care facilities in B.C. The one problem, however, for management purposes was the concept of "True Employer." Provisions relating to "True Employer" declarations of the Labour Relations Code[12] were excluded from Bill 29. The True Employer provision states that a worker will not be considered an employee of "the health sector employer unless the employee is fully integrated with the operations and under the direct control of the health sector employer" (Legislative Assembly of British Columbia, 2002). As such, to ensure contract workers (i.e. cleaners) were not considered employees of the health authority, health authorities had to employ strategies and implement organizational structures that did not require the integration of their staff with contract workers. By drawing a clear line between cleaning work and care work within the health sector, Bill 29 contributes to the further undermining of housekeeping work and provides the context within which management at VCH initially proceeded to construct the new organizational boundaries.

---

[12] The Labour Relations Code is concerned with collective bargaining and labour-management relations in B.C.

3.2 The new organizational structure: Divide between cleaning and care

Prior to the outsourcing of cleaning services at VGH, the cleaners assigned to each clinical unit reported to the supervisor of housekeeping. Each supervisor was responsible for certain clinical units. For example cleaners of all clinical units located in the Jim Pattison Tower at VGH reported to one supervisor, who reported to the head of housekeeping. The supervisor would in turn interact with the Patient Services Managers (PSM) and Patient Services Coordinators (PSC) [13] of each clinical unit to resolve outstanding issues or fulfill specific request. Cleaners worked according to a schedule that was created for them by the housekeeping department. If the PSM or PSC required an alternative schedule or had special requests (e.g. washrooms cleaned twice per day rather than once), they would make this request to the housekeeping department, who would then change the assigned cleaner's schedule to meet the request, so long as the additional task was still within the cleaning budget of that unit.

With Aramark assuming the responsibility for hospital cleaning, the VGH housekeeping department was dismantled. The majority of existing cleaners, close to 300 people, were laid off, out of which approximately 10 signed new contracts with Aramark (Personal interview, 14). The reporting structure remains similar to that prior to outsourcing, except that it is outside the jurisdiction of VGH. Cleaners all report to an Aramark supervisor, who is in touch with the PSM and PSC of the units and if s/he is unable to resolve reported issues s/he escalates them to her/his manager, who in turn interacts with the ValueIN group.

Administrative management reminded me that not much had structurally changed since Aramark had taken over the delivery of cleaning services at VGH (Personal interview, 16). structural differences at VGH since the outsourcing of cleaning services can be summed up as follows:

1. The development of the ValueIN group, who as part of their responsibility, facilitates the relationship between Aramark and the clinical units, ensures staff's requests are met, and that requests are within the scope of the contract between VCH and Aramark. ValueIN is also responsible for auditing and monitoring the work performed by Aramark.

---

[13] The Patient Services Managers of each unit are responsible for the overall management of the unit and act as the intermediaries between the clinical units and upper level management at VCH. The Patient Services Coordinators are the head nurses for each shift who are more involved in the operational functions and the day-to-day management of the wards.

2.   The replacement of each clinical unit's logbook, where cleaning requests used to be written and which the cleaning staff would consult for their daily tasks, with the Aramark call centre. Staff, from any of VCH's facilities, is now responsible for calling in their service requests to the Aramark call centre.

3.   The replacement of cleaners, some of whom had worked on the same clinical unit for years and had thereby built relationships with other staff members, with new Aramark cleaners, who initially were not even consistently working on the same clinical unit.

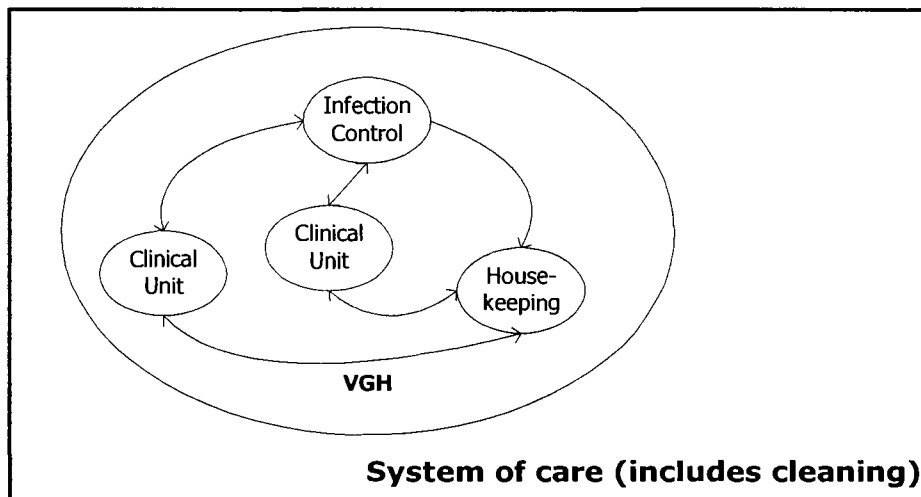**Figure 1 – VGH organizational structure pre-outsourcing**

Figure 2 – VGH organizational structure post-outsourcing
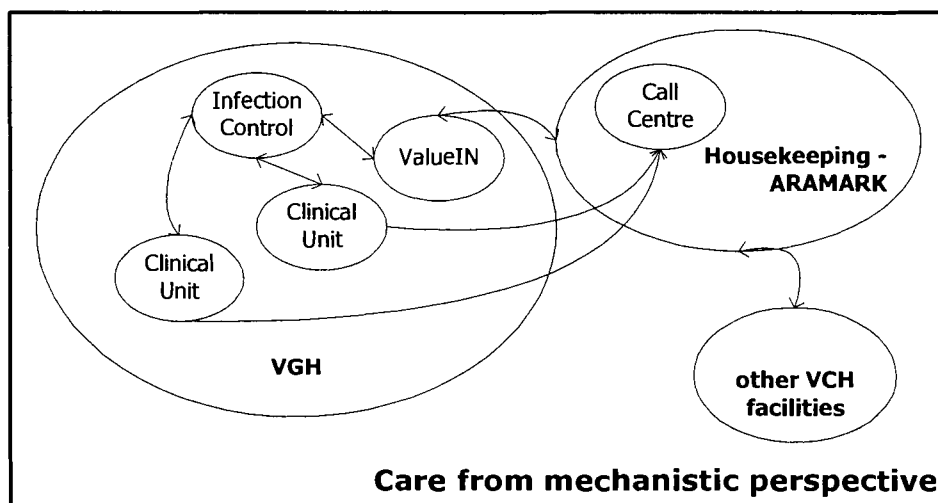
Examining the structural changes to VCH after outsourcing from a mechanistic perspective can lead to the conclusion that there have not been any significant changes in the organization. Viewing the organization as a machine, the only change has been the replacement of one of the machine parts (the housekeeping department) with a new component that is no longer inside the machine but rather on the outside (Aramark's housekeeping department). ValueIN is now responsible for ensuring cleaning services are performed rather than the department of housekeeping, and hospital staff are responsible for calling a new phone number for their service requests. As per one of the administrative management staff:

> ... there hasn't been a big change to the organization really...they still call it housekeeping. They still have to call somebody. It's not that they had anybody there all the 24 hours. It's just a different number that they have to call. The organization feels that they don't have direct control over what's going on, but we do. Through the ValueIN group. (Personal interview, 16)

While it might appear that there have not been any significant changes, one of the administrative management staff indicated that the hospital is no longer in the business of cleaning. This is reflected in the figure illustrated above, depicting housekeeping outside of the boundaries of VCH. As such, the role of ValueIN is:

> ...finding efficiencies within healthcare in different initiatives that had been identified as having potential for improvement. The main aim was financial, to find some cost savings and to be able to channel any additional savings towards health care, primary health care, which is our core business. And another thing that we were looking to do was to really get more productivity out of the resources. Find efficiencies, capture value, and so on. So, in terms of ValueIN, one of the options that we had was to outsource, to collaborate with private sector and see where we could use their expertise in providing these services and as you know housekeeping is one of the areas we're working with Aramark.... Our business is not cleaning. So we concentrate on outcomes, how Aramark goes about it, that's their business. That's their core competency. Our core competency is providing the best possible healthcare to patients. As long as we can provide that, whatever they use - [it doesn't really matter how Aramark goes about doing their work]. (Personal interview, 15)

The role of the ValueIN group, which is removed from the day-to-day practice of the clinical units, is to find cost savings, and as Armstrong et al., (2003) note, when the objective is cost cutting, the focus becomes statistical thinking and the measurement of everything. Focus on counting, timing and costing, makes management more prone to employ a mechanistic view towards the organization. VCH management at this level, which is responsible for designing the new organizational structure and defining the new structural boundaries of the organization,

therefore, draws a clear distinction between cleaning and patient care, in order to maintain focus on its core competency.

3.3 The transition: Employing a mechanistic model of management

Management initiatives prior, during and after the outsourcing of cleaning services are indicative of a mechanistic view of organizations. Within this paradigm organizations are seen as rational enterprises that are designed to achieve a defined objective. Routine operations, well-defined structures, jobs and tasks, predetermined procedures and standards and the efficient working of different functional areas with each other, are some of the underlying assumptions of the mechanistic paradigm. Management strategies employed by VCH are reflective of these underlying assumptions and are indicative of the belief that labour is divided into specific roles without any substantial overlaps in tasks, while management is responsible for controlling labour and disciplining employees (Cameron & Green, 2004). From a mechanistic paradigm, the realization of the objective of patient care requires the performance of certain functions, which are taken separately and controlled by management. In this sense, the organization is the sum of its parts – the sum of all the functions that are performed. Hence, having the cleaning function performed by another organization, should not result in any major changes in patient outcomes.

Before any change implementation, the ValueIN group identified all the major stakeholders who would be affected by the change and sought their input and also provided the group with updates on the planned changes. This initiative, as one of the administrative management staff described, was a way for them to obtain the stakeholders' "buy-in on making change" (Personal interview, 15). To prepare for the transition of services to Aramark, the ValueIN group engaged in the mapping of the many different work processes undertaken by the housekeeping departments of different facilities within VCH. It was important to understand the various tasks performed by housekeeping, so that the requirements would be listed within the contract and communicated to Aramark. For this purpose housekeeping managers and supervisors at each site were consulted and desired processes and outcomes were mapped out. While the majority of these employees were to lose their jobs after the contracting out of services, I was assured by one of the hospital managers that even if they did not agree with the contracting out process, "they always understood that we needed to do the right things up front to make sure that this worked. And we all had that sense of responsibility to our patients and so we tried very hard to make sure to cover all those things" (Personal interview, 16).

Ward staff were prepared for forthcoming changes through various education sessions. One of the managers, while claiming that there "hasn't been a big change to the organization really," describes the sessions as follows:

> The education I'm talking about for the organization is making them ready for the change. Yeah, you're still going to have housekeepers here. They're still going to be here during the day. You're still going to be able to access them. This is how you do it. This is who you call if you don't like what's being done. And we've done that, over and over and over again. Almost every couple of months we go out with a bulletin and tell them just as a reminder this is how you do things. (Personal interview, 16)

During these education sessions, due to the "True Employer" legislation, VCH also drew a very hard line when it came to communicating with cleaning staff. Staff were told that no directions were supposed to be given to cleaners and that all communication and service requests had to go through the Aramark call centre.

Posters were placed throughout the wards with the new Aramark call centre phone number and the change in procedures for obtaining cleaning services. VCH prepared all the security badges and keys for workers for the day of the transition, while Aramark prepared the work schedules, and provided training to its staff. VCH's involvement, through the ValueIN and Infection Control teams was to provide Aramark with its training manuals for housekeeping, and aside from that, it did not have authority to direct Aramark in its training and staffing of housekeepers. Various maps of the work sites were prepared with an associated rating for each area. Four different types of areas were identified for cleaning services, each with a different cleaning frequency, intensity, and staffing requirement. Group 1 includes office areas, common non-patient spaces, admitting, inventory control. Group 2 includes outpatient care units, laboratories, and pharmacy. Group 3 includes all the patient wards, and finally Group 4 includes some of the more intensive care units, such as Bone Marrow Transplant, the Burn Unit, and Operating rooms. For each group a table outlines the pre-outsourcing cleaning frequencies for each element within that area (i.e. entrance and stairwells, walls and ceilings, hard floors, furnishing, IV poles, bathroom fixtures, etc.). This reflected the importance of the cleanliness of each element within a given area, helping in defining work priorities.

During the day of the transition, there were two separate teams, the VCH and Aramark transition teams, who worked along side each other in the various facilities. Aramark coaches were available for their own staff, helping them with the work processes, while the VCH team was responsible for resolving VCH staff issues. Despite the existence of the many maps and

guidelines, one of the members of the VCH transition team tells me that initially the Aramark coaches were not able to find their way around the facility, and as a result, areas such as the staff washrooms or the soiled utility rooms on the clinical units had gone unnoticed and were not being cleaned, as workers were not familiar with the site and the areas that had to be covered (Personal interview, 6).

The Aramark call centre was set up for the purposes of assigning tasks to cleaners, monitoring activities and tracking work information. It is also the means through which hospital staff are able to communicate cleaning requirements to Aramark and to obtain non-routine cleaning services on units. One of the hospital administrative management staff defined the call centre as the "accountability part of the process. Because if it doesn't go through the call centre, they could say well I'm not going to do it. The call centre ensures cleaning staff get their work done" (Personal interview, 14).

Each of the cleaners carries a pager through which they receive their assigned tasks from the call centre. Once a page is received, the cleaner must stop the activity at hand and respond to the call. The time the call is made is recorded, as is the time the cleaner responds to the call. The cleaner indicates the beginning of an activity through the messaging system and once the task is completed, is again responsible for calling in and reporting the completion. All of the calls are recorded in order to track the duration of each task and to also cross reference tasks to the cleaner responsible for performing it (similar to cleaning activities performed in hotels). For example, data collected through the call centre indicates an average room turnaround time[14] of 66 minutes in December 2003. For June 2004, the data shows a reduction of approximately 14 minutes in average room turnaround time. Based on the collected data, reports are generated, posted on the VCH website, and are accessible to the public.

Other than certain units (i.e. burn unit) that were specified in the contract as requiring a dedicated and consistent staff member, different Aramark cleaners were assigned to other areas or units. For the majority of clinical units, a cleaner would be assigned to a pod[15] on weekdays from 8:00 a.m. - 3:00 p.m. to attend to all the requirements of the pod. After hours hospital staff were able to obtain cleaning services by contacting the call centre. During the weekends, in the VGH tower, housekeeping staffing was cut by 50% in comparison to weekdays, making one

---

[14] The turn around time for a room is the average duration for a cleaning task to be completed, from the time the request is placed with the call centre until the completion of the cleaning has been logged with the call centre (the sum of the average response time and duration of the cleaning time).
[15] In the majority of cases a clinical unit only covers one pod. If a unit is stretched in two or more pods, there is a cleaner assigned to each pod.

cleaner responsible for covering two pods, which is generally two separate clinical units. Initially, the work processes were designed around tasks. For example, the cleaner would start off with filling all the soap dispensers on the unit, and once that task was complete, he or she would move on to another task such as cleaning the floors. The only task that during the earlier days of the contract was assigned to a separate cleaner was the collection of garbage. The responsibility of this cleaner started and ended with the collection of garbage bags and he or she was not involved in any of the other required cleaning tasks.

3.4 Contract management

ValueIN is responsible for monitoring, auditing and managing the contract between Aramark and VCH. When VCH entered a contractual agreement with Aramark, it forfeited its direct control over cleaning services. All cleaning requirements were outlined in the contract and were placed within Aramark's jurisdiction of responsibility. VCH administrative management acknowledges that Aramark's core business is not patient care, and is also clear that cleaning has to happen in the context of patient care:

> Quality outcomes [within the contract] are tailored to a clinical environment, a hospital environment. There are certain standards and service levels they must achieve. If any deficiencies were present, they would be a breach of the contract, basically. So, Aramark's core business is cleaning, but the contract's quality outcomes are tailored to a clinical environment and they must meet those outcomes. (Personal interview, 15)

Where VCH continues to have authority is in the outcomes. If Aramark is not able to deliver on outcomes outlined within the contract, VCH can raise the matter, and then it is up to Aramark to make changes to resolve the matter. Outlined in the contract are a set of standards and quality outcomes that Aramark is contractually obligated to meet, within specified time frames and response times. If those outcomes are not met, certain processes have been delineated within the contract for resolving outstanding issues. On the other hand, if additional services are required by clinical units or VCH in general that have not been specified within the scope of the contract, further negotiations have to take place between VCH through the ValueIN group and Aramark, and additional funding has to be secured for the new services.

3.4.1 Problem resolution

Problems encountered by hospital staff can be reported to the ValueIN group in a variety of different ways. According to one of the administrative management staff, "we're a pager away"

(Personal interview, 16). This was confirmed during our interview, as the research participant received a message on her pager regarding a clinical staff member's issue and interrupted the interview to make a few phone calls in order to deal with the matter. Information is provided to the units about how to report and have issues resolved. The first step is to report it to the Aramark call centre. If it is not addressed at that level, they can then escalate the matter through one of the hospital's Customer and Quality Service representatives that are on site.

