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## From white dress to white collar - A historical perspective on the hospital ward administrator

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*Published in:*

In tension between organization and profession: professionals in Nordic public service

2008

[Link to publication](#)

*Citation for published version (APA):*

Rosengren, C., & Ottosson, M. (2008). From white dress to white collar - A historical perspective on the hospital ward administrator. In A. Carola, & N. Lars-Erik (Eds.), *In tension between organization and profession: professionals in Nordic public service* (pp. 155-169). Nordic Academic Press.

*Total number of authors:*

2

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## Preamble

At the end of the last century, the role of the nurse handling the hospital ward administration changed from a mainly clinical job to a purely administrative one – implying that the patient was left behind. However this shift has not always been accompanied by shifting expectations on the incumbent of the role which could be exemplified with the fact that the ward managers feel that their co-workers expect them to participate in the clinical work on the ward. This questioning of the legitimacy of ward managers is described in terms of different time horizons between professional identity and organizational role.

*Calle Rosengren & Mikael Ottosson*

# From white dress to white collar

## A historical perspective on the hospital ward administrator

### Introduction

Contemporary studies on working life indicate that the ways in which we live and make our income are undergoing revolutionary changes. Among other things being put forward are the development of information and communication technology (ICT), an increased globalization of markets and a general shift towards customer-orientated production systems. However, the rapid transition of work organization could be contrasted with more stable cultural structures. In connection with this, Beck (1992) and Hydén (2002) argue that dramatic changes within social systems are not automatically followed by corresponding changes in norms and values. They argue that expectations are based on historical experience rather than on the present situation – a circumstance that could create a gap between reality and ideology. The tension between different time horizons, which Beck and Hydén discuss, is made explicit in the following quotation from one ward manager.

Yes, the staff members don't think I live up to their expectations. They feel disappointed with me. And I can understand them because they can't see the new role of the leader. The longstanding tradition is that, on a ward like this, you've had someone who was called a ward sister. And that meant that you had administrative chores but were also involved in the clinical work. [...] and our role isn't designed like that. We are employed on totally different premises. We're employed to develop the operation. [...] But we're not employed to work clinically. And that's a bit hard to understand.

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In the quotation, the ward manager expresses how expectations on her as a leader are based on tradition rather than present organizational setting. In order to understand the varying expectations posed on the ward managers a historical perspective is needed. According to Henriksen (2002), Nilsson (2005) and Petersson (1993), ward administration was traditionally handled by the most skilled nurse on the ward. Besides her clinical chores, she was responsible for manning the ward, educating its staff and mending supplies and equipment. Basically, the position consisted of ensuring that the present needs of the ward were matched with the proper personnel and equipment. Despite her administrative chores, she was foremost a nurse and as such was naturally part of the operative clinical work.

During the second half of the twentieth century, the administrative structure of Swedish public health care evolved dramatically and became an extensive bureaucratic apparatus. This development can be illustrated by the fact that the administrative staff increased 27 times in number during this period in relation to that of physicians, whose number only increased 6 times. Nurses came to play a significant role in this bureaucratization process. In his thesis *Gender, Salary and Careers – The transformation of the nursing profession during the twentieth century*, historian Sune Dufwa (2004) points out that the number of nurses with an administrative function increased during this period to comprise 8 percent of the total medical staff at the end of the past century. Studies indicate that increased bureaucratization has led to a purification of everyday work on the wards (Dufwa 2004). At the end of the past century, administrative functions became clearly separated from clinical functions. The nurse handling ward administration filled her working day with paper work rather than with traditional clinical work. Hence, the role of ward administrator became increasingly “managerial” in orientation.

### Aim and purpose of the article

One way to study the increased health care bureaucracy is to analyse in what way changed organizational roles are related to more stable cultural structures such as professional identities. The present article examines a series of interviews with a group of nurses who work with administration and on separate wards in one county council, Region Skåne, in Sweden. The interviews were conducted during 2005 by Calle

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Rosengren as a part of his doctoral studies. The main question, which structured the interviews, was how they perceived the increase in administrative chores in their role as ward managers. A total of nine interviews were conducted. At the time of the interviews, six of the respondents were working as ward managers. Two of the interviewed nurses were working as the above six respondents' immediate superiors, and both had previous experience as ward managers. The final interviewee came from central administration. Eight of the respondents were female and one was male. As the material is rather small, any generalizations being made are not primarily based on a representative sample. In this article, the interviews are rather used to serve as illustrations and exemplifications in a discussion on organizational roles, historical change and professional identity.

