

RATIONALES FOR BREAKING MANAGEMENT RULES—THE CASE OF HEALTH CARE WORKERS

JÖRG W. KIRCHHOFF

JAN CH. KARLSSON

Østfold University College, Norway

ABSTRACT

The aim of this article is to describe the mechanisms that legitimise organizational misbehaviour, that is, rules with a rationale for breaking management rules. It builds on case studies of four Norwegian health care enterprises, in which the main method of data collection in each case was through focus groups and in-depth interviews with registered nurses, auxiliary nurses, care workers, and home care assistants. We identify three distinctive rule sets: service rules, collective rules, and professional rules, based on distinct work relations within the context of wage labour. The relations are with clients, colleagues, and professional group, respectively. The identification and analysis of rules contribute, we argue, to a better understanding of organisational behaviour and organisational misbehaviour.

In order to consciously break one rule, you follow another—there is no such thing as rule-free rule-breaking. Deliberately breaking a rule involves the rule-breaker drawing on a rule that he or she thinks overrides the first one. “The (intentional) act of rebelling,” Tony Lawson (2003: 37) points out, “requires as much knowledge of the rules as does that of conforming.”

In research on employees’ opposition to employers, Ackroyd and Thompson’s (1999) notion of organisational misbehaviour—“self-conscious rule-breaking”—

has had an important impact in several ways. Most significant, perhaps, is these authors' insistence that resistance and organisational misbehaviour are in fact common phenomena in workplaces; all is not quiet on the workplace front (Thompson & Ackroyd, 1995), despite what several researchers have claimed. But the importance of rules other than those emanating from the organisation itself has been insufficiently analyzed.

The aim of this article, therefore, is to describe mechanisms that legitimise organisational misbehaviour, that is, rules providing the rationales for breaking management rules. The identification and analysis of work relations between the agents in an organisation, as well as the rules developed within these relations, provide us, we suggest, with a better understanding of organisational behaviour and misbehaviour in the workplace.

A CRITICAL REALIST PERSPECTIVE ON RULES

Workers are not passive receivers of management rules and norms; they can form and uphold their own sets of rules, which modify or replace organisational rules. Rules among workers directed against management control were discovered at an early stage in modern working life research. There is, of course, Taylor's (1998: 5–10) argument against "systematic soldiering" and workers' sanctions against those not following the norms. Furthermore, in the famous Hawthorne plant studies outside Chicago in the 1920s and 1930s, these rules were found among workers:

- (1) You should not turn out too much work. If you do you are a "rate buster."
- (2) You should not turn out too little work. If you do you are a "chiseller."
- (3) You should not tell a supervisor anything that will react to the detriment of an associate. If you do you are a "squealer."
- (4) You should not attempt to maintain social distance or act officious. If you are an inspector, for example, you should not act like one. (Roethlisberger & Dickson, 1965: 522)

The same informal rules existed among workers at a Norwegian factory in the 1950s (Lysgaard, 1972)—and they still existed there in 2007 (Hansen, 2007). In a workplace, opposing rules often clash. But what are rules?

Questions regarding the nature of rules form part of the long and intense debate taking place in the social sciences on whether or not social structures exist, and, if they do, what they consist of. We will not, however, be entering into this debate here; let us simply declare that we side with critical realism positions and obtain assistance from the underlabouring of this philosophy. Our perspective on rules is as follows. Rules are connected to positions (or "slots") in social structures. A social structure is constructed by internally related positions, such as employer–employee or home care assistant–client, meaning that one side of the relationship cannot exist without the other. There are interrelated networks or

“latticeworks” of relations (Fleetwood, 2008: 258–259) attached to positions, each connected to certain rules. Rules, like institutions and social structures, emerge from human actions. However, rules differ ontologically from human actions. As rules have emergent powers—they are the result of human actions, but they have powers that cannot be reduced to these actions or the individuals who perform them—they are to some extent autonomous from the social group that made them. Therefore, social rules and human agency cannot be reduced to each other. Consequently, in analytical terms rules always exist prior to the actions that relate to them. Nonetheless, rules cannot predict actions—there is an ontological gap between them.

Rules are injunctions and they take the form “if x do y under conditions z” (Lawson, 2003: 36). Of course, “x” is something to be achieved—rules are directed toward goals—while “y” is an action that the rule prescribes in order to achieve the goal. Thus far, this is quite a common definition of a rule. For example, Bunge (1998: 332) provides this formulation: “To attain goal G, perform action A.” But in Lawson’s critical realist conception, the action always takes place in a specific space-time and sociocultural context, “z.” An example of a management rule in the work of a home care assistant could be: “To do your work properly (x), clean the floor and do the dishes (y) when visiting client NN’s house (z).”

Even though rules in working life are most obviously connected to bureaucratic organisations, they exist in all organisations. In fact, it is impossible to imagine an organisation without rules. At the same time, rules cannot be expected to be followed in any strict sense; in workplaces, they are constantly treated as objects of interpretation, experimentation, and struggle, and they are always being “interpreted in action” (Edwards 1986: 81). Imagine the very effective resistance strategy of “working to rule,” which made jurists raise the question as to whether working to rule is really a breach of the employment contract (Napier, 1972). When employees follow all the rules, the process of work quickly breaks down. According to Ackroyd and Thompson (1999: 81), this is a factor that “affect[s] the judgements managers make about the appropriateness and likely effectiveness of taking action against specific instances of potential misbehaviour.” Breaking rules can be important for the labour process to run smoothly, but it can also be a form of rebellion.