The hospital's Customer and Quality Service representatives are each responsible for monitoring the work of contractors in different VCH facilities, facilitating the day-to-day activities between the different contracting organizations (i.e. Aramark, K-Pro Linen, etc.) and VCH, and addressing staff problems. The "Customer" component of their title makes them responsive to both internal and external customers, including all staff, patients and visitors. However, they often do not directly interact with patients and their families. The hospital clinical staff and unit managers are the people who receive the bulk of complaints from patients and patient families. According to one of the hospital staff, it is ultimately the hospital unit manager who is accountable to patients and their families for everything that goes on in a clinical unit (Personal interview, 2). However, that does not mean that they have the ability to solve the problems. For that purpose, they need to involve the hospital Customer and Quality Service representatives, Aramark supervisors and the ValueIN group.

Issues that are reported to the ValueIN group are logged and tracked through an Issues Management database. They are assigned different priority levels that determine the time frame within which they have to be resolved. Through this database, the group is able to track and report on the number of issues that are identified each month, their status and resolution. During the transition and the first couple of months after the outsourcing of services there were more issues and a more discernable pattern among the issues identified, such as high average room turn around times. As the changes have become more established, the issues are more of a one-off nature, such as an office not being cleaned. If the issue starts reoccurring, such as the same office not being cleaned by the same person on a more regular basis, then the issue is followed up with Aramark to identify the cause of the reoccurring problem, such as the absence of that office in the Aramark work schedule.

3.4.2 Performance monitoring

In addition to tracking and reporting on issues, the ValueIN group is also responsible for performing quality audits in conjunction with Aramark, as outlined in the contract, at pre-

established times, and formats and to report on the findings on a regular basis. As there are currently no uniform housekeeping standards in B.C.,[16] the performance indicators and standards specified in the contract are based on a combination of industry standards from across Canada the UK and Australia. The hospital Customer and Quality Service representatives conduct audits based on a checklist of housekeeping items they need to evaluate. This checklist contains 31 items, plus the required standard for each item, and checkboxes to indicate whether the standard is met or not. Ratings are than tallied for each room and a percentage is obtained. The monthly score is derived from the average of all the audits within a facility (British Columbia Nurses' Union et al., 2004). This information combined with the data gathered from the Aramark call centre, provides the input for the quality audits.

In response to the gathered information, if there are visible problems, the ValueIN group and Aramark attempt to find the sources of the issues and address them. One of the hospital administrative management staff further explains how the data gathered is used for performance monitoring and quality assurance:

> With the response time, if we realize that there is one area that is lagging in response time, we will try to drill down and find the reasons why. It could be a staffing issue. They could not respond fast enough. And again within the contract there is a stipulation that if there is a terminal clean or a discharge clean it must be done in a specific amount of time. And if an area is not meeting those standards we will find out why and we will work with Aramark to rectify the situation. It could mean adjusting staffing on a level, it could mean you know, shifts, change of shifts. (Personal interview, 15)

Data tracked by the call centre provides detailed information about the timing and duration of different activities, the number of certain activities (such as discharges) that happen on a particular unit on a certain day in the week. The identification of patterns in activities is used for to improve scheduling and staffing of units.

In addition to the quality audits conducted on a monthly basis by ValueIN, recently Westech Systems Inc., which is a B.C. based business that provides cleaning services and has experience conducting audits in retail and healthcare facilities, conducted an independent audit of VCH facilities. The same quality measurement tool that VCH utilizes was employed by Westech in conducting this audit. The results of this audit give VCH a score of 92%. However, there has been much criticism of this audit. While VCH claims that the audit was conducted independently

---

[16] On December 17, 2004, VCH issued a Request for Proposal to find a vendor who would help the B.C. government in developing housekeeping standards and a single audit tool that could be used by health care facilities across B.C.

and unannounced at each site, the BC Nurses' Union president claims that both the health authority and the private cleaning contractors were aware of when the audit was going to be conducted. Furthermore, as outlined in the report produced by the HEU and BCNU, there are problems with the auditing tool used by VCH, as it does not provide a scoring weight to different issues. For example, "the cleanliness of a bed is as significant as the cleanliness of a foot stool, even though the infection risk of a soiled bed is much higher" (British Columbia Nurses' Union et al., 2004, p. 49).

3.5 From "transition to stabilization": Tensions between mechanistic models of management and work practice

After the transition of housekeeping services from VCH to Aramark, it soon became apparent that hospital management's mechanistic strategies were not congruent with the reality of work practice at the clinical level. Initially when the ValueIN group set out to map housekeeping tasks and work processes, there was the realization of certain overlaps in smaller facilities between activities undertaken by housekeeping and maintenance (Personal interview, 16). For the clear division of labour between Aramark and VCH, these overlaps had to be sorted out. Housekeeping tasks had to be clearly identified and outlined in the contract. This approach follows a "commonsense notion of a boundary as a clear line of demarcation between an inside and an outside depicted as radically distinct with minimum interactions between the two" (Marshall, 2004, p. 57), and is evident in organizational theories based on transaction cost economics. The assumption that work processes can be mapped out and fully controlled for the attainment of organizational objectives is reflective of a mechanistic approach towards organizations. Constructing structural boundaries, as Wheatley (1992) suggests is based on a machine image of the world, where every part of the machine has its place. On the other hand, from a social systems perspective, there is the recognition that while cleaning is its own profession, as is nursing, and each group has its own set of functional tasks to perform, it is the integration of the performed tasks that leads to the realization of the common objective of patient care. In this sense, the organization is greater than the sum of its parts.

The reality of an organization is that there is more fluidity in the roles and responsibilities of employees, and work processes do not always mirror the mapped out plans. As Suchman (1987) has noted, plans differ from situated actions. One of the problems with mapping out courses of action is management's expectation that activities will follow those plans. Action plans are based on the assumption that the plans are exhaustive accounts of all possible scenarios. However,

41

plans do not represent practices and circumstances in all of their concrete detail (Suchman, 1987). In a healthcare setting, where patients are present, there are many unexpected scenarios that cannot possibly be mapped out.

By consulting the supervisors of each facility prior to outsourcing, rather than the actual cleaners and other hospital staff, the ValueIN group also made the assumption that there is no discrepancy between planned activities and work processes, and that which actually occurs in work practice. While washing floors and cleaning beds are some of the visible tasks that are undertaken by housekeeping, there are also other activities that cleaners perform, which remain unrecognised unless the outcome of the activity is compromised. For example, a short while before Christmas when all the celebratory lights and decorations were put up across the city, the ValueIN group recognized that prior to outsourcing housekeeping had been the group who undertook this responsibility (Personal interview, 16). As this was not outlined in the contract with Aramark, the ValueIN group had to either pay additional fees to Aramark for the performance of this task or to find an alternative solution for ensuring the hospital was appropriately decorated.

With each new season and the occurrence of new incidences, ValueIN has come across tasks that were not visible during the process mapping that took place prior to outsourcing. This is reflective of a paradigm that fails to acknowledge the complex web of interrelationships and interactions between the different components making a system. Within a highly integrated social system, components do not always follow predetermined work processes (Suchman, 1987). This is especially true in healthcare facilities that are far from assembly line productions. Due to the frequency of unpredictable circumstances and the web of interrelationships that is required for patient care, there is much overlap in the activities undertaken by various staff in the clinical units (Personal interview, 7). Prior to outsourcing, cleaners were very much part of this web of interrelationships. While they may not have engaged in direct patient care, before the clear distinction was drawn between jobs directly related to patient care and those on the periphery, as part of their responsibilities as healthcare workers, cleaners engaged in more interaction with patients and were part of the care team on the clinical ward (Personal interview, 7). Often times they would inform nurses and other clinical staff when they noticed a patient who was in need of care, or they would inform clinical staff about patients' complaints. These tasks are not noted in a work schedule or job description. They exist because of a team environment, where the overall objective of the team is the delivery of patient care.

One of the clinical staff on the unit recalls the best cleaner and working arrangement she has experienced throughout her years of working at the hospital, and describes the cleaner as being part of the family, part of the ward.

> The thing that worked with him, he didn't just do it, I mean, he made a point of getting to know us and to make sure that we were okay, and we got a way of knowing him. And when he went into someone's room it wasn't just to clean, like - he would just say - you know it's just light conversation - it wasn't like he was sitting down and doing counselling, but he was sitting down and going: "how's your day? oh, that was tough," or "that must've been hard for you." ... He was just being an active listener, he wasn't giving advice, he wasn't telling families about - you know - he was just doing what was appropriate for his level. And I never had an issue with that. I loved it! It was great. And the patients loved it. And they felt that everybody that was coming into their room was part of the team. When we first got outsourcing, the thing that I had the most difficulty with, was the idea that we weren't allowed to speak to them (the cleaners). (Personal interview, 7)

Ward administrators, who are more involved in day-to-day work practice issues on clinical units, and have had to directly deal with the consequences of the division between cleaning and patient care, are adamant about continuing to have cleaners as part of their patient care teams .Personal interview, 2, 7). One of the requirements for the development of a team environment is having some sort of consistency in the team members. Initially there was no consistency in the cleaners present on the majority of the wards. Each day an unfamiliar person and new face would be present on the ward conducting the cleaning chores, making it harder for staff to develop new personal ties or to welcome new members to their team. One of hospital ward staff expressed her feeling as follows:

> I mean, you've been working with somebody for a long time, and then there is a new face. Or someone knew what to do, and things are now being done differently from the way it used to be done. Of course people are not going to be happy about that. (Personal interview, 7)

Her statement acknowledges the importance of having consistency in team members, not only for the purposes of developing interrelationships, but also to ensure team members know the intricacies of work on the unit. According to one of the ward administrators, if the ValueIN group had consulted the clinical staff prior to transition, it would have been able to develop a better understanding of how things were actually done on the wards (Personal interview, 2). ValueIN and Aramark have gradually responded to these requests and have made attempts to ensure consistency in the workers assigned to each unit. This consistency will help in team formation and ultimately enhance work practice on the clinical units.

Integration of the functionally distinct sub-systems requires that they "respond to each other's behaviour through observation or communication" (Ackoff, 1999a, p. 61). In the context of the 'true employer' legislation and warnings from the ValueIN group, initially all educational material and communication with staff focused on staff not being permitted to direct Aramark employees. One hospital administrative staff clarified that this does not imply that no communication should take place between Aramark employees and VCH workers, just that "they weren't supposed to give Aramark staff direction. They couldn't say that there is a spill there, can you please clean it. But they could say are you aware that there is a spill over there?" (Personal interview, 14). The subtle semantic difference between these two statements, as another staff member pointed out, has led to the myth among hospital employees that they are not supposed to exchange any words with Aramark cleaners. This imposed boundary, whether misinterpreted or miscommunicated, prevents the formation of teams and the smooth performance of work on units. The ability to achieve a common objective is largely dependant on effective interrelations among people (Denison, 1990).

The existence of the call centre is an acknowledgement that a certain level of coordination and integration needs to be achieved between staff and cleaners. However, having the call centre also denotes communication as a mode of transmission of information rather than a process of meaning construction between actual participants. The call centre, in this sense, does not accommodate the development of interrelationships between cleaners and hospital staff, and also acts as an impediment to workers engaging in direct interactions. The call centre acts as an artefact that creates the illusion of integration.

A call centre as a mode for the transmission of information from any of VCH facilities to Aramark for the purposes of service requests is based on the information-theory view of communication, where communication is seen as a means to transmit information (Leveque & Poole, 1999). This model of communication fails to recognize the social component of organizations. Taylor (1993) rejects the information-theory view to communication and views it preferably as "a fusion, not a concatenation; a dance, not a cause followed by an effect... resulting in coordinated involvement relations" (Taylor, 1993, p. 167). While Taylor's metaphor of organizations is a "text" that is created by different authors through conversation, it does invoke notions of systems thinking, where an organization is viewed as a web of interdependent activities and relations (Leveque et al., 1999). Taylor's model of organizational communication assumes that through organizational communication, organizational actors develop webs of mutual obligation and meaning (Leveque et al., 1999). The call centre, thus, while seemingly facilitating the organization of work, prevents the development of webs of mutual obligation and meaning between Aramark cleaners and staff.

For the purposes of work practice, boundaries need to be continuously crossed. Rather than solid structures, these boundaries as Marshall (2003) describes them are more like zones of interaction. With the passage of Bill 94 – the Health Sector Partnerships Agreement Act, in late November 2003, which eliminated the application of the "True Employer" provisions of the labour code within the health sector, the ValueIN group gradually started to communicate a different message to staff. Within a few months staff, were being told, and even encouraged to communicate with cleaners and to consider them as part of the team. Gradually, it was recognized that organizational boundaries are not immutable lines and that they need to be negotiated between workers. "Boundaries are not simply put in place and then left to their own devices; they are actively maintained and reproduced through continuing action and interaction" (Marshall, 2003, p. 61).

The structured boundaries acted as impediments to the integration of workers and of activities required for patient care. However, the requirements of work practice gradually challenged the constructed organizational boundaries and in time have yielded changes that are helping hospital staff in the performance of their daily activities in delivering patient care. One of the hospital administrative management staff noted:

> In the beginning [a] lot of people didn't talk to each other. The true employer concept. And staff were informed about that. But then they realized that it just wasn't going to work that way. And it started to change.... They realized that you can't function on [a] unit without working as a team. (Personal interview, 14)

Tensions between the different paradigms, the mechanistic model of management and the social systems approach of staff on the clinical units, is gradually giving way to the understanding of the requirement for more fluidity in where organizational boundaries are drawn and the need for more interaction between the different components of the system. These struggles could have been avoided had management been more cognizant of the contribution of the gendered work of cleaning to care. According to one of the ward administrators, nine months after the transition of cleaning services to Aramark, the issues are just starting to be addressed (Personal interview, 2).

For example, initially the constructed boundaries required Aramark to provide training to its own staff. While this is still the case, in times of infection outbreaks (such as Norwalk) VCH has opened its education sessions to Aramark staff, for regardless of the employment status of the worker, everyone who works in the hospital has to know the precautions and be responsible for it. As one of the staff involved in Infection Control noted:

45

When we had the outbreak in the summer, whenever we had education sessions for the staff, I invited everyone so there was never a distinction between contract and non-contract. Because the issues affected everyone, so therefore through the patient service coordinator I would inform them that there was going to be an information session on Norwalk and transmission and the use of barriers and I said please include everyone and then they would invite everyone and in several of those education sessions there were Aramark staff. It just seemed silly to have them go offsite or to bring someone in. The turn around time wouldn't be what we want. (Personal interview, 13)

Shifting of organizational boundaries is also reflective of the gradual relationship development between VCH and Aramark. Outsourcing involves complex relationships between buyer and vendor and the development of the interpersonal relationship between the parties is one of the critical elements for the success of an outsourcing contract (Sclar, 2000). With the passage of time a certain level of trust has formed between the parties to the contract. One of the hospital administrative management staff described contracting out as a relationship where "you have to build that trust and the confidence level that so-and-so is going to fix that problem that I brought to them yesterday. There's still the one-off's that don't get fixed. [But] as in any relationship you have to cut each other some slack sometimes....We both want to be successful" (Personal interview, 16). This approach allows more flexibility and fluidity in where the boundaries are drawn. The construction of boundaries becomes about a process of negotiation rather than a one-time event, where everyone and everything is put in a predetermined place, similar to a machine, to perform a specific function.

3.6 Conclusion

It is fully acknowledged that organizational change cannot be a perfect process, without any learning involved. Organizations are not independent of organizational members, as such; they are "the continually changing product of a human process in which social reality is socially constructed" (Checkland, 1999, p. A47). As such, developing better and stronger ties between workers and teams is significantly important in organizational change implementations (Cameron, et al., 2004).

In outsourcing its housekeeping services, VCH has constructed an artificial divide between cleaning and care work and has forfeited its direct responsibility over cleaning services and implemented strategies that minimize direct interaction between hospital staff and Aramark cleaners. The role of VCH in relation to housekeeping services has thus become that of contract management and performance monitoring, to ensure outcomes outlined within the contract between Aramark and VCH are being met.

Taking a mechanistic approach towards the hospital after outsourcing of cleaning services fragments the system of care. Patient care is viewed as the sum of all functions. From a systems perspective, patient care is more than the sum of its parts and functions. Patient care cannot be compartmentalized into direct and indirect services, or core and peripheral. All components of care are highly integrated; as such, a more holistic approach towards care is required. Drawing a clear divide between cleaning work and patient care prevents the development of strong interrelationships between different groups of workers and prevents workers from working together in negotiating the new organizational boundaries.

CHAPTER 4
THE REALITY OF
WORK ON THE WARD

Traditional organizational and management theory assumes that organizational boundaries are stable. Contrarily, the social systems perspective on management highlights the reality of the changing boundaries of organizations. "Boundaries may be drawn purposely by organization management. Walls may be built, certain desired limits for social behaviour may be fostered, and so on, but boundaries also evolve more or less unconsciously through social interaction and shared experiences" (Hernes, 2003, p. 51). Management, which generally places finance above service and value, frequently engages in functional mapping, planning and project management based upon agreed and visible tasks and objectives (Maddock & Morgan, 1998). However, the actual engagement and participation in the work processes almost always involves shifts from the original planned frameworks of management (Maddock et al., 1998).

While the previous chapter focused on management strategies and systems of structure, this chapter takes the discussion to a more detailed level and examines the actual work processes on clinical units and how the work of housekeeping fits into the work preformed by hospital staff on a ward. I will argue that performing caring tasks on a ward requires collaboration between different groups of workers, including cleaners and hospital staff (i.e. nurses, care aides, unit clerks, etc.). Depending on the task, the extent of collaboration varies; however, within a collaborative environment different groups of workers are more responsive to each other's requirements and this results in a smoother workflow, which in turn affects quality of patient care. Consequently, organizational structures should allow workers to negotiate the organizational boundaries, rather than the boundaries being fully imposed by managers.

