Nordic journal of working life studies Volume 7 ▮ Number 4 ▮ December 2017

Employees' Conceptions of Coworkership in a Swedish Health Care Organization[1]

- **Caroline Bergman**[2]
  PhD candidate, Section for Social Medicine and Epidemiology, The Sahlgrenska Academy at the University of Gothenburg, Sweden, and Institute of Stress Medicine, Region Västra Götaland, Sweden

- **Jesper Löve**
  PhD, researcher at Section for Social Medicine and Epidemiology, The Sahlgrenska Academy at the University of Gothenburg, Sweden

- **Annemarie Hultberg**
  Senior developer, Institute of Stress Medicine, Region Västra Götaland, Sweden

- **Katrin Skagert**
  PhD, researcher at Faculty of Caring Science, Work Life and Welfare, University of Borås, Sweden

ABSTRACT

The concept of coworkership is widely established as a top-down communication strategy within organizations. However, interpretations may differ between organizational levels, and the employees' point of view is still largely unexplored. The aim of this study was to explore and describe conceptions of coworkership among employees with different professions in a Swedish health care organization. Twelve focus group interviews were conducted with 68 employees, and the data were analyzed using phenomenography. Coworkership was experienced as a collective process, which included colleagues but not explicitly managers. Five categories emerged, representing different conceptions of coworkership: group coherence and striving toward a common goal, cooperation over professional and organizational boundaries, work experience and trusting each other's competence, social climate and sense of community, and participation and influence. The collective process in terms of cooperation is closely related to team climate, which in turn influences the quality of patient care and a health-promoting work environment.

KEY WORDS

Coworkership / employee / focus group interview / health care organization / phenomenography / profession / salutogenesis / workplace health promotion

Introduction

In both private and public organizations in Sweden, the concept of coworkership is well-established and used as a top-down communication strategy, for example, in policy documents. However, the understanding of what coworkership means may differ, both between organizational levels within the same organization and between different

[1] You can find this text and its DOI at https://tidsskrift.dk/njwls/index.

[2] Corresponding author: Caroline Bergman, Institute of Stress Medicine, Carl Skottsbergs gata 22B, SE-413 19 Göteborg, Sweden, E-mail: Caroline.bergman@vgregion.se.

organizations (Kilhammar, 2011). In addition, the understanding of coworkership and how it should be developed is often normative in terms of 'good employeeship', and is seen from a leader's perspective (Wikström & Dellve, 2009). However, the relevance and understanding of coworkership as a phenomenon are still largely unexplored. This study focuses on employees' conceptions of coworkership in a health care organization in Sweden.

In the Nordic countries, coworkership as a concept has evolved from a long working life tradition (Hällstén & Tengblad, 2006; Møller, 1994; Velten et al., 2017). Employers began to use the concept in policies and documents in the 1990s, as part of efforts to increase efficiency and handle organizational changes (Hällstén & Tengblad, 2006). During this time period, organizations were characterized by relatively flat organizational structures and few managers, which led to individualization of responsibility and the role of the employees becoming more active and responsible (Møller, 1994). New public management evolved during the same period in Sweden, with more focus on individual performance, particularly within the health care system. As applied in research and practical contexts, this individual role of taking responsibility still seems to be the main core of coworkership.

In contrast to the amount of leadership research from different research traditions, research into coworkership is limited. The structural perspective of leadership as a function has its origin in the sociological and management research field, while the relational perspective originates from the field of psychology. Yet, these different perspectives seem to agree that leadership is a process of influence between the leader and the led (Yukl, 2002). Coworkership, on the other hand, has many different and diffuse definitions. In this article, we have chosen the frequently used definition by Hällstén and Tengblad (2006), describing coworkership as those practices and attitudes that employees develop in relationships with their manager, their colleagues, and their employer at large (i.e., the organization as a whole). The normative model for development of coworkership described by Hällstén and Tengblad (2006) includes important and necessary preconditions such as trust and openness, community spirit and cooperation, engagement and meaningfulness, and responsibility and initiative. This model of development of coworkership, inspired by ethical theories and originating in the field of business economics, is used in this article to analyze the preconditions experienced by employees in a health care organization.

