

Employment Regimes and Organization Forms: Organizational Change at the Close of Modernity

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The Institutional Context of Work

The employment and work systems that dominated twentieth century capitalism seem to be undergoing significant transformations (Castells, 1996; Fligstein, 2001; Kallinikos, 2003). Some of these transformations are accommodated within the established framework of institutional relations. Others may necessitate, though, radical changes in that framework, such as the reconsideration of waged or even paid labour and the organizational forms within which employment relations are instrumented, carried out and controlled (Beck, 2000). While being comprehensive, current developments exhibit both variety and subtlety. Their appreciation requires thus the investigation of the specific forms by which they are manifested in particular contexts placed none the less within the wider institutional relations that regulated labour relations in the modern age. Such a task is inherently difficult as contextual specificity and historical awareness may work at cross purposes.

While employment systems, as we know them today, were basically formed during the course of the twentieth century (Offe, 1982), their roots go back, at least, to the middle ages. Wage labour was part of the medieval urban economies and to some extent of the cities of the ancient Mediterranean economy (Braudel, 1982). With the breaking of industrialism, traditional forms of labour and subsistence (e.g. agricultural work, family as an economic unit, self-employment) declined in a long and stepwise historical process, and waged or salaried labour became the dominant form of work. Despite the strong presence of independent professionals sustained by scientific specialization and the edu-

cation system (Abbott, 1988; Fligstein, 2001), by mid twentieth century, in the advanced industrial societies, work was predominantly carried out within the context of formally constituted organizations, i.e. companies and state bureaucracies (Gellner, 1983; Tilly and Tilly, 1998). Neoclassical economics identify these developments with the emergence of *labour markets*, whereby work became the object of market trading according to the laws of labour demand and supply (Fligstein, 2001; North, 1981). Marxism, on the other hand, sees the modern transformation of work as a process of *labour commodification* (Marx, 1954 and 1956). Work was gradually conceived and treated by the ruling economic elite and its social allies as a commodity, i.e. abstract labour, to be bought for a wage or a salary and used as merely an input in the production process (Braverman, 1974; Thompson, 1968).

The labour developments that took place from approximately the end of nineteenth century to 1970s could be seen as implying the gradual demarcation and *constitution of work as a separate social field*. Work became increasingly standardized and packaged to those distinct ensembles of duties we call jobs and occupations and was subject to specific rules, conventions and procedures. As already indicated, the standardization/institutionalisation of work coincided with the steady decline of older forms of work and subsistence and the establishment of formal organizations as the primary context in which work was carried out. But it entailed too the interplay of social forces whereby work was steadily brought under legal and economic regulation and shaped by the actions of crucial institutional actors, such as employers, trade unions and state agencies (Offe, 1982).

An important consequence thus of these social and institutional developments was that the agendas of institutional actors and the power relations underlying them increasingly shaped the very processes that regulated work (Knights and Willmott, 1990). The forms by which such relationships were articulated undeniably exhibit historical and cultural diversity (Fligstein, 2001). However, a common denominator behind these developments was the insertion of the occupational initiatives of individuals/groups into a dense network of wider, often national, regulations and institutional relations that increasingly came to define the formation of employment relations at the local level. The emergence of work as a distinct field of social life was part of wider and far reaching social transformations that defined the distinct character of a new age, often referred to as modernity (Bauman, 1992; Giddens, 1990). The institutionalization of work both expressed important modern preoccupations and help to embed them in social relations. Work as we know it today is inseparable from the institutional and political edifice of the modern welfare state and the cultural orientations of the modern social order (Gellner, 1983,

1996).

Now, modernity and its accompanying forms of organization and work are said to undergo profound change. A reverse process of work *de-institutionalization*, *re-individualization* and *re-contextualization* (decentralization) is often argued to be accompanying the current economic, social and technological change (Beck, 2000; Castells, 1996; Murray et al., 2002). Work becomes progressively deregulated, individualized and locally shaped. An increasing part of the initiatives and risks associated with work and vocational training are off-loaded from the welfare state and other societal institutions and transferred over to individuals, local groups or smaller occupational communities (Beck, 1992). In the more delimited realm of everyday practices, work is currently claimed to be acquiring forms that contradict the very premises by which it was typically conducted in the modern age. Self-employment, temporary employment, part-time and flexible-time arrangements, extended daily schedules, freelance and virtual work are all gaining significance, in ways that seem to be redefining the occupational landscape that dominated modernity (Blocklehurst, 2001; Kallinikos, 2003; Sennett, 2000).

The claims about the current changes in work and employment invite the thorough examination of the social and institutional edifice associated with the employment systems that dominate twentieth century capitalism. Catchwords like ‘flexible employment’, ‘nomadic work’ or ‘telework’ are suggestive metaphors that nevertheless fall short of the crucial task of accounting for the complex social transformations currently underway. As we will attempt to show in this paper, the labour contracts of the modern industrial age exhibit far greater variability and flexibility than what is commonly assumed. Most significantly, current developments entertain many and complex bonds with the transformations of work that were briefly described above. Modern forms of work detached human effort from its embeddedness into particular contexts (nature, location, community and family) and made human labour a mobile component of the contemporary world. Despite the widespread assumption about the stability of modern forms of work, employment mobility is essential to the modern occupational order. The modern workplace is the first historical context in which individuals came to be tied to their employment in mobile and reversible terms, i.e. in terms that are in principle negotiable and possible to revise or terminate (Gellner, 1983, 1996; Kallinikos, 2001; Luhmann, 1982, 1995). Current developments build on the mobile labour relations modernity constructed at the same time as they challenge these in some important ways (Kallinikos, 2003).

This paper sets out to reconsider some of these questions. It basically deals with three sets of issues. First, it examines variations on labour contracts as a function of the complexity of the underlying work. Labour contracts are thus seen as rational devices that seek to accommodate work complexity by minimizing the transaction costs that would have been otherwise incurred. While making a contribution towards revealing the variable character of employment forms, transaction-cost-based typologies of labour contracts are unable to capture the historical transformation of work arrangements and the institutional complexity into which they find themselves embedded. We then move on constructing a brief history of the medical profession and the recent New Public Management (NPM) inspired reforms in health care as a way of showing the dense institutional relations within which the production/delivery of health care services develop. Such a history reveals a tension between two major regimes of employment and governance, i.e. those of professionalism versus managerialism. Next to it we use some empirical evidence from the Swedish health care sector to explore some of the consequences of this tension and the recent tendency of a small but growing minority of medical doctors to work on a contingent basis. In the final section, we attempt to draw the implications of our observations and to reflect on the nature of work and the institutional transformations underlying the late modern age.

