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Ethnography of experiencing organizational deadlocks in an intervention of hospital work

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ABSTRACT

The work-related emotional experiences and feelings of employees are often considered undesirable occurrences that need to be managed and controlled so that they do not interfere with rational functioning of an organization. But as Fineman (1996) asserts, “feelings connect us to our realities” and should not be divorced from the reality of an actor’s work practice. In this study, employees’ work-related emotional experiences are charted as a fertile ground for organizational change in an intervention that a group of researchers facilitated in a hospital surgery.

The specific focus is on staff members’ experiences of organizational deadlocks and the role the expression and collective discussion of these expressed emotions play in work-related change processes. Staff members’ experiences are often bypassed in daily work but here they become a critical source of transition as *collective experiencing* in solving organizational deadlocks at work. Experiencing is in this study understood from the perspective of cultural-historical activity theory according to which emotional experience, personal motives of activity and speech are connected (Sannino, 2008a; 2008b). Experiencing is then examined as an integral part of a change process—how change becomes experienced and embodied in talk and action through collective process. The research question is *how change is carried out in experiencing of organizational deadlocks.*

Keywords: ethnography of change, experiencing, deadlocks, transformation, intervention, hospitals

INTRODUCTION

The work-related emotional experiences and feelings of employees are often considered undesirable occurrences that need to be managed and controlled so that they do not interfere with rational functioning of an organization. But as Fineman (1996) asserts, "feelings connect us to our realities" and should not be divorced from the reality of an actor's work practice. In this study, employees' work-related emotional experiences are charted as a fertile ground for organizational change in an intervention that a group of researchers facilitated in a hospital surgery.[1]

The specific focus is on staff members' experiences of organizational deadlocks and the role the expression and collective discussion of these expressed emotions play in work-related change processes. Staff members' experiences are often bypassed in daily work but here they become a critical source of transition as *collective experiencing* in solving organizational deadlocks at work. Experiencing is in this study understood from the perspective of cultural-historical activity theory according to which emotional experience, personal motives of activity and speech are connected (Sannino, 2008a; 2008b). Experiencing is then examined as an integral part of a change process—how change becomes experienced and embodied in talk and action through collective process.

The surgical unit in question was in a near-crisis situation as a consequence of demands from hospital management to increase the number of operations at a time when they had lack of resources. Put on display as a 'mirror' by the researchers' videotaped glimpses of recurrent obstacles in daily work enabled the uncovering of staff members' emotional experiences of organizational deadlock in intervention sessions. The reflection of these experiences led to a successful change of organizational and leadership practice in the surgical unit also reported in other studies (Engeström et al., 2010; Kajamaa, 2010; Kerosuo et al., 2010).

The methodology of this study—the ethnography of change—captures an open-ended process of change (Kerosuo, 2006; Engeström, 2000). Ethnography of change is interested in exploring critical aspects of activity in terms of development, learning, and change instead of describing the "status quo" of an activity (Hasu, 2001). The focus on development and change extends the ethnographic observation spatially and temporarily to a sequence of critical events in a change process (Des Chene, 1997). Such a research site is often produced in local struggles and interactions as they unfold and become transformed (Gille, 2001). In particular, such events as contradictory situations, organizational deadlocks, questioning the

[11]Members of the research group are Professor Yrjö Engeström, PhD Student Anu Kajamaa and the present author.

prevalent practice, or suggestions that expand the status quo are indications of the unfolding of the change process.

The structure of the paper is the following. First, the framework of study in which experiencing, talk and organizational change are connected is discussed. Second, the context of the study, the Change Laboratory project in a surgery unit is presented during which the staff members engaged in the collective process of change. Third, the data and methods of analysis is explained. Fourth, the narrative of experiencing including experiencing, identification and reflection of organizational deadlock, and transformation is given in three episodes. Fifth, the summary of the case example is provided, and finally concluding remarks are made.

Framework of the study: Connecting experiencing, talk and organizational change

The analysis of an emotional experience puts language in a special position to make meaning out of emotional experiences. Sannino (2008b) reviews the different uses of the concept of experience in cultural historical activity theory. In this approach, talk, activity and actions are dialectically connected. Vygotsky, the founder of the cultural historical school, discussed experience by means of the word "perezhivanie." The word "perezhivanie" has been translated by Gonzales Rey (2002, p. 136/Sannino, 2008b, p. 272) with the expressions of "experiencing" or "living through a certain experience." According to Vygotsky (1994, p. 342), an emotional experience is an overall experience in which the environment, emotions, thoughts and the past experiences of a person specify that particular experience. Vygotsky's analysis of meaning involves the social aspects of making sense, shaped by culture and appropriated through social interaction (Mahn and John-Steiner, 2002).