Further, there are different sets of rules in workplaces, connected to different structural positions. These positions are part of what we generally term “work forms,” defined as internal social relations in working life (Karlsson, 2004). Our concern here is wage labour, which initially consists of the relation between employer and employee. In exploring the rules in workplaces, our starting point, therefore, is management rules. These are the rules that employees are supposed to follow but that they break while committing organisational misbehaviour. What we are searching for are the rules on which they draw when misbehaving. This question revolves around agents’ interactions in relation to

different sets of rules connected to different work relations. In our study of different occupational groups in the health care sector, we have, more concretely, found service rules in relation to the client, employee collective rules within workgroups, and professional employee rules in relation to a profession based outside the workplace—all related to each other and to the clients.

THE STUDY: DESIGN AND METHODS

The data presented are derived from organisational case studies of employees in four local health care enterprises within two municipalities in Norway (Kirchhoff, 2010). These enterprises were selected on the basis that they were organised in accordance with the purchaser–provider model, inspired by New Public Management reforms aimed at improving efficiency in public organisations, which will be presented in detail later in this article. The employees of these organisations consisted of four occupational groups: registered nurses, auxiliary nurses, and care workers providing primary health care services, and home care assistants providing domestic services. In order to cover all the services provided by these enterprises, the study sample was constructed by selecting employees from within all of the occupational groups in each enterprise (see Table 1).

In order to understand the context and content of employees' work, participant observation at the beginning of the study was utilised to observe them at work. His background as a registered nurse gave the first author of this article the opportunity to work with one informant from each occupation in all four organisations for one day, and thus to gather information about the services being provided and the employees' interactions with their clients and the other employees. This information was summed up in field notes and analysed in order to construct a semistructured interview guide ahead of the next phase of data compilation, which consisted of focus group and individual in-depth interviews. Even though the interviews were based on a semistructured interview guide, new issues and topics

Table 1. Informants Included in the Study

	Case A	Case B	Case C	Case D	Total
Registered nurses	1 informant	6 informants	4 informants	4 informants	15 informants
Auxiliary nurses	1 informant	2 informants	3 informants	4 informants	10 informants
Care workers	3 informants	1 informant	2 informants	1 informant	7 informants
Home care assistants	2 informants	2 informants	3 informants	6 informants	13 informants
Total	7 informants	11 informants	12 informants	15 informants	45 informants

were added when these were considered to be of relevance to the study. At the end of the study, the main content of an interview consisted of the following issues: the overall content of employee services provided to clients; employee attitudes to management rules; their relationships with clients, colleagues, and other members of the organisation; and the ways in which employees legitimise services that deviate from management rules.

Focus group interviews were the primary interview method, but difficulties in establishing the focus groups meant that 4 of the 16 interviews became individual in-depth interviews. However, employees from each occupation in each organization were represented and they provided information about their work, their attitudes to management rules, and their rationale when breaking them. Employees were selected if they worked for at least 75% of a full-time position. All the interviews were based on informed consent, digitally recorded, and depersonalised during transcription.

Pre-coding, that is, using codes derived from previous work life studies and critical theory, open coding, and displays were used to analyse field notes and transcribed interviews. The analysis consisted of coding the transcribed text, constantly comparing codes in order to work out concepts, and using causal network displays to structure and relate concepts.

THE LOCAL HEALTH CARE ENTERPRISES

In Norway, health and social services are public services, based on and regulated via legislation, and administered by municipal authorities. Since 1990, they have undergone comprehensive reforms, inspired by concepts related to New Public Management (NPM) (Rasmussen, 2004; Vabø, 2005). NPM is portrayed as a response to budget crises, failures in economic policy, and a rigid bureaucratic public administration, becoming in the early 1980s the answer to expansive, expensive, and inflexible public sectors in the United States and Europe (Rasmussen 2004; Simonet 2008). NPM consists of several central principles, for example, the use of market forces to serve public purposes, the principle of individual manager accountability, the need for competition within the public sector through the use of contracts, close attention to the outcome of public sector activities, and concern for standards that regulate the public sector (Hannigan, 1998; Simonet, 2008; Vabø 2005; Wilkinson, 1995). In sum, these principles emphasise the importance of changing public sector organisations into business companies and they represent a shift from public administration to public management.

The purchaser-provider model encompasses many of these principles and was imported from the United States to the UK in the early 1990s (Hannigan, 1998); it was introduced to Scandinavia during the 1990s (Green-Pedersen, 2002; Rasmussen, 2004; Vabø, 2005). According to this model, municipalities

are reorganized into two separate organisational units: the administration of health and social services becomes the purchaser organisation, and the institutions providing health and social services become the provider organisation. Through this split, the municipality can invite tenders in order to find the most cost-efficient provider. In 2004, almost 30% of all Norwegian municipalities were organising their health and social services in accordance with the purchaser-provider model; this involved almost 50% of the Norwegian population, since it was mostly large municipalities that had introduced the model (Ramsdal & Hansen, 2005).