The Variability of Labour Contracts

The claims of the current decline of standard practices of work are quite often predicated on assumptions that do not do justice to the variability of employment forms, underlying the modern industrial age. A *standard labour contract* is usually invoked, the major characteristics of which are claimed to be its *long-term* and *predictable status*. Life-time employment, clear-cut job assignments and the advancement of job holders along the steps of a clearly demarcated career ladder are usually seen as the basic components of the typical work arrangements that dominated the modern industrial world (see, e.g. Castells, 1996; Carnoy, 2000). Thus conceived, the standard labour contract makes a whole lot of sense as a brief description of those historical processes that were referred to in the preceding section. Modernity did move from highly fragmented, locally embedded work practices to highly regulated and standardized employment forms.

And yet, there is a variety of labour relations and working practices underneath the mentioned standardization and institutional regulation of work. Examples that easily come to mind include low-skill work, exercised in contingent and temporary forms in a variety of industries (e.g. tourism, agriculture and entertainment). But even the so-called standard labour contract exhibits a significant variation, depending on whether it is applied to routine, mechanical work easy to measure and monitor or to other forms of

work (i.e. professional and managerial work) that are not subject to precise measuring and monitoring (Goldthorpe, 1998). There are indeed several dimensions that could be used to distinguish between labour contracts and the work practices with which they are associated. Tilly and Tilly (1998) identify differences in *incentives*, *time orientation* of the contract, *autonomy of work*, *job requirements*, *career ladder* and *training*. Professional employees for instance enjoy more discretion in the work process than lower skill employees, their career ladder is more elaborate than the latter's, while their incentives cover a variety of types of rewards and so forth.

Rather than being accidental, differences in labour contracts seems to be associated with the complexity of work that the contract seeks to accommodate. Goldthorpe (1998) has used the dimensions of *measurement-monitoring* and *specificity* of work to arrive at a four-fold matrix onto which he placed a variety of work situations and contracts. The general contours of his argument are as follows. Work whose quantity is easily measurable and its quality possible to assess without major difficulties can become the target of severe controlling strategies and piece-related payment schemes that favour *short-term contracting*. Under transparent and measurable work conditions, most aspects of work can be carefully laid out (i.e. what is to be done and how) and payment schemes tied to performance in a clear and unambiguous fashion. Work of this sort renders the elaboration of incentives costly and superfluous. Strategies of employee commitment and motivation incur costs for the employer without bringing about performance improvement. For, motivation becomes a viable and appropriate behavioural strategy under work conditions that the employer cannot fully control and under which adequate levels of performance demand the active participation of employees.

Furthermore, the lack of work specificity does not provide any incentives for the employer to offer a long-term employment contract. Work specificity refers to the acquisition of value-adding skills that accrue often *in situ* as the outcome of context-embedded forms of learning. A long-term contract usually makes sense only under conditions that are governed by knowledge accumulation and skill development as essential components of performance improvement. By contrast, low degrees of work specificity combined with work that is easy to measure and assess speak up for short-term labour contracts that basically involve pecuniary compensations for specified amounts of work. Labour relations of this sort are therefore simple and relatively straightforward. Indeed, they come close to the ideal of spot market exchange. Routine manual, administrative or service work usually conforms to this type of working conditions.

On the opposite side of measurable and low-specificity work stand working conditions

that are not easily subject to measurement and under which the skills of employees demand continuous improvement and performance-enhancing work adjustments. These circumstances render meaningless the introduction of performance-related schemes, as the link between work inputs and outcomes cannot be established. While performance is heavily dependent on human contributions, the specific forms such contributions need to take are not well understood. Under such conditions the employer must develop organizational policies directed towards ensuring the commitment of employees to the goals of the organization. Furthermore, the development of organization specific skills makes necessary an organizational environment that ensures effort continuity and consistency, and encourages context-embedded forms of learning. A long-term contract, a carefully designed career ladder and a variety of incentives are therefore crucial means through which the employer may seek to provide the conditions necessary for the accomplishment of these ends. Labour contracts of this sort provide the motivation for employees to actively participate to the accomplishment of organizational goals. They also help establish an enduring employee affiliation that supports context-embedded and organization-specific forms of learning. Professionals and managers are typical groups that fall within this category.

The first group of conditions, Goldthorpe (1998) claims, is akin to the establishment of *labour contracts*, i.e. conditions that unambiguously define the contributions to be made for a specified amount of pecuniary rewards. The second group of conditions, however, is bound to constantly face unexpected contingencies. The handling of such contingencies necessitate an open contract that has the character of a *service relationship*, i.e. the buying of skills and capacities to be employed in the future, under conditions that are not as yet specifiable. The service relationship represents thus a meaningful strategy on the part of the principal (i.e. the employee) to the transaction costs that would have otherwise been incurred in specifying the conditions of work performance and the rewards associated with it. The enduring bonds of a service relationship (i.e. a hierarchy) address these difficulties as a mechanism of uncertainty absorption.