In Leont'ev's (1978) work emotional experience or experiencing refers to "a subject's motives and the possibility of succeeding in realizing actions corresponding to these motives" (Sannino, 2008b, p. 273). Leont'ev (1978) uses the concept of personal sense to define the motivation and meaning that a person gives to connections between activity, actions and materialized objects. The personal sense determines the actions and the participation of a subject in activity and experiences or experiencing are an essential element of the formation of a subject's personal sense. "Personal sense, therefore is both a function of motive and a function of experience, which means that it permeates both activity and individual actions" (Sannino, 2008b, p. 274).

In this study, emotional experiences or experiencing is considered a critical part of the actualization of organizational deadlock in the process of change. Organizational

deadlocks resemble double binds that emerge in intense and irresolvable relationships in which a human being is facing opposing situations (Bateson, 1972, pp. 206-207). Engeström (1987, p. 165) suggests that double binds experienced by individual human beings can be reformulated as social dilemmas. These dilemmas cannot be resolved on the individual level only but joint co-operative actions are needed to push a historically new form of activity to emerge. Experiencing of an organizational deadlock then “refers to a process through which an individual, supported by others, engages in a quest to overcome critical situations” (Sannino, 2008a, p. 240). Critical situations such as deadlocks can be connected to events that emerge at the intersection of conflicts and contradictions. Conflicts are personal and interpersonal crises whereas contradictions relate to systemic tensions within an activity and/or between multiple activities (Sannino, 2008a).

A contradiction is a historically accumulated, structural tension between opposing forces in an activity (Il’enkov, 1977). Contradictions are not entirely good or bad, but can also function as an opportunity to change prevailing practices (Putnam, 1986). Contradictions do not manifest directly in daily work practices, but they can emerge through structural tensions, disturbances, and disruptions in practitioners’ everyday work actions (Engeström, 2000). Blackler *et al.* (1999) assure that incoherencies and tensions in organizational activity can provide a motive and a possibility for collective change and development. By tracing a recurrent pattern of tensions, disturbances, and disruptions, it is possible to learn about the manifestations of contradictions and their connections to larger societal and historical transformations in organizations and at work.

Anthropological studies encourage researchers to pay close attention to interactions in order to scrutinize to processes of social life and to treat social happenings as active doings (Emerson, 2009). The interpretation that an anthropologist has to make when focusing on a new experience is an interpretation both of culture and of the very process of making sense. However, the process of interpretation emphasized here cannot be categorized in the framework of interpretative anthropology. According to interpretive approach meanings are there to be unraveled whereas here they are approached as emerging (Rudie, 1994). Rudie considers that transformation from experience to knowledge passes through stages of increasing articulateness. Unarticulated experiences can be observed by others as they are carried out but the communicative aspect is required for experiences to function on an inter-subjective level. Therefore, instead of seeking structures of discourse, the ethnographic analysis here is interested in *how change is carried out in experiencing of organizational deadlocks.*

<u>CONTEXT OF THE STUDY: CHANGE LABORATORY PROJECT IN A SURGERY UNIT</u>

The context of the study is a research and development project of a central surgical unit during the years 2006-2008. The central surgical unit is part of a Surgery and Intensive Care Unit in a Finnish university hospital, and it consists of sixteen operation theatres and three recovery rooms. The number of operations requiring specialized surgery is approximately 10 000 per year, and the number of staff members is approximately 300 in the central surgical unit— of which the majority are nurses. The surgical specialties of the unit are orthopedics and traumatology, plastic surgery, hand surgery, urology, heart and thorax surgery, neurosurgery, vascular surgery, gastroenterology, and general surgery. The daily activity of the unit is led by an Operations Manager—an anesthetic by profession—and two head nurses—a head nurse of surgery and a head nurse of anesthesia. Two nurses in a "monitoring room" assist the Operations Manager and head nurses in the coordination of operation theatre activity. Each specialty is led by a head doctor of the specialty.