The aim of the article is to identify any conflicting expectations placed on the ward managers and to try to discover how individual ward managers deal with the tensions inherent in the role. How do the ward managers perceive the different expectations placed on their role and in what way are these expectations handled? An additional aim of the article is that it should constitute a foundation for further studies in which historical changes and professional identity are analysed in terms of psychosocial work environment. In a time when most public organizations are experiencing constant reorganization, it is interesting to pose questions regarding how identities are constructed and maintained in turbulent and shifting contexts (see Sennet 1998).

### Health care bureaucracy and the nursing profession

Seen in an international perspective, the Swedish health care administration is not unique. In most Western countries, ward manager posts are occupied by nurses (Salvage & Heijnen 1997). In a study of British ward administration it is shown that nurses with administrative functions are the foundation of the British health care hierarchy (Savage & Scott 2004). It is also shown that different hospitals have designed the positions in different ways. The health care administrations in Britain and Sweden are shown to have major similarities. In both countries, the foundation of ward administration is constituted by a balance between nurses' administrative and clinical tasks. This construction could be expected to contribute to a situation in which different, and conflicting, expectations are placed on this occupational role.

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The dramatic expansion of the health care system in both Britain and Sweden during the twentieth century must be seen in light of the build up of the post-war welfare state. In Western countries, an expansive health business has been built up, the aim of which is to produce good care for citizens as well as a healthy and strong nation. In both countries, this public and tax-financed expansion has been transformed into a period marked by heavy-handed economic and reorganization measures. Hospitals, nursing homes and clinics have been closed at the same time as societal demands for efficiency and financial control have increased. Concurrently with this transformation of the medical services, the character of nursing has also changed. Traditional nursing has become capital intensive and medically and technically more advanced. This process has brought about increased demands on the skills and knowledge of personnel.

One way of meeting these challenges has been to rationalize the operation through personnel specialization. In the medical services, doctors and nurses have faced increased demands on their special training. At the same time as demands on advanced knowledge have increased dramatically, the breadth and extent of medical personnel's knowledge has been reduced. As the work has been split up the administrative tasks have been given to specialized administrators – the ward managers. From a management perspective, the changes in the role of the ward manager could be described as moving from hands-on leadership – with authority derived from extensive knowledge of the clinical operation – to a leadership focussed on resource planning. In terms of the competence needed to carry out the assignment, the transition has implied less emphasis on clinical skills and more on administrative skills. However, even given these new demands, ward administrators are still recruited from the regular nurses on the ward. Regarding the title of the person who is given this role, the two most common are 'ward sister' (avdelningsföreståndare) and 'ward manager' (avdelningschef). The former implies a focus on clinical chores and patients and the latter on administration and staff. In moving towards an increased focus on administration, ward manager has become the most common title. This conceptual change is clearly indicative of the above-mentioned ideological shift in the public sector. However, it could be questioned if this conceptual shift has been accompanied by changed staff expectations.

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”The ward staff want you to be”

Henriksen’s (2002), Nilsson’s (2005) and Petersson’s (1993) picture of the early ward manager as being the most skilled nurse on the ward is also corroborated in the interviews. One of the ward managers states:

You usually took the person who had been working the longest time on the ward, for example the old lady who knew everything about surgery. It was she who became boss... because that was pretty natural. Of course she knew how to do everything.

Concerning the character of this “old lady”, a clear image of a very authoritative character emerges. This is a general perception among the respondents and can be illustrated by a small anecdote told by one of the ward managers.

When I was a nurse I worked under an old traditional ward sister who practically owned the whole ward. [...] She had a bell so every time she’d gone the round with the chief physician. She did it by herself. We weren’t allowed to follow. [...] So she had a bell she rang. In the hallway. Then we’d all come running.

As the quotation indicates, the traditional ward sister’s authority was mainly based on her profession as a nurse and less on her managerial skills. She was a very salient person on the ward, and the leadership she performed was of a hands-on character. The ringing of the bell can be seen as a clear expression of the hierarchical relations on the ward. One of the interviewed ward managers’ immediate superiors describes the change in the role as moving towards an increased focus on personnel and a decreased focus on the patient.

Today’s ward managers are so much more. They don’t work like that. The ward managers of today don’t even have a relationship to the patient. They are pure administrators. Their focus is primarily on staff members.

Here, the bureaucratization process is seen as leading to a purification of daily chores on the ward and, thus, you become either an administrator or a carer. The supervisor gives several reasons as to why this change in focus has occurred.