As shown in figure 1, important differences emerge in the terms by which people join organizations that depend upon the type of work they are called upon to perform. The modern institutionalization and standardization of work therefore involves two archetypical and widely contrasting employer-employee contracts. A variety of other contracts that combine elements of both these archetypical forms do exist (see figure 1). Mixed contracts are formed to address conditions that lie somewhere between those that are captured by the labour contract and the service relationship, and represent varying combinations of work specificity and difficulties of monitoring. Goldthorpe's scheme

therefore suggests that *labour contracts exhibit diversity and represent organizational responses to the effective management of the variety of underlying task structure.*

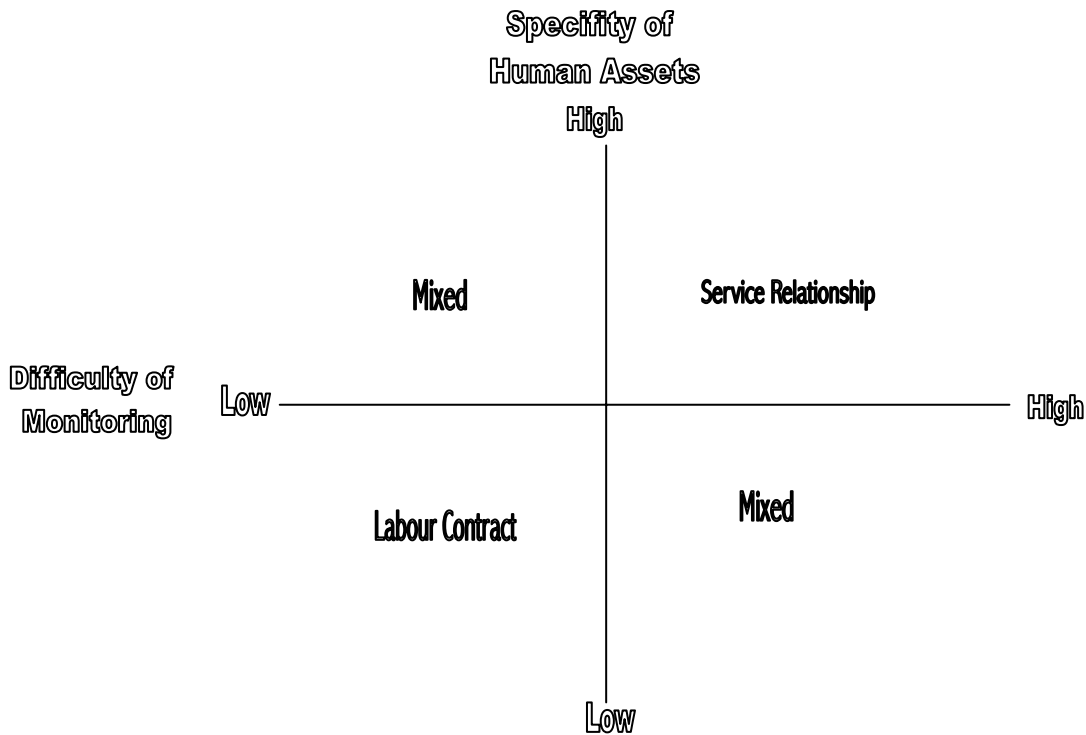


Figure 1: Dimensions of Work and Employment Forms
(Adapted from Goldthorpe 1998: 223).

The Institutional Complexity of Work: The Case of the Medical Profession

Goldthorpe's analysis has several merits. It reveals in a straightforward fashion the inherent variability of work arrangements and thus debunks the fiction of one and standard labour contract. Most significantly perhaps, Goldthorpe's analysis stands as an epitome of labour studies utilizing what is known as the rational action perspective. Drawing on transaction cost and agency theory (Arrow, 1974; Coase, 1937; Williamson, 1975), he carries over and applies the two basic organization forms of *market* and *hierarchy* to the analysis of the employment contract (i.e. the principal-agent relation). In his respect, Goldthorpe's analysis demonstrates what can be and what cannot be accomplished by means of the rational action framework. These merits notwithstanding, the sort of analysis Goldthorpe performs represents none the less a forceful simplification of the world of work.

The simplifying predilections of the rational action perspective are well known (e.g.

Fligstein, 2001; Perrow, 1986) and we will not pause here on these matters at any length. Let us very briefly refer to the most conspicuous of these limitations that bear on the purpose of this paper. There is the issue of instant causality, where the conditions of work are assumed to be unambiguously and without any institutional mediation reflected into the labour contract (see Figure 2). In such a scheme, social tradition, history or social power are not given any larger credit. Labour contracts are seen as local accomplishments that reflect the strategies of rational actors optimising their utility functions. Such is the vision of methodological individualism to which neo-institutional economics, despite some objections, ultimately subscribes to. Rather than seen as inherent forces that shape the contexts of work and the very choices of social agents, social traditions and institutions are considered as exogenous (i.e. unexplainable) factors. Despite some merits, the type of labour studies exemplified by Goldthorpe's analysis, gloss over the social and institutional embeddedness of work to such an extent as to become almost a detached conceptual exercise with little practical use.

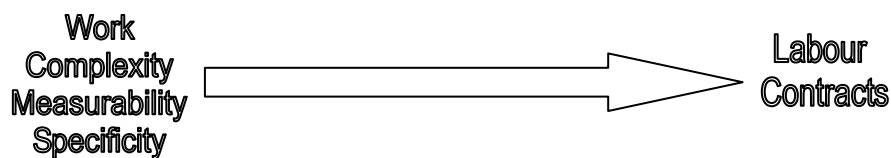


Figure 2: Univocal Causality between Work Conditions and Employment Forms in Rational Action Perspective.

This univocal causality that is assumed to lead straightforwardly from work content to employment form can perhaps make sense under circumstances that involve the short-term instrumental manipulation of work conditions. But in other cases, being concerned with understanding the institutional roots and effects of work in larger time spans, it ends up as too constraining and woefully inadequate. A deeper understanding of employment forms makes necessary to place the appreciation of the conditions of work into the dense social and institutional texture to which they belong. Conditions of work are not exogenous to labour relations. They do not have an ontologically independent status that unequivocally and straightforwardly determines employment relations. Rather than being given by a transcendent power, work conditions are the outcome of the social and institutional relations and the cultural predispositions underlying a social order (cf. Hassebladh and Kallinikos, 2000; Powell, 1991).