Inspired by NPM, all the enterprises in our study were organised in accordance with the purchaser-provider model. In practice, this model leads to an employee of a purchaser enterprise deciding whether or not clients who request public services are entitled to them, and then ordering a provider enterprise to provide the services. These instructions were stated in service contracts that defined in detail the type, regularity, and content of services to clients. Consequently, service contracts became a management rule for determining the standard of services delivered by employees in provider enterprises, resulting in robust restrictions on employees' possibilities of controlling their work.

All the enterprises had a similar formal organisational structure, despite some minor differences. They employed staff from comparable occupational categories, provided both health and social services, and were organised using the same structure, that of an administrative manager at the top and a large staff of employees at the bottom of the hierarchy. Although the formal structure of the enterprises appeared simple on an organisational map, differences between employees regarding the distribution of formal academic education resulted in a differentiated social structure of positions and differences in the distribution of the tasks provided by each occupational group. First, due to their professional status, registered nurses were placed in administrative positions, where they managed enterprises and were authorized to manage medical issues. Registered nurses thus provided clients with advanced medical services, in addition to basic health care services, and they supervised other employees in other occupations in their work. Second, auxiliary nurses and care workers, possessing basic medical knowledge, were certified to provide basic health services, that is, to take care of clients' essential medical needs. Finally, home care assistants were employees without any formal education, and thus not certified to provide health services; these employees were assigned solely to domestic services, for example, vacuuming clients' apartments or cleaning windows. A formal education thus contributed to a social structure among the occupations, with registered nurses at the top and home care assistants at the bottom of the work organisation hierarchy. As a consequence, the rationales for breaking management rules differed between employees, since their social position within the enterprise resulted in variations in work relations with different rationales.

FINDINGS

The overall content of the health and social services provided to clients can be categorised into two types: services in accordance with management rules and services neither defined nor regulated by management rules. The latter type mostly consisted of additional services, provided by employees from all occupational categories in all enterprises. These services were neither expected nor wanted by management and were usually in conflict with management rules, that is, the service contracts standardising the services provided to clients. Therefore, additional services provided to clients can be categorised as organisational misbehaviour. The phenomenon of employees breaking organisational rules in order to satisfy clients, patients, or customers has been noted before, especially in the management literature; it has, for example, been conceptualized as “pro-social rule breaking” (Morrison, 2006) or “responsible subversion” (Hutchinson, 1990). These analyses do not, however, ask which rules this rule-breaking is based on.

The rationales for providing these additional services, and in doing so breaching the service contract, differed between employees and were related to three distinct categories of rules, namely, service rules, collective rules, and professional rules. Furthermore, these rules were based on three distinctive categories of work relations between the agents of the enterprises, that is, client–employee work relations, collegial work relations, and work relations among the professionals in the enterprises. However, although these categories of rules gave rationales to break management rules, all the rules were related to the work form of wage labour. Hence, the content of management rules with regard to wage labour must be presented in order for the emergence of “rule-breaking” in our study to be understood.

The Content and Influence of Management Rules

The management rules consisted of legal and organisational rules. The legal rules found expression in laws and judicial instructions and were related to legal conditions for public services, job qualification requirements, and interactions between employees and clients, which established legal working conditions and thus avoided judicial review by the authorities. In addition, the management rules also consisted of organisational rules for interpreting the legal rules in an organisational context: these were rules to place employees in a social position in the organisation; rules to define the interrelationships of these positions; and rules regarding how to organise, coordinate, and distribute work.

Although management rules varied between organisations, mainly because of different organisational rules, their influence on the employees was the same. First, management rules emphasised medical knowledge as being crucial to the work, thereby establishing a hierarchical structure of social positions within the enterprise, with registered nurses at the top and home care assistants at the

bottom of the pyramid. In addition, medical knowledge had an impact on the distribution of work and on employee autonomy, resulting in greater autonomy among registered nurses than among employees in other occupations. Second, management rules, in the form of service contracts, defined the content and number of the employees' services to their clients by means of standards and instructions regarding the work and the processes involved. The service contract was a legal document that was based on citizens' civil rights regarding public services and specified the content and number of services to be provided to individual clients. In doing so, the service contract became a legal standardisation of the employees' work. For example: "Vacuum clean the apartment once a week and clean the windows twice a year" would be a normal service contract relating to social services, whereas "Dress the wound on the left leg and administer the client's medication" serves as an example of a contract relating to health services.

Despite the differences between the contents of service contracts relating to health or social services, these contracts restricted the employees to providing no further services than those defined within them. Therefore, management was constantly emphasising that the service contract was the main management rule for the employees:

I always say to them, the service contract tells you what to do. If you deliver your car to the garage for a service control, they have a procedure to follow, and that is what you are paying for. It's what you expect them to do. You can't polish the car, or change its colour, or do more—whatever they are. The organisation would suffer from a deficit. We wouldn't make it financially. (Manager)

This quotation illustrates management's instrumental view of the service contract. Based on a financial argument, its purpose was to ring-fence the employees' duties, to confine their work. The resources of the organisations were regulated by service contracts, and additional services provided to clients would result in organisational imbalances. The employees recognised this, although they sometimes found it hard to provide services confined to the contract.

Interviewer: Do you have any kind of work instruction to follow?

Care worker 1: Yes, we have service contracts we must comply with.

Interviewer: And there it tells you in detail what to do?

Care worker 2: Yes. On the whole we do what they say, but not always.