Several other concepts are closely related to coworkership. Bertlett et al. (2011) use the term *employeeship*, defining this as the employee's ability to handle duties, social interactions, and relationships between two or more employees (Bertlett et al., 2011). Employeeship has also been conceptualized in normative ways as 'what it takes' to be a good employee (Møller, 1994). Although employeeship is a synonym of coworkership, the concept of coworkership is preferable because it has a clearer association with related concepts such as cooperation and codetermination, two other central parts of Nordic working life. *Organizational citizenship behavior* is another concept associated with coworkership; this can be described as individual-oriented behavior involving taking responsibility beyond one's duty (Mamman et al., 2012). However, the concept of organizational citizenship behavior does not distinguish between the responsibilities of managers and employees, while coworkership considers different responsibilities for managers and employees to be important in making the relationship work. Another concept related to coworkership is *empowerment*, which is a process that aims to strengthen

individuals and groups in order to help them improve their situation and gain greater control over their own lives (Arneson & Ekberg, 2006). Empowerment has been used as a normative top-down process in order to improve efficiency and results within an organization (Kilhammar, 2011) by making workers more autonomous and independent, while coworkership emphasizes the mutual dependence of leaders and employees. In international research, the concept of *followership* is most closely related to coworkership. The main focus in followership is the relationship between the leader and the followers (Baker, 2007). Coworkership, on the other hand, is a broader concept and includes more dimensions than just the relationship between leaders and followers.

Coworkership can occur in different forms, depending on specific conditions in an organization and how the work is organized (Hällstén & Tengblad, 2006). There may be more than one form of coworkership within a given organization. *Traditional coworkership* is common at workplaces that are characterized by employees having a passive role, team leaders having an active role, and lack of opportunity for participation among the employees. In *organizational coworkership*, the role of employees becomes more active and responsible. There is also a clear expectation of how this should be manifested. This form of coworkership includes an obvious and consistent delegation of responsibility and authority. *Group-oriented coworkership* typically involves the working group having a large influence over its work, and there is often a team leader included in the group. *Individual-oriented coworkership,* on the other hand, is based on individual responsibility. One positive aspect is that this form of coworkership may promote engagement among the employees, but conversely, the social climate may be affected and competition between employees may occur. Another form of coworkership is *leaderless coworkership*, characterized by an undeveloped relationship between the employee and the manager. Workplaces with no formal manager are not common, but the role of the manager could be more or less peripheral for the employees.

There are still very few explorative empirical studies about coworkership in peer-reviewed research journals. One such study investigated the process of implementing the idea of coworkership in practice (Kilhammar & Ellström, 2015). The findings indicate that there was a higher degree of development of coworkership if the implementation strategy was characterized by a high level of participation and integration into daily work routine. Another study examined coworkership from a communication perspective, with a focus on co-workers as active communicators who interpret, make sense of, and formulate messages, instead of the traditional role of coworkers as recipients of information (Heide & Simonsson, 2011). Bertlett (2011) studied coworkership on the individual level, and developed a model focusing on the relation between the leader and followers (Bertlett, 2011). Coworkership has also been studied from an organizational perspective, in terms of how coworkership can be seen as an important social resource that generates organizational resilience (Andersson, 2018). Although preconditions for development of coworkership within elderly care have been studied before (Andersson, 2013a), there are still very few explorative empirical studies of coworkership in the specific context of health care organizations, and especially from the employees' point of view.