If models like the one Goldthorpe constructs were to explain employment forms across most European countries, established forms of employment would often come through as peculiar deviations from what the theory would predict. Social values, citizen ideals

and the institutional protection of the weak through the welfare state would emerge as a flawed model of rationality incapable of standing up to the maxims of the model. It is obvious that the institutional complexity of work, of which the state legislation and the role played by trade unions are but one aspect, is difficult to reconcile with the model. It would perhaps be possible to make a case for the fact that employment regimes across Europe are deviations from those conditions associated with the undisturbed functioning of the labour market in its “pure” form. The non-economic foundations of economic action suggest however that such a fiction must be debunked as well. As Polanyi (1944) made clear, a “pure market” is no less a social and political accomplishment than a regulated market. Unless collective bargaining is forbidden and the state maintains a policy of *laissez-faire*, it is hard to imagine an economically developed country where employment security and other terms of employment would not be negotiated, at least to some extent and under a regime of legal regulation, above the local level.

In what follows, we use the example of medical doctors as contingent workers to analyse the development of new forms of employment, and show how they might be understood as a result of far more complex social processes than the mechanistic match between the nature of work and the forms of employment it is supposed to trigger. Placed in the greater historical context, our empirical observations suggest the existence of three distinctly different forms of employment relations among medical doctors in Sweden, unaccounted by the nature of medical work which basically remains the same over the relevant period. What differs across time are the institutional setting of medical work, the expectations, strategies and ascribed meanings related to it among doctors and their employers, and the wider economic terms provided by health care as part of the welfare state.

Medical doctors are in many senses the archetypical profession. They control a demarcated field of scientifically based knowledge and practice, serve ideals not defined by any particular employer (the professional ethos) and are allowed a high degree of discretion at work (Abbott, 1988). Traditionally, the only type of imposed regulations that restrict their professional conduct are either state legislation, concerning what is considered as proper medical treatments (which in practice have been formulated by medical doctors serving state agencies in dialogue with the associations of the profession), and the financial means supplied by the principal, public or private. Medical work is, in addition, characterized by all those vagaries of professional work where the application of medical expertise to particular patients is not subject to standardizable cause-effect sequences and a work regime of standard operating procedures and routines. The established view of medical work as non-standardizable, knowledge-based and experience-

attuned expertise has essentially supported the professional claims for the autonomy of medical work.

The medical profession has also been involved in various ways in the making of modern society, i.e. the working-out and specification of welfare ideals and the organizational embeddedness of the welfare state. Medical knowledge has been brought to bear on a multitude of human, economic and social conditions since early industrialism (ref.). Safety in working life, housing, child rearing and nutrition are but a few objects of political intervention that acquired their status as problematic but manageable phenomena in modern life. Many of the proposed solutions (i.e. social benefits, safety regulations, housing) became, as they were piled one upon another over the years, the welfare state, as we know it. The impact of the medical profession has thus reached beyond the sheltered practice of medical work, as it took active part in how to design collective solutions to the problems and frictions associated with early industrialism.

Against this background it would be reasonable to expect that the employment forms of doctors would conform to the service relationship. Medical knowledge is essential to the entire gamut of activities in health care. The modern hospital is indeed organized according to the professional specializations of medical doctors –surgery, oncology etc. As suggested above, medical work is not readily transparent, measurable or standardizable and for this reason long-term intra-professional processes are essential to establish the rules/criteria for defining proper medical treatment. Accruing competence in medical work has never merely been a matter of mastering a set of formal knowledge, provided by a long formal education. To become a competent clinician, practice and continuous dialogue with senior partners has been indispensable. In one sense, medical doctors have been offered something of a service relationship. They have generally been hired with “tenure”, which was something few were 60 years ago but is less unique today, when most European work legislation provides strong protection for employees. Wage scales for doctors in Sweden have traditionally been steep, a typical pattern of the service relationship, overcompensating senior staff and under compensating junior staff. But apart from that, the medical profession has been allotted a large, non-negotiated and un-regulated space in the formal organizations of health care. Historically, there were no efforts to “gain the commitment of their professional ...personnel” (Goldthorpe, 2000, p. 219), which would be the rational solution to the control dilemma posed by the type of work performed by medical doctors.

Historical and cultural diversity suggests that the medical profession by no means displays identical forms of involvement in the medical apparatus of the late twentieth cen-

tury welfare states. There is a common conceptualisation of fairly distinct, and different, relations between the state and the profession's, making up a *Liberal* (Anglo-Saxon), a *corporatist* (German) and a *Social-democratic/etatist* model (cf. Esping-Andersen, 1990; Jepperson and Meyer, 1991; Fligstein, 2001; Dent, 2003). A rather distinct form of independence vis-à-vis the state characterizes the first type of professional status. The medical doctors are a free profession, within the realm of the state in terms of funding and employment, with a distinctly different role than the average civil servant. The corporatist model on the other hand, perhaps most typical to Germany and Netherlands, implies a more negotiated independence, i.e. the professional associations strike different kind of deals with the state, local public agencies or private providers of health care. The etatist model, lastly, constitutes medical doctors as a special type of public servant – freer, serving certain generalized ideals and less tied to conventional expectations. They are involved in the working of government, appear as government experts on health, regulate their profession through state agencies and are less of an external partner. Thus, the employment relation of medical doctors is part of, expresses and reproduces a certain type of regime. But while it may serve certain analytical purposes to treat countries in wholesale manner, it may be as wise to emphasize that employment regimes also, to some extent, are specific to each occupational domain. We are inclined to see our study as exemplifying the employment and organizational dynamics of the health care sector, even though health care reforms are obviously intertwined with society at large.

The last two decades have brought wide reaching reforms in the public sector in many countries, perhaps most pronounced in UK, Australia, New Zealand, Sweden, Denmark and the Netherlands (Hood, 1995; Clarke and Newman, 1997; Olson et al, 1998). The reforms cover a broad range of issues, of which some are less relevant here. In the empirical context of this study (i.e. Sweden), medical doctors have been affected mainly by two interrelated sets of changes. The first relates to the simple fact that health care funding has been restricted over the last 15 years. For the first time in the history of the profession, medical work had to operate under a tighter material and financial regime. In practical terms, this has meant increasing workload, shorter staffing, and less opportunities to do clinical research and get involved in professional activities (Aronsson and Gustafsson, 1999). The second trend is a manifold of initiatives to tie medical doctors closer to the priorities and goals of the principal and bring them under an organizational regime. Tighter systems of management accounting to strengthen budget discipline and a whole new set of management techniques that bring ways of classifying, thinking and acting drawn from a managerial framing of medical work have been introduced (Garpénby, 1999; Twaddle, 1999; Ackroyd; 1996; Llewellyn, 2001; Bejerot and Hassel-

bladh, 2003). Especially senior medical doctors, serving as heads of clinical departments, have been major targets (as well as bearers) of these initiatives.