Today, labour laws and working life are designed in such a way that personnel administration demands an awful lot. In some ways, I guess it was simpler before. The ward sister of the past she could both

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work... have a patient perspective and still busy herself with paperwork in some way... it was easier back then. Things didn't move as fast as today. Back then you probably had more time so that you could have both perspectives. It's completely impossible today.

The informant perceives that the health care organization of today is more complex in nature than previously, which in turn makes it difficult, or sometimes even impossible, to combine clinical and administrative work. If we look in detail at the ward manager's work, it still consists – much like it did before – to a great extent of manning the ward and solving daily problems there. One ward manager puts it as follows:

Yes, big as well as small problems appear all the time. From someone who wants to change work shifts to big problems [...] like someone who is sick-listed for serious things and the like. It can happen in the blink of an eye. And cooperation problems within the work group. That a patient has a complaint. So a lot of things occur during the day that I didn't know about in the morning when I came in.

As the ward manager describes it, much of the work is reactive, in the sense that it is unplanned. But at the same time, it is also expected of the ward manager that he/she be proactive and visionary in developing the quality of the ward. As one ward manager expresses it: "It's a lot about visions. I have many ideas. About how we should work more customer oriented here for example."

A general perception among the interviewed ward managers is that people's prior experiences of ward managers still linger on – such as the expectations placed on them. They feel this especially among the older generation or those who have worked in the medical services for a long time. They consider that personnel of this kind have very clear expectations with regard to the ward manager. While the elderly personnel expect the ward manager to perform clinical tasks, the younger ones see the ward manager as a pure administrator. One of the ward managers says:

The ward staff want you to be... to know the patients... to be able to answer any question. At the same time, you are expected to do work on the ward, help the others in the morning rush. Perform everyday work. After that you are expected to take care of rehabilitation and human resource development. The problem is that there are old expectations too. Particularly from those who have been around for a while, those who have worked for many years and have old views. I think



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that many of the new nurses and assistants have a different view of the ward manager, but the ones who have worked in the old days... sometimes you can hear: 'The ward sisters could do it before – why can't you do it now?'

According to this ward manager, the conflict between the present situation and expectations is most obvious in those who have worked as nurses and assistants for some years. They have expectations with regard to the ward managers that are based on previous experiences and the historical development of the medical services.

## "Is she on the Internet or what?"

It is not self-evident that every aspect of the ward manager's work is viewed upon as work at all. In the interviews, a clear distinction appears between clinical and administrative work, such that paper work does not count. "The ward manager of the past she could both work... have a patient perspective and still busy herself with paperwork in some way..." The perception of what constitutes work is a cultural construction and therefore varies from time to time and from organization to organization (Silvén 2004). Irrespective of institutional care, the culture on the ward is based on the nursing profession. As was made clear above, nursing training is distinguished by its clinical elements, explaining why only caring has come to be considered work. In addition to this indistinctness regarding the ward manager's work, the increase in administrative tasks has resulted in a situation in which the ward manager's work is not as visible as the clinical work. Thus, the ward managers themselves as well as their staff can experience that they are not doing anything.

I mean my worst fear as a new ward manager was that someone should ask: 'What have you done today?' 'Well, what have I done today? Talked to a lot of people.' Still I've been busy with work all day. When somebody asked me as a nurse 'What have you done today?' 'Oh, I've transported this many patients to the operating room, I've taken this many blood samples, I've done this many intravenous drips, I've tended to this many wounds.' 'Cause that was concrete in some way. That was real work. And I'll tell you that this attitude is sometimes held towards directors' work. Recently I met a doctor. So I asked 'Where is our boss?' And then he said: 'He's working today.' 'Oh really, I responded. I thought he did that everyday.' 'But he's performing an operation.' That says a lot!

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A conclusion that can be made from the quotation above is that administrative work is sometimes not regarded as “real work” – a circumstance that the ward managers perceive is a cause for suspicion among their co-workers. This is explicated by one of the ward managers’ immediate superiors, who says “I know that many ward managers sometimes feel frustration when people look into their office and say ‘All right, there she is sitting at her computer again. Wonder what she’s doing? Is she on the Internet or what?’”