4.1 A snapshot of a clinical unit

> There is no distinctive smell about the unit. A clear vase with old water sits on the nursing station, various black garbage bags have been placed under the sinks outside the patient rooms, and blue linen bags, some full, some empty are located next to them. There is the sound of big band music coming from one of the patient rooms otherwise the unit is relatively quiet. A few nurses are sitting at the nursing station updating patients' charts. Two of them are talking about their cats. The unit clerk leaves her desk and enters an empty patient room, and

as she leaves, she says out loud to the person (float staff) who is now occupying her chair: "actually, it is not clean." The person picks up the phone and dials a number and requests for cleaning services for that room, room XYZ. While she is on the phone, another person is on the phone next to her, providing an update on the status of a patient.

A cleaner is mopping outside one of the rooms and places a yellow wet sign on the area before she pushes the cleaning cart down the hallway. A nurse checks in with the unit clerk about the status of the room and the unit clerk updates her that a call has just been placed. Their conversation is interrupted by a hospital staff, who is pushing a cart with various bags on it. He asks the unit clerk where to put the belongings of a patient that is going to be transferred from emergency. The unit clerk provides the necessary information and goes to fax an order. The nurse call system goes off and a beeping sound starts with a voice over announcing a code blue in one of the units. Meanwhile, a patient speed walks by, pushing his IV pole in front of him, trying to get his daily exercise.

A nurse (responsible for scheduling) walking into the unit stops and listens to the nurse call message and once she realizes the code blue is not on this unit, she continues along her way. She is approached by the unit clerk from the other pod, and they step into an empty room to discuss the unit clerk's scheduled vacation days. Someone from pharmacy comes to the unit to replenish the stock in the automatic drug dispensing system.

A nurse leaves a patient's room and goes to the sink outside another room to wash her hands. The nurse call goes off again, this time the beeping sound indicates a bed exit. Two nurses, working on their charts, leave the nursing station towards the room that has triggered the nurse call system. The lady from food services enters the unit, pushing the trolley that carries the food trays, and stopping at each room to deliver the food trays to the patients. The patient, who is exercising around the unit, zooms by again, his IV pole rattling in front of him. He passes by two people in the middle of the hallway who are exchanging information about a patient. Once they have reached an agreement they walk up to one of the nurses and provide her with an update. Another staff member and a patient, who is barefoot, walk by.

Two visitors arrive for an MRSA (Methicillin-Resistant Staphylococus Aureus) patient. They wash their hands at the sink outside patient's room and from a bag hanging off a small table outside the patient's room they grab two gowns. A nurse approaches them and tells them that the gowns in that bag are dirty and that they should take clean gowns from another bag. They wear clean gowns and gloves and go inside the patient room.

The paramedics show up with an empty stretcher. One of the guys walks over to the linen cart and grabs the required sheets and occupies himself with making the bed, while the other guy goes up to the unit clerk to inquire about a patient. The cleaner walks down the corridor, pushing the cleaning cart in front of her and stops at the phone mounted on a wall in front of the nursing station and as she pushes some buttons on her pager, she picks up the receiver and starts punching in numbers on the phone. There is no dialogue. After hanging up, she

pushes the cleaning trolley in front of room XYZ, that had been called in by the unit clerk to be cleaned, approximately 20 minutes ago.[17]

Individuals and teams from a variety of areas come together at different times, locations and durations to help in the process of patient care. "Health care necessarily involves a team that includes those who do surgery and those who make sure the surgery is clean; those who determine whether patients eat and those that help them eat; those who determine what records should be kept and those who keep them" (Armstrong et al., in press, p. 4). Someone from escort services enters the unit at the exact time a patient has to be taken for blood tests. The mobile radiology group comes to the unit with the required technology and equipment at regular intervals during the day to x-ray an MRSA patient. Linen carts are generally stocked with linen and towels, despite the high usage rate, because someone is responsible for exchanging the carts at certain times during the day. Food trays are delivered to the unit at certain times, and generally patients receive the food diet they require (i.e. diabetic trays).

It can be said that the clinical unit is a complex social system and as in any social system, coordination of activities is one of its necessary properties. From a performance objective perspective, a system would be considered coordinated if the components making up the system worked harmoniously together and there was appropriate linking and sequencing between the elements within the system (Alter et al., 1993). Coordination is also used interchangeably with cooperation and collaboration. Cooperation is the extent of collaboration between the system elements. Alter et al. (1993) extend the definition of coordination to include the "quality of the relationship between human actors in a system consisting of mutual understanding, shared goals and values, and an ability to work together on a common task" (p. 86).

The functioning of a unit is dependent upon two different types of actors: the permanent and the transient actors. It could be said that the permanent actors main work site is the clinical unit, while the transient actors flow in and out of the unit as required. For example the nurses, care aides, and unit clerks are the most common core actors on each unit. While the same person does not occupy each position at all times, it could be assumed that for the most part of the day someone is on the unit who occupies that actor role. Hence, the role is a permanent one on the unit. On the other hand, the transient actors, such as physicians, escort services, food services, or pharmacy personnel flow in and out of the unit as required. One of the other permanent actors on the unit during the day is the cleaner.

---

[17] Extract from observations conducted on October 25, 2004.

Permanent actors on a unit are frequently relying on each other for help and they view their work as strongly interconnected with other hospital staff working on the unit, even with the transient members. For example, early one afternoon a transient worker appeared on the unit with a cart containing boxes of cards and a computer, and worked with the unit clerk to confirm the patients who had requested television services in their rooms. During her short stay on the unit, she was warmly greeted by various hospital staff who were working on the ward, and was asked why she was on the unit earlier than usual that day and why she had not been there the day before. Contrary to this tight interaction and communication, while cleaners are one of the permanent actors on a clinical unit, they are not necessarily integrated into the social fabric of the unit, but are rather treated as additions to the system. In the observation extract above, I have pointed out to the absence of communication between hospital staff and Aramark cleaners. While three hospital staff were following through on the status of a room that required cleaning, not one of them attempted direct communication with the cleaner who was present in the vicinity (earshot distance), nor did the cleaner approach the staff to inquire about their request.

4.2 How does housekeeping fit in

Tasks performed by cleaners on a ward range from mopping the hallways to wiping patient mattresses and cleaning the non-clinical parts of clinical equipment. The Request for Proposal (RFP) that was prepared by VCH has categorized these tasks into five distinct areas:[18] building (includes wall, windows, ceilings, ducts, etc.), fixtures (includes furnishing, drapes, desks, shower stalls, etc.), patient equipment (has not been specified), patient room (includes bed, mattress, chair, bedside table, etc.) and environment (includes general tidiness and odour control). The RFP also provides the square footage of each facility, and breaks it down into different functional areas; each area is then rated for the required cleaning frequency. Contractors use this information to estimate the required staffing, which they would ideally like to keep at the lowest level possible, as staffing is the highest operating cost to companies specializing in housekeeping. One of the methods used for determining staffing requirements is the "Zero-based" model, which estimates staffing needs based on the square footage of all cleanable areas, and the type of covering and type of room, in order to ensure the lowest number of staff is employed (Death, 2003). Such a model requires justification for the inclusion of each labour position within the work organization (Frings, 2005). This model prefers to shy away from assigning dedicated cleaners to a unit, as this is not considered the most cost effective way of organizing work, since labour utilization might be below one hundred percent. Team cleaning is another common model

---

[18] As VCH did not provide me access to the business contract that was signed between Aramark and VCH, I have relied on data from the RFP that was prepared by VCH and Providence Health Care.

that employs teams of three or more people to perform a specific task, such as waste pick up. The individual cleaner is viewed as a specialist in that task and as a result, is expected to perform the work faster and better (Meyers, 2003).

Aramark initially used a combination of Zero-based staffing models and team cleaning. Such rationalized models of work organization are used in organizing and planning those aspects of cleaning work that are visible. The work can be categorized into two main groups: routine and non-routine activities. Routine activities form the fixed component of cleaners' work schedules, which they are responsible to perform on a regular basis.[19] Non-routine activities are the variable parts of cleaners' work schedules, which are assigned to them through the call centre on an as needed basis.

4.2.1 Routine activities

Routine housekeeping tasks that have to be performed on the ward include: refilling all the soap and microsan dispensers, glove boxes, paper towels, and toilet paper; emptying the garbage, the dirty linen bags and the sharps containers; cleaning non-clinical equipment such as IV poles and commodes; cleaning sinks, hallways, patient and staff washrooms and showers; and finally, cleaning patient rooms. These routine tasks have been clearly specified and standardized, and are part of cleaners' regular work schedule.

Standardization of routine work has it own advantages, especially in complex work situations. It allows the worker to rely on the taken for granted routines for dealing with repeat tasks, thereby, providing her/him more space to mentally engage in the more complex tasks. However, as Suchman (1987) notes, the assumption of an unproblematic sequence of events does not take into account local, unique and unexpected situations. Representations of work that steer towards rationalization and formalization assume stable and consistent clinical units. Realities of the ward, however, cannot be condensed into black boxes of routines. As the conditions of patients residing in a clinical unit become more complex, the complexity of the system increases. According to Hage (1980), as systems become more complex, there is more need for coordination and task integration.

For example, in a clinical unit with many MRSA patients there is a higher usage rate of gowns and gloves, as workers are required to take precautionary measures when entering an MRSA room. This results in dirty linen bags for such rooms becoming full more frequently and thus,

---

[19] This also includes seasonal tasks, such as floor refinishing or washing windows.

requiring more frequent emptying from that specified in standardized work plans. This also applies to garbage bags and sharps containers. The rate at which the sharps containers and garbage bags are filled, is dependant on the acuity and the requirements of patients in that section of the ward. The sinks and sharps buckets that are located closer to patient rooms that require increased care are used more often and as a result, the cleaning requirements for those artefacts is greater. As new patients enter the ward and other patients leave, the usage rates of the artefacts in different areas of the ward changes accordingly. Sinks that are used more frequently require more regular replenishment of supplies, such as soap. Following Infection Control practices, clinical staff and everyone who enters a ward is required to wash their hands. However, many hospital staff complained that often times when they go to a sink to wash their hands, the soap dispensers are empty. One of the ward staff said:

> I've been joking that you need to go to three sinks around here to get your hands washed! At one sink you get soap, at another you get paper towel, etc., and in between you just drip, drip, drip, on the floor. And it stays like that for a few days. (Personal interview, 5)

To respond to the variations in local requirements of some of the clinical units, Aramark has applied other standardized practices. One of the hospital administrative management staff says:

> Aramark does have a schedule for a third garbage pick up in some of those critical care areas, however, if there is an abundance of stuff going on and that can happen with different traumas and different types of stuff, they can call the centre and say I need a garbage pick up or I need a linen pick up. (Personal interview, 16)

The additional scheduled third garbage pick up might address the problem of excess garbage produced on some of units. However, it is still based on the assumption of standard work practices on clinical units and an estimate of the standard amount of garbage produced by all units on a daily basis. This formalized solution falls short of understanding that the intricacies of local practices requires the coordination of tasks, and the cooperation between different groups of workers.

The alternative solution for addressing unique local requirements, which is to contact the call centre for service requests, also fails to recognize the local demands on a ward and hospital staff's workload. Hospital ward staff are finding that they spend significant amount of time on the phone with the call centre to request simple services, such as the refilling of a soap dispenser or the emptying of a sharps container. They also have to repeatedly call in their requests, or place follow up calls to request the completion of unfinished tasks. According to observations

conducted on the clinical units, on November 13, at 15:30 a request was made for the sharps containers on the unit to be emptied. On November 14, at 8:00 am, a follow up call had to be placed, as the containers had not yet been emptied. At 10:00 am on the same day, the service request had still not been attended to and another contact with the call centre was established. Full sharps containers are hazardous, involving blood exposures and needle stick injuries. As per one of the hospital staff, two hazard reports had to be placed for the month of November regarding overflowing sharps containers.

There is also no answering service connected to the call centre, consequently, staff find that they are often put on hold. On a clinical unit, where staff has to juggle many different responsibilities, as one of the head staff on the unit pointed out "the attitude of the nursing staff is that if I can't get it done in time, I'll just do it myself because it will take less time" (Personal interview, 8). One of the hospital ward staff noted:

> My workload has definitely gone up. There aren't enough cleaners. They are short-staffed. It's not their fault. They are not to be blamed. There is tons of garbage and it's not picked up. So we have to call supervisor. And then I have to stomp garbage down with my foot, to make room for more. (Personal interview, 9)

Requirements for additional cooperation between different groups of workers than that which is planned for through the structured boundaries, is also evident when examining the cleaning of non-clinical equipment. An "I'll do it myself" attitude of hospital staff is also reflected in the cleaning of this type of equipment. Cleaning non-clinical equipment has always been a grey area. The reason behind it is that housekeeping staff are worried about damaging expensive equipment, and the boundaries between clinical and non-clinical components of a piece of equipment are not always very clear. For example, in the case of IV poles, Aramark workers are responsible for cleaning the actual poles, while clinical staff on the ward are responsible for the cleaning of the IV bags and lines. However, during observations it became apparent that sometimes when nurses were not able to find a clean IV pole available on the unit, they would resort to cleaning a dirty pole themselves. On the other hand, it was also noted that cleaners frequently removed the IV bags and lines from the poles when cleaning patient rooms after discharge. Consequences of this form of non-communicative coordination of work might not be significant in the case of IV poles; but it could become problematic when dealing with more complex equipment. As one of the clinical staff on the ward noted:

> If you're trying to clean around it [a piece of equipment], you need to be like-saying to the nurse: "There's a spill here. I need to clean the floor, and that this

man has a piece of equipment that I don't know what do with, can you help me?" "Yeah, sure." But they don't talk to us as much, so they just kind of work around it, and it just impacts the cleanliness of your environment. How are you going to clean around that chest tube on the floor if you don't at least understand that that's something that you shouldn't touch - if it's in the wrong place, or you're not sure what to do with it, you should come and ask. (Personal interview, 7)

Lack of communication between the different groups of workers, though, cannot be blamed on Aramark workers. It is assumed that routine tasks can be performed by cleaners with almost no interaction with other hospital staff on the unit. Cleaners are told to follow through their routine work schedules and to respond to service requests (non-routine activities) that are communicated to them through their pagers. Streamlining and standardizing work processes serves well for meeting the minimum cleaning requirements of the ward, and for this purpose coordination can be achieved through work plans set at the program level, such as through the call centre. However, to be more responsive to the local intricacies of a clinical unit, coordination has to be achieved by feedback, and this involves the transmission of information between the different groups of workers (Hage, 1974).

The call centre might facilitate coordination in the sense of linking and sequencing work tasks, but it prevents coordination as a means to improve the quality of relationships between the different groups of workers on the ward to achieve the common task of patient care. For that purpose, workers have to actively engage in the process of boundary negotiation and coordination has to be achieved by workers, directly engaging in social interaction and the creation of shared experiences.

4.2.2 Non-routine activities

Tasks, such as cleaning a patient room after a discharge, cleaning required during outbreaks, or cleaning as a result of an unexpected incident, such as a spill or patient vomit, would be considered non-routine work. Complexity of the non-routine activities determines the amount of collaboration that is required for performing the work. When tasks are complex there is lots of uncertainty surrounding them, and they cannot be controlled with simple rules and procedures. Cooperation in this sense will be an adjusted learning experience, where participants engage in the process of information feedback, and define, redefine and improve work processes (Alter et al., 1993). For example, in one incident where a nurse was dealing with a difficult patient who had just thrown up and had spit on another nurse, it was observed how the nurse, in order to attain the trust of the patient had to gradually introduce the cleaner to the patient so the cleaner

could perform the necessary tasks. To maintain the patient's steady state, the nurse continued to provide detailed explanations to the patient about the activities of the cleaner. In turn, the cleaner, adjusted her activities to the detailed explanations the nurse was providing to the patient.