We, the group of researcher, were invited to facilitate a research and development process at the surgical unit in 2006. The unit was facing a crisis situation thatcan be connected to recent advancements in the Finnish health care system. Ministry of Social Affairs and Health implemented a new law that outlines the availability, quality, and sufficiency of health care services (Kerosuo, 2006). The basic premises of the new legislation put time limits on access to care. For instance, a person seeking care is entitled to access to medically justified treatment within three months and no more than six months after the hospital has received the treatment referral. The health authorities have also enacted a penalty for health care organizations if they fail in their task to meet the time limits. As a consequence, the number of elective operations increased during the years 2004-2006 in the surgical unit, whereas the daily resources to carry out operations even decreased due to difficulties in hiring new staff— especially anesthetists and nurses— and a high number of sick leaves.

The activity-theoretically based method of the Change Laboratory was used in the change project (Virkkunen et al., 1997). In Change Laboratory, participants engage in a process of development and learning by focusing on critical tensions and contradictions in their work practices and organization. The tensions and contradictions are analyzed in connection to their historical and local context with the aid of a set of learning tools. From the perspective of this study, the *mirror* represents a central learning tool that was used in the laboratory of the surgical unit. In the case example of the surgery unit, the mirror had an important function as uncovering the deadlock and related contradictions in the activity. In Change Laboratory settings, the "mirror" represents the original task or problem. The mirror

is constructed on the basis of the research findings of day-to-day work and it is used as a device for a collective reflection in laboratory sessions. The mirror data can include for instance videotaped episodes of work, stories, interviews, and customer feedback. The activity-theoretical models, e.g., the model of an activity system, and the model of expansive learning are used in the analyses of the problem situation (Engeström 2007).

A pilot group of approximately 20 staff members were invited to collaborate in the Change Laboratory. The members were selected to represent the whole range of practitioners working in the unit, from the head doctor of the unit to the surgeons, anesthesiologists, nurses, porter, and secretary. The laboratory sessions were videotaped, and a research assistant transcribed the recordings. The researchers collected ethnographic data in the unit and interviewed the key actors throughout the process. A new organizational model was created as an outcome of the process (see Engeström et al., 2010; Kerosuo et al., 2010). In the new model the responsibilities of the unit were allocated to activity areas instead of directly to single staff members as a solution for the problems of managing the expanding activity in the surgery.

The expansive learning process is usually realized during several sessions in Change Laboratory and it lasts typically from three to six months. Change Laboratory begins often with a collective analysis of present problems and tensions in an activity. The roots of the problems are usually traced from the history by modeling the past activity system. After that the present activity system is modeled with the internal contradictions of the activity. Finally, the envisioning of the future model including the plan for examining and implementing the new model takes place.

The project in the surgery unit was carried out in five Change Laboratory sessions and two follow-up sessions. However, what was special about this case was that the process of development and learning proceeded fast (Kerosuo et al., 2010) which proves that the need to change the current activity was urgent in the surgery. The analysis of the contradictions, i.e., the organizational deadlock and finding a solution happened during the first three sessions. In the last two sessions, the new solution, i.e., the new model of organization and leadership was finalized in a document including also the details of the new practice.

DATA AND METHODS OF ANALYSIS

The data chosen for the analysis contains the transcriptions of the first Change Laboratory session in 2006. The first session was chosen for the analysis because the relevant parts of data about experiencing the organizational deadlock and the

transitional point towards future action took place in this session. The session lasted about two hours. The transcript of the first session includes 413 turns of talk. The mirror data discussed in the session contains interviews with staff members, and the observation of the daily activity in the surgical unit during several ethnographic visits.

The discussion in the paper uncovers the importance of the collaboration between research subjects and between research subjects and researchers. The connection of the participants' actions, thoughts, and emotions to social practice and the ways in which they take part in social practice is an important part of an analysis (Dreier, 1999). In order to grasp the experiences of deadlock a process of co-experiencing involving empathy is essential between research subjects and researchers (Kerosuo, 2007). The experiences emerging in discussions are in this study observed by a co-experiencing researcher who took part in the change process. Empathy is here understood as an "imaginative reconstruction of another person's experience, without any particular evaluation of that experience" (Nussbaum, 2001, p. 302). However, it is not clear how such an analysis could be conducted. Next I will search methods from anthropological and activity-theoretical analysis for the analysis of experiencing in this study.