The cursory examination of the history of medical practice and the employment regimes under which doctors have worked are difficult to reconcile with the type of analysis Goldthorpe's model exemplifies, even though some affinities initially suggest themselves. To begin with, there is a long period from the formation of the modern hospital in the late nineteenth century, in which doctors and their work displayed all the criteria that are supposed to nurture the service type of employment. There was no practical possibility for employers to monitor or evaluate work. Given the nature of the medical process as described above, we should expect: "The key connection that the contract aims to establish is that between the employees' commitment to and effective pursuit of organizational goals and their career success and lifetime material well-being." (Goldthorpe, 2000, p. 220). The means to accomplish that goal envisaged by Goldthorpe is the wage system mentioned previously, and hesitantly, pension schemes. The steep wage scale and delayed enumeration certainly was a barrier to leave the profession in, say, the early forties of a doctor's career. But did it imply any kind of loyalty towards the employer's goals? The traditional career track for a medical doctor wasn't tied to promotion within one hospital or one regional council: Senior positions were obtained on a national level competition. Advancement to senior positions often necessitated moving from one employer to another rather than staying loyal to a particular one.

If we give leeway to a broader repertoire of means for connecting the professional employee to the goals of the employer, the possible breadth of ties between them increases. But when such measures were introduced lately, doctors often regarded the initiatives as strange and sometimes insulting. To put it simply, previously nobody including the employers expected that medical doctors would behave as other civil servants in terms of loyalty to the employing organization and its managers. Despite the fact that the work of medical doctors before the mid 1980s seemed to fit like a glove for a service contract, no means were at hand that *secured their commitment to organizational goals*. The wage system made them reluctant to leave the profession, but did not nurture any commitment to the employee. In fact, we find it highly dubious to expect such commitment to develop from merely a wage system. To introduce the priorities of the employer into daily work probably requires a more multifaceted and dense type of continuous transactions (cf. Kunda, 1992; Grey and Garsten, 2001).

A more traditional explanation is readily available if the institutional complexity surrounding medical work is taken into account (Turner, 1987; Friedson, 2001). Medical

doctors were, to some extent, only formally employed by the principals of health care around the world (and still is to some extent in many countries). They were, as individuals, involved in a rather ambiguous tripartite relationship between profession, employers and the state (the latter two coincided in many countries, but were separated in terms of regulating and employing state agencies). The employer provided resources for wages, buildings and technology and left the profession to organize hospitals and primary care. Commitment and status were oriented towards the collective projects specified by the profession and its sub-specialities – mainly in terms of excellence in clinical work and research. Professional achievements were exchanged to improvements in the terms of the employment, i.e. advancement to senior positions in hospitals. A strong generalized, professional ideology prevailed among medical doctors. The ethos of obligations towards the generalized patient; the needs of the patient met in daily clinical work; the joy, challenges and achievements of research and the “*gemeinschaft*” of a professional association had little to do with any particular goals of health care principals. Fligstein (2001) refers to such an employment regime as professionalism, which he contradistinguishes from two other important regimes, i.e. those of vocationalism (technical occupations supported by trade unions and the welfare system) and managerialism (markets and corporations).

The NPM-inspired health care reforms from the mid 1980s and onwards in countries like UK, Sweden, Finland, Denmark and New Zealand destabilized the established system of relations between profession, administration and principals. Media often report that doctors have reacted with suspicion, estrangement and outright resentment against the recent changes. That is not to say that a united profession unanimously rejected the new mode of governing health care. Several reports testify that a new brand of “doctor-managers” appeared in the traditionally professionally senior role as head of clinical departments, combining professional knowledge with a new orientation towards organizational goals and loyalties (Coombs, 1987; Llewellyn, 2001, Kurunmäki, 2003). In Sweden individual doctors have been involved in almost all major planning and execution of state and regional initiatives in quality management in health care (Hasselbladh and Bergerot, 2003). Studies in Finland and UK report that many doctors with managerial responsibilities were quite keen to accept management accounting (Kurunmäki, 1999; Llewellyn, 2001). The public sector reforms in Western Europe also exhibit significant diversity to be sufficiently summarized in any simple fashion. There are considerable differences between countries and even in countries considered to score high on the degree of impact of New Public Management, like UK, the changes are multifaceted (Hood, 1995, Olson et al, 1998). If we, however, delimit ourselves to considering the impact these reforms have had on the medical profession and the doctors’ conditions of

employment, a number of traits might be said to catch the gist of the reforms.

Almost all kinds of reforms over the last two decades or so refer to *accountability* as an ideal (cf. Power, 1997), often motivated by external contingencies construed to demand new forms of governance (cf. Naschold, 1996). Citizens are claimed to be more critical and in demand of individualized responses, strained public economies call for more stringent monitoring of the employed resources while managerial forms of control and management prove themselves superior to the old administrative culture etc. The truth-value of these statements is less important than the truth effects they produce. Upon a closer scrutiny these statements suggest that the relationship between the medical profession, the public employer and the regulating state cannot any longer rely on trust. It cannot be assumed that largely self governed, intra -professional processes among doctors, in the long run and without manifest incentives, control and evaluation, should serve the needs and concerns of patients, employers or the state. Instead an entirely new way of designing the relationship is put forth, relying on a systemic logic. Formal procedures, transparent and standardized information enabling comparisons within and across settings, systematic control and evaluation are suggested as functional prerequisites of a health care system operating in an effective fashion that responds to the demands of its various stakeholders.