With the increase in the complexity of situations, and the requirement for high quality and customized work activity, the amount of information feedback that is required for the system to attain its objectives increases, and yet attaining the required information also becomes more difficult (Alter et al., 1993). The more unique the situation, the more integration is required between workers and tasks. For example, in the case of outbreaks, such as SARS or Norwalk, significantly higher coordination levels are needed between Aramark cleaners and hospital staff. In these situations the VCH Infection Control group becomes more involved in the process and contacts Aramark supervisors to provide them details about the outbreak, educational training and the response time required. As per the Infection Control group, based on the experience they have had with Aramark thus far, in regards to outbreaks the response time and compliance has been excellent.[20]

Attempts at attaining a certain degree of control over non-routine activities are made by management of Aramark by compiling data collected by the call centre. For example, information about the number of discharges or patient transfers per unit, per day, or per month, helps develop estimates that aid in work scheduling and staffing of cleaners on each unit. Estimates that are based on the number of beds per unit alone fail to take into account the patient turnover and the number of transfers between clinical units. The higher these numbers, the more cleaning is required on the ward. However, these figures alone are also not sufficient input for work scheduling and staffing, as sometimes despite low turnover rates, the complexity of patients' circumstances could result in higher demands on required cleaning services. For example, rooms with MRSA patients require higher intensity of cleaning and disinfecting.[21]

One of the problems with data collected through the call centre, especially during the early days of outsourcing, was that staff did not necessarily report all problem issues. The reluctance was due to different reasons that could be grouped into three categories: lag time, fear of consequences and, absence of a closed communication loop. Firstly, the attitude of nursing staff

---

[20] As there were no outbreaks during the course of this study at the VGH site, this research will not examine coordination between Aramark and VCH at the time of outbreaks.
[21] As I was not able to obtain Aramark's input for this study, details about how Aramark estimates its staffing requirements is not available.

is to perform a task themselves, or to find work-arounds[22] when it is not done at the time it is needed. Therefore, on many occasions, instead of going through the process of requesting a service through the call centre, nurses just did the required cleaning themselves. On a few different occasions I noticed nurses engaged in cleaning work. Once, a nurse required a clean IV pole and since none was available on the unit, she chose to clean one of the dirty IV poles that was located in the soiled utility room. In another instance, I witnessed a nurse cleaning the surface of the nursing station and replacing the empty paper towel dispenser. Secondly, hospital staff are concerned that by logging issues through the call centre they would get cleaners in trouble with their supervisors. Thirdly, an ongoing issue with the call centre has been the absence of a closed communication loop. For example, staff is not aware when a room has been cleaned and is ready for a new patient. There have been occasions where the assumption has been made that a room has been cleaned and patients have ended up waiting on a stretcher in the hallway. The absence of a closed communication loop also means that at times a service request is closed without it having been completed. One of the hospital administrative management staff provided the following example:

> a lot of times a report is filed for [a discharge clean] with the call centre before the patient has left the room. So when the housekeeper goes to the room to have it cleaned, the patient is still in there and they can't do anything about it. So they go back to the call centre and cancel the log. So the room doesn't get cleaned. (Personal interview, 16)

Difficulty in estimating the amount of non-routine activity for each unit frequently results in low levels of staffing and significantly high workloads for cleaners. Occasionally, at times when work demands are very high, relief staff are provided to help with the workload. However, the comments made by the majority of hospital staff, both ward and administrative ward staff who were interviewed, is a clear indication that cleaners are overworked and the cleaning staff on the unit are not sufficient to meet the requirements of the wards. One hospital ward staff expressed her concerns for the cleaner who generally works on her pod: "The guy regularly here, works really hard, he is going to pass out" (Personal interview, 1). On another occasion, one of the hospital ward staff tells me: "They are so busy. I feel sorry for them. They work so hard" (Personal interview, 9).

---

[22] When the processes designed to perform a certain activity are counterproductive, actors rely on alternative means for accomplishing the work. This type of invisible work is referred to as work arounds. Work arounds are efforts employed by actors to bridge the gap between the differences in the logics of technology (which includes work processes) and the logics of human work (Berg, 1998).

Hospital staff also expressed their concerns regarding the consequences of low staffing levels and high workloads of cleaners. One of the ward administrator staff members says: "They race from bed to bed, to get the rooms ready. The general cleanliness has gone down. The workers are really stretched" (Personal interview, 8). This and other similar comments were verified by observations on site. As workloads increase, in order to complete all required assigned tasks, the standards of cleanliness could potentially be compromised. For example, the average time it should take for a patient room to be cleaned, according to one of the ward administrators and also by one of the administrative management staff is estimated to be 20 minutes (Personal interview, 15, 8). There were quite a few occasions where it was observed that this work was performed in less than 10 minutes.

Considering that prior to admitting a patient to a clinical unit the patient room and bed have to be cleaned, cleaners' heavy workload could also result in higher waiting times for patients to be admitted to a room on the ward. One of the hospital ward staff recalls her experience from the early days after the transfer of cleaning services to Aramark:

> Even though the turn around time has gotten better it's our biggest problem. In the beginning Emerg would be screaming for beds and we would be waiting hours to get a bed clean and that has gotten better. But we still get as many and I'm not going to say more, because i don't know for sure, but certainly as many complaints from patients as we ever did before. (Personal interview, 7)

Another hospital ward administrator says: "beds weren't ready when the patient came and there were times that patients had to wait in the hall because there was miscommunication about beds" (Personal interview, 2).

These issues are best illustrated in the following observation, conducted on November 14, 2005.

> Prior to noon, a tall man walks in the ward and approaches the unit clerk, asking her about the whereabouts of his wife. The unit clerk places a phone call and obtains additional information on the patient and then asks the husband to wait in the waiting room. The patient is currently on another unit and will be transferred to this unit soon. An hour later, the husband returns to the ward and again inquires about his wife. The unit clerk places another phone call and tells the husband to go to another clinical unit and that once a room is ready on the unit, his wife will be transferred. At 14:30, there is a discussion between the unit clerk, and two nurses about the cleaning status of one of the rooms. The unit clerk informs the nurses that she has already placed a "stats" call, which means that the cleaning request is a high priority clean that has to be done immediately. One of the nurses says that the room has already been cleaned. The other nurse explains that she knows it hasn't been cleaned because prior to leaving for a break she had deliberately left the bedside table in a certain

location and that it hadn't been moved, nor had the bedpans from the last patient. The unit clerk places another call to the call centre and asks for the room to be cleaned. While this conversation is occurring, a cleaner walks by, leaving the unit. Half an hour later, one of the two nurses calls the call centre and informs them of the Stat request, telling them that the patient cannot be admitted until the room is cleaned. Nurse says: "we are ready and if we can't admit it's because you are not ready." She then asks when they can expect to have it cleaned. Holding the receiver to the side, she says out loud, "they just hung up on me." She redials the number and updates the person who has answered the call about the service request and incident, and asks to speak with a supervisor. She provides the unit's phone number and informs others that the supervisor will call them back. At the exact time a cleaner walks into the unit and goes inside the room that requires cleaning. The cleaner places a call with the call centre to log the start time of the task. No conversation takes place between the cleaner and the hospital staff. She gets busy cleaning the room. Five minutes later, a hospital staff member shows up pushing a woman on a wheelchair, while her husband walks along side them. Once they are in the room the cleaner leaves. She seems distressed, and keeps touching her pager. Meanwhile, the nurse removes a dirty walker from the room and goes to grab a clean IV pole. The nurse leaves the room and lets the unit clerk know that the washroom had not been cleaned and that there were still dirty bedpans in the bathroom from the previous patient. The unit clerk places another call with the call centre. This time when the cleaner shows up, the unit clerk asks her whether her shift was over or she was still working. Cleaner says that she was working for another half an hour. The cleaner then goes into the patient room and starts cleaning the washroom. Nurse leaves patient room and tells unit clerk that the patient had to go all the way around the other side of the unit to use the main washroom as she felt the washroom in the patient room was too dirty for her to use. The patient returns with her husband accompanying her, as she pushes her IV pole along with her.

This observation illustrates the inefficiency that ensues in work practice due to the absence of coordination and collaboration between hospital staff and Aramark cleaners. In total, five phone calls were placed with the call centre and three hospital staff were involved in having the patient room cleaned. However, the involvement and integration of workers ends at the point where hospital staff and cleaners come together. Other than the exchange of a few words between the cleaner and the unit clerk, there is an absence of direct communication and information sharing between the different groups of workers, which prevents workers from coordinating their activities with each other. The call centre, as the boundary object[23] that is used to sequence and link the activities of the workers, prevents workers from directly engaging with each other and in working harmoniously together. Furthermore, it acts as an obstacle for the different groups of

---

[23] According to Star (1989), boundary objects are artefacts that can be adapted to the local needs and constraints of several actors, while at the same time maintaining a common identity. They are used to communicate and coordinate the perspectives and objectives of various constituencies, and one of the main purposes they serve is supporting the interaction between different communities of practice (Arias & Fischer, 2000).

workers to develop a mutual understanding of the problem and be able to work cooperatively on the shared goal of patient care.

4.3 Working around structured boundaries: The process of boundary negotiation

Coordination is a process, not an outcome and has to be achieved at different levels within the organizational hierarchy (Alter et al., 1993). This chapter is about coordination at the operational level, while the previous chapter focused more on administrative coordination. According to research conducted by Van de Ven, Delbecq and Koenig (1976), at the operational level there is more reliance on informal means for coordinating activities. With outsourcing, the working arrangements and relations between different units and groups are new, which "alters how individuals and groups relate to each other in the organization" (Paulsen, 2003, p. 14). As a result, the informal collaborative networks have to be rebuilt and redeveloped. Outsourcing leads to disruption in the social structures of an organization. With this disruption, "the personal favours and informal processes that allow things to happen quickly in exceptional circumstances will disappear through the loss of personnel and changes in the structure of an organization" (Tourish & Hargie, 2004, p. 24). The administrative levels of control and the structured organizational boundaries in this case can either facilitate or hinder the development of these networks. What is important for management to recognize is that changes are not just about the reorganization of work, but also that change requires employees to negotiate new ways of working with each other (Paulsen, 2003).

Management generally engages in the planning of work processes, which, according to Suchman (1987) is the process of abstracting situated actions away from the circumstances and representing them as standards. However, there should also be the recognition that rationalized models of work frequently do not include invisible work. This is work that remains unseen and unrecognised. Rationalized models of work, which are based on a clear divide between cleaning and care, overlook the invisible web of interactions between these tasks. Consequently, the structured organizational boundaries that are created undermine the extent of coordination required between human actors within the system and restrict workers in negotiating new boundaries and work arrangements.

As an example, in the repeat case of overflowing sharps containers, rather than strengthening the interrelationship between different groups of workers, the solution to the problem of the containers not being emptied on a regular basis has been to have head nurses and Patient

Services Managers of the clinical units monitor the containers. PSM's are also responsible for ensuring hospital staff are aware that the content of the containers is not to exceed the two third mark. One of the administrative staff involved in reaching a resolution to this problem suggests that while Aramark staff are ultimately responsible for emptying the containers, hospital staff can help in monitoring their work (Personal interview, 13). On the other hand, one of the ward staff assigned with this new responsibility says that she has other things to do and does not want to be the person responsible for monitoring the work of Aramark staff (Personal interview, 8).

An alternative solution to this problem, rather than focusing on the monitoring of work and creating additional work for management, could have been facilitating the integration of the different groups of workers and allowing them to coordinate their activities. It is the interaction between the parts within a system, and not the actions of the individual components taken separately that make up the essential properties of a system (Ackoff, 1999a). It could be argued that if cleaners become more integrated into the practices of the ward, they would also become more responsive to the local requirements of the ward, ensuring that their work of cleaning is contributing to the unit's common goal of patient care. Situational demands of the unit, would thereby determine the level of task and worker integration that is required. As Suchman (1987) notes: "Every instance of coherent interaction is an essentially local production, accomplished collaboratively in real time" (p. 94). Interactions are not necessarily enactments of a predetermined plan, but rather dependant on social circumstances.

Coordination and integration of workers and tasks allows for the work activities and the efforts of each individual to be directed toward the objectives of the overall system (Alter el at., 1993). According to Smith (1987), when the "subject is located at the beginning of her acts – work and other practical activities; through these she joins with others, known and unknown, in bringing into being a world that they have, but do not necessarily know, in common" (Smith, 1987, p. 141). Therefore, alongside the formal structured boundaries of an organization that are planned based on visible tasks conducted on the units, it is important to recognize the informal negotiated organizational boundaries, the invisible work that connects care and cleaning, where workers coordinate their work activities.

While VCH management has not actively been supportive of work arrangements that contribute to the integration of hospital staff and cleaners, workers are gradually adopting strategies to circumvent the created artificial divide. As one nurse pointed out: "More direct communication would be helpful. It is frustrating that every time we have to go through the call centre, even if a

cleaner is right there. Of course we bend the rules, and sometimes just ask them" (Personal interview, 8). According to one of the hospital ward administrative staff:

> To me, everybody has direct patient care. I wouldn't be able to draw that line, because I don't differentiate, I don't think we should differentiate. It's ridiculous to say that you're not going to talk with the people that are on your ward everyday. And if you want them to be working with you and happily doing so, you're going to be pleasant and say hello. If there's something that's sitting right in front of you, that's just a quick fix, or something, you're not going to make a phone call to some contact centre miles away and then have them beep. I mean that's just totally stupid. (Personal interview, 7)

Out of the two pods on which this research was conducted, hospital staff on one of the pods, which has had a consistent and regular cleaner, expressed more satisfaction with the cleaning standards of their area. Hospital staff working on the unit knew the cleaner by his first name, knew his story of how he was a practicing nurse in his home country before immigrating to Canada, and engaged in more direct communication with him. "His background makes a difference in the work he does. He knows what to do, he knows about contaminated rooms and how to go inside them" (Personal interview, 9). Cleanliness of the pod was visibly better when he was working on the unit and it was also better in comparison to the other pod. Staff working on the other pod, who were still experiencing inconsistency in the cleaners working in their area, generally commented about how they would like to have a cleaner who was more integrated with the clinical team on the ward. One of the hospital staff on this pod, in response to what she thought should be done differently on the pod in order to improve the level of cleanliness and smoothen the workflow, said that she would like to see the cleaners getting more used to the routines of the unit, "so that it becomes their ward not 'a' ward" (Personal interview, 12).

As noted in a study conducted by Denis et al. (1999) about the dilemmas associated with boundary redefinition and integration at different levels within the healthcare system "the new ideology of healthcare delivery is associated with structural changes that demand greater collaboration and integration across organizational boundaries at all levels" (p. 107). This should also apply to the integration of cleaners and clinical staff. One of the hospital ward administrators suggested that:

> ...when someone is hired for the unit, there should be more connection with the people on the unit. When I hire a nurse, they go through an interview, now I wouldn't expect that for a cleaner, but I would expect an introduction. You know, this is so and so, and orient them to the unit via the supervisor or whatever. Here I'd like you to meet [the head nurse], and spend a few minutes with her. And maybe even follow her for an hour, just to see kind of what the

ward is about and what our concerns are. And this is [the unit manager], she's going to tell you a little bit about the history of the ward and what kinds of things we expect. And we're also going to tell you about where the staff room is, we have potlucks, you know. We do things and you're more than welcome to join us. If you have concerns, here's the avenue to take them and we'd be happy to help, you know, whatever. I mean obviously they have their own supervisory system, but ... if there's a patient problem [who to go to]. (Personal interview, 7)

Cleaners have their own supervisory system through Aramark, but their worksite is VGH and as much as they are Aramark employees, they are also permanent workers on the VGH clinical units, and as such should be treated as part of the team. In recognition of the contribution cleaners make to care work, the same staff member also noted:

We can't do what we do without the cleaners. I can't. Part of delivering patient care is ensuring that they have a clean environment. You know, and when i worked primary care, in someone's home, washing the floor was part of my job because it was my patient's environment. And I was to clean it. So, whether I'm attending to their pain or washing the floor it made no difference. I don't really see how it's different with them either. If I don't have a cleaner to make sure the environment is clean, there's no point in us being here. (Personal interview, 7)

4.4 Conclusion

In the process of contract negotiation, visible tasks have been organized and planned, however the invisible task of integrating workers and the informal processes required for coordinating work activities on clinical units, remains unrecognised. The call centre acts as a boundary object to provide the level of integration that has been assumed to be required, but it also prevents workers from directly engaging in communication and interaction, thereby, not allowing the informal networks of relationship to be formed. According to Anselm Strauss: "for this purpose the unstudied has to be studied, those areas of work that happen behind the scenes (Starr, 1991). Rationalized models of work organization fail to take the invisible work of coordination into account. Cleaners' work happens within a care setting, and as such should be performed within the overall objective of patient care. Outsourcing practices decontextualize cleaning from care, and care becomes an ends in itself, where collaboration and coordination between workers is minimized. In conducting both routine and non-routine housekeeping activities on clinical units, the integration of cleaners with care workers and the work practices of the ward, would provide for smoother workflows on clinical units.

CHAPTER 5
MARGINALIZATION OF CLEANERS
AND ITS EFFECT ON PATIENT CARE

The crux of outsourcing is the segmentation of functions performed in the hospital and as a result the workforce, into core and periphery components. This division leads to the polarization of the workforce and the creation of organizational insiders and outsiders (Kalleberg, 2003). Perceptions of the work performed by outsiders affects the ways in which organizational boundaries are constructed. Within a medical model of healthcare, where cure is placed at the top of the organizational hierarchy, cleaning is viewed as a low status job at the very bottom of this hierarchy (Messing, 1998). Organizational boundaries constructed after the outsourcing of cleaning services are built on this hierarchical model.

In this chapter, I argue that the structural organizational boundaries created as a result of outsourcing and the professional boundaries between hospital staff and cleaners could lead to the further marginalization of cleaners. These boundaries communicate the separation between cleaning-work and care-work, which is reflective of the underlying societal beliefs that devalue cleaning work; consequently, cleaners are not able to recognize the importance of the work they perform in the context of care. Marginalization of cleaners has implications for the emergent properties of the hospital as a system and could affect patient care and safety.