Rudie (1994) explains how it is possible for a researcher to "invent" the culture of an informant by linking creativity to convention[2]. Rudie (1994) suggests that we can analyze experiential contrasts—such as practitioners' contrasts between past and present or researchers' contrasts between the research subjects and researchers — emerging as inventive edges for building bridges between wordless experiences and their linguistic descriptions. In this study, the identification of such experiential contrasts enables the identification of discursive events that are meaningful for a participant for instance in terms of connecting experiences of personal sense to organizational activity.

Rudie's method follows the idea of comparison of (1) the daily experiences of the informants with the researcher's experiences, or (2) the comments of the informants with the ones of the researcher in relation to specific situations and events. The design here is more complicated than the one of Rudie's. The focus of research here is strongly on organizational change in which both the research subjects and the researchers are active participants. For instance, uncovering experiences of staff members or comments of the researchers may intervene the *status quo*.

Sannino (2008a) uses the methodology of the interlocutionary logic in her analysis of Change Laboratory interaction. The key point of the method is to identify the

[2] Rudie refers here to the work of Wagner, 1981.

pragmatic and cognitive functions of speech acts by the way they are exchanged and affect individual talk in the course of interaction. In this way it is possible to identify patterns of discourse that are interlinked with activity and actions. Such patterns of discourse are here analyzed as transitional episodes. Transitional episodes focus on interactional moments involving expressions of deadlocks such as disputes or trouble cases (Emerson, 2009). Such an interactional moment "directs attention both to how ordinary routines and social order come to be stressed and challenged and to how people experience and deal with those stresses and challenges" (p. 538). Transitional episodes resemble key incidents in that they open up new issues for analysis (Emerson, 2004).

In ethnographic studies it is observed that emotions and experiences related to organizational troubles are not always expressed (Emerson, 2009). Critical ethnography pays attention to social contexts in which hidden emotions occur (Nugent and Abolafia, 2007). This is because the research subjects are often unable to expose social injustices and because they often lack the analytical tools for the disposal. Therefore, Nugent and Abolafia suggest that it is the responsibility of the critical ethnographer to identify hidden emotions and persuade other of their existence. Included in the process of displaying hidden emotions is also to uncover why these emotions are hidden. Nugent and Abolafia introduce a concept of 'leak' that captures those moments in which authentic negative emotions are not successfully hidden. The examination of the use of information uncovered in leaks enables the researchers to show how the information is related to the organization and especially to organizational controls. In this study, the leaks of emotion are related to expressions of organizational deadlocks. Leaks and the role of researchers as displaying hidden emotions are interesting from the perspective of this study. Especially, the function of a mirror as uncovering day-to-day tensions in organizational practices resembles the role of critical ethnographers in studies of hidden emotions.

In the case example, the mirror represents a starting point for the collective experiencing of organizational tensions and troubles. In Excerpt 1, the Researcher 1 and the Researcher 2[3] explain the choice of the data in the mirror that represents a problem of closed operations theatres in a situation where there are patients in the waiting list for operations. After the mirror the participants are invited to react and reflect the experiences and activity presented in the mirror which in this case was a video. According the Change Laboratory method, the aim of the reflection in first session is to chart the need state of development in an activity.

[3] Researcher 2 is the author of this paper.

Excerpt 1

> ***Researcher 1:*** *But on the basis of this data that we have gathered we did this what we call mirror material, for this first session. We had to structure it largely out of the top of our heads, those problems. So now I would hope that you will say if this goes wrong, that you quite bravely resist if and let us know that this is not how things are. Or if we have forgotten something essential or if we somehow haven't seen the problems correctly, so correct us and say what you think. We have divided these into four areas of which the first concerns the operating theatres, the second the recovery room, the third the emergency service, and the fourth the scattering of anesthesia functions. So these are now the four main areas. (…)[4] So the meaning is that because these are video clips and the message doesn't necessarily come understandably through at once that H. [Researcher 2] will tell you a little bit of what the clips are about. And we would go through these areas one by one in such a way that when one is – when operation theatres are the first thing – that then we would discuss. And we would get your views on whether this is on the whole a fundamental question and what are the reasons that there are problems. And of course if you right away get ideas or views of how this could be solved or more detailed analyses or what all is possible. However, at this point the purpose of this session is to agree on what are the central problem areas which we are about to tackle. And our own division, like I said, is quite open to your corrections and adaptations. But first of all we have the operating theatre.*
>
> ***Researcher 2:*** *Yes. And it [the theme of closed operations theatres] was taken on because we thought that it is such an important issue for you that they should not stay closed. Especially, when the care guarantee queues are so long. And this has been assembled, this clip, in such a way that of Operation Manager's work, we present how she controls it that they would be as little as possible closed, these operating theatres. And then we have a clip of the working of the recovery room. And of the things that happen that obstruct it. And then there are a couple of clips of an interview with head nurse of surgery where she comments a little bit this question of the closure of the operating theatres. (…) And this is for the time being really only the tip of the iceberg, what we have now outlined. I will put it a bit bigger… [The video clip starts, because of the bad voice quality the video has not been transcribed.] (Change Laboratory September 28, 2006, turns 30-31)*