The primacy of accountability establishes a certain order of generalized problems and solutions in health care that carries over into a set of measures to induce medical doctors to take into consideration issues that transcend their strictly professional way of approaching problems (cf. Kurunmäki, 1999). Structural mechanisms, and to some extent strategic communication, are deployed to make doctors pay attention to things like budgets, political goals (prioritised diseases or patients) and organizational procedures in clinical work and administration. On the surface very different practices, such as DRG and vaporous managerialist ideas about shared beliefs and organizational culture, converge in a project of changing the established way doctors understand their duties, derived from a long history of professional practice, and bring them under a different regime that stresses the inexorable economic involvement of health care operations. What type of reactions are reasonable to expect on the part of professionals confronting the demands of employers for forms of involvement underlain by a deeper and broader organizational loyalty beyond that implicated by the traditional medical ethos? In the next section, we will discuss some recent developments in medical doctors' terms of employment that conform even less to the service contract.

Profession, Principal and Workplace: Doctors as Medical Workers

One pertinent feature of labour markets in the 1990s has been the rise of contingent forms of work. Employment of this sort has been often associated with less qualified types of work but has lately made inroads into expert work. With few exceptions (e.g. Beck, 2000), little attention has been paid to how contingent work may have broader effects that reconstitute the employment relationship in various settings of society. Research so far has been limited to the so called polarization debate (e.g. Carnoy, 2000). Yet, when it comes to highly specialized, well paid professionals with a high value on the labour market, a quite substantial part of the research hitherto on contingent work is less relevant (Kunda et al, 2002). They are obviously not exploited, they are not forced to choose contingent work as a result of being squeezed out of the regular labour market and it cannot easily be argued that they suffer material or immaterial welfare losses as contingent workers. But many questions remain regarding what they opt out from and how they, and the employer, construe a contingent relationship of employment. In a study of high-tech engineers working as contingent contractors (self-employed or in a staffing firm) in Silicon Valley the respondents articulated their experience of work in high tech corporations in a manner very similar to the cartoon "Dilbert" (Kunda et al, 2002). They saw themselves as "techs", competent, loyal and honest workers in a continuous war with self-serving, ignorant and politicising managers. But most of the 52 engineers in the study did not leave their employment until further grievances occurred, such as downsizing, deteriorating work conditions etc. Then they chose to recast the balance between security and enumeration, to protect their occupational (rather than professional) pride and steer away from all sorts of organizational infighting.

We found a somewhat similar but also different picture in a minor study of medical doctors in Sweden who had left their public employers to join staffing agencies. The choice to study doctors in contingent employment must be seen against the broader trends in employment and work conditions of doctors. In our empirical context, the working conditions of medical doctors have deteriorated over the last decade. In a recent survey among its members, the Swedish Medical Doctors Association found that large numbers reported discontent with work and lack of confidence in their relationship with the employer (Läkartidningen, 41, 2000). Nearly half of the doctors experienced repeated psychological fatigue after work and about 25 % longer periods of fatigue and tiredness. 39 % had regular opportunities to discuss and take part in how their work was planned. 58 % considered that their work is performed under unacceptable time pressure. The answers to a number of open questions in the survey contributed a more detailed picture to the rather gloomy state of the medical doctors employment relationship expressed in the

these summary figures.

To further obtain an insight into the details of medical work, a research assistant conducted six deep interviews with medical doctors working for staffing firms in autumn 2002¹. The construction of the questionnaire was informed by an analysis of 56 answers to the previously mentioned open questions. The respondents, who were approached through their staffing firms, were medical doctors in contingent employment for more than one year. Five out of six were fully qualified primary specialists, and had from 4 to 20 years of experience as doctors. The interviews lasted between 40 to 80 minutes, were tape-recorded and transcribed to about 70 pages text. The transcriptions have been analysed in first-hand by the present authors. The respondents report a negative, or very negative, view of their previous employments in various regional councils², i.e. the employer in Sweden. A lot of the critique derogatively described politicians, administrators and sometimes also their closest managers as exhibiting a lack of long-term commitment towards the medical doctors and negligence of the results of medical work in favour of publicly appealing razzamataz. The doctor's increasingly felt as interchangeable parts in a machine bureaucracy.

What do the results of the survey and the six deep-interviews tell us about the conditions that have produced the experiences doctors and engineers to some extent seem to share? And what sort of novel orientations do such experiences seem to entail among doctors and employers? Common to both (doctors and engineers), is their reaction against the attempt to reframe work in terms that reflect the concerns of the employer. Traditionally, qualified staff in formal organizations was seldom subject to intrusive control measures; white-collar work was to some extent constituted by its reliance on the employees internalised discipline and commitment (Edwards, 1979; Jacques, 1996). The last decades have brought changes in that respect –internal markets, profit centres, process analysis in order to re-engineer or customize has penetrated deeply into previously sheltered enclaves of professional work, whether these concern product development, engineering, or doctors in hospitals or primary care. In terms of systemic communication and formal arrangements, the transactions between the position of the individual employee and the organization have increased in density and scope.

¹ The work was conducted and financed within research project “The Third Wave of NPM: Quality Management and Professional Autonomy”, financed by Swedish Council for Working Life and Social Research.

² The regional councils are responsible for health care in Sweden, and act thus accordingly as employer. The government monitors health care through national legislation and a number of control practices performed by a government agency. The government also pool financial resources between more and less wealthy regional councils and cover costs for higher education and research in medicine (for a summary in English, cf. Twaddle, 1999).

In a previous seminal study of a Swedish hospital, it was evident that the links between the administration and the principals, on the one hand and the clinical departments and their medical work, on the other, was very thin, on the verge of nonexistent (Rhenman, 1969). At that time, when medical agency was only slightly involved in administration, doctors were, by and large, a self-assured and happy group of professionals. Their general standing in society, status, ascribed importance etc., were high. Their everyday duties were conducted in a fashion that did not interfere, at least not *prima facie*, with the administrative processes by which hospitals and health care units were managed. These pastures of professional freedom are forever lost. The increasing use of managerial practices to evaluate medical results, management of “flows” of patients and a cap on total spending have together with an increasing work load been interpreted by the doctors as lack of commitment, negligence of results and an unwieldy instrumentalization of the role of doctors in health care. It is not necessary to delve into a discussion whether the discontent is justifiable or not. In this context it is more appropriate to investigate the conditions of discontent and the effects they may produce in terms of new orientations/attitudes towards medical work.