The fact that work has become more administrative in character means that it is no longer as bound to the ward facilities as it used to be, which, for example, opens up for telecommuting. The question to be asked then is: Is work conducted outside the ward facilities perceived as “real work”? And the answer is: No. Similar to the different perceptions of concrete clinical work versus more abstract administrative work, the respondents experience that this kind of work is looked upon with suspicion by other staff members. In this connection, the ward managers claim that they are expected to be present during office hours – an expectation that can be deduced from the ward manager’s historical role as a very visible person on the ward. If the ward manager were to telecommute, it is presumed that the staff would view such work as not working at all. “No, personally I don’t think that would work for me. I would probably feel guilty if I left earlier one day. And think that ‘Now they think I’m not doing anything at all’”.

As mentioned earlier, much of the change in the design of the ward manager’s role is that clinical chores have been reduced or ceased all together. However, the interviews show that several of the respondents still spend a great deal of their time on clinical chores and that they are committed to such chores. The fact that they were conducting nursing tasks was something they felt was perceived very positively by the staff. “What a great boss who is out there!” Moreover, the informants feel that decisions made on the basis of personal experience receive more attention.

In some way I think that I’ll get more trust if I say ‘This looks very bad. You really have to do this better.’ Then they’ll have an easier time accepting it if I’ve been out there and seen it in person. [...] It’s not just a desk product so to speak.

In other words, administrative experience does not count – it is, as we saw, not even considered work. In order to gain increased respect

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– and at the same time make their work more visible – the ward manager performs clinical work with no pay – outside his/her line of duty. In certain contexts, the ward manager is not free to make this decision at all, but, due to an acute need, must throw him-/herself into the clinical work.

Last year it happened that I sat on this chair and in came a colleague, a midwife, and screamed at me that I had to come. Then I had to take care of a couple. And help out with that delivery. There was simply no one else.

Here, the ward manager takes on the traditional female role as the caretaker. Nursing is not merely salaried work, but, as shown in previous research (Dufva 2004), can also be considered a calling. This calling underlies the role as a nurse as well as the role of being a human being – you cannot let a fellow human being come to harm because you are “sorting your paper”. The ward managers who did not perform clinical chores explain this in terms of their lack of clinical competence. They argue that because they have not been working clinically for a long time, they feel they do not have sufficient knowledge of new routines and equipment. The argument that it is simply not their job is not enough. By referring to their lack of competence in conducting nursing tasks, they are downgrading their professional competence as nurses, and at the same time showing that the administrative chores of the ward manager are not enough to dispel the demands of the calling.

## ”Then I’m dressed in white”

As mentioned in the beginning of the article, professional identities must, in relation to organizational roles, be seen as rather stable over time. Central to the understanding of professional identities is that they are based on conceptions of masculinity and femininity. Studies on working life history show that different professions have a clear gender encoding depending on the specific historical context from which they have evolved (Wikander 2006). By tradition, the nursing profession is associated with what are traditionally regarded as feminine qualities such as thoughtfulness, empathy and sensitivity (Björklöf 2006, Greiff 2006, Ekstrand 2005). The connection between the nursing profession and gender is made explicit in our language, in that

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a nurse is also called “sister” – a fact that has led to certain problems of designation. What do we call a male nurse (Dufwa 2004)? It is reasonable to assume that changes in the medical services have made traditional gender encoding problematic.

In the medical services, it is not only the professions that have a specific gender encoding but, according to Alvesson and Due Billing (1999), also the organizational hierarchy. Like many other businesses, the health care hierarchy is marked by a pattern in which women are found near the bottom and men near the top. What will happen when a female nurse makes a career and perhaps even becomes the superior of male doctors? Is a career in the medical services encoded as masculine, in that it moves from caring (feminine) to management (masculine)? Macdonald (1995) argues that the role of the ward manager must be seen in relation to the professional project of nurses. The ward manager was to ensure greater autonomy for the nurses working within the hospital organization. Is the ward manager then to be seen as a protector of her fellow sisters, which, according to Macdonald, was the original purpose of the role, or is she to be seen as a traitor to her sex – a traitor who wants to get closer to the men at the top of the hierarchy? From this point of view, the conflict could be analysed as disloyalty on the part of the ward manager towards her fellow sisters.

One former sister, who became a ward manager, supports this interpretation when she describes her career move as a break with the female collective on the ward.

It's a large group. It's a strong group of women. Only women. It's a tradition. We don't have many men [...] Most staff members have worked here for many years and they're a strong group, welded together, with different wills. First I just said no... definitely no!