Next I will present the narrative in order to explore the experiencing of organizational deadlocks in interventions. I have divided the narrative in three episodes according to the proceeding of the two laboratory session.

[4] (…) means that the author has removed text that is irrelevant for the present study.

CASE NARRATIVE OF EXPERIENCING IN THREE EPISODES

Episode 1: Mirror and "leaks" of emotions in the Change Laboratory interaction

The first episode started with researchers showing the mirror focusing on closed operations theatres. The role of the Operations Manager was a central one in the episode because the decision to close the theatres is made by her. After showing the "mirror" the researchers invited comments from the participants (excerpt 2). The Operations Manager was first one to comment. She took on a defensive position in terms of the subject "closed operation theatres." She put the claim on small resources that forced her to close some of the operation theatres. Head nurse in surgery and staff nurse of the unit supported the Operations Manager's explanation and explained that there was also a disagreement about the salary of the nurses that made some nurses to leave the hospital.

Excerpt 2

> ***Operations Manager:*** *Well the question is that we have too small resources, a lot of absences because of illness. So we have had a shortage of nurses, anesthesia nurses as well as anesthesiologists since last spring. (...) So of course this is reflected in the fact that there is not enough [staff] (...) it is better to close the theatres electively so we can calm down the working atmosphere a little bit. How we have succeeded in this is something other people can comment on too, but it spares at least my nerves in the sense that it already exists, the plan. And we had to hold on to it until this autumn and we still do, at least partly.*
> ***Head Nurse Surgery****: In the background we have the battle over salaries that we have had in this house. So it was not solved at the time, when a lot of our old nurses left us. And then last year all we did was train the new nurses. And a lot of the ones who left also stayed in easier jobs with higher salaries.*
> *(Change Laboratory September 28, 2006, turns 35-36)*

Although the closing of the operation theatres were rationally justified by the Operations Manager and Head Nurse of Surgery, there were also hints of uncovered emotions in their comments. The Operations Manager referred that there was a need to "calm down the working atmosphere" and the Head Nurse told about "the battle over salaries." The discussion went on with the Charge Nurse explaining the number of daily absences of anesthesia and surgical nurses. It was about 15-10 nurses away each day.

After the discussion about daily absences the emotional experiences of the deadlock situation in the unit became more obvious. In excerpt 3, the Researcher 1 returns to the question of closed operation theatres. The Operations Manager exhibits an experience of failure that is not only related to the paradoxical situation of closing down operation theatres that displays clearly the organizational deadlock.

Excerpt 3

> ***Researcher 1**: (...) could we put the question in this way that is there some kind of a problem that they have to stay closed, the theatres?*
> ***Operations Manager:** It's a problem in the sense that there are patients in the waiting list who need the operations, and there is a lot of pressure on the other side that they must get treated. This can be seen in the public. So you are between a rock and hard place all the time. Which gives you the feeling that here we are constantly failing, even though we work harder than ever, we are bad all the same because we cannot get the waiting list to move. (Change Laboratory September 28, 2006, turns 47-48)*

The uncovering of the organizational deadlock can be called a "leak" of emotion (Nugent and Abolafia, 2007). The leak of emotion did not, however, emerge in the free floating discussion but it was catalyzed by the question of the Researcher 1. The display of the Operations Manager's experience of closed operation theatres led to the identification and reflection of the problem in detail.

Episode 2: Identification and reflection of an organizational deadlock: the problem "Closed operation Theatres"

In the second episode, staff members reflected and analyzed the lack of resources related to the problem of closed operation theatres from many angles and from the perspectives of different professional and occupational groups. As an example, the head nurse of anesthesia describes the problems from the perspective of anesthesia nurses (excerpt 4). The reflection of the head nurse is partly charged with emotions that can be seen from expressions in which she describes the change of the patient material. The interaction between the Head Nurse and the Researcher 1 is also different in excerpt 4 compared to excerpt 3. In excerpt 4, the researcher speaks in accordance with the head nurse whereas in excerpt 3 the communication between the researcher and the Operations Manager is in contrast.