The nature of work in health care organizations involves having close contact with patients and responsibility for their health and wellbeing. Within professional bureaucracies, such as hospitals, the primary focus is on the operational core and is dependent on the employees' knowledge and professional skills (Mintzberg, 1983). Glouberman

and Mintzberg (2001) illustrate the hospital as an organization that is separated into four different and separate worlds (mindsets): community (public or private owners/politicians), control (managers), cure (physicians), and care (registered nurses and other care professionals). Each of these worlds represents a different understanding of organizational reality (Glouberman & Mintzberg, 2001). Furthermore, the identity of nurses and physicians is also closely associated with their own professions. A qualitative study found that upholding the autonomous traditional role of physicians may be associated with less engagement in health care development, whereas the role of an employee appears to be associated with more engagement in development work (Lindgren et al., 2013). This example of two opposing roles (mindsets) perceived by physicians provides motivation for further studies into how coworkership is characterized, not only among physicians but also among other professions in a health care organization.

Collaboration between professionals from different disciplines has long been a widespread form of work organization within health care organizations. A 'team' can be defined as a group of people who are set to work together on a common task, and 'teamwork' captures how people work together toward a common goal that could not be achieved by individuals working alone (Marks et al., 2001). Teamwork is a well-established concept and an essential component within health care organizations in order to achieve high reliability (Baker et al., 2006). Coworkership in strong professional organizations is based on a strong relationship to the team and the group members' profession, which may result in an undeveloped relationship with their employer and indirectly with their manager (Andersson, 2013b). This may form a barrier, since the concept of coworkership also emphasizes a close relationship with the organization and employer.

To summarize the above, there are several concepts that are comparable to coworkership. However, the definition of coworkership that is often used in Sweden, and also in this article, has wider implications because it considers a broader set of relationships; both horizontally, between employees with different professions, and vertically, between different levels in the overall organization. Coworkership is not a new phenomenon. It has a long history, it is well-established, and it is used as a top-down communication strategy in most Swedish organizations. However, there is still little knowledge of the phenomenon, and the definitions are rather complex. The ways in which it is used and interpreted differ according to context, as well as to who is using it and for what purpose. To be meaningful when applied to promote efficiency, quality, and a health-promoting work environment in organizations, as well as in research focusing on such questions, coworkership needs to be further explored. As already mentioned, there are few explorative studies about coworkership in the context of health care. The aim of this study was therefore to explore and describe conceptions of coworkership among employees with different professions in a Swedish health care organization.

Methods

Study design

The study had a qualitative explorative design with a phenomenographic approach (Marton, 1981). The rationale was to analyze and highlight differences in how employees with different professional roles in a health care organization experienced coworkership.

In the light of Glouberman and Mintzberg's (2001) illustration of the hospital as an organization separated into four different and separate worlds, in which each world represents different understandings of the organizational reality, phenomenography was considered to be a suitable methodological approach for this study. The aim of phenomenography is to describe the qualitatively different way a group of people experience and understand a phenomenon in their surrounding world (Marton, 1981); in this case, coworkership in a health care organization in western Sweden. Focus group interviews were used to elicit the participants' understandings of coworkership (Krueger, 1994).

Setting

The setting was a hospital with emergency, planned, and psychiatric care in western Sweden with a total of about 800 beds, 4500 employees, and 140 wards. The organization is multi-professional; about 50% of the employees are nurses or assistant nurses, more than 10% are physicians, fewer than 10% are medical secretaries, and 3–4% are physiotherapists.

Participants

Employees were strategically selected in order to include a variation in profession (nurse, assistant nurse, medical secretary, occupational therapist, physiotherapist, and physician). The selected employees worked within different clinical settings (psychiatric, medical, and surgical wards). Employees with the same profession but from different wards were placed in the same focus group. The main reason for this was to enable an analysis and description of differences in how employees with different professional roles experienced coworkership. To select employees, managers from different clinical wards were contacted with information about the study and invited to select or request one to three employees to participate in the study. Three ward managers declined due to lack of time, lack of relevant profession for the study, or the geographical location of the ward; other ward managers were contacted instead. The total sample of participants in the focus group interviews consisted of 68 employees with various professions (29 nurses, 21 assistant nurses, eight medical secretaries, two occupational therapists, three physiotherapists, and five physicians), length of work experience, length of employment, sex, and age (Table 1).