Although employees generally acknowledged the importance of management rules and referred to them as "guidelines for work," the above quotation serves to show that the employees did not always comply with their service contracts. Independently of their occupational or organisational background, the employees often consciously violated this management rule (the service contract). On these occasions, they provided services outside the service contract by providing

alternative or additional services, which were neither expected nor wanted by management.

The employees' main reason for doing so was to meet their clients' needs, as presented by the clients to the employees during the delivery of social or health services. The employees then had to decide whether to reject the clients' requests or accede to them, breaking management rules in doing so. Therefore, the point of departure when breaking management rules was an acknowledgment of the clients' needs. However, even though the clients' needs gave rise to the issue of rule-breaking, the rationales for breaking management rules differed between employees and were related to different categories of rules at the companies. We start our discussion of this by using the category of service rules.

The Rationale for Service Rules

Service rules are informal rules or tacit agreements that evolve through an interpersonal relationship between employees and their clients, that is, through an informal client–employee work relationship. This relationship is based on, and related to, the formal employer–employee relationship, since this relationship also constitutes the employee's relationship with the client, that is, by the provision of services based on management rules. Following these rules, the employees became acquainted with their clients and simultaneously developed an informal work relationship within the formal work relationship, and then service rules took form. Therefore, all employees across all occupations established an informal client–employee work relationship. However, this work relationship was strongest among the home care assistants and provided their main rationale for breaking management rules. In earlier studies, it has been noted that the relationship between the home care worker and her client can become so intimate that she becomes “fictive kin” (Karner, 1998). Further, Aronson and Neysmith (1996: 66) found that these workers “commonly used the language of friendships and family relations to describe their ties with clients.”

The constitution and strength of the service rules used by home care assistants were related to three different structural aspects of their work. First, employees within this occupation had a fragile employer–employee connection as a result of their position of social isolation within the organisation. They were seldom in contact with the other employees or with management, since they worked alone in the homes of their clients and rarely reported on or discussed their work with other colleagues or management. Furthermore, the other employees rarely gave them a hand when help was needed, or listened to their problems at meetings. Therefore, the clients were their primary contacts at work, and their relationships with their clients became vital:

I'm only at the office half an hour a day. Most of the time I'm together with my clients. They are my workplace, not the office. Having a good relationship

with my clients out there is much more important to me than with employees in here [the office]. (Home care assistant)

Second, the inherent structure of their work led to long-lasting encounters with clients and provided good conditions for the development of a strong informal client–employee work relationship. To begin with, home care assistants provided their clients with social services over a long period of time, often until clients died and new ones were added to their list. In addition, the nature of the social services provided resulted in prolonged interactions with clients: cleaning a flat could, for example, take up to an hour. Therefore, enduring encounters between clients and home care assistants, as a result of the structure of the assistants' work, provided an opportunity for the establishment of strong social bonds.

Third, no home care assistant enjoyed her work, since the tasks were monotonous, led to physical stress, and were far from stimulating. These negative characteristics of the home care assistants' work made them value a good, close, and informal relationship with their clients, since this relationship provided them with an opportunity to enhance the quality of their working conditions.

Interviewer: How is work? Good, bad?

Home care assistant 1: It's monotonous and sometimes boring.

Several voices: That's true.

Home care assistant 1: Every day is the same.

Home care assistant 2: On the other hand you have all these nice clients.

You meet other people. That's okay. But I'd gladly avoid doing housework if I could.

Home care assistant 3: That's true. Housework is monotonous, but since it puts us in touch . . . with all kinds of people it's easier to put up with.

In sum, the social position of the home care assistants at the company, the enduring encounters with clients, and the negative characteristics of the work all enhanced the importance of an informal client–employee work relationship, thus weakening the formal employer–employee work relationship. Therefore, service rules provided alternative working rules with a rationale for breaking management rules, for example, providing additional services prohibited by management. While service rules tended to be connected to an individual relationship with a client, the next type of rule is collective.

The Rationale for Collective Rules

Collective rules constitute a collective understanding and interpretation of work and work-related issues; they evolve in consequence of the formal and

informal interactions between employees in the workplace. This interaction was based on a network of collegial work relations, as a result of the social position of the employees within the organisation. It constituted and maintained collective rules through employees' working together, participating in discussions about procedures, and sharing experienced encounters with clients and others in the workplace.

Collegial work relations existed in all of the companies and provided the basis for collective rules. However, collegial work relations were in place only among the employees providing health services, that is, registered nurses, auxiliary nurses, and care workers, since these were organised into teams. Each team shared a pool of clients, and the team members were thus in frequent contact in order to distribute and coordinate work and to share information about clients. Additionally, all the teams in a company interacted on a daily basis, for example, at lunch breaks and at report meetings where employees exchanged information about work-related issues. Therefore, the social position of the employees as team members placed them in collegial work relations, which provided a foundation for collective rules on how to interpret management rules, how to perform and distribute work, and the extent to which the employees should meet their clients' needs and thus break management rules.

Working as team members resulted in collective interpretations of management rules, since there was a common understanding that these rules, that is, the service contract, had to be adjusted to make sense of the team members' work. Thus, the employees redefined their job through collective discussions:

Interviewer: About this service contract, when you visit clients, does the contract match their needs?

Care worker 1: Not always.