Excerpt 4

> ***Head Nurse Anesthesia**: Well. So the patient material is surely the worst of all. And the operations are the biggest, and the operations are the heaviest…*
> ***Researcher 1:** [Speaking over] In here [refers to the city in question]?*
> ***Head Nurse Anesthesia**: No, inside this University Hospital for example.*
> ***Researcher 1**: Compared to short surgery, of course?*
> ***Head Nurse Anesthesia**: Yes. And quite the same pay. And then the patient material that I already mentioned. It is worse and it will remain worse because now the private sector combs out the easiest patients and operates on them there at a different time when we get all the worse patients. Then a big problem for us is the postoperative care, the immediate postoperative care, in other words the recovery room which gets not only all our patients,*

> *but patients from the central clinic, and the emergency service, internal medicine patients, intensive care patients…(…)*
> ***Head Nurse Anesthesia****: So this is a big work area.*
> ***Researcher 1****: Work area is large, and it is in three shifts and the patient material is getting worse.*
> ***Head Nurse Anesthesia****: Yes. And the number of staff is large, and really as I said the area of responsibility is big.*
> *(Change Laboratory September 28, 2006, turns 88-92; 94-96).*

The difficulty of the staff of anesthesia and surgical nurses seemed to be that they were required to expand their competence instead of being able to focus on one specialty only. There were disruptions in the flow of information and lack of motivation. Especially, the recovery room was considered a big challenge for anaesthesia nurses. The descriptions of the challenges in the unit provided by the Head Nurse in Anesthesia were contrasted to other parts of the hospital and private sector. This is displayed in turns such as "the patient material is surely the worst of all" and "the private sector combs out the easiest patients and operates on them." Her description was also coloured by the contrast between past and present activity. For instance, she says that the patient material "is worse and it will remain worse."

The discussion proceeded on a general level. Some staff members felt that they did hardly ever experience the rewards of work outcomes. The training at work, keeping up with the new knowledge, and training of the newcomers were also experienced as problems by the staff of anesthesia and surgical nurses. But not all staff members felt the problems in their work. They were also some members that enjoyed their work as is shown in excerpt 5. In excerpt 5 the anesthesia nurse describes the challenges of work related to large work area and unpredictable situations in which the know-how of anesthesia nurses is tested and how meeting the challenges with creativity and talent is rewarding.

Excerpt 5

> ***Nurse Anesthesia****: So that we say that the hard drive in the sing we make it. That there you have to solve problems in unreasonable situations. So really, if you think that they throw you in the outpatient clinic or in some x-ray department, where the situation is such that (…) you don't necessarily have the tools [needed in x-ray], but in a way that [create solutions that] takes you over the worst bit. So they are such where the hard drive is tested. And when we get it to function and then you see that the system works, so there you have it. It is not always so. (Change Laboratory September 28, 2006, turns 102).*

The surgeons representing orthopedics also considered the "real work" with patients rewarding, although, they felt it was heavy. Some of the surgical specialties had also created a training system that supported the entrance of newcomers and sharing

new knowledge among surgeons in general. But then surprisingly an outburst of emotions emerged among surgeons who expressed their frustration of closed operation theatres in excerpt 6. The excerpt is interlinked and continuation of the excerpt 3 in which the Operations Manager displayed her personal experience to organizational deadlock in the surgery unit. Excerpt 6 uncovers that other professional groups also experience the organizational deadlock. In excerpt 6, the Operations Manager is put in another position in relation to her experience of deadlock. She needed to defend her decisions about the closed operation theatres. However, her defense unveiled also a personal dilemma that it was against her ethics to close the theatres when there were patients in need of operations.

