Intervening in a social crisis context. How to create the conditions for a dialogue about work?

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1. A social crisis context added to financial difficulties

For the past two decades, the French healthcare system has faced an increasing number of challenges, one of which is a financing system that doesn't compensate some medical services up to their fair value (Or & Renaud, 2009), leading many public or non-profit sector hospitals to experience economic hardship.

This paper is the result of a research-intervention carried out over 14 months in a healthcare institution facing not only large financial troubles, but also an acute social crisis, that affected its functioning. The managing association of the institution (the client) requested the intervention of ergonomists to understand this crisis and to support them with the development of action plans. This crisis consists of several historical markers (Pentecôte *et al.*, 2022), including: negative financial results leading to the lay-off of the previous director and the arrival of a new one; disagreements between the new director and the medical team (physicians and midwives) on several strategic decisions leading to strikes, and the resignation of several doctors and of two presidents of the Hospital Medical Committee. All these elements contributed to a climate of distrust and feelings of insecurity among the staff, which led to a breakdown in dialogue between the director and the medical practitioners, which progressively extended to the entire staff, leading to organizational malfunctions (such as a department's shut down) and a deterioration of the social climate.

2. Understanding the determinants of the crisis

In line with some previous works (Detchessahar, 2011; Conjard, 2015; Dujarier, 2015), we hypothesized that the governance actors (the client as well as the hospital top management) were completely unaware of the realities on the ground, and that there was a gap between their perception of work and the employees' experience at work. This gap is due to a top-down vision of the organization conceived as *a space to be regulated*, which frames the activity of employees through multiple processes and devices (Detchessahar, 2019). These devices become the object of managers' work. They are placed between prescribers and employees, which leads to a distance between them, thus reducing the frequency of meaningful interaction. The consequences are often: an increasing gap between prescribed and real work; a reduction in the margins of maneuvers which inhibits staff independence and agency, affecting health and performance (Mollo, 2022); and a possible deterioration of the social climate (Dugué & Petit, 2022).

Based on the ergonomic analysis of work, our objective was to understand the origins of social tensions and create the conditions to bring real work at the centre of debates and decisions. Our approach is part of a systemic and holistic vision that studies the reciprocal influences between organization and activity and develops participatory and reflective methodologies aimed at

supporting a continuous process of interactions in management practices (Gaillard & Mollo, 2021).
In this paper, we will describe the main actions and regulations carried out by ergonomists to bring work to the heart of the concerns of governance and social dialogue, in this social crisis context that has strongly impacted our own maneuverability.

3. The questionnaire as a means to bring work into discussions

3.1. An ergonomic pre-diagnosis rejected without any chance to dialogue

An initial pre-diagnosis phase, based on a documentary study, open observations and 38 interviews with all the stakeholders of the institution, made it possible to build a history of the social crisis, and highlighted a deleterious management style of the director, specifically characterized by a lack of listening and dialogue with the employees, as well as strong differences with regard to the criteria for the quality of work (Clot *et al.*, 2021) and the actions to be undertaken to improve the financial situation.

The pre-diagnosis was strongly rejected by our client who, calling our neutrality into question, showed a kind of mistrust towards us. The results were considered illegitimate, since they were based on "subjective" data, and we did not have the opportunity to compare our respective analyses in a constructive exchange. We then measured how much the opposition practices we were facing were modeled on existing forms of relationships in the institution. The expression of divergent points of view about work was not allowed, leading either to organizational silence (Morrison & Milliken, 2000; Rocha *et al.*, 2015, 2019) or to conflicting relational modes. We too experienced this social crisis that impacted the course of our intervention.

3.2. An organization for dialogue about work: setting up a space for dialogue and conducting a questionnaire on working conditions

While we were planning to develop a diagnosis based on the analysis of employees' activities, we had to adapt our methodology to maintain the link with our client, who was considering stopping our work.
On the one hand, the setting up of a joint Steering COmmittee (SCO) representing all hospital actors, which was responsible for the methodology and the follow-up of the approach, enabled us to maintain an equidistant relationship with all the stakeholders. It constituted of an experimental discussion space governed by operating rules that the ergonomists didn't hesitate to remind of, when necessary, namely: no one holds the truth; understanding listening (without interrupting or judging); one has the right to disagree (the clarification and discussion of differences is encouraged); we are responsible for what we say and what we don't say. Although the first exchanges were very aggressive, a form of constructive conflict (Follett, 1924; Mollo, 2022) gradually emerged, with each member having the opportunity to express himself or herself freely and to debate with the others to overcome disagreements and develop a common response to the issues raised whenever possible.
On the other hand, we designed a questionnaire to allow employees to express their views on their working conditions anonymously, and to generate statistical data that would guarantee the balanced representation of the results and preserve our neutrality. Developed by ergonomists

based on existing surveys (Saphora Job of the CCECQA[1] and SUMER of the DARES[2]), the questionnaire was discussed, adjusted, completed, and validated collectively within the SCO.