Care worker 2: Then we change them. Contracts can be reformulated.

Interviewer: Who changes the content of the service contract, can anyone do that?

Care worker 1: Well, we discuss it when we're giving the report at the end of the day.

Care worker 2: That is right, when we report. No changes can be made until we've discussed it. You can't just go there and change it.

Care worker 1: No, you can't do that on your own.

Care worker 2: It must be discussed before you make any changes.

Collective discussions could lead to adjustments being made to the service contract when management rules were regarded as not being fully relevant to a client's needs. However, adjustment did not necessarily conflict with management

rules, since discussions often led to a better understanding of them. Sometimes, however, collective discussions and collective rules provided a basis for overriding management rules, for example, by providing services in accordance with clients' needs, even though these needs were not defined in the contract.

Interviewer: To what extent do service contracts regulate your work?

Auxiliary nurse 1: Not at all, they don't regulate what I do in any detail.

Several voices: No, not at all.

Auxiliary nurse 2: A service contract might restrict the services we offer to dressing a wound, for example, but the client has to have something to eat as well. Or we do the dishes. We have to adjust our services to the client's needs.

Although management's interpretation of service contracts resulted in restrictions being placed on health services, the above quotation illustrates the collective understanding on the part of the employees that all the needs of the client had to be taken into account when health services were being provided.

There were also, however, disagreements among employees as to the extent to which they should meet their clients' needs. These disagreements mainly concerned service rules, based as they were on a great variety of individual, informal client-employee work relations. This frequently resulted in discussions and arguments about where to "draw the line" as regards the clients' needs. Employees at all the companies had disagreements about this and even categorized their colleagues as "good" or "bad" employees, where good employees made more extensive efforts to meet their clients' requests than did bad employees. Consequently, tensions emerged between good and bad employees, becoming a potential source of conflict at the company. Collective rules, through providing collective compliance with individual requests from clients, offered a means of coping with these disagreements and thus of avoiding conflicts. This is illustrated by a conflict between good and bad colleagues about picking up a client's newspaper, which led to informal negotiations resulting in an agreement. One nurse said:

Nurse: Well, I'll have to give and take a bit. And then everybody has to agree that we're going to do it that way. Then the client has to bring in the newspaper herself, even though I'd like to be able to do her that favour. Because we all jointly agreed that she has to do it herself, and that everybody has to act in accordance with our agreement.

The statement illustrates how negotiations between employees generate and reinforce collective norms, thus affecting additional services. In consequence, collective rules restrain the number of services provided by the good employees and become a mechanism of collective control.

Collective rules, then, were related to health services in different ways as they interpreted management rules, restricted informal service rules, and provided a rationale for breaking management rules. Although collective rules influenced the employees and their work at all the companies, the impact of these rules varied between the organisations. One reason for this was differences in the number of professional employees, that is, registered nurses, between the organisations, and the strength of professional rules among registered nurses, our last rationale for breaking management rules. This, too, is collective, but it is based on a collective stretching across the organisations: the profession of registered nurse.

The Rationale for Professional Rules

Contrary to management, service, and collective rules, professional rules are established outside the organisation and are the result of formal academic education, providing their own standards in relation to health services. These rules are sustained and reinforced by the professionals working in organisations in order to legitimise professional working standards, which often override management rules when the rules are in conflict with professional standards. The only occupational group that referred to professional knowledge in their arguments regarding the necessity of overruling the service contract was registered nurses. Studies of nurses' resistance have mostly concerned their relationship with doctors (e.g., Bolton, 2004), less frequently their relationship with management (e.g., Timmons, 2003); however, it is the latter relationship we will deal with here.

Registered nurses maintained and reinforced professional rules through formal and informal interactions with other professionals, and in doing so realized a professional community that consisted of work relations between professionals. In order to establish and strengthen their professional work relations, registered nurses made efforts to meet regularly for professional discussions, sometimes even in their spare time, during which they talked about and reflected on their work and relationships with clients and colleagues. Thus, the work relations of professionals maintained their professional rules.

Furthermore, the organisational structure provided good conditions for the professionals and their standards, often resulting in the transformation of professional rules into management rules. First, the organisation's acknowledgment of professional knowledge resulted in the registered nurses' control over their work processes, since their education qualified them to perform medical services without supervision. Registered nurses were frequently also responsible for the preparation of procedures for specific health services, for example, a protocol regarding how to dress a client's wound. In consequence, this protocol became a management rule that was based on the registered nurses' professional standards. Second, having a formal education gave the registered nurses the authority to supervise and instruct employees lacking formal academic training for their service work.

Interviewer: What do you mean when you refer to nurses' responsibility?
How does it make a difference to other employees of this organisation?

Registered nurse 1: We guide our other colleagues at work.

Interviewer: Do you do that a lot?

Registered nurse 1: Well, it happens. They [auxiliary nurses and care workers] come to us and ask for our help and advice in various situations.

Registered nurse 2: We have some kind of supervisory responsibility for them.

Interviewer: What do you mean by supervisory responsibility?

Registered nurse 2: We have to ensure that they do their job properly. In a justifiable way, you know.

Registered nurse 3: After all, we have more professional knowledge than they do. So it's only natural.

The nurses' professional knowledge confirmed their social position within the organisation and led to an acceptance of their supervision of the other employees. Although the professional rules were frequently complied with, and influenced management rules, they could also come into conflict with the service contract when it interfered with professional work processes.