Excerpt 6

> ***Head of Anesthesia:*** *Well there is still this big problem with closing the theatres – or I don't know if it is a big problem – but at least there is the threat that the surgeons are often such action women and action men, so they want to operate. And if theatres are closed the surgeons don't get to operate and at some stage you probably reach the point when they start voting with their feet. I don't know if there has been such a problem, but at least theoretically.*
> ***Researcher 1:*** *Yes, how do the surgeons take it that the theatres are closed?*
> ***Surgeon 2****: It is a red flag.*
> ***Surgeon 1****: It is really bad…*
> ***Surgeon 2:*** *It is all the bad there can be on the earth..*
> ***Surgeon 1:*** *It doesn't make sense to educate people to work and then we don't let them work, and there are sick patients as much as anyone can count and then they don't get treated, so it is a completely idiotic system. That is generally the reason to found hospitals that we would get to treat the patients.*
> ***Operations Manager****: And this is not easy for me either, I find it a crazy situation, that we have to do it like this..*
> ***Researcher 1****: [Speaking over] You are in such a crazy situation that you have to do it in order to stay in some kind of an operational readiness, isn't it so.*
> ***Operations Manager:*** *Yes, and I feel that in a sense in my mind I am responsible for the fact that otherwise even the people who are left wouldn't survive. That – you get to do it, but it is totally against ethics.*
> *(Change Laboratory September 28, 2006, turns 159-167)*

In excerpt 6 emerged a contrast between the desirable and actual activity in surgeons' work. The issue of not being able to operate on patients was a "red flag" for them.

In the discussion that followed, the pilot group members seemed to dwell on the topic by uncovering new angles to the situation. There were metaphors used to color the situation. For instance, the surgeon 2 characterized their work in the following way in excerpt 7.

Excerpt 7

> ***Surgeon 2**: It is so that when you look at it as a bit larger entity, when you compare it, so this kind of an analogy, that if you drive a car in the desert and you get low on petrol and you know you should do something. There is the petrol station two kilometers away, you don't stop there, but you slow down and try whether you can manage that way. Or possibly you take lower octane petrol or so… So it is a natural way of course if there is a 10%, 15% daily shortfall of staff, so you should oversize the personnel 10-15% over, so that this gets taken into account.*
>
> ***Researcher 1**: [Speaking over] So a good refueling and not…*
>
> ***Surgeon 1**: Yes. Because it is very hard to drive all the time the fuels gauge ---. I have sometimes tried to make it with little petrol and very likely when you try to drive slowly then it will eat up more, when there will be some hill in front of you…(Change Laboratory September 28, 2006, turns 189-191)*

However, there some members that did not wanted to get into the creation of solutions of the organizational deadlock. The interaction related to emerging solutions and the future of the surgical unit is rendered in episode 3.

Episode 3: Emerging solutions and the future of the surgical unit

Possible solutions were raised for the observed organizational deadlock already in the first laboratory session. In many Change Laboratory processes finding solutions is a process that takes time. First, it was suggested that the problems regarding patients queuing to operations could be solved by the increase of staff resources. But it was difficult to find new staff members that were qualified for the specialized surgery or anesthesia. Second, it was suggested that new staff members needed support and guidance in their work. This was not, however, easy to organize in a short time, especially among nursing staff. Third, it was suggested that the identity of the surgical unit needed to be redefined so that the unit could attract new staff members. Fourth, a new leadership and management model was suggested by the Surgeon 3 as a solution for the experienced organizational deadlock (excerpt 8). The suggestion was posed quite suddenly right after the description of the situation in excerpt 7. However, it might be that the Surgeon 3—specialist in heart surgery—might have waited for his turn to speak for some time.

Excerpt 8

> ***Surgeon 3:** Yes. Such a thought that as the nurse of anesthesia [refers to excerpt 4] said, the unit is terribly big, and therefore hard to control, that what if we divided it into parts. Orthopedics would get their own department, as would soft tissue surgery, cardio-thoracic surgery, and vascular surgery their own. Into three parts so that each would have their own nurses, their own doctors there, so that we would have smaller units, easier to manage,*

> *better to build such own identity for each and everyone and easier to recruit new people. Would that be more functional?* *(Change Laboratory September 28, 2006, turn 192)*

The Surgeon 3 referred to the size of the surgery and the difficulty control it as a reason for his suggestion. Interestingly, the surgeon 3 repeated his suggestion few turns further in excerpt 9. In excerpt 9 the Surgeon 3 also emphasized the impossible task of the Operations Manager in the unit and how the difficulty of the managing the unit could be divided between the Operations Manager and the teams. An anesthetic supported his suggestion and referred to responsibility that needed to be more shared than before.