If we return to Goldthrope's scheme, it is difficult to claim that medical work has now become standardized enough to allow a high enough transparency to successfully instrumentalize medical work. There has since long existed general guidelines for medical treatments in Sweden from the National Board of Health and Social Welfare (Gustafsson, 1988), which the doctors strongly adhere to as the only true regulating force of their work, but that is far from rendering medical work standardizable. *In situ* diagnostic work and treatment are performed as an application of formal knowledge on a special case. Strong ambitions to control medical work are articulated from the principals of health care but have not yet made their way into the core of medical practice. The doctors are still in command of the medical process, and they know they are, and react to new initiatives from administrators and politicians accordingly. So far, the principals have succeeded in accomplishing tighter financial control, resulting in a less benevolent climate in hospitals and primary care. A large number of “integrating practices” have been in use for several years. Various ideologies and techniques intended to enhance customer orientation and loyalty with politicians and administrators, and thus downplaying the orientation towards professional goals is proliferating in Swedish health care (Bejerot and Hasselbladh, 2003). While it is not possible to discern any kind of concerted collective, professional action or even policy towards the recent changes in Swedish health care, individual doctors have begun to opt out from the established employment regime to work in largely contingent forms. A quite different response is to

opt out from the profession by assuming the role of doctor-manager whereupon medical expertise gives way to managerial/administrative duties.

An effect of these significantly restructured relationships to profession and organization is the considerable instrumentalization (deinstitutionalization?) of the contingent doctors' employment situation. Employment as a contingent doctor to some extent coincides with abstaining from intra-professional processes. It is difficult to imagine a contingent doctor to make a professional career, to acquire status and standing by success in clinical work and research. By choosing exit, professional work becomes just a means of fulfilling private aspirations by providing possibilities to improve earnings and dispose work time, work at nice places in the summer etc, rather than a collective project imbued with notions of serving patients or citizens, competing for professional recognition and enhancing professionals skills.

But also medical work under contingent forms is itself divested from its professional and organizational commitment, partly due to the limited presence of contingent doctors at a particular work site, and partly as a result of a renegotiation of the boundaries of work and those of professional and private subjectivity. Five out of our six interview respondents reported that they had felt invaded by work when upholding a regular employment. They had been unable to find ways of delimiting their involvement in work in tangible terms such as hours spent on work, as well as in intangible terms such as emotions and perceived obligations. Contingent employment has allowed them to develop individual strategies in that respect. As already suggested, contingent work has enabled them to delimit their commitment to the colleagues to a mere exchange of what should be done every day. A consequence of that has been that their responsibility vis-à-vis the patients has been delimited to what can be done at particular consultations (even though one highly qualified doctor turned this to an opportunity to put an end to ceaseless investigations). The three female respondents among the doctors especially emphasized how they had been able to seal off the emotional burden of work by becoming "temps". To some extent, this new mode of employment as a medical doctor has transformed the individual's attachment to the traditional medical ethos. Their reported new orientation can be summarized as an individualized responsabilization (Rose, 1999), a subjectivity attuned to loose attachments, individual calculation and a semi-hedonistic moral.

The experiences of contingent medical doctors as summarized here are of course based on a small number of interviews, and has been limited to doctors in primary care. Some caution is obviously needed as to what can be inferred from such a limited amount of interviews. But a larger study of qualified nurses in hospitals may serve to both

strengthen and modify our material. 34 nurses in contingent employment at hospitals in Stockholm were interviewed during 2002 (Allvin and Jacobsson, 2003). The major difference was that the nurse respondents could be divided in two groups, one as negative to their previous employment as our doctors, while the second (younger as a whole) was more attuned to identify contingent work as being associated with individual opportunities in a less conventional employment. But common to all the nurses is their construction of another mode of orientation towards work as a contingent nurse. In this case, the reconstitution of nursing work was heavily promoted by the staffing agency. They used various individual counselling and collective binding techniques to establish a more distanced and calculating approach to work among the nurses. The nurses identified themselves with the staffing agency much more than the doctors, and were more attuned to the appeals from the agency to display employability, on top of their professional skills.

Together, the two studies suggest a number of preliminary findings. The most significant, perhaps, of these findings confirms the predictions suggested in the introduction about the increasing individualization of labour relations. Contingent doctors, and nurses, emerge as an individualized breed of knowledge workers. They no longer work in a setting that nurtures continuous professional relations or affiliations to any particular organization. They change place of work on a monthly or weekly basis. Their interaction with doctors and nurses working under the standard employment regime becomes limited to information exchange about scheduling patient consultation and following standard operation procedures at particular sites. They don't take part in discussions relating to more profound local or professional issues. Professional development is no longer an integrated part of work. It becomes an individual project, sometimes offered as a benefit by their employment agency, sometimes as an entirely private activity in free weeks. They read their journals, go to conferences or attend education on offer from pharmaceutical companies. The local council in charge of their workplace is thus no longer their employer; it is rather their customer, who mainly is involved in a relation with the contingent doctors' employment agency. The breaking of ties with the public health care organizations the doctors declare has been felt as a great relief. They no longer need to care about the employer's insensitivity to doctors, about political whims in organizations and health care priorities or the dismal task of planning under a tight managerial regime. They have chosen exit. An important consequence of this strategy is that they have declined to maintain a dialogue on professional matters with their colleagues and have turned their back to the processes by which the organizational realities surrounding health care are constructed.

But aren't the patterns reported here a marginal phenomenon, limited to those in the

medical profession with meagre expectations to become anything but over worked doctors in primary care? Contingent employment is far more common among doctors in primary care, a specialization with low professional status among medical doctors in Sweden. But on the other hand, of the contingent nurses interviewed almost all had specialist training, representing the upper end of the nursing profession. The prevalence of contingent work among different groups in health care is also heavily influenced by the supply and demand in various segments of that sector. In primary care there is a shortage of doctors, in hospitals on qualified nurses. As in the American case mentioned above, when something was layered upon a latent discontent, some reacted by opting out, when the opportunity was at hand. In this case, the market conditions (which are heavily shaped by political processes in health care) made those who could benefit from them to act.