Data collection

Twelve focus group interviews were conducted in order to collect data about different experiences of the phenomenon of coworkership through group interactions. Employees' practice and attitudes may be difficult for the employees to articulate in a normal interview situation, and may be unspoken or taken for granted. The process of sharing and comparing among the participants was thus a valuable aspect of the focus group interviews, which were aimed at eliciting understandings and experiences rather than reaching agreement (Morgan, 1997). The focus group interviews were held in conference rooms at the hospital between November 2011 and January 2012, and lasted

Table I Characteristics of the study sample for focus group interviews

Focus group	Participants (n)	Profession	Length of employment (years)	Sex (women/men)	Age
1	5	Nurse	6–42	5/0	30–62
2	8	Assistant nurse	10–34	8/0	41–55
3	7	Nurse	3.5–37	7/0	35–58
4	4	Nurse	7–35	4/0	35–60
5	8	Medical secretary	5–36	8/0	26–58
6	5	Occupational therapist and physiotherapist	0.5–11	5/0	25–52
7	5	Assistant nurse	3–38	4/1	38–59
8	6	Nurse	5–31	4/2	28–57
9	8	Assistant nurse	5–38	7/1	29–59
10	7	Nurse	1–36	6/1	28–59
11	3	Physician	3–35	2/1	29–60
12	2	Physician	3–10	1/1	36–40

approximately 1 hour each. The participants were distributed among the 12 focus groups based on common professions, and each focus group consisted of 2–8 persons (Table 1). More than 68 employees were selected for participation, but only 68 turned up in total. Reasons for absence among the selected employees were sickness, schedule change, high workload, or low staffing at their ward.

The focus group interviews were performed by a moderator (KS/CB), with a comoderator (CB/AH) taking field notes. Each interview started with renewed information about the aim of the study. An interview guide was used, with one main open interview question: 'What does the concept of coworkership mean to you?'. Follow-up questions were asked to encourage the participants to give concrete examples from their everyday work and practices. For example, if they described cooperation or influence in relation to their conceptions of coworkership, the moderators could ask how they had experienced cooperation or if they had opportunities to exert influence at their workplace.

All focus group interviews were recorded and transcribed verbatim by a person experienced in this type of work. To ensure the accuracy of the transcriptions, the moderator (CB) compared all the transcriptions with the audio recordings. After all the focus group interviews had taken place, the preliminary data were presented to the employees during a mirroring feedback seminar to which all participants (n = 68) were invited. Twenty of them attended the seminar, during which they provided additional opinions that were helpful in the analytical process.

Data analysis

The interviews were analyzed using a phenomenographic approach (Alexandersson, 1994; Marton, 1981) inspired by Alexandersson's four steps (Alexandersson, 1994). In the first step, the transcribed interviews were read through to get an overall impression of the material. In the second step, data concerning conceptions of coworkership were highlighted in the material, and similarities and differences between the professions were noted. In the third step, similar conceptions were grouped into descriptive categories, from which a theme emerged. In the fourth and final step, the underlying structure of the categorization system was examined. In order words, the outcome space constituted the main result and formed the basis for a more systematic analysis of how the conceptions were related to each other. The results are described below in terms of one theme and five descriptive categories generated from the data. To validate the results, the preliminary results were discussed and verified by the employees (n = 20) who participated in the mirroring feedback seminar.

Ethical aspects

The data in this study were collected, analyzed, and presented at group level, and individual data cannot be traced. All participants provided their informed consent after being assured of privacy and the voluntary nature of participation. Complete confidentiality is not possible in focus group interviews, since participants from the same organization may know each other. However, the interviewer emphasized the importance of not sharing other group members' opinions afterwards. The study was part of a larger research project approved by the Regional Ethical Review Board in Gothenburg, Sweden (Ref. No. 433–10).

Results

The results of the analysis formed a pattern of one theme and five descriptive categories. The theme was *coworkership as a collective process* and the categories were *group coherence and striving toward a common goal*, *cooperation over professional and organizational boundaries*, *work experience and trusting each other's competence*, *social climate and sense of community*, and *participation and influence*. These categories represented different conceptions of coworkership as a collective process, and all categories covered more than individual aspects of coworkership.