5.1 Structured boundaries and the othering of cleaners

Cleaning is seen as an activity related to disease prevention, which is not directly related to patient care, the core mission of hospitals (Messing, 1998). As such, cleaning work is treated as a component of the organizational machine that can be replaced by another part. The low value attributed to cleaning work also extends to workers performing cleaning tasks. These workers are viewed as replaceable machine parts, without necessarily any unique qualities and attributes that they bring to their work. This is reflected in management practices of Aramark that initially failed to have a dedicated cleaner on each ward. It was not recognized that each cleaner would bring his/her own set of skills and interests to the job and as result it would be important to find a cleaner who was the most suitable for each ward. Failing to provide dedicated cleaners on each

ward affects cleaners' ability to develop a sense of ownership and belonging towards a specific ward and to establish relationships with the hospital staff working on that ward. As a result, housekeeping, while a permanent role on a ward, continues to be seen as an organizational outsider. Gradually, though, as a result of the pressures faced by managers of clinical units, Aramark is changing its strategy and is starting to introduce dedicated cleaners for each unit. One of the hospital administrative management staff describes this issue as follows:

> One of the things you have to do is make sure that the employee is the right fit for the area. Not everybody is suited to work in a long-term care facility, nor are they suited to work in the O.R. So they did do some moving staff around as appropriate, and making sure that there was the right fit for people. (Personal interview, 13)

When a dedicated worker is assigned to a ward, the worker feels a sense of pride in his/her work. In a study conducted by Messing (1998), she points out how cleaning staff feel that their pride for their work is challenged when assigned to different departments. According to the one of the hospital staff members:

> I think the concept of a dedicated worker is extremely important because number one, the worker, appear to be happy working in those speciality areas and also there is an expectation that there is a very high level of performance on their part, because they are working in such really serious situations and areas. And if they aren't working properly the implications could be quite serious. (Personal interview, 13)

However, having a dedicated cleaner on each unit cannot be equated with inclusion. The artificial divide that is created between cleaning and care reinforces the insider/outsider polarization. Communicating the clear message of a separation between cleaning work and care work in a hospital setting undermines the specific skills that are required for cleaning work within a healthcare setting, and thereby trivializes the skills and contribution of cleaners to the working of a ward. Practices employed by management, both Aramark and VCH, reinforce the marginalization of cleaners. For example, the practice of all communication between cleaners and hospital staff having to go through the call centre, as one hospital staff pointed out, is degrading. To exemplify this point, she draws a parallel between having to go through the call centre and how she assumes cleaners must feel, with her own experience when a physician bypassed direct communication with her and how she felt:

> We were told not so much not to speak to them but we were told that we could not give them any direction of any kind. That we would have to phone and I'm like, that's just stupid. Like, how do you develop a relationship - if i have to

phone someone. There was a doctor one time we had a conference room over on west 8th. He went in one morning, we were having rounds and he was there early and the place was a mess. There was coffee cups and stuff he walked out into the hallway, literally 10 feet from the nursing station, to a hallway phone, phoned his office to phone the nursing station, to tell them that the conference room was a mess. He was an asshole [laughter]. And that's how i would feel. I would feel like I was being looked at like that guy. (Personal interview, 7)

Circumvention of direct communication between different groups of workers could be construed as their invisibility to each other. There is a hierarchical component to this invisibility, where those who are at a relatively higher position in the organizational hierarchy are more visible to those subordinate to them. In the incident above, the physician is more visible to the nurses than are the nurses to the physician. Cleaners, due to the outsider position that they have had to assume as a result of outsourcing, are one of the most invisible groups of workers in the hospital. This invisibility is, to a certain extent, spelled out as a requirement for cleaners within the Request for Proposal that was prepared by VCH: "All cleaning operations are to be conducted in a manner that facilitates minimal inconvenience to staff, patients, and the general public" (Vancouver Coastal Health Authority & Providence Health Care, 2002). Messing's (1998) study also finds that the invisibility of cleaners is reinforced by the way in which they must organize their work, in order for it not to interfere with the work of other personnel. According to a cleaning supervisor in Messing's (1998) study, invisibility is a desirable characteristic for a cleaner.

Cleaning, as a function also becomes invisible. The routine nature of this function renders it as invisible as it becomes part of the background (Star et al., 1999). According to Messing (1998) cleaners deal with this invisibility in three different ways: by making the work visible (i.e. leaving lights on in the bathroom when they have finished cleaning), emphasizing their competence (i.e. focusing on the appearance of their work by using a variety of different techniques to make surfaces shine), and exacting respect (i.e. dressing up and wearing heals at work). At VGH, the wet signs often left behind throughout the corridor could be interpreted as a method used by cleaners for making their work visible. Within a ward with high turnover or patients with severe conditions, it is much harder for cleaners to make visible the work they perform. Dirty linen baskets for MRSA patients at times fill up so rapidly that within only a few minutes after a cleaner has emptied the basket it is refilled, rendering fully invisible the task performed by the worker.

Star and Strauss (1999) argue that work in and of itself is not invisible. A range of indicators underscore the work that has been performed, whether that is strained muscles, or the changed state of affairs. However, despite these indicators there is a dynamic interplay between visible

and invisible work. What counts as work is a matter of definition that is situated along a continuum of visible and invisible work (Star et al., 1999). "It is possible to observe another sweat and suffer and not see exertion as work...[as] it is possible to observe no direct physical action, but to have that lack of movement defined as work" (Star et al., 1999, p. 15). Cleaning work is frequently considered exclusively physical. This physical emphasis of the work, renders the intellectual components of the work of cleaning as invisible, consequently leading to the assumption that cleaners are incapable of intellectual work. "If doctors have been considered men with brains, and nursing staff as women with hearts, then cleaners are animals with strong backs and arms" (Messing, 1998, p. 179).

Management, through the call centre, assumes the role of the thinking component of cleaning work. Physical aspects of work, which are the visible features of work performed by cleaners, is broken down into steps and used by management for developing rationalized models of work organization. Workers are viewed as machines, whose role becomes that of performing plans laid out by management. According to Braverman (1974), this follows a model where the unity between the conception and execution components of the labour process is dissolved, which leads to the dehumanization of those workers engaged in the execution aspect of work. Workers lose control over their labour process and the manner in which it is performed (Braverman, 1974) and management assumes control over each step of the work process. Rigidly setting boundaries by dictating the processes contributes to the preservation of relations of power and is a primary characteristic of the state of domination (Durant & Cashman, 2003). According to Foucault (1988), this contributes to concretization of the relations of power, leading to oppression, which as Freire (1993) maintains, is "based on a mechanistic, static, naturalistic view of consciousness" (p. 59) that treats people as objects and limits the variability in both their thinking and actions. In other words, the way in which the function of cleaning is perceived, in Goffman's terms, leads to the creation of the "non-person" (Messing, 1998).

Plans are communicated to cleaners through the control centre via the pagers that cleaners are mandated to carry. As such, cleaners become absolved of performing those invisible aspects of their work which are not incorporated into the rationalized work plans, such as coordinating their activities with hospital staff. The absence of any incentives for taking the initiative to engage in the invisible components of work, that of coordination of activities with other groups of workers which provides for smoother work flows on units, further distances cleaners from their work and removes any meaning from the labour process. "The social relations of exploitative technological societies produce the science and technology which are applied to the work process and

increasingly subdivide, de-skill, routinise, brutalise and reify it until there is no craft, no meaning" (Young, 1998).

To illustrate this, one of the ongoing complaints of hospital staff has been the additional workload created for them by having to check rooms for which discharge-cleaning service have been requested. Hospital staff generally place calls for such requests at the time they are notified that a patient will be leaving, and not necessarily after the room has been vacated. In turn, when the cleaners receive the service request through their pagers and are confronted with an occupied room, they call into the call centre and cancel the request. Models of management that prevent the coordination of activities at the unit level between hospital staff and cleaners, and that discourage cleaners from using their own discretion in performing their tasks by controlling their every move, result in additional workloads created for different groups of workers, in addition to longer lag times between when a room is cleaned after a discharge, and when a new patient can be admitted.

The call centre also acts as a means to control and monitor workers, which is reflective of a mechanistic view of organizations. According to Braverman (1974), the control of labour is the basis for the development of a profession called management. The decision making criteria for management is based on efficiency, and it is achieved by taking skills and decisions out of the hands of the workers, and developing processes and procedures through which labours' every move is controlled. Through the call centre, Aramark is able to obtain more detailed information about the length of time it takes for each worker to perform a certain task, and to calculate the average time for the performance of a task. As labour costs are the most significant expense incurred by Aramark, reducing labour costs would yield higher profit margins for the company. Using information obtained through the call centre, Aramark can develop more efficient work schedules, where labour costs are minimized. However, as Braverman maintains, "the more science is incorporated into the labour process, the less the worker understands of the process.... The more the worker needs to know in order to remain a human being at work, the less does he or she know (Braverman, 1974, p. 424-425). The labourer is thus reduced to atomization and monitoring. The worker becomes alienated from the outcomes of her/his work and can no longer see the importance of the work and its impact on other people. Within a healthcare setting, such work alienation is quite problematic as patients' health and safety is the outcome that is compromised. As one ward administrator described the situation:

> I do think they're [cleaners] probably over stretched. But I don't know that. I know they were in the beginning. Because in the beginning when we were

having all that trouble with the turnaround time and we were just freaking out we were calling - it's like everyday. And what I was told from the higher ups was that they hadn't anticipated how much work it would be. They could have asked! You know, they should have prepared better for it, other than just guessing or listening to the higher ups that don't know what the hell goes on. (Personal interview, 7)

Another ward administrator said:

I was saying for almost a year-one that you couldn't cover this whole floor on the weekend with one person, on Saturday and Sunday. The ward activity is pretty much the same on the weekends, right? And they had only one person on and there's just no way that I could see that working and it was like I was talking to dead space. And finally [one of] the supervisors from Aramark said, you know, if you just add up the bathrooms and apply 10 minutes per bathroom, you're already over an 8 hr working day. (Personal interview, 2)

Work that is tracked and valued provides for a new challenge between visible and invisible work. The crux of this challenge is what is considered productive work. For example, the creation of visible indicators to monitor performance of cleaners further abstracts the job of cleaners and provides for a more panoptic way to account for their work (Star et al., 1999). In Britain, new forms of contracting out have resulted in more detached management who follow the tough manager model and the generic systems of performance management (Davies, 1995). The focus is on outcome data, cost information and performance measures. This is very much the model of management employed by Aramark and VCH, tracking the performance of workers using data collected through the call centre. These models "are insensitive to local diversity, change and time, such that even the most transforming efforts of staff cannot overturn the effects of such a democracy of deficit and lack of user sensitivity" (Maddock, et al., 1998, p. 236). Pollitt (1990) sees these models of management that have become prevalent in the public sector, as based on the same old male cultures that used to be common in public bureaucracies, except that they are now free to be more entrepreneurial and aggressive (Maddock et al., 1998). Management models that are focused on outcomes frequently fail to recognize the importance of invisible work. They are based on a very male approach towards interactions, which focuses on communication outcomes and gravitates more towards the abstract (Ashcraft & Mumby, 2004). However, women, who form the majority of permanent workers on clinical units, tend to rely on communication as a process for the building and maintaining of relationships (Ashcraft, et al., 2004). For example, the absence of sufficient flexibility built into cleaners' schedules, and structures that do not support direct communication between different groups of workers, while focusing on outcome measures, tend to dismiss the requirement for workers to engage with each

other and to coordinate their activities. This type of abstraction results in the suffering and silencing of workers and leads to inefficiencies and obfuscation.

As has been discussed, the structural organizational boundaries created as a result of outsourcing lead to the further marginalization of cleaners. Undermining of cleaning work and cleaners is rooted in the low prestige attributed to this type of work, generally performed by women in the home and associated with non-productive labour. Low wages, heavy workloads, mechanistic models of management all attest to the undermining of cleaning work and cleaners. Furthermore, cleaning work, as Messing (1998) notes, is viewed as belonging to the underclass and connotates the social inferiority of those engaged in this type work. Relying on secondary quantitative and qualitative research, Thomas (1988) concludes that one of the main problems with contracting out is its impact on labour. In a literature review conducted by Young (2000), she refers to numerous studies that find reductions in employees' wages and increased labour flexibility, in the form of contingent work, as the main sources of cost savings in outsourcing arrangements.[24] To illustrate these points in action, Aramark cleaners are paid on average $10.00 an hour and many of them have to adjust their life to flexible work schedules and work sites. One cleaner noted, that she would receive phone calls from Aramark frequently with less than 24 hour notice to inform her of the time she was expected to show up at work and the location that she was expected to work at for the day. Failure to accept an assignment was not an option, as there was the threat of job loss.

Hodge (2000) also finds that contracting out reforms have led to some unfortunate social impacts, where women and minority groups are paying the costs for the savings that might be realized by companies. Cohen (2003) found that the majority of workers affected by contracting out in B.C.'s health services are women, older, visible minorities or immigrant women, and many of the women are their family's primary wage earner. During the observations conducted for this study, it was noted that the majority of cleaners observed belonged to visible racial minority groups and were mostly women. Out of the eleven cleaners observed, eight belonged to visible racial minority groups, one while not a visible minority, spoke with a very heavy eastern European accent, and seven were women. In a study conducted in Australia on the detrimental effects of outsourcing on immigrant workers, it was found that these workers feared losing their jobs and had difficulty gaining access to information (Young, 2000). This could be one of the explanations for why workers submit to the unfair treatment to which they are subjected. One of

---

[24] As was explained in Chapter2, using the dual labour market theory.

the nurses commented on the demographics of cleaners employed by Aramark and the way in which they are being treated:

> And they are mostly immigrants and they get bullshit from everyone. They are being slaved. White people won't do the work they do. But these people don't have a choice. They take all kinds of jobs. I feel sorry for them. They work very hard. There is no union to protect them either. They are being slaved. I feel sorry for them. They are scared. They can lose their jobs. (Personal interview, 9)

5.2 Professional boundaries reinforce othering

On the wards and throughout the hospital, Aramark cleaners are marked by their grey uniforms that blend into the background. Wearing uniforms dissimilar to those worn by hospital staff is set out as one of the requirements in the RFP. On the other hand, the printed statement: "Property of Vancouver General Hospital," plasters the uniforms worn by many hospital employees. Segregating the different groups of workers by using their uniforms as the visible identifiers, is the physical manifestation of the underlying belief of the separation of cleaning from care.

Research conducted by Young (2000) finds that "segregating contract workers, remunerating them differently and moving their authority focus outside the organization" (p. 112) contributes to issues of equity between different groups of workers. It also affects the level of trust and commitment between different groups of workers who have to work in close proximity. New organizational structures that are put in place as a result of outsourcing change the way individuals relate to each other. "In a newly changed organization, employees are likely to retain a strong sense of identity with the old organization until a new process of identification with the new organization takes place" (Paulsen, 2003, p. 23).

Aramark cleaners, who were viewed by many hospital employees as having taken away jobs of many of their unionized colleagues, entered the VCH job sites where an atmosphere of mistrust and resentment was already brewing (Personal interview, 14). While many HEU workers were laid off as a result of outsourcing, there are still many HEU members present in the hospital, such as patient escort service workers and unit clerks. As one hospital ward administrator on the unit pointed out, it probably is not easy for cleaners to work in such an environment:

> You've got cleaners spread out all over the place, they already feel under pressure because of the way they've had to come in - you know, and they're already working around other HEU employees who I'm sure don't make it easy for them. (Personal interview, 7)

In addition to this type of othering that cleaners might be subjected to by union members, cleaners also work within an environment where distinct professional boundaries exist between different groups of healthcare workers. Within a medical model of health care, there are generally two categories of work: care and cure. Before the recent industrial classification systems that moved ancillary work outside the domain of healthcare work, care work included "the full range of women's traditional care along with newly emerging clinical tasks" (Armstrong et al. in press, p. 3). To gain recognition for the work they performed, women working in the health sector have frequently emphasized the 'care' aspect of health and have used many of the strategies adopted by the dominant medical model, such as the emphasis on university education. Consequently, this has led to more fragmentation of the nursing work and the creation of various nursing categories. Fragmentation of nursing work became more predominant by the early seventies, where categories such as Nursing Assistants, Nursing Aides and Orderlies were added to census categories (Armstrong et al., 2003). Then there were also all those hired to do other tasks, such as cleaning, food preparation, admission and record keeping. This fragmentation was also encouraged by institutions who in response to the rising pay of RN's preferred to hire workers at lower pay to perform tasks that required less formal training (Armstrong et al., 2003).

Nurses responded to these changes favourably as this new division of labour allowed them to gain more status and to dis-engage from the more unpleasant tasks of patient care. One of the more senior nurses on the ward tells me that for instance Licensed Practical Nurses (LPN) do not necessarily like to engage in certain aspects of care work, such as taking care of a patient's skin, for they "are not as sexy" as activities such as overseeing patient's medication and interacting with the new technology (Personal interview, 7). "In smaller hospitals, due to the lack of resources, nurses have to undertake a wider range of tasks and do more cleaning work. As small as the work is, it is part of patient care and all those small parts are important to patient care" (Personal interview, 7).

Given that the work nurses perform is generally perceived to be an extension of care work women at home provide as part of their natural and instinctive capacity of being women, the skills involved for this type of work are often times rendered invisible and are undervalued (Armstrong et al., 2003). In order to gain recognition for their work, nurses have thus had to struggle to carve a space for themselves and have had to construct professional boundaries between themselves and other care workers. "Individual employees are differentiated from each other through membership of social categories that define departments, work units, levels of hierarchy, and/or specialized roles. Individuals identify with the groups to which they belong or to

which they are perceived to belong" (Paulsen, 2003, p. 16). Professional boundaries have both negative and positive implications, while they protect workers included within the boundaries; they exclude and alienate those in more inferior positions. Frequently, those in positions of relative power initiate the construction of boundaries and in this sense, the "processes of inclusion and exclusion are unavoidably political" (Marshall, 2003, p. 61).