The questionnaire included 82 questions distributed in 9 headings: "Work Organization and Content", "Social Relations", "Professional Development and Employment", "Local Management", "Acknowledgement", "Salary", "Top Management and bodies of the Hospital", "Human Values", "Global Satisfaction".
Following our pre-diagnosis, we also included questions directly related to the hospital. Our open observations showed poor hygiene and security conditions as well as a lack of adapted workplace and equipment. We thus wanted to confirm these matters with the questionnaire. We also wanted to question the employees about whether they felt they worked in a peaceful and trusting climate. This is because our pre-diagnosis had revealed a climate of distrust and confusion. Besides, we wanted to learn about employees' perceptions of the hospital's future and of their own future in the hospital. As the pre-diagnosis had brought the deleterious management of the director to light, we decided to duplicate the questions about local management with the same questions related to top management. For example, one of the questions under the "Local Management" heading concerned the manager's behavior with his staff. The same question was repeated in the "Top Management and bodies of the Hospital" heading regarding the director's behavior with the hospital staff. As some of the members of the hospital's board had expressed some suspicion about the staff's knowledge of the financial situation of the hospital, we needed to check this statement and we also included a question regarding the staff's perception of the board's strategy and decision-making.
The questionnaire was distributed among the staff for a 33-day period.

The 57% response rate ensured the reliability of the results, which confirmed our pre-diagnosis. In particular, the management style of the director emerged very significantly as a source of dissatisfaction due to the lack of listening and consideration (65% of the respondents), the lack of recognition and involvement (54%), and the lack of information and communication (64%) (Pentecôte *et al.*, 2022). Unlike what was assumed by some of the board members, 62% of the employees were aware of the financial difficulties of the hospital and 76% were worried about the hospital's future.
Despite some minor opposition, this diagnosis was received by our client as a necessary call to action and an opportunity to reflect upon the actions to be taken to overcome the social crisis.
The questionnaire was thus the tipping point for our action, on two levels. On the one hand, the conditions of dialogue created to build it (parity and based on operating rules) enabled the different members of the SCO to experience and observe that a constructive dialogue was possible. On the other hand, we took advantage of this new perspective of our client to initiate a dialogue based on the results of the questionnaire between the different actors of the institution.

3.3. Organizing the questionnaire feedback to experiment with spaces for dialogue about work within the institution

[1] CCECQUA : Coordination Committee for Clinical Evaluation and Quality in Nouvelle-Aquitaine: https://www.ccecqa.fr/publications#Rapports
[2] DARES - SUMER : Directorate for Research, Studies and Statistics - Medical Surveillance of Occupational Risks: https://dares.travail-emploi.gouv.fr/enquete-source/la-surveillance-medicale-des-expositions-des-salaries-aux-risques-professionnels-2

Beyond the SCO, the dialogue about work was extended within the hospital by the organization of feedback sessions. Representatives of our client were invited as observers, but our deepest intention was to create the conditions for them to hear what the employees had to say about their work and the conditions of its realization in the hospital. Each session took place in two stages: first, a presentation of the results of the questionnaire by the ergonomists, then a collective discussion. 14 feedback sessions were first organized for all the staff, targeting an inter-departmental dialogue after the presentation of the global results of the questionnaire. In a second step, 12 feedback sessions were organized within each department where the global and the department's results were presented, which allowed the employees to compare their department's results with the global results of the hospital. We set up a framework for exchange to bring the real work and the conditions of its realization into the heart of the discussions, which had never been possible until then. We wanted to highlight the links between work organization and managerial practices on the one hand, and the activity, the employees' health, and the quality of care on the other, by mentioning concrete work situations. We never limited the discussion time to allow everyone (employees and the client's representatives) to feel comfortable enough to say what they wanted to say.

For many of our client's representatives, these feedback sessions were an opportunity to physically come to the hospital for the first time, which was quite symbolic and showed the desire to go to the places where the work was being done. Employees, for their part, appreciated the fact that governance representatives came to them, as some of them, who had been working for the hospital for more than 10 years, had never met a single person from governance until then. Moreover, these sessions enabled our client's representatives to hear the point of view of field employees and to engage in a dialogue with them, which had never happened before. They made it possible to make the work relatable and understandable.

In the maternity department, a midwife reported that in a room where a patient was in labor, the needed equipment was malfunctioning. She knew that her colleagues were very occupied and didn't want to disturb them. She thus had to look for a functioning equipment elsewhere in the department, leaving the patient alone for a while. She reported that accompanying the patients is part of her work and that she felt that she didn't do a good job because of the missing equipment.