Excerpt 9

> ***Surgeon 3:*** *So because this is, the unit is getting to be so big that it is hard to manage, the production manager has a hard time managing it, that [let's divide it] into smaller units-, if this were divided into smaller units, so maybe the problems would be easier to handle, easier to train, easier to… They would be more compact teams.*
> ***Researcher 1****: Please.*
> ***Anesthetist****: I feel that taking the responsibility would perhaps be-, or should I say, that there would be more people taking the responsibility when we would have such a smaller system. That now it is easy to throw everything to the Operations Manager and maybe some little goes to the head nurse of anesthesia too.* *(Change Laboratory September 28, 2006, turn 200-202)*

The last suggestion was strongly supported by the representatives from surgeons and anesthesia and the discussion proceeded with assessing the suggestion given by the Surgeon 3 from different points of view. It was agreed that the members of the pilot group would examine the suggestion from the different professional angels for the next session. After the first Change Laboratory, the discussions proceeded with plans of the new model of organization and leadership in the laboratory sessions. The new model was then presented to the staff of Surgery and the Intensive Care Unit in a staff meeting and improved thereafter in a fifth Change Laboratory in December 2006. The new model was implemented on 19 March 2007 and evaluated in two follow-up sessions in the spring and fall of 2007. The new model is currently in use in the surgical unit.

SUMMARY OF THE CASE EXAMPLE

The ethnography of experiencing organizational deadlocks included here three episodes: experiencing, identification and identification of organizational deadlocks, and transformation. The personal emotional experiences of organizational deadlocks were displayed by staff members in a Change Laboratory meeting. The key persons were the Operations Manager, the Head Nurse in Surgery, the Head Nurse in

Anesthesia, the Anesthesia Nurse, the Surgeon 1 and the Surgeon 2. However, the Operations Manager had a key role in starting the collective experiencing.

In this study, experiencing was examined as process of how change becomes experienced and embodied in talk and action through collective process. Emotional experiences acted as a ground for a collective process of experiencing. During this process the identification and reflection of the organizational deadlock took place. It the case example, the organizational deadlock related to the contradiction between the increase in the number of operations in a situation in which the resources to conduct operations were even diminished due to sick leaves and other absences.

The identification and the reflection of the deadlock led to a transformation of the activity in the surgical unit. A new leadership and management model was suggested as a solution for the experienced organizational deadlock. In the new model the responsibilities of the unit were allocated to teams in activity areas instead of directly to single staff members as a solution for the problems of managing the expanding activity in the surgery.

CONCLUDING REMARKS: FROM INDIVIDUALLY EXPERIENCED DEADLOCKS TO COLLECTIVELY CREATED TRANSFORMATION

The study provided insights of how change is carried out in experiencing of organizational deadlocks. The activity-theoretical framework of the study connected emotional experiences, collective experiencing, talk and activity dialectically. The methodology of the study—the ethnography of change—applied methods from previous anthropological studies (Rudie, 1994; Nugent and Abolafia, 2007; Emerson, 2004; 2009) and activity-theoretical studies (Sannino 2008a; 2008b). The methods of analysis involved the identification of patterns of discourse in which affects of individual exchanges to others can be seen (Sannino, 2008a). Such exchanges were analyzed as transitional episodes (Emerson, 2009). Transitional episodes involved expressions of deadlocks such as problems, tensions, and contradictions as well as suggestions of solutions to identified organizational deadlocks. The identification of experiential contrasts (Rudie, 1994) enabled the identification of discursive events that were meaningful for a participant. The examination of leaks emotion (Nugent and Abolafia, 2007) provided insights of how the hidden emotional experiences were uncovered. The data of the study was gathered in a research and development project that used a Change Laboratory method (Virkkunen et al., 1997).

In this study, organizational deadlocks emerged as personal conflicts and systemic contradictions. The emotional experience of the Operations Manager is an example of a personal conflict whereas the contradiction between the increase in the number

of operations and cutting down the number of services referred to a systemic contradiction. The process of change was carried out in an intertwined and temporal process that began with exposing the individual experiences of the deadlocks, identifying and reflecting the organizational deadlock through collective experiencing, and creating solutions for the transformation of the observed organizational deadlock. Experiencing proceeds action in the intersection between personal conflicts and contradictions (Sannino 2008a).

The collective experiencing was triggered by the mirror in the case example. The Change Laboratory, and especially the "mirror" enabled the display of hidden emotions as shown in the case example. The analysis of the case example demonstrates that experiencing can even accelerate change. The ethnography of such accelerated change processes can provide insights that are not visible in traditional change processes.

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