Theme: Coworkership as a collective process

Category: Group coherence and striving toward a common goal

Coworkership was considered to develop through working together and taking responsibility for the work as a group, rather than working alone and taking individual responsibility. Conceptions of who was included in the group varied between the professions.

Some of the physicians worked at several units and only included physicians in their view of coworkership. Due to similar work situations and shared aspects related to difficulties and sadness when working with patients, they felt that they could understand each other better than other professions.

> No … but I am closer to them, or I have more connections and share problems with them, and sometimes their grief, or whatever it is, and they understand it in a completely different way than any other profession can understand. (Focus group 11)

The opposite conception was expressed by the nurses and the physicians who worked in a single unit; they described group coherence as a central part of coworkership, and included all the professions they worked with. Although the employees had different professional backgrounds and different work situations, they all expressed that they worked together toward a common goal. This, along with having a clear goal, was stated as important for group coherence.

> That you work toward the same goal and that you know what the goal is. What we have to do in the workplace, that it is made clear, and that everyone pulls in the same direction. (Focus group 10)

Most of the professions had the common goal of caring for the patient. The physicians also mentioned the common goal of solving problems together, for example, finding time for new patients despite a huge inflow of referrals. The role of the manager was not explicitly included in coworkership, which was described as a collective process, but managers were indirectly included by having a supportive role and ensuring that everyone worked toward the common goal.

Category: Cooperation over professional and organizational boundaries

Cooperation was described as a central aspect of coworkership. The cooperation took place around the patient, indirectly or directly, and often involved several employees with different professional backgrounds. A common view was that this kind of cooperation, comparable to teamwork, was positive and important in order to create a well-functioning workplace. Some of the nurses used a sports metaphor to describe coworkership in terms of cooperation, pointing out the importance of using everyone's resources.

> I use to compare it with a lineup in hockey: two runs, two forwards, and one center. And no one is good at everything, but everyone is good at something. So, use everyone's resources, that's what I think (Focus group 10)

Most of the professions cooperated over unit boundaries. The assistant nurses pointed out that although this could promote understanding between colleagues and getting to know each other over unit boundaries, it could also contribute to concerns about not knowing where to work. Among the medical secretaries, factors that hindered cooperation over unit boundaries included different work routines and the different terminologies used by the physicians.

> I think it works badly because everyone has their own version of how they want their things, or how you decide and assess a referral, so I take the pile of referrals and make preliminary appointments for patients, and then all the doctors have their views on how to assess … (Focus group 5)

The physicians pointed out that conflicts of interest in terms of prioritizing different patient groups could be an obstacle to cooperation. Occupational therapists and physiotherapists cooperated with each other to promote the patient's return home, but physiotherapists also needed to exchange experiences with colleagues with the same professional background. The physicians also mentioned a similar need. A common understanding among the employees was that well-functioning communication not only promoted better cooperation between employees but also improved their relationships with managers and the organization as a whole.

Category: Work experience and trusting each other's competence

Conceptions of coworkership as a collective process were described as dependent on mutual trust in each other's competence. This was a common view among most of the professions. The nurses stressed the importance of a climate of trust in order to promote dialogue, which meant that employees could tell each other if they felt unconfident. A climate of trust was also important for work with patients, as stated by assistant nurses.

> It's important to feel secure with your colleagues, that you know roughly where they are when you're working with the patients you have. (Focus group 9)

Trusting relations were important not only between colleagues but also between employees and managers. Managers were perceived as promoting a culture of transparency, security, and trust at the workplace. The physicians pointed out that people who had worked together a lot automatically compensated for each other's weaknesses and drew advantage from each other's strengths. The employees felt that work experience and knowledge needed to be complemented with other colleagues' reliance and confidence.