Figure 1: example of the incidence of lack of equipment on an employee's perception of quality of work

Participation in several inter- and intra-departmental sessions brought our client to the realization that his assumptions were far from the realities of the work and helped him understand that the social crisis was in fact a crisis of work, which was crystallizing in the concrete conditions of the activity. The representatives were thus able to measure the impact of certain decisions, actions or behaviors on activity and social relations, as well as the commitment and need for accomplishment of employees who were just looking for doing high quality work.

Figure 2: example of the director's lack of listening

In the palliative care department, a fact that had affected all the department's employees was relayed about the director's management. In a meeting concerning the department's organization, the nurses said that more of them were needed to enable work under good conditions. As an example, they stated that they could not leave the department at lunchtime because that would mean leaving just one nurse in the department who, if ever a patient fell from his bed, could not take care of him alone to put him back into his bed. The only answer they obtained from the director was that the patient could stay on the ground for 30 minutes, waiting for the second nurse to come back from lunchtime and help his/her colleague. All the employees that had heard the director's answer were shocked, leaving some of them in tears.

By allowing those of the members who were present at the feedback sessions to understand the importance of taking care of real work in managerial practices, we also rebuilt trust with our client, with whom we were able to establish a constructive dialogue.
At the end of the feedback sessions, a summary of the priority areas for improvement, both in general and by department, was presented, discussed, and validated by the SCO and then given to our client, with the recommendation to implement 3 rapid actions per department to improve working conditions. It was indeed urgent to send signals to the employees showing that they had been heard.

4. A necessary first step in bringing work into discussion, to be continued…

When starting this research-intervention, our objective was to produce an inventory of the situation in the institution based on the analysis of work and activity and identify the determinants of the social crisis. This initial work was meant to lead to the sharing and discussion of the results by creating spaces for debate (Rocha *et al.*, 2014) within each department and then, in a transversal way, between departments. Through a participatory and systemic approach, our objective was to achieve a shared diagnosis and the co-construction of action plans that would allow for the development of activity and staff health, as well as the quality and safety of care. Our ambition was also to support the implementation of work management through action training to emphasize a processual and dynamic vision of the organization (de Terssac, 1992; Weick, 2001; Cordelier *et al.*, 2011; Lorino, 2013).
Of course, the hospital in which our intervention took place, like many others, is impacted by major structural changes of the French healthcare system, among which are staff shortage and limited resources which have seriously deteriorated work conditions for the past several years. What exacerbated the difficulties of the hospital was the deleterious management of the director and his support among members of the board which deteriorated the social relations. The employees, especially the medical professionals, tried to alert the board about the behaviors of the director but they were ignored. Even workers' representatives were unable to have a peaceful dialogue about work conditions with the director and the board.
Given the magnitude of the social crisis that strongly impacted our approach and the dialogue with our client, we always sought not to lose sight of the real work. Although we didn't have the opportunity to analyze the activity as we had considered, we worked to create the conditions for a calm social dialogue based on real work in a form that we had not imagined, by regularly making

methodological adjustments to ensure that our approach was always fitting the pace of our client. As the qualitative data of our pre-diagnosis was simply not accepted, we decided to generate quantitative data that could not be fully rejected. The questionnaire forced us to get out of our comfort zone but was the best strategy to continue our intervention and to encourage employees to share their point of view about their work conditions. For us, the ergonomists, the diagnosis resulting from the questionnaire was the best way to encourage our client's representatives to meet the employees in the departments, where real work was accomplished daily. In a form of iterative process, the feedback sessions were then spaces where real work could be debated to produce new qualitative data.

These elements are the basis of the pedagogical approach that constitutes ergonomics intervention (Dugué *et al.*, 2010). They describe a situated engineering of the ergonomic intervention and show the importance of an approach based on an experiential pedagogy, where the participants are actors in the understanding of their work system and experiment new forms of collective action. Such an approach is part and parcel of an awareness-raising process by leading the various stakeholders of the institution to "access a global awareness of all the elements, personal and structural, that contribute or have contributed to their difficulties" (Vallerie & Le Bossé, 2006, p. 90), and thus contributes to opening up the spectrum of opportunities for action, i.e., to the development of their power to act (Le Bossé, 2016).

Our objective of co-constructing spaces for debate on work was partially achieved since we succeeded in putting real work under discussion, encouraging the confrontation of divergent points of view and aiming for work conditions transformations. On the other hand, we were not able to deepen our work by establishing this type of debate in the existing organizational structure in a perennial way, and by organizing subsidiarity (Mollo & Nascimento, 2013; Rocha, 2014). Nevertheless, we know that our research-intervention had effects since the governance of the institution did consider and act on the main determinants from the diagnosis and feedback sessions, adopting a new posture learned during the action.

Keywords
Ergonomic intervention, work management, social crisis, social dialogue, spaces for debate.

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