Therefore, as much as hospital staff and nurses have voiced their desire for more integration with Aramark cleaners, through their actions and the overtone of their comments, they have also indirectly implied their desire to maintain the professional divide. This is not a phenomena resulting from outsourcing, but rather a response to a system that has historically not valued the contribution of nursing to a patient's well being. However, with outsourcing, the professional divide is compounded by new organizational boundaries between workers that transform the "other" into a "stranger" (Albert, Ashforth & Dutton, 2000). Within the old structures, different groups of workers through time and interaction had learned how to negotiate the boundaries between them. While boundaries are built, they "also evolve more or less unconsciously through social interaction and shared experiences" (Hernes, 2003, p. 51). The new organizational structure changes the nature of these interactions and new relationships and ties have to be developed. An organizational structure that does not support cooperation and direct communication between the different groups of workers makes the process of boundary negotiation more difficult and further exacerbates the othering of those groups lowest in the hierarchy of work.

One of the frequently observed incidences that attests to the invisibility of cleaners and cleaning work, and also exemplifies how the work performed by cleaners is the lowest on the organizational hierarchy, is how commonly cleaners' work is interrupted. Interrupting cleaners' work occurs so regularly that it is normalized, where often an apology is not even expressed. For example, cleaners are frequently interrupted while mopping the floors. People generally walk right through the surface that has just been mopped and is still wet, without even acknowledging the work that has been preformed. It is taken for granted that a cleaner would stop his/her work, to allow for everyone else's activity, regardless of the act, to take precedence. Within the professional hierarchy of the medical system, physicians' tasks take precedence over everyone else's, while cleaners are one of the lowest on the totem pole.

Inferiority of cleaning work is so ingrained that even when hospital staff acknowledged that cleaners were being treated poorly, they did not necessarily realize that they too were contributing to cleaners' marginalization and othering. In one incident a hospital staff member

who had just expressed to me how the way in which cleaners were being treated was problematic, stood in the hallway on a wet spot that had just been cleaned, and talked to me about her experience with shiatsu. Meanwhile, a cleaner was mopping around her feet, as she stood there engaged in conversation with me, failing to notice the existence of a cleaner in her proximity. Finally, when she was through with her conversation she said goodbye and walked right through the wet strip that the cleaner had just finished mopping.

The invisibility of cleaners is to such extent that earlier on in my field work, a cleaner working on one of the pods, with whom I had briefly spoken with on different days, upon seeing me one day, said to me: "It's nice to see a familiar face." A few months later, when I was getting ready to wrap up my field work and I asked her how things were going, she told me that things were getting a little better, and that staff were talking to her. "If sometimes they just say thanks to me. It makes my day. Cause they notice my job and my person" (Personal interview, 11).

5.3 Marginalized cleaners and patient care

"People get sick in the hospital. You should stay until you're better. Not any longer." I overhear a physician saying this to a patient as he leaves the patient's room. He is referring to infections patients acquire during their stay at the hospital, which could have serious consequences for patients and could also lead to significant cost increases in the system. Hospital acquired infections could increase patient's length of stay and also increase return visits. For example, MRSA has been an ongoing problem in hospital environments. Risks of acquiring this bacterium for patients who have undergone surgery can be fatal. In Canada, Antibiotic-resistant "superbug" infections kill approximately 8000 people and cost the health care system close to $100 million annually (Canadian Broadcasting Corporation, 2005a). The cost of curing each infected patient, according to Dr. Andrew Simor, who heads the microbiology department at Sunnybrook Hospital in Toronto, is close to $14,000 (Canadian Broadcasting Corporation, 2005b).

The debate about whether dirty hospitals cause infections is ongoing. This is partially because of the host of many different variables (i.e. staffing levels, infection control procedures, etc.) that play a role in both the prevention and control of infection (Patel, 2004). Research also suggests that environmental surfaces can give rise to nonsocomial (hospital acquired) infections (Murphy, 1998). Health Canada associates the transmission of viral infections to cleaning standards and patient environments (Health Canada, 1998). Generally, Infection Control departments in hospitals set the standards of cleanliness on wards that help in preventing the spread of infections. As it is impossible to exclude all microbes from the hospital environment, cleaning

becomes one of the methods used for ensuring the control of microbes. The purpose of cleaning is thus to ensure a surface or object is safe for its intended use, that it is also aesthetically clean, and to prevent the environment from contaminating items that are going to be in direct contact with patients (Sub-group on Ward Hygiene, 2001). Cleaners play the pivotal role of maintaining standards of cleanliness on units to ensure patient safety.

With the objective of lowering operating costs to maximize profit margins, housekeeping vendors attempt to cut down on labour costs by providing less training to workers, hiring less skilled workers and lower compensation levels. This is confirmed by the "experience in British Columbia and Great Britain [which] shows the end result [of outsourcing] is lower wages for staff who have less knowledge, fewer skills, and a reduced commitment to the hospital" (CUPE, 2003, 1). Such practices generally result in high turnover of workers, which in turn results in the deterioration of quality services; and ultimately affects patients. Cohen (2003) examines the relationship between wage levels and the turnover rates of workers and concludes that very low wages are correlated with higher turnover rates and this in turn effects cleaning levels and patient care. In a case study research conducted about the quality of hospital cleaning services by a contractor in the UK, it was found that "cleaning standards declined due to understaffing, poor training and were reflected in increased cross-infection rates" (Bach, 2000, p. 20). In another study, of the Australian government cleaning service, "[it is] reported that contracting out increased workloads, leading to increased injuries, stress and decreased job satisfaction" (Bach, 2000, p. 20). Based on the findings of these studies, there is irony in that the deterioration of the quality of a service that is categorized as support, non-core, non-directly-related to patient care, results in direct implications to patient care.

According to Hackman and Oldham (1975), worker's job satisfaction is influenced by the extent to which the worker perceives his or her work contributes to the organization as a whole. The low status attributed to cleaning work and those performing cleaning chores, results in their exclusion from the social organization of the ward. When cleaning work is decontextualized from care, cleaners do not feel part of the larger team and are not able to see how the work they perform contributes to the greater objective of the unit, that of patient care. Cleaners frequently have direct patient contact and can thereby affect the patient experience. "Housekeepers often received important information from patients while cleaning rooms, but had no mechanism for reporting this information to the nurses" (Hagenstad, Weis & Brophy, 2000, p. 40). The importance of domestic workers in providing patient care has also been confirmed by a study conducted by Elizabeth Hart, sponsored by the Economic and Social Research Council of England. In this study, after spending six months working as a housekeeping staff, Hart concludes that the

role of domestic workers is a vital part of patient care (Salvage, 1989). The problem, however, is that the care remains invisible and hence, is not accounted for. Recognizing the contribution that cleaning staff could make to the total ward routine and other tasks related to patient care, in some hospitals, administrators are focusing their efforts towards improving employees' skills by careful selection and cross training in housekeeping jobs, to ensure more consistency in the workforce (Appelbaum, Berg, Frost & Preuss, 2003).

Patients also contribute to the marginalization of cleaners. The inferiority of cleaning work and cleaners is engrained and part of the social fabric of understanding. Patients frequently test the cleaners working in their rooms, by leaving behind bloodstains and monitoring whether the cleaner removes the stain.

> I had deliberately left some blood on the floor and I was waiting to see how long it would take for them to clean it. I'm not a clean freak, but I think if what we see is so disgusting, what else is dirty that we can't see, that's behind the scenes. It's scary. (Personal interview, 3)

One of the cleaners recalls his experience with a rude patient, who had pointed at him saying: "cleaning boy, come here", and at some point had gone as far as spitting on him. Patients also tend to complain to hospital staff when cleaners spend too much time in their rooms performing their cleaning chores. This combined with the marginalization cleaners feel as a result of both structural and professional boundaries, does not leave much incentive for them to perform outside of their job descriptions. In the case of the cleaner who has already been insulted by various patients, despite the fact that he used to be a practicing nurse in the Philippines prior to immigrating to Canada and as a result could be a very valuable addition to the ward team, he expresses that he would much rather just focus on his cleaning tasks and maintain a minimal level of interaction with patients.

Hackman and Oldman's (1975) theory of job design also identifies a sense of autonomy as one of the characteristics that could increase job satisfaction. Management strategies employed by both Aramark and VCH act as obstacles to this autonomy. "Having been forced to sell their labour power to another, the workers also surrender their interest in the labour process, which has now been 'alienated'" (Braverman, 1974, p. 57). The labour process is abstracted and becomes the responsibility of management that oversees every move of the worker. This marginalization of cleaners acts as an obstacle to them having any desire to understand the intricacies of the ward in order to adjust their work to the local requirements of the unit for the attainment of patient care. With the removal of workers' autonomy and the centralized control of work process,

"workers cannot use their skills to respond to the variability in work demands and to crises which are regular aspects of work in care," which in turn not only affects the health of workers but also the quality of care (Armstrong et al., in press, p. 5).

Trivialization of cleaning work and failure to provide adequate and specialized training to cleaners who work in a health setting, has consequences for cleaners' health and also patient care. For example, one of the ValueIN managers acknowledged that they had issues concerning cleaners with inadequate training who had walked into rooms with lots of radiation. One of the nurses raised her concerns with the insufficient amount of training provided to workers, which results in them not being knowledgeable enough to protect themselves. One of the incidences that came to the attention of this individual was when a cleaner who had pricked herself with a used needle that was lying on a bed she was cleaning insisted on continuing to work while her finger was bleeding (Personal interview, 8). While this incident could have direct implications for the cleaner, it is also not conducive for having a clean environment.

Structural boundaries that maintain a tight control on cleaners and the labour process also create an environment of fear, where workers, who feel under constant surveillance, are pressured to fulfil their tasks within certain time limit, regardless of the circumstances. One of the hospital staff recalled her experience when she once wanted to contact the call centre to request a service that had not been performed and was faced with a cleaner who was in tears, fearing that the call would result in her job loss. Being aware of the tight mechanistic models of management that govern the work of cleaners, nurses and hospital staff feel reluctant to report cleaning issues as they do not want to further contribute to the marginalization of cleaners. On the other hand, if management is not aware of the issues, they will not be in a position to rectify them. If management is made aware of these issues they could increase the level of staffing so that cleaners are not faced with such heavy workloads, that in an attempt to perform their tasks, they would compromise their own health or fail to recognize the ramifications of cleaning a healthcare environment while they are bleeding.

Inadequate training combined with a heavy workload, have resulted in poor quality cleaning. A nurse pointed out that due to inadequate information many times cleaners avoid entering rooms with MRSA patients. The walls of rooms with MRSA patients after discharge are not being cleaned. "They clean the bed and the floor, but not the rest of it. You can't tell me that you can clean a patient's room in 5 minutes. That just isn't possible. Cleaners are running from one place to the next, there just isn't enough of them. Basically everywhere a person can touch, has to be cleaned" (Personal interview, 8). For a while after the transition of services to Aramark, beds

were not even being washed between patient moves. Issues of inadequate training were starting to be addressed close to a year after the transition of services and Aramark apparently acknowledged that "there had never been proper training in the first place of the employees, that is the front line employees as well as the supervisory staff. So they're re-training all of them" (Personal interview, 13).

The problem, though, is that workers should not be held responsible for the deterioration of quality. As Armstrong maintains, "women are made to feel responsible and they are held responsible for the impact of restructuring on the quality of services they are delivering" (Armstrong, 1998, p. 29). As one of the nurses interviewed also noted: "cleaners shouldn't be blamed. They have really high work ethics. It's their employers. They aren't doing the right thing overworking them like this. They are exposed to so many different things, Hep C, AIDS, etc" (Personal interview, 8). Cleaners are performing within the structural organizational constraints that limit their autonomy and dictate their organization of work. "Regardless of how diligently and efficiently any individual works, his or her ability to enhance organizational productivity is constrained by the institutional arrangements under which their agency functions" (Sclar, 2000, p. 15).

Management needs to become more aware of the organizational attributes that impact workers' job performance and should employ strategies that support workers in their chores rather than inhibit them from performing to their capacity. In a study conducted by Appelbaum et al. (2005), it was found that wages improved staffing and employment security and are the key variables for reducing turnover. By paying more attention to these attributes, management can in turn reduce turnover rates of cleaners, improve the work and life experiences of workers, and thereby attain the health authorities objective of higher quality care. According to one of the more senior nurses on the unit: "if you have job satisfaction you're going to do a better job. If you're not connected to the people around you, how'd you expect to have job satisfaction?" (Personal interview, 7).

To reach a place where cleaners working on a clinical unit will perform as if it were "their ward" and not just "a ward", an environment has to be created that encourages collaboration and integration between workers, where each individual and the work they perform within the system is valued. Individual parts can impact the functioning of the whole system. As Lewis (2002) states, if damage is done to one of the components of the system, it is more than likely going to impact the performance of the overall system. Therefore, it could be argued that a negative impact on labour, as one of the components of the system, has the likelihood of affecting the overall performance of the system. That is why it is important to acknowledge the individual

members within the system, who each "have purposes of their own, and that these members must be allowed to participate in decisions that concern them, so that they experience a higher quality of work-life" (Lewis, 2002, p. 37). After all, "the way to encourage people to care more about their work is to care more about them" (Salvage, 1989, p. 5).

5.4 Conclusion

Organizations are social systems, and it is important to recognize that within these systems every employee has his/her own ideals, interests, and purposes. When organizations are treated as machines, the people within the system are ignored and viewed as replaceable machine parts. Structural organizational boundaries lead to the marginalization of cleaners and reinforce societal perceptions of the invisibility of cleaning tasks and cleaners. Professional boundaries also tend to become exacerbated after outsourcing, as hospital staff is not able to develop relationships with cleaners in the confines of the structural boundaries, and thereby, negotiate the professional boundaries. Boundaries communicate the separation between cleaning-work and care-work, which is reflective of the underlying societal beliefs that undermine cleaning work; consequently, cleaners are not able to recognize the importance of the work they perform in the context of care. The marginalization of cleaners has implications for the emergent properties of the hospital as a system and affects patient care and safety.

CHAPTER 6
CONCLUSION

Organizations as social systems are built on the foundation of groups of individuals working along side each other towards the attainment of a specific goal (Paulsen, 2003). Within larger organizations, the interdependency and interaction between the different groups is even more complex. Outsourcing adds another layer of complexity, as it leads to changes in the boundaries within which groups of workers and individuals interact, and the nature of their interactions.

This thesis began by questioning how within a hospital setting, workers employed by different organizations are working together along the new divide created by outsourcing to deliver patient care. To respond to this question a qualitative research method was employed within a feminist methodological framework. Following Flood's (1999) categories of Critical Systems Thinking, that of structure, process, meaning, and knowledge and power, the following questions were asked and each was addressed in a separate chapter within this thesis:

1. What has been the role of administrative management at VCH, in ensuring hospital cleanliness and patient care after the outsourcing of cleaning services (question of structure)?

2. How does the work performed by housekeeping fit into the work performed by hospital staff (question of process)?

3. How have cleaners been impacted by outsourcing strategies and what are the implications for patients, if any (question of power, knowledge and meaning)?

6.1 Summary

This study was conducted at a time when there was significant media coverage on higher infection rates in Canadian hospitals, linked back to a deterioration of cleaning services in hospitals. Patients who acquire infections during their stay in hospitals, are required to stay in hospitals for longer durations, as in addition to recovering from the illness that got them to the hospital to begin with, they also need to recover from the infection acquired during their stay. For example, the two patients that were interviewed during the course of this study indicated that their return to the hospital was due to infections they had acquired during their prior visits and the side affects of those infections (Personal interview, 3, 4).

Considering the significant economic burden associated with MRSA, it is surprising that one of the first areas affected by budget cuts are housekeeping departments that play a major role in ensuring commonly touched surfaces are free from bacterial contamination. Contracting out housekeeping departments to private for profit companies has become a common business strategy employed by health authorities with the objective of lowering costs of hospital cleaning. Private companies operating within a competitive market, who compete for the housekeeping contracts of the public health sector monopolies, maintain low labour costs by hiring workers from the secondary labour market pool. Low wages, poor working conditions, absence of benefits, no job security and dead-end jobs without any prospects for promotions and career development are characteristic of jobs within the secondary labour market. This contingent workforce is dominated by women and other minority groups.

Since privatization of cleaning services, the wages of cleaners has been cut by almost 50%, many of the cleaners work part time hours, and do not know the number of hours they will be working, when those hours will be scheduled nor the location where they will be required to work (Cohen, 2004). Shifting hospital cleaning work which is seen as an extension of the low value work historically performed by women in the domestic sphere to the secondary labour market, leads to the further underestimation and under valuation of this work. A medical model of care that places physicians at the top of the health care hierarchy and cleaning work at the bottom supports the categorization of cleaning work as peripheral to patient care and its relegation to the secondary labour market.

To realize efficiencies in delivering patient care, VCH administrative management divided healthcare staff into clinical and non-clinical groups, and contracted out support services, such as housekeeping to private companies. VCH forfeited direct responsibility for housekeeping services and its role became that of monitoring and managing the contract between VCH and Aramark, to ensure outcomes outlined in the contract were being met. The artificial divide that was created between cleaning and care, stemming from management's failure to acknowledge the intricacies of the gendered work of cleaning work and its contribution to patient care, led to a mechanistic view towards the organization and the development of organizational structures that supported this approach. Integration was viewed as a form of information sharing rather than relationship development, which was to be achieved through the call centre. This model of work organization was not congruent with work practice requirements on the ward that entail more interdependence between cleaning and care workers.