> I think probably, when I work with staff who've been there for a while, when we've really got to know each other, then I think it works well. There's no need to say what you're going to do, because everyone knows what's going to happen and what to do, and so on. Then it works very well. (Focus group 1)

The group of occupational therapists and physiotherapists expressed that trusting each other's competence was about taking professional responsibility in order to treat the patient on the basis of both professions' knowledge and competence. One of the physicians stated that even though a new colleague could be unfamiliar with the work routines, they needed to trust that colleague's professional background.

Category: Social climate and sense of community

The nurses, assistant nurses, and physicians described normative statements of what was perceived as 'good coworkership'. It was about something more than group coherence

and working together with patients. They expressed the importance of supporting and helping each other, as well as maintaining a positive climate and a familiar atmosphere where everyone could rely on each other. This was also mentioned by the other professions, but not in normative terms of what characterized 'good coworkership'.

> This give and take, that if you don't have the time to do something, your colleague supports and helps you … I think that's also important, to give and take. Absolutely. Not just carry on working and working. You need help sometimes, too. (Focus group 1)

Even though social climate could be seen as negative, in terms of knowing too much about each other, it could also be important when job satisfaction was perceived to be negatively affected by organizational changes.

> R1: Yes, and then everyone talks about job satisfaction, but there's a lot that has been closed down, too.
>
> M: How do you mean?
>
> R1: I mean all the decisions and reorganizations that have been made, and new changes on the go, and so on. But because we still have it, that's why so many people stay on and work here.
>
> R2: There's a good atmosphere between colleagues. That's why many people have chosen to carry on working here. (Focus group 6)

The medical secretaries stated the importance of helping each other with their duties, especially when there was a heavy workload. The assistant nurses expressed that they got feedback from each other, rather than from their managers. Other participants stated that the role of the manager was to listen, to be engaged, and to acknowledge employees. Respect between colleagues was perceived as important for sustainability. The physicians pointed out that even if they had to argue, they should do it in a respectful way.

Category: Participation and influence

The employees stated that participation and influence were fundamental to coworkership. This was mainly due to aspects of their work with patients, such as improving continuity and contact with patients and creating processes for better patient flow. Some aspects of influence were also viewed from with an organizational perspective. The employees had different views about how much of the organization was included in the concept of coworkership.

> R1: Coworkership … I think that I'm part of the organization.
>
> M: Do you have any examples of when you've felt that you're a part of the organization?
>
> R1: Well, I suppose it's when you're asked what you think about organizational issues or how you want your job to be organized.

R2: … I feel quite distant from the large organization, I must say. It's more to do with your everyday work. (Focus group 4)

The occupational therapists and physiotherapists questioned how much influence they needed to have on overall organizational issues, especially since they felt that their priority was the patient. Participants' perceptions of how much influence they had on the working day varied between professions. The physicians felt that they could influence clinical work, while the other professions felt they had less say about their working day and their own schedule.

It's about the amount of work and how many people you share it with. I think, like, there are more and more tasks that must be done, and you have very little influence because you're pretty much limited by the situation around you. Which means that you don't have so much influence. You can't organize your working day yourself. (Focus group 11)

The medical secretaries pointed out the importance of a good communication climate in allowing people to speak up. The assistant nurses and nurses stated that they did not have very much influence in relation to physicians, for example, during workplace meetings, and so that the assistant nurses and nurses had meetings without the physicians. They also stated that it was difficult to influence professionals with more education and responsibility.

Discussion

The aim of this study was to explore and describe conceptions of coworkership among employees with different professions in a Swedish health care organization. The main results relate to the employees' conceptions of coworkership as a collective process formed around the patient. This collective process included colleagues but not explicitly managers. These findings are in line with a study on the development of coworkership (Kilhammar, 2011), where coworkership was primarily associated with group coherence and how the group worked together. Our results indicate that the individual aspects of coworkership that are taken up in closely related definitions of coworkership such as employeeship (Møller, 1994) might not commonly occur in practice. This is particularly the case in health care organizations and other places where there are specific conditions of strong professions relying on each other's competence. However, although the collective aspect of coworkership was dominant in the present study, aspects of individualistic responsibility were also illustrated, such as giving the patient treatment based on professional knowledge and competence. These can be seen as related to taking responsibility as a team and working together toward a common goal.