For the registered nurses, professional work entailed several processes, mainly making diagnoses, administering medical treatment, and evaluating the health services provided to clients. Furthermore, each process was related to their body of professional knowledge.

You have to use your head. That's what we learnt at nursing school. You have to consider all needs since they are interrelated, for example, physical and mental conditions. (Registered nurse)

In contrast to this professional approach, service contracts could enforce other standards than their own on the registered nurses, since a purchaser was diagnosing and making decisions about the treatment of a client. Furthermore, the registered nurses often perceived their professional diagnosis to be diverging from the diagnosis and treatment specified in service contracts. Therefore, they rejected service contracts when these contracts were in conflict with their own professional standards. When asked about the impact of the service contract on their work, some registered nurses answered as follows:

Interviewer: Did service contracts from the purchaser change your job?

Registered nurse 2: No, I don't think so.

Registered nurse 1: You see, most of the contracts didn't match the reality. So you couldn't work in the way contracts ordered you to.

Registered nurse 3: Because, if you worked in accordance with the contract, the client wouldn't receive the correct health service. The contract was like a map that didn't match the terrain.

The nurses' misbehaviour in relation to the service contracts was based on their professional rule of diagnosing clients in accordance with their professional knowledge. Hence, this professional knowledge provided the basis for rules with a rationale for breaking management rules.

In addition to rules based on their professional knowledge, the registered nurses also referred to ethical rules, that is, rules in accordance with their professional code, when breaking management rules. One of these rules was the holistic approach to clients, which implied an ambitious standard of care, thus providing a justification, and thus also an obligation, to meet all the needs of a client.

Interviewer: This might be a bit provocative, but when you are short of time, that could be a result of doing more than you're required to in the contract?

Registered nurse 1: What I do at work depends on the clients' need. You can't just go in and do your stuff; you've got to be human as well.

Registered nurse 2: At nursing college, we learnt that there's a connection between mental issues and physical illness. Sure, I can do my job faster, just running in and out, giving them their medication, and writing my reports and so on. But that would result in depressed clients—you see, everything's connected.

Registered nurse 1: Sure, I'd be better off just doing what I'm supposed to do. But I have to view my client holistically.

Being "human" illustrated a caring rule implying that the registered nurses were obliged to meet their clients' needs, although these needs were without limit, since their holistic approach neither restricted nor ranked them. Therefore, ethical rules made it compulsory for the registered nurses to provide additional services when needed, and in doing so to deviate from the limitations of the service contracts.

In sum, professional knowledge and ethical rules were interrelated and constituted a set of professional rules providing a rationale for breaking management rules. Although professional rules were related to socialisation during education, they were maintained through work relations between professionals, that is, the registered nurses. Therefore, the impact of professional rules on work was related to the strength of these work relations, even if the content of the professional rules was similar between companies.

CONCLUDING DISCUSSION

The findings concerning additional services provided by the employees of health care companies are consistent with those of previous studies (Hutchinson, 1990; Morrison, 2006; Næss, 2003; Vabø, 2007). Næss (2003) concludes that almost all employees in the public health sector in Norway provide additional services at work, and, furthermore, 40% of them offer help in their spare time. However, the mechanisms of doing this have not been adequately investigated. Therefore, our concluding discussion not only summarises the employees' rationales for breaking management rules but also elaborates on a theoretical framework in order to elucidate the emergence and conditions of rule-breaking.

Table 2 summarises our findings by presenting three rationales, or distinctive rule sets, and thus answers our question regarding what rules employees invoke when they are breaking management rules. Furthermore, Table 2 provides an overview of how these rules were distributed between employees across the various occupations working for public health care enterprises.

In addition to summarising our findings, Table 2 also illustrates the fact that there is an uneven distribution of rules between the occupations in the various companies. Registered nurses could draw on all the rationales when they were deviating from the service contract. Auxiliary nurses and care workers could fall back on service rules and collective rules, while home care assistants gained their rationale for breaking management rules solely from service rules.

When there is more than one type of rule in the rule set for an occupation, there seems to be a tendency for one of them to become more important than the other(s). Service rules provided the rationale for home care assistants, mostly as a consequence of their isolated position within the organisation, which resulted in a lack of other rules. For auxiliary nurses and care workers, collective rules provided the main rationale for breaking management rules, since these collective rules were shared by the majority of the employees. Collective rules defined the situations in which one could break management rules, as well as where to "draw the line" regarding clients' needs. Thus, collective rules restricted the service rules between "good" employees and clients. However, collective rules also made

Table 2. Rationales for Breaking Management Rules at Public Health Care Enterprises

Occupation	Service rules	Collective rules	Professional rules
Registered nurse	✓	✓	✓
Auxiliary nurse	✓	✓	
Care worker	✓	✓	
Home care assistant	✓		

“bad” employees extend their services to some degree. At one company, for example, the employees organised a shopping day for a client, although this kind of service went far beyond the organisational resources. In this case, collective rules were hierarchically ordered above service rules because of their potential to overrule both “good” and “bad” employees.