Out of all the people working on clinical units, care workers (RN, LPN, care aides, including unit clerks) and cleaners are the only permanent actors on clinical units. However, since privatization of cleaning there is minimal interaction between cleaners and care workers on a unit, since all interactions must be processed through the Aramark call centre. This poses a challenge to conducting both routine and non-routine cleaning activities. Rationalized models of work organization prepared by upper level management, which is removed from actual work conducted on clinical units, fails to take into account the invisible work of coordination that takes place between workers. According to Smith (1987), work cannot be taken to an abstract level for it is located in a particular space and time. Patient care requires that components within the system interact and work together towards this common objective. Familiarity of cleaners with the local conditions on each ward and the integration of cleaners in the work practices on a ward would allow for smoother workflow on the unit and the realization of the objective of patient care.

Communicating the message that cleaning is separate from care ensures cleaners remain outsiders on a clinical unit. Cleaners who are predominantly women and frequently from other marginalized minority groups in society already have an outsider role, and the structural organizational boundaries that act as impediments for any kind of relationship development between cleaners and hospital workers further exacerbate this marginalized position. Professional boundaries within a health care setting also communicate the separation of cleaners from other health care workers. Cleaners find their work frequently interrupted by those in higher positions of the healthcare hierarchy and also by patients. This further attests to their invisibility, and that of their work. The undermining of cleaning work, which is reflected in the heavy workload, poor working conditions and wages of cleaners, results in higher turn over, which in turn effects cleaning levels and patient care. By positioning cleaning as peripheral to care, cleaners are no longer able to see how their work directly relates to the final outcome of patient care, and the importance of their work in ensuring a safe and clean environment for patients.

While ValueIN and Aramark conduct quality audits, these audits are service specific and they do not examine the performance of the entire system. They are based on outcomes and do not look at the source of problems, such as cleaners' working conditions, training needs, work load, or the communication and integration of workers. When an organization is viewed from the mechanistic paradigm and cleaners are governed through the call centre, the problems could very well be stemming from the inability of cleaners to use their own discretion in reacting to emergent situations and problems on the ward. This inability is not an individual choice, but rather a

managerial approach that removes autonomy from workers, in order to attain more control over their work.

Within a hospital setting the delivery of patient care requires the integration of many different activities and workers, including cleaning work and care work. Outsourcing fragments the activities required for the delivery of patient care. A component within the system of care is removed and replaced with another part, assuming that the system will operate more efficiently. However, as the new private organization providing housekeeping services has its own objectives and timelines which are not identical to that of the health authority, integrating the new component within the existing system of healthcare delivery has proved to be quite challenging and has not necessarily resulted in a more efficient system.

6.2 Recommendations

Following the problems the NHS has faced regarding hospital cleanliness, the Health Secretary John Reid told the British Broadcasting Corporation (2005): "I have made it plain to chief executives that cleanliness cannot be regarded as an optional extra - it has to be be put right back at the centre of what hospitals are about." The artificial divide created by outsourcing leads to the decontextualization of cleaning from care and has ramifications for patient care. Management, both Aramark and VCH, should thus emphasize the importance of cleaning work and its contribution to patient care. A shift is needed in the underlying beliefs and values that have historically devalued cleaning work and cleaners and this should be reflected in the way in which cleaners are compensated for the work they perform.

Cleaners are not machine parts that can be easily moved or replaced within the system of care. Clinical units require designated cleaners to be integrated within the practices of the ward and for cleaners to be part of the care team. Management of both Aramark and VCH should be supportive of providing flexibility in cleaners' work schedules to account for the invisible work of coordination that is required between hospital staff and Aramark cleaners. According to a study conducted by Sheila Harrison (1986), examining the contribution of domestic staff to the welfare of mentally ill patients, the interdependent roles of cleaning staff and nurses can improve patient care. Harrison (1986) concludes that private companies assuming the role of cleaning services should provide flexibility in the work planning of domestic staff to allow for the formation of interdependent working arrangements. Flexibility in cleaners' work schedules will allow for the formation of interdependent working arrangements and will also allow cleaners to familiarize themselves with the intricacies of the organization of work on clinical units. This will help cleaners

become more responsive to the local requirements of the ward and thereby help in improving workflow on the ward. Cleaners should also be provided sufficient training in order to understand the ramifications of low quality cleaning work for patients. When the skills of individuals are recognized and acknowledged, there will be a sense of pride in the work they perform. Cleaners need to be given autonomy and should be empowered to take action in unforeseen circumstances and incidences. This is contrary to the strategies employed by management, to date. Mechanistic models of management are based on "centralized control and the treatment of subordinates as mindless parts" (Ackoff, 1999a, p. 35). For example one of the administrative management staff at VCH suggested that the way to resolve the cleaning problems was to implement a systematic surveillance system operating on a regular basis (Personal interview, 13). This is symptomatic of the underlying belief that underestimates the skills and knowledge of cleaners.

Paulsen (2003) suggests that any kind of reorganization strategy results in the "redefinition and renegotiation of organizational boundaries" (22) and the creation of new work processes, reporting lines, and work teams. The artificial divide created between cleaning and care, to enable the outsourcing of ancillary services, makes it difficult to integrate cleaners and hospital staff. Management strategies and the structural organizational boundaries further reinforce the separation between cleaning and care. Domestic workers are not part of the ward team because they are not employed by the same employer as the rest of the team. They are perceived as contractors, not as health service employees. Not being part of a single team caring for patients, and the erosion of the necessary interaction required between domestic workers and care staff for work practice purposes, has consequences for the smooth running of the ward and thereby, affects patient care.

Aramark's core business is cleaning, while the hospital's is patient care. In this sense, outsourcing has led to the fragmentation of the team, where each component now works towards its own objectives. Within the transaction cost economic theoretical framework that views organizations as acting opportunistically to serve their own objectives, all requirements of outsourcing arrangements should be spelled out in a contract. However, contracts cannot possibly contain all the detailed intricacies and complexities of work required on clinical units. As such, a strategy that started out with the objective of realizing efficiencies for the health authority could result in additional costs to patients and the system. As one of the ward staff pointed out: "They [Aramark] just want to get it done as cheaply as possible. Before it wasn't great, but it was safe, now though it's bordering on safe" (Personal interview, 1). As the objectives of Aramark and VCH are different, efficiencies realized by one organization are not identical to the realization of

efficiencies for the entire system of patient care. In fact, what might be efficient for one organization might be highly inefficient for the entire system of patient care.

When a systems thinking perspective is applied, the common objective of the organization is considered to be patient care, and the different components within the system work towards the realization of this objective. Outsourcing leads to the fragmentation of this system, and as Ackoff (1999b) suggests, dividing a system into independent parts could lead to the loss of the essential properties or functions of the system. The delivery of patient care is the primary objective and property of the hospital as a system, which it intends to maintain after outsourcing. Among the many other functions, cleaning work is also vital for patient care, and failing to provide this function will be detrimental to patient safety and care. To ensure the system maintains its essential properties and functions after outsourcing, it is important to recognize the different objectives of the organizations party to an outsourcing contract. Sclar (2000) also notes that in establishing networks of private profit seeking providers and public organizations that provide human services, it is important to consider the role of organizational goals. From a social systems perspective, while outsourcing might be an attractive business strategy for certain types of organizations, it is much more difficult to achieve in systems that require fluid structures of cooperation between different communities of practice and where the health of individuals is at stake. Attaining a common goal depends to a great extent on effective interrelations among people (Denison, 1990). The idea of such collaborative systems is expressed quite eloquently by Claus Otto Scharmer, in summarizing an interview he conducted with Lucy Suchman about her work (1999):

> Our social world has two modes of operating. The first mode consists of highly fragmented autopoetic islands. Every system is totally decoupled and blind to its environment. And every individual lives in one and only one system. The other mode operates based on the primacy of relationships. The social worlds are interconnected and each individual participates in multiple worlds or systems. People are the nexus of exchange, where one world is relating to another one, or becoming another one.

In the NHS, having learned the drawbacks of not recognizing the requirement for coordination and integration of these different groups of workers, Health Secretary, John Reid, admits that one of the mistakes made by the NHS after contracting out domestic services was "breaking the link between the ward sister and the nurses, and the actual cleaning on the wards" (British Broadcasting Corporation, 2005). Since then millions of pounds have been spent to rectify the situation. What remains to be seen is whether B.C. will follow the UK's past footsteps or learn from the UK experience and, before incurring a heavy financial burden on a hospital cleanup

campaign, recognize the important contribution of cleaning work to patient care. Creating an artificial divide in the system of care, and undermining the interdependency of the components within the system could lead to failure in realizing the objectives of the entire system, that of patient care, and attaining efficiencies for the system as a whole.

APPENDIX:
INTERVIEW QUESTIONS

Hospital ward staff (i.e. Nurses, unit clerks)

- What are the processes for obtaining cleaning services on the units?

- What are the different types of cleaning that are needed on the units (i.e. routine, emergency, discharge, etc.)?

- Is there one cleaner assigned to your unit?

- What about cleaning services after hours?

- Is there generally a cleaner on your unit or do you rarely see the cleaners?

- How do you go about describing the details of the task that have to be performed to the cleaner assigned to the task?

- When you have a cleaning issue how do you deal with it?

- If you could change the processes what would you do differently?

- How would you describe your relationship and interaction with cleaners and housekeeping?

- Do you communicate directly with cleaners when you need something done?

- What are the jurisdictional boundaries between hospital staff and cleaners? (what is the responsibility of the nurses and what tasks are cleaners responsibility)

- Would you say in delivering patient care you need to work more closely with cleaners?

- How do you think, if at all, the new work arrangements impact patients?

- How would you describe your workload since outsourcing of cleaning services?

- How do you see the work of cleaners fitting into the work performed by you or/and other staff?

- Who on the unit is responsible for ensuring the unit is clean? Basically, who is accountable to the patients?

- What are some of the challenges with the new processes?

- What are some of the things that are working well?

ValueIN employees

- What is your role in relation to housekeeping and what are your responsibilities in this role?

- Who on the unit is responsible for ensuring the unit is clean? Basically, who is accountable to the patients?

- What are the organizational guidelines and reporting structures in terms of housekeeping?

- What performance measures and controls are used to assess the work of cleaners?

- What institutional structures are in place monitor performance and impact of outsourcing on the work of other staff?

- What are the processes for obtaining cleaning services on the units?

- What are the different types of cleaning that are needed on the units (i.e. routine, emergency, discharge, outbreak, etc.)?

- Is there one cleaner assigned to each unit?

- What about cleaning services after hours?

- Are cleaners assigned to certain tasks (i.e. one cleaner is responsible for emptying garbage, etc.)?

- If you could change the processes what would you do differently?

- How can you go about changing the processes, especially with the feedback you receive from units?

- How would you describe the relationship and interaction between staff and housekeeping?

- Is there direct communication?

- Would you say in delivering patient care staff need to work more closely with cleaners?

- How do you think, if at all, the new work arrangements impact patients?

- How do you see the work of cleaners fitting into the work performed by other staff?

- What are the jurisdictional boundaries between hospital staff and cleaners (what is the responsibility of the nurses and what tasks are cleaners responsibility)?

- If you were going to go through this process again what would you do differently?

- What are some of the things that are working well?

Ward administrators (i.e. Patient Services Manager, Patient Services Coordinator, Clinician)

- In your role, what is the extent of your responsibility and accountability to patients and staff for ensuring a clean unit?

- What is the extent of your authority in this regard?

- If you could change the existing processes for housekeeping, what would you do?

- How do you see the work of cleaners fitting into the work performed by other staff?

- Would you say in delivering patient care staff need to work more closely with cleaners?

- How do you think, if at all, the new work arrangements impact patients?

- What are the jurisdictional boundaries between hospital staff and cleaners (what is the responsibility of the nurses and what tasks are cleaners responsibility) ?

- Are you concerned about MRSA rates and patients acquiring infections?

- If you were going to go through this process again what would you do differently?

- What are some of the things that are working well?

Infection Control team

- What is your relation with housekeeping?

- In this relation how much authority do you have in making things/processes change?

- Which aspects of housekeeping activities concern you most, as they pertain to infection control (i.e. cleaner's in MRSA patient rooms, cleaning of clinical equipment, etc)?

- Since outsourcing how have the infection rates changed?

- How do you see the work of cleaners fitting into the work performed by other staff?

- Would you say in delivering patient care the integration of different groups of workers, including cleaners, is important?

- How do you think, if at all, the new work arrangements impact patients?

- What are the jurisdictional boundaries between hospital staff and cleaners? (what is the responsibility of the nurses and what tasks are cleaners responsibility)

- If there were no financial constraints and no legal requirements and you were going to go through this process again what would you do differently?

- What are some of the things that are working well?

REFERENCES

Ackoff, R. L. (1999a). *Ackoff's best: His classic writings on management.* New York: Wiley and Sons.

Ackoff, R. L. (1999b). *Re-creating the corporation: A design of organizations for the 21st century.* New York: Oxford University Press.

Adamson, N., Briskin, L. & McPhail, M. (1988). Feminist practice: Organizing for change. In N. Adamson, L. Briskin, & M. McPhail (Eds.), *Feminist organizing for change: The contemporary women's movement in Canada* (pp. 165-197). Toronto: Oxford University Press.

Albert, S., Ashforth, B. E. & Dutton, J. E. (2000). Organizational identity and identification: Charting new waters and building new bridges. *Academy of Management Review, 25,* 13-17.

Alter, C. & Hage, J. (1993). *Organizations working together.* Newbury Park: Sage Publications.

Appelbaum, E., Berg, P., Frost, A. & Preuss, G. (2003). The effects of work restructuring on low-wage, low-skill workers in U.S. hospitals. In E. Appelbaum, A. Bernhardt, & R.J. Murnane (Eds.), *Low wage America: How employers are reshaping opportunity in the workplace* (pp. 77-117). New York: Russell Sage

Arias, E. & Fischer, G. (2000, December). Boundary objects: Their role in articulating the task at hand and making information relevant to it. *International ICSC Symposium on Interactive & Collaborative Computing (ICC'2000),* (pp. 567-574). Australia: ICSC Academic Press, Retrieved January, 10, 2005 from http://l3d.cs.colorado.edu/~gerhard /papers/icsc2000.pdf

Armstrong, P. (1998, March). Work reorganization: How work reorganization shifts responsibility for quality to women, leaving them responsible but powerless, and thus in poor health. *Proceedings of A Meeting of representatives of women workers and researchers – Improving the health of women in the workforce,* (pp. 29-32). *Montreal, Quebec.*

Armstrong, P. & Armstrong, H. (2003). *Wasting away: The undermining of Canadian health care.* Toronto: Oxford University Press.

Armstrong, P. & Laxer, K. (in press). Mapping precariousness in the Canadian health industry: Privatization, ancillary work and women's health. In L.F. Vosko (Ed.), *Precarious employment: Understanding labour market insecurity.* Manuscript submitted for publication.

Ashcraft, K. & Mumby, D. (2004). *Reworking gender: A feminist communicology of organization.* Thousand Oaks, CA: Sage Publications.

Bach, S. (2000). Health sector reform and human resource management: Britain in comparative perspective. *International Journal of Human Resource Management, 11(5),* 925-942.

Belenky, M., Clinchy, B., Goldberger, N. & Tarule, J. (1986). *Woman's ways of knowing.* New York: Basic Books.

Berg, M. (1998). The politics of technology: On bringing social theory in to technological design. *Science, Technology, and Human Values, 23,* 456-490.

Berger, S. & Piore, M.J. (1980). *Dualism and discontinuity in industrial societies.* Cambridge: Cambridge University Press.

Braverman, H. (1974). *Labour and monopoly capital: The degradation of work in the twentieth century.* New York: Monthly Review Press.

British Broadcasting Corporation. (2005). MRSA fight needs more cleaners. *BBC News.* Retrieved March 10, 2005 from http://news.bbc.co.uk/1/hi/health/4158565.stm

British Columbia Ministry of Health Planning (2002). *The picture of health: How we are modernizing British Columbia's health care system.* Victoria: British Columbia Ministry of Health Planning.

British Columbia Nurses' Union, Hospital Employees' Union & Health Sciences Association (2004, October). Falling standards, rising risks: Issues in hospital cleanliness with contracting out. Retrieved January, 10, 2005 from http://www.heu.org/2004/falling_standards_rising_risks.pdf

Cameron, E. & Green, M. (2004). *Making sense of change management.* London: Kogan Page.

Canadian Broadcasting Corporation. (2005a). Superbug infections spiralling in Canadian hospitals. *CBC News.* Retrieved March 24, 2005 from http://www.cbc.ca/story/canada/national/2005/03/21/infections-canada050321.html

Canadian Broadcasting Corporation. (2005b). Restaurants have more germ-fighting rules than hospitals. *CBC News.* Retrieved March 24, 2005 from http://www.cbc.ca/story/canada/national/2005/03/22/germ-restaurant050322.html

Checkland, P. (1999). *Soft systems methodology: A 30-year retrospective.* New York: Wiley and Sons.

Coase, R. E. (1937). The nature of the firm, *Economica, 4,* 386-405.

Cohen, M. (1997). What women should know about economic fundamentalism. *Atlantis, 22,* 97-107.