The collective process in terms of team and team climate is not a new concept in health care organizations. Studies have shown that the quality of the team climate seems to be important for patient care (Wheelan et al., 2003), mental health among employees (Sinokki et al., 2009; Ylipaavalniemi et al., 2005), and innovation within the team (Anderson & West, 1998). The results from the present study show that group coherence, striving for a common goal, trust in each other's competence, and an open communication climate seem to be important for coworkership. Even though most of

these conceptions are quite similar to the preconditions for team climate (Anderson & West, 1998), this study also highlights dimensions of coworkership from an organizational perspective, focusing on communication and cooperation between different organizational levels. In contrast to team climate, the concept of a developed coworkership considers a broader set of relationships and includes not only horizontal relationships between group members in the team but also vertical relationships with the manager and overall organization (Hällstén & Tengblad, 2006).

The different work situations among the professions in this study were experienced as affecting coworkership. The physicians generally worked alone rather than in a group, whereas the other professions described group working as a central part of coworkership. This could be related to the 'organizational homelessness' described by physicians in a previous qualitative study (Lindgren et al., 2013). Another study showed that verbal dominance during team meetings can be linked to a hierarchy related to profession (Thylefors, 2012). The physicians' fuzzy organizational affiliation, as well as their own behavior (i.e., preventing other employees with less education from having an influence) could cause other professions to exclude them from the collective process of coworkership.

In previous research, coworkership has been defined as those practices and attitudes that employees develop in relationships with their managers, their colleagues, and their employers (i.e., in relation to the organization as a whole) (Hällstén & Tengblad, 2006). However, the employees in the present study indicated that their primary relationship was with their clinical work and their colleagues. In the light of Glouberman and Mintzberg's (2001) illustrations of the hospital as an organization divided into four separate worlds (care, cure, control, community), the results may have been influenced by the different worlds to which the employees belonged. The 'care' and 'cure' worlds dominated the organizational dimensions, whereas 'control' and 'community' were weak, even though the role of the manager in the collective process was expressed as supportive and enthusiastic. A review of leadership styles showed the significance of managers' relational and transformational leadership skills for promoting employee health, work environment, productivity, and effectiveness in health care organizations (Cummings et al., 2010), while more task-focused leadership was related to lower job satisfaction and effectiveness.

Normative interpretations of what is judged as being 'good' leadership as well as 'good' coworkership (Møller, 1994) might vary between different organizational contexts and different professional groups. Depending on the specific conditions in an organization and how the work is organized, coworkership may exist in different forms (Hällstén & Tengblad, 2006). Within the context of this study, the forms of coworkership varied between the different professions. Most of the employees described some group-oriented coworkership, due to strong conceptions of belonging to a group and taking responsibility in a group together with other colleagues. Other factors were that the manager's and employer's roles were not explicitly included in this group process. Among physicians, on the other hand, it also seemed that there was some individual-oriented coworkership. This was illustrated with conceptions of working alone and not in a group, as perceived by the other professions. In this organization, coworkership could be organization-oriented in aspects of significant organizational rules. However, based on the employees' conceptions about taking responsibility in a group and individual responsibility based on professional knowledge, it appeared that the organization-oriented coworkership

was rather undeveloped. One reason for this could be that the primary focus in professional bureaucracies such as hospitals is on the operating core and the specific conditions of strong professions. The identity of nurses and physicians is often closely associated with their own profession, not just with the organization itself. Thus, the findings from the present study indicate that coworkership in this specific context seems to be based on a strong relationship to the team and a rather undeveloped relationship to the employer, and indirectly to the manager.

There were some obvious variations in the employees' conceptions. Horizontally, between employees with different professional roles, there was friction concerning opportunities to exert influence, prioritization of different patient groups, and belonging to a group with other professions. In relation to the vertical perspective in the organization, the major friction arose from employees not feeling they were part of the overall organization. Coworkership was primarily a