Finally, professional rules provided the dominant rationale for the registered nurses and were hierarchically ordered above collective rules, service rules, and management rules; they were thus referred to most frequently when the nurses were breaking management rules. The acknowledgment by colleagues and management of professional rules was one cause of their superiority over other rule sets. The auxiliary nurses and care workers, for example, turned to the registered nurses in order to discuss clients and work-related issues, thus subordinating themselves to the standards of the registered nurses. In addition, the registered nurses were assigned by management to supervise work and work out procedures and other organisational rules, which reinforced their position and resulted in the acceptance of professional standards in the companies.

All in all, our findings show that organisational misbehaviour among employees can be related to different rules and rule sets, and that the various occupational groups referred to rule sets that were in part different when breaking management rules, although the outcome of rule-breaking in the form of provision of additional services was similar.

We relate the emergence of different rationales to distinctive work relations within the context of wage labour. The concept of work relation is based on rules, as mechanisms of action, being connected to positions within social structures, such as the position of the employee of a health care company. The social position of an employee in the context of wage labour is thus part of an employer–employee work relation, in which management rules are developed—at least in part—in order to control employees. In consequence, however, using this work relation and these management rules, employees were assigned to further social positions related to work. In our study, wage labour and management rules placed employees in relation to clients, colleagues, and professionals in order to provide and coordinate services to clients. Therefore, as a result of an employer–employee work relation, other work relations that are dependent on the social structure of wage labour also emerge.

Figure 1 illustrates how wage labour leads to a social structure of work relations at health care companies, based on the employees’ social positions in the organisation.

Figure 1 illustrates how, as a result of being employed, an employee can be placed in various distinct work relations. The basic work relation in wage labour is the one between the employer and the employee, which leads to management rules for employees providing services to clients and rules about how to organise and coordinate work. In consequence, a number of other work relations emerge at the companies: between employees and clients, among employees in teams, and

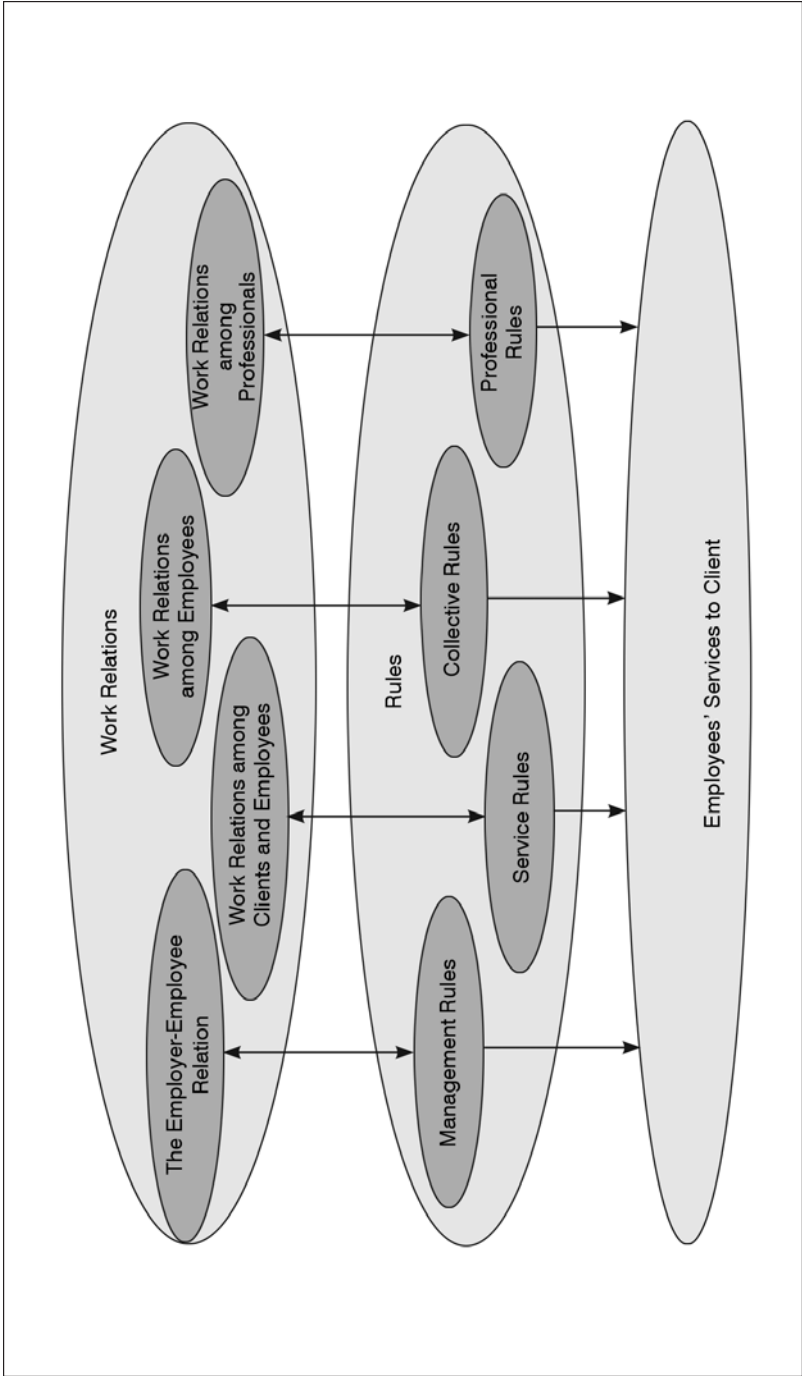


Figure 1. Work relations, rules, and services at health care enterprises.

among professionals. These relations form the basis of opposing sets of rules relative to management rules: service rules, collective rules, and professional rules. As there is a gap between rules and activities, management rules will not automatically result in the provision of services to clients as laid down in the service contract. The actual services rendered are also affected by the other three rule sets, providing rationales for breaking management rules. Wage labour and management rules thus form the basis of contradictory outcomes: services both in accordance with service contracts and in the form of additional or alternative services—the latter breaking management rules.