Cohen, M. (2003, March). *Destroying pay equity: The effects of privatizing health care in British Columbia.* Vancouver: Hospital Employees' Union. Retrieved March 24, 2005 from http://www.marjoriegriffincohen.com/

Cohen, M. (2004, January 15). How privatization destroys pay equity: The example of health care. *Friends of women and children in BC. Report card, 3(1).* Retrieved July 10, 2004 from http://www.marjoriegriffincohen.com/

CUPE. (2003, September 30). SARS, other outbreaks possible unless next provincial government stops health care privatization, CUPE tells Campbell Inquiry. Retrieved July 10, 2004 from http://cupe.ca/www/News/6090

Davie, C. (1995). *Gender and the professional predicament in nursing.* London: Routledge.

Death, D. (2003, April 16). Start your calculators: Using zero-based staffing as a guide for ES management and budgeting. *Health Facilities Managemet,16(4).* 40-44.

DeLeon, L. & Denhardt, R. B. (2000). The political theory of reinvention. *Public Administration Review. 60.* 89-97.

Denis, J.L., Lamothe, L., Langley, A. & Valette, A. (1999). The struggle to redefine boundaries in health care systems. In D.M.Brock, M. J. Powell, & C. R. Hining (Eds.), *Restructuring the professional organization: Accounting, health care and law* (pp. 105-130). New York: Routledge.

Denison, D. (1990). *Corporate culture and organizational effectiveness.* New York: Wiley and Sons.

Dix, A. (2003, February 6). Editorial. *Times Colonist.* Retrieved April 22, 2005 from www.bcpolitics.ca

Doeringer, P. B., and Piore, M. J. (1971). *Internal labour markets and manpower analysis.* Lexington, Mass: D.C. Heath.

Domberger, S. & Jensen, P. (1997). Contracting out by the public sector: Theory, evidence, prospects. *Oxford Review of Economic Policy, 13,* 67-78.

Domberger, S. (1998). *The Contracting Organization: A Strategic Guide to Outsourcing.* New York: Oxford University Press.

Durant, R. A. & Cashman, J. F. (2003). Theorizing limits: An exploration of boundaries, learning and emancipation. *Journal of Organizational Change Management, 16,* 650-665.

Esmail, N. (2002, January). Labour costs in the hospital sector revisited. *Fraser Institute,* Retrieved July 10, 2004, from http://oldfraser.lexi.net/media/media_releases/2002/20020111.html

Feigenbaum, H. B. & Henig, J. R. (1997). Privatization and political theory. *Journal of International Affairs, 50,* 338-355.

Flood, R.L. (1999). *Rethinking the fifth discipline: Learning within the unknowable.* London: Routledge.

Flood, R.L. (2001). The relationship of 'systems thinking' to action research. In P. Reason & H. Bradbury (Eds.), *Handbook of action research* (pp. *133-144).* London: Sage publications.

Flynn, R. & Williams, G. (1997). Contracting for health. In R. Flynn & G. Williams (Eds.), *Contracting for health: Quasi-markets and the National Health Service* (pp. 1-13). New York: Oxford University Press.

Foster, D. & Braddon, D. (1996). An interdisciplinary approach to the analysis of privatization and marketization. In D. Braddon & D. Fostor (Eds.), *Privatization: Social science themes and Perspectives.* (pp. 287-311). Brookfield: Dartmouth.

Foucault, M. (1988). The ethic of care for the self as a practice of freedom: An interview. In J. Bernaure & D. Rasmussen (Eds.). *The Final Foucault* (pp. 1 - 20). Cambridge, MA: The MIT Press.

Freire, P. (1993). *Pedagogy of the oppressed.* New York: Continuum.

Frings, C. (2005, February). Addressing management issues. *Medical Laboratory Observer.* Retrieved March 1, 2005 from http://www.mlo-online.com/articles/0205/0205managementQ&A.pdf

Gardner, M. J., Paulsen, N., Gallois, C., Callan, V.J. & Monaghan, P.G. (2001). Communication in organizations: An intergroup perspective. In W.P. Robinson & H. Giles (Eds.), *The new handbook of language and social psychology* (pp. 561-584). Chichester, Sussex: John Wiley and Sons.

Golden, B.R. & Martin, R.L. (2004). Aligning the starts: Using systems thinking to (re)design Canadian healthcare. *Healthcare quarterly. 7(4).* 34-42.

Gorelick, S. (1996). Contradictions of feminist methodology. In H.Gottfried (Ed.), *Feminism and social change: Bridging theory and practice* (pp. 23-45). Chicago: University of Illinois Press.

Government of British Columbia (1991). *Closer to Home: The Report of the B.C. Royal Commission on Health Care and Costs,* Victoria: Crown Publications.

Greaver, M. F. (1999). *Strategic outsourcing.* New York: American Management Association.

Grint, K. (1991). *The sociology of work.* Cambridge: Polity Press.

Gross-Stein, J. (2001). *The cult of efficiency.* Toronto: House of Anansi Press Ltd.

Gulland, A. (2001). Private cleaners lose their sparkle. *Nursing Times, 97,* 10-12.

Hackman, J. R. & Oldham, G. R. (1975). Development of the job diagnostic survey. *Journal of Applied Psychology, 60,* 159-170.

Hage, J. (1974). *Communication and organizational control: Cybernetics in health and welfare organizations.* New York: John Wiley.

Hage, J. (1980). *Theories of organizations: Form, process, and transformation.* New York: John Wiley.

Hagenstad, R., Weis, C. & Brophy, K. (2000, June). Resolve decentralization issues to get the best of both worlds. *Nursing management. 31(6).* 39-43.

Haines, S. (1998). *The manager's pocket guide to systems thinking & learning.* Amherst, Mass.: HRD Press.

Harding, S. (1987). *Feminism and methodology: Social science issues.* Bloomington: Indiana University Press.

Harrison, B. (1994). *Lean and mean: The changing landscape of corporate power in the age of flexibility.* New York: Basic books.

Harrisson, S. (1986). A valuable part of the team. *The Health Service Journal, 96(5029),* 1608-1609.

Hartley, K. (1990). Contracting out in Britian: Achievements and problems. In J.J. Richardson (Ed.), *Privatisation and deregulation in Canada and Britian* (pp. 182-205). Aldershot: Dartmouth.

Hayes, M. V. & Dunn, J. R. (1998). *Population health in Canada: A systematic review.* Vancouver: Canadian Policy Research Networks Inc. (Rep. No. CPRN Study No. H01).

Health Canada (1998, December). *Supplement infection control guidelines: Handwashing, cleaning, disinfecting and sterilization in health care.* Ottawa: Canada Communicable Disease (Rep. No. 24S8).

Hernes, T. (2003). Enabling and constraining properties of organizational boundaries. In N.Paulsen & T. Hernes (Eds.), *Managing boundaries in organizations: Multiple perspectives* (pp. 35-54). New York: Palgrave Macmillan.

Hirsch, W. Z. & Osborn, E. (2000). Privatization of government services: Pressure-group resistance and service transparency. *Journal of Labor Research, 21,* 315-326.

Hodge, G. A. (2000). *Privatization.* Oxford: Westview Press.

Hospital Employees' Union. (2005, February 1). 700 privatized hospital cleaning workers join HEU. Retrieved March 1, 2005 from http://www.heu.org/

Jackson, M. C. (2003). *Systems thinking: Creative holism for managers.* New Jersey: Wiley and Sons.

Jackson, M. C. (1991). *Systems methodology for the management sciences (Contemporary Systems Thinking).* New York: Plenum Publishing Corp.

Kakabadse, A. & Kakabadse, N. (2002). *Smart Sourcing: International best practice.* Hampshire: Palgrave.

Kalleberg, A. L. (2003). Flexible firms and labour market segmentation. *Work and Occupations, 30,* 154-175.

Kim, D. H. (1999). *Introduction to systems thinking.* Waltham, MA.: Pegasus Communications Inc.

Knox, S. & Irving, J.A. (1997). An interactive quality of work life model applied to organizational transition. *Journal of Nursing Administration. 27 (1),* 39-47.

Lather, P. (1988). Feminist perspectives on empowering research methodologies. *Women's studies international forum 11. 6,* 569-581.

Lau, A. (2004, August 11). Is RCH 'dangerously dirty? *The Record.* Retrieved August 15, 2004 from http://www.royalcityrecord.com/issues04/082204/news/082204nn3.html

Legislative Assembly of British Columbia. (2001). *Bill 29 – 2002 Health and social services delivery improvement act.* Legislative Session: 2nd Session, 37th Parliament. Retrieved July 10, 2004 from http://www.legis.gov.bc.ca/37th2nd/1st_read/gov29-1.htm

Leveque, C. B. & Poole, M. S. (1999). Systems thinking in organizational communication inquiry. In P.Salem (Ed.), *Organizational communication and change* (pp. 79-97). Cresskill, NJ: Hampton Press Inc.

Lewis, J. P. (2002). *Working together: Twelve principles for achieving excellence in managing projects, teams and organizations.* New York: McGraw-Hill.

Maddock, S and Morgan, G. (1998). Barriers to Transformation: Beyond bureaucracy and the market conditions for collaboration in health and social care, *International Journal of Public Sector Management. 11(4).* 234-251.

Marshall, G. (1998). Parsons, Talcott. In *The Oxford Dictionary of Sociology.* (pp. 480-481). New York: Oxford University Press.

Marshall, N. (2003). Identity and difference in complex projects: Why boundaries still matter in the boundaryless organization. In N.Paulsen & T. Hernes (Eds.), *Managing boundaries in organizations: Multiple perspectives* (pp. 55-75). New York: Palgrave Macmillan.

Mason, J. (2002). *Qualitative researching*. London: Sage Publications.

McArthur, W., Ramsay, C. & Walker, M. (1996). *Healthy Incentives: Canadian health reform in an international context*. Vancouver, BC: Fraser Institute.

McKinley, W. & Mone, M. A. (2003). Micro and macro perspectives in organization theory: A tale of incommensurability. In H.Tsoukas & C. Knudsen (Eds.), *The Oxford handbook of organization theory* (pp. 345-372). New York: Oxford University Press.

Messing, K. (1998, June). Hospital Trash: Cleaners Speak of Their Role in Disease Prevention. *Medical Anthropology Quarterly 12(2)*, 168-187.

Meyers, S. (2003, January). Smooth move: Advice on easing the transition to team cleaning. *Health Facilities Managemet. 16(1)*. 42-44.

Midgley, G. (2000). *Systemic intervention: Philosophy, methodology, and practice*. New York: Kluwer Academic.

Morgan, G. (1986). *Images of organizations*. Thousand Oaks, CA: Sage.

Murphy, J. (1998). *Literature review on relationship between cleaning and hospital acquired infections*. Vancouver: Hospital Employees' Union.

NHS Estates (2001). *National Standards of cleanliness for the NHS*. Norwich: Crown copyright. April 2001. Retrieved July 1, 2004, from http://www.nhsestates.gov.uk/download/ publications_guidance/es_NHS_cleaning_standards.pdf

Ostry, A. (2001). International trade regulation and publicly funded health care in Canada. *International Journal of Health Services, 31*, 475-480.

Parsons, T. (1951). *The Social System*. Glencoe, IL, Free Press.

Parsons, T. (1971). *The System of Modern Societies*. Englewood Cliffs, NJ.: Prentice-Hall.

Patel, S. (2004). The impact of environmental cleanliness on infection rates. *Nursing Times, 100*, 32-34.

Paulsen, N. (2003). "Who are we now?": Group identity, boundaries, and the (re)organizing process. In N.Paulsen & T. Hernes (Eds.), *Managing boundaries in organizations: Multiple perspectives* (pp. 14-34). New York: Palgrave Macmillan.

Phillips, P. & Phillips, E. (2002). *Women and work*. Toronto: James Lorimer and Company Ltd.

Pollit, C. (1990). *Managerialism and the public services: The Anglo American agenda*. Oxford: Blackwell.

Price, D., Pollock, A. M. & Shaoul, J. (1999, November). How the World Trade Organisation is shaping domestic policies in health care. *Lancet, 354(9193)*, 1889 - 1892.

Reinharz, S. (1992). *Feminist methods in social research*. Toronto: Oxford University Press.

Riordan, E. (2002). Intersections and new directions: On feminism and political economy. In E.R.Meehan & E. Riordan (Eds.), *Sex and money: Feminism and political economy in the media* (pp. 3-15). Minneapolis, MN: University of Minnesota Press.

Salvage, J. (7-1-1989). The importance of hospital domestics. *British Medical Journal, 298(6665)*, 5-6.

Samson, C. (1994). The Three Faces of Privatization. *Sociology, 28(1).* 79 -97

Scharmer.Claus Otto. (1999, August 13). *Dialog on Leadership: Conversation with Lucy Suchman.* Retrieved July 3, 2004, from http://www.dialogonleadership.org/Suchman-1999.html#six

Sclar, E. D. (2000). *You don't always get what you pay for: The economics of privatization.* London: Cornell University Press.

Senge, P. (1994). *The fifth discipline: The art and practice of the learning organization.* New York: Currency/Doubleday.

Sergeant, H. (2003, December, 2). The truth about NHS hospitals: hygiene. *Telegraph.* Retrieved September 15, 2004 from http://www.telegraph.co.uk/news

Smith, D. E. (1987). *The everyday world as problematic: A feminist sociology.* Toronto: University of Toronto Press.

Star, S. L. (1989). The structure of ill-structured solutions: Boundary objects and heterogeneous distributed problem solving. In L. Gasser & M.N. Huhns (Eds.). *Distributed Artificial Intelligence: Volume 2* (pp. 37 – 54). London: Pitman.

Star, S. L. & Strauss, A. (1999). Layers of silence, Arenas of voice: The ecology of visible and invisible work. *Computer Supported Cooperative Work, 8,* 9-30.

Starr, P. (1988). The meaning of privatization. *Yale Law and Policy Review, 6,* 6-41.

Stone, D. A. (2002). *Policy Paradox: The art of political decision making.* New York: W.W. Norton.

Sub-group on ward hygiene (2001, February 6). *Report of the North West Region Communicable Disease Task Force.* London, England: North West Region Health Authority.

Suchman, L., (1987). *Plans and situated actions: the problem of human-machine communication.* Cambridge: Cambridge University Press.

Taylor, I. (2000, November). New labour and the enabling state. *Health & social care in the Community, 8(6),* 372-379.

Taylor, J. R. (1993). *Rethinking the theory of organizational communication: How to read an organization.* Norwood, NJ: Ablex.

Thomas, C. (1988). Contracting out: Managerial strategy or political dogma? In V.V. Ramanadham (Ed.), *Privatization in the UK* (pp. 153-172). New York: Routledge.

Tourish, D. & Hargie, O. (2004). The crisis of management and the role of organizational communication. In D. Tourish & O. Hargie (Eds.). *Key issues in organizational communication* (pp. 1 –17). New York: Routledge.

Van de Ven, A. H., Delbecq, A. L. & Koenig, R. (1976). Determinants of coordination modes within organizations. *American Sociological Review, 41,* 322-338.

Vancouver Coastal Health Authority & Providence Health Care (2002, November 22). *Request for Proposal – Cleaning Services. (RFP 2002-SS-004)*

Vancouver Coastal Health Authority (2002a, April 23). *Strategies for a sustainable health system (Health system redesign plan).* Retrieved June 25, 2003 from http://www.vch.ca/ newslinks/media/vcha_redesign_plan_final.pdf

Vancouver Coastal Health Authority (2002b, April 10). *Health system restructuring: VCHA begins first phase of corporate support services redesign.* Retrieved July 10, 2004, from http://www.vch.ca/newslinks/bulletins/bulletin_10.pdf

Vancouver Coastal Health Authority (2002c, November 18). *First agreement signed to enhance value in support and allied services.* Retrieved July 10, 2004, from http://www.vch.ca /newslinks/bulletins/bulletin_22.pdf

Vancouver Coastal Health Authority (2003a, January 15). *ValueIN update and review: Building on early success.* Retrieved July 10, 2004, from http://www.vch.ca/newslinks/bulletins/ bulletin_25.pdf

Vancouver Coastal Health Authority (2003b, July 30). *Vancouver Coastal Health announces housekeeping vendor.* Retrieved July 10, 2004, from http://www.vch.ca/ newslinks/articles/2003-07_Aramark%20release%20-%20final.pdf

Vancouver Coastal Health Authority (2005). Quality Assurance Team – Monthly Report. January 2005. Retrieved March 20, 2005, from http://www.vch.ca/vi/Docs/QA%20Team%20- %20Monthly%20Quality%20Report%20-%20Jan%202005.pdf

Vining, A. R. & Globerman, S. (1999). Contracting Out Health Care Services: A Conceptual Framework. *Health Policy, 46,* 77-96.

Von Bertalanffy, L. (1949). The concepts of systems in physics and biology, *Bulletin of the British Society for the History of Science, 1.* 44-45.

Wheatley, M. J. (1992). *Leadership and the new science.* San Francisco: Berrett-Koehler.

Williamson, Oliver E. (1979). Transaction cost economics: The governance of contractual relations, *Journal of Law and Economics, 22(2),* 233-261.

Young, R. (1998). *Braverman's labour and monopoly capital: The degradation of work in the twentieth century.* Retrieved July 12, 2004 from http://human-nature.com/rmyoung/ papers/blmc.html

Young, S. (2000). Outsourcing: Lessons from the literature. *Labour and Industry, 10,* 97-118.