Concluding Remarks: The Institutional Basis of Work De-institutionalization

There is little doubt that our observations need further conceptual elaboration and they must definitely be brought to bear on larger strips of empirical reality. However, coupled with other empirical findings and ongoing theoretical debates (Beck, 1992; Castells, 1996; Murray et al, 2002), the medical doctors' and the nurses' experience of contingent employment reported above can be seen as indicative of wider developments, signifying the disentangling of the institutional complexity of work typical of high modernity.

The trends reported above are to some extent concordant with the major theme of *work individualization* seen as characterizing late modernity (Beck, 1992; Castells, 1996). At first sight, work individualization suggests that individuals tend to obtain a greater leeway in defining the conditions of their work, as societal institutions (professional associations, trade unions, state agencies) assume a less active role in the making/negotiation of these conditions. As reported above, time schedules and choice of work site, modes of payment, degrees of contextual involvement are among those conditions that may be influenced by individual medical doctors, working on a contingent basis. True as this may be, it is important to point out that such an influence takes the binary form of *accept/reject*. Individual doctors may chose to accept or reject an offer but they do not participate in the making of the conditions underlying health care. They have become, as it were, externals to the health care system. They can therefore influence their work conditions only in this indirect way, which needs to be distinguished from the sluggish yet more substantial forms of collective influence exercised through

trade unions and professional associations. The outcomes of these trade-offs are difficult to predict but work individualization is no doubt a double-edged process. Professional associations restrict individual discretion but provide support too to their members' vis-à-vis the state, employers or other competing professions. Now expertise, as that commanded by medical profession, may provide protection from the manipulative intentions of employers (Kunda et al., 2002). And yet, the de-collectivization of the forms under which medical expertise is exercised under contingent employment is destined to have effects both on individual doctors and the quality of their work.

Seen as a general trend, the lower degree of medical doctors' professional involvement joins the NPM-inspired reforms to suggest an institutional transition from one major employment regime to another, namely from *professionalism* to that of *managerialism* (Abbott, 1988; Fligstein, 2001). Professionalism describes an employment regime where strong professions considerably shape the conditions under which expert labour is organized and professional members work across the various social settings. Managerialism on the other hand implies the subordination of individual occupational initiatives and professional codes to corporate or organizational interests and work-role structures. The description of the public sector reforms associated with NPM described earlier in this paper could be interpreted as the political struggle to change the conditions of medical employment from a professionalism to managerialism. Such a trend has been noted earlier in the literature on professions (Abbott, 1988; Larsson, 1980) but its consequences for the themes that concern us here, (i.e. work individualization, the institutional embeddedness of work and the polity issues associated with it) remain basically unexplored (Beck 2000).

Fligstein (2001) considers the conflict between the two regimes in a historically relativist way but Luhmann (1994) attributes it to the maturation processes of modernity. The conflict between profession and organization emerges thus as major battlefield in these late modern dates. If Luhmann is correct we would then perhaps witness in the future a considerable decline of professionalism as an employment regime and a form for organizing and carrying out expert labour. Now, the number of medical doctors that work under contingent employment forms is still very limited. If the role of the medical profession in the health care system is taken into account, it is reasonable to conjecture that contingent employment will remain limited in the future, even though it may expand and perhaps noticeably if the plans for standardizing the work process of medical doctors in health care are pursued and implemented successfully. At the moment, however, no solid argument about the transition from professionalism to managerialism can be build with exclusive reference to medical temps. However, placed in the wider context

of the declining power of the medical profession, contingent employment can be considered as just one among several indicators that suggest the considerable erosion of the employment regime of professionalism by the alternative regime of managerialism.

Does contingent medical work lend support to Goldthorpe's claims? At first sight it does. At a closer scrutiny, however, the processes out of which contingent employment of medical doctors emerges carry the heavy influence of social and institutional processes that develop well beyond particular contexts and even beyond the reach of the medical profession itself. Such an influence exemplifies the ostensible paradox of what we would call *the institutional basis of the current de-institutionalization of work*. The deregulation of labour relations and the NPM-inspired reforms in the public sectors of many European countries, described earlier in this paper, reflect the struggle of powerful institutions (e.g. professions, bureaucracies, markets, political parties, civil society) to shape important premises onto which the functioning of late modern societies should be predicated. The deregulation of labour relations and the marketization of the public sector have been heavily influenced by a broader trend in the western world to reconfigure the entire notion of government (Gordon, 1991, Rhodes, 1997; Rose, 1999). As suggested above, our empirical excerpts from Swedish health care and the reinterpretation of NPM-inspired reforms may be taken to suggest that professionalism as a steering and employment regime is on the decline. The efforts to construe a stronger and more comprehensive bond of the professional's previously highly circumscribed employment relationship may have quite significant unintended consequences. But, the ambition as such to transform health care to a managerialist type of regime may be seen as local instantiations of a wider process of re-arranging the landscape of the modern polity (Jeperson and Meyer, 1991).

The loosening of the grasp, which institutions like the law, the state and professional associations/trade unions have had on employment forms and relations seem to be, furthermore associated with the surreptitious effects the growing individualism of contemporary societies (Beck and Beck-Gernsheim, 1996, 2002; Sennett, 1992). Individualism is undeniably a complex social phenomenon/institution that demands its own lengthy treatment. Let us however make a few comments on it here as a means of referring to the intricate web of relations into which current employment developments find themselves embedded. Individualism has always been a prominent institution in the liberal democracies of the west, entrenched as principle (rights and obligations of the sovereign and accountable subject) in constitutional, civil, commercial and penal law. In this respect individualism is part and parcel of modernity. However, individualism has obtained a remarkable twist during the last two or three decades that has made it a perva-

sive component of everyday life. It has thus been involved in the further decline of public life (Sennett, 1992), the de-collectivization of such central social institutions as the core family and the further weakening of the already fragile kinship ties (Beck-Gernsheim, 1996, 2002; Fukuyama, 1997; Giddens, 1999). The post-collectivist individualism of the late stage of modernity is thus involved, though less conspicuously than other factors, in the mentioned transition of the employment regime of professionalism (a sort of collectivist structure) to that of managerialism. Its influence must no doubt be studied in connection with how it helps to define new roles, initiatives and labour relations and shape new forms of actor-hood at work. These issues cannot but be the target of further and enduring investigation.

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