Furthermore, as a result of being related to different types of work relations, rules appear in different forms, mainly formal and written or informal and unwritten. This is not a sharp dichotomy, but rather a continuum related to different types of structural slots. Table 3 summarises the characteristics of the rules presented in this study and their placement on the continuum between written and formal or unwritten and informal rules.

Table 3 shows that service rules and collective rules in general take informal unwritten forms, whereas management rules are formal and written, although some may be informal and unwritten. Professional rules however, can be found at the middle of the continuum, as some of them are formal, for example, the written ethical codes for nurses, while others are informal. Nevertheless, although rules appear in different forms, they are all injunctions toward action and provide rationales for organisational behaviour and misbehaviour.

Table 3. The Characteristics of Rules at Health Care Enterprises

Category of rules	Rule characteristics
Management rules	Based on formal work relations. In general, formal written rules, e.g., the service contract.
Service rules	Based on informal work relations between employees and clients. Informal unwritten rules, e.g., informal agreements about specific services.
Collective rules	Based on informal work relations between employees who share similar social positions and work tasks in the enterprise. Informal unwritten rules, e.g., a collective agreement on where to “draw the line” with regard to clients’ needs.
Professional rules	Based on formal and informal work relations between professionals in the enterprise. Formal written rules, e.g., professional codes, as well as informal unwritten rules, e.g., informal agreements among professionals.

We end by suggesting an answer to the following question: Would health care workers or clients be better off without management and their rules, such as service contracts? The fact that rule-breaking enhanced employee autonomy at work and was beneficial to clients through the provision of additional services could support an argument against management rules. There are, however, side effects of rule-breaking that weaken employees' workplace rights.

First, breaking management rules based on service rules implied a potential conflict among employees, and was present in our findings as a tension between "good" and "bad" employees. The mechanism was quite simple: a good employee rarely drew a line with regard to a client's needs. As a result of the provision of additional or alternative services, clients' expectations with respect to other employees in the enterprise grew. Clients started to demand from other employees, including bad ones, that they too should break management rules, which resulted in irritation and quarrels among colleagues, with a destructive impact on the work environment. In addition, as a result of providing additional or alternative services, good employees often ended up with a lack of time to provide services to other clients on their work list. Therefore, good employees sometimes needed help from their colleagues in the team, which intensified the tension between good and bad employees.

Second, and even more important for workplace rights, rule-breaking weakened employees' legal rights in the workplace. As part of the employer–employee relationship, employees gain protection through judicial and organisational rules, establishing legal working conditions. Consequently, through providing additional or alternative services, employees lose security in the workplace, since these services are not part of the contract. Employees, therefore become more vulnerable in questions of workplace rights whenever they break management rules.

Given these side effects, we acknowledge the need for management rules, but we argue for a different approach to developing these than the narrow standardisation of work in which the service contracts result. Our approach is based on three principles related to work in health care enterprises. First, work in health care enterprises is varied as a result of clients' shifting health conditions; management rules should therefore allow employees to respond to various conditions in the workplace, not prescribing each work task. Second, health care services imply employees with the competence to respond satisfactorily to clients' needs. Therefore, management rules that encourage employees to provide services based on their knowledge and competence not only improve employee autonomy but also improve the quality of the services. Finally, in order to develop management rules that are recognised by employees, mutual adjustment of rules through management's acknowledgment of other rule sets through frequent discussions and dialogue with employees is required. All three principles argue against the narrow service contracts of the purchaser–provider model.

SUMMARY

This article tries to provide a further understanding of organisational misbehaviour, in which employees consciously break management rules, by presenting findings from case studies in four health care enterprises in Norway. Drawing on a critical realist perspective, we argue that wage labour results in a social structure that sets up distinct sets of work relations; within these emerge different sets of rules, making up rationales for breaking management rules. Therefore, in order to comprehend employee behaviour and misbehaviour, we have to consider not only management rules but also work relations and rules in consequence of these relations.

The findings of our study reveal three distinct rule sets, providing rationales for breaking management rules: service rules, collective rules, and rules among professionals, based on different work relations among employees in the health care enterprise. Our theoretical framework emphasizes that rule-breaking is inherent in organisations and can serve as a contribution to studies of organisational behaviour and misbehaviour in health care enterprises. Our framework can provide a starting point for further research on a larger scale in order to reveal the degree to which different types of rules affect employees' services.

Finally, the article discusses some side effects of rule breaking and concludes with an acknowledgment of management rules, while it advocates an approach that is different from the standardisation of services through service contracts.

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Direct reprint requests to:

Jörg W. Kirchhoff
Østfold University College, Norway
Høgskolen i Østfold
Avd. for helse- og sosialfag
1757 Halden
Norway
e-mail: jorg.kirchhoff@hiof.no