The above picture of women's relations to their gender role and career is confirmed by Lindgren (1992). In her study of career patterns in the medical service, she found that a woman who strives upwards in the hierarchy is looked upon with suspicion. Their female colleagues said that such women just wanted to get closer to the doctors, that they were more interested in their superiors than in their fellow sisters (Lindgren 1992). It is reasonable to assume that making a career within an organization with explicit gender encoding is problematic. It is also reasonable to assume that a woman who moves upwards in

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this kind of organization is defying traditional gender patterns. This interpretation is supported by the fact that the interviewed male ward manager said that he did not experience any role conflict in his work. Although our empirical foundation is small, it seems fairly clear that the relationship between nurses and the ward managers has gender implications and that the female ward manager runs the risk of being excluded from the female fellowship.

However this interpretation, that nurses who pursue a career as ward manager are looked upon as traitors to their sex, could be complemented and nuanced from several different perspectives. One obvious fact is that organizational hierarchies not only express a gender encoding, but also reflect class. In line with Sverre Lysgaard's (2001) analysis of the relation between "the workers' collective" (Arbeiderkollektivet) and management, it could be assumed that the nurse who pursues a career is also considered to be disloyal towards and to lack solidarity with colleagues on the ward. By moving closer to the doctor – who not only symbolizes male dominance, but also the upper class – the ward manager betrays the other nurses both as fellow sisters and as colleagues. Another consequence of the nursing profession's clear female gender encoding is that patient care constitutes the core of the profession (Greiff 2006). Thus, by moving away from the patient – leaving the white dress and becoming a white-collar worker – the ward manager leaves the core of the nursing profession – the patient – behind.

In this article, two different expectations have been discussed, that of the administrator and that of the nurse. Ward managers are supposed to be colleagues, women, nurses and supervisors simultaneously. Similarly to other professionals, the ward manager uses different symbols to indicate identity, and in cases of conflict to indicate which identity applies at the moment. In order to indicate our position in relation to others, we use language in different ways; we assume different postures in relation to superiors and subordinates; we use titles and nametags to show who we are (Barth 1994, Ottosson 1999, Peterson-Royce 1982). Within the health care service, as in other uniformed professions, clothing is perhaps the most important symbol in different situations. One way of handling tensions between being an administrator and being a nurse is in the selection of clothing. One of the ward managers mentions white clothing as a symbol of her clinical role. "Then I'm dressed in white. Yes. 'Cause they know that when

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I'm wearing white I'm working clinically. Then I'm available". This quotation illustrates that this ward manager marks a difference between the person performing clinical work and the one performing administrative work through her choice of clothing. When she leaves her administrative role, the white dress replaces "the white collar" – an indicator of the fact that there actually exist two roles that the ward manager must handle within his/her working day.

### Conclusion

The present article has focused on the establishment of ward managers as a sub-profession of the nursing profession. During its initial phase, this establishment could be seen as reflecting the nursing profession's ambition to gain a higher degree of self-determination inside the medical service organization. When the administrative apparatus enlarged during the twentieth century, the participation of nurses with administrative functions became more common. At the end of the century, the role of the ward manager changed from a mainly clinical job to a purely administrative one. At the same time, the ward managers feel that their co-workers expect them to participate in the clinical work on the ward. The descriptions provided by the informants also show that the predominant view of what characterizes "the real work of a nurse" focuses on its clinical elements. Our present interpretation, based on the interviews, is that this view of the nature of the work involves a questioning of the legitimacy of ward managers. Moreover, we can see the origins of the tension in the ward manager's role in the nursing profession's gender encoding. The nurse (the woman) who makes an administrative career (ascribed to men) runs the risk of being seen as a traitor to her sex. Taken together, the interview material shows that ward managers often see themselves as partially renounced by the nurse collective and that they, therefore, even see themselves as suspicious characters.

They leave the professional fellowship of the nursing group; they receive new duties that have little if any connection with their professional training as nurses. A majority of the interviewed ward managers say that their posts have become purely administrative and that they do not have time enough to participate in clinical work on the ward. Despite this experienced alienation, most of them occasionally perform clinical work. When they, like their predecessors, are per-

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forming the role as the “most skilled nurse”, they secure their authority on the ward. Sometimes they perform clinical chores with the explicit ambition to maintain their competence as nurses; sometimes because they must do it – they are trained nurses surrounded by ailing and sometimes even dying patients; sometimes they do the work simply because they find it stimulating and enjoyable. In other words, the clinical work performed by the ward manager does not necessarily have to be seen as a symbolic action in relation to certain expectations deduced from the nursing profession, but could rather be seen, from the individual’s point of view, as a valuable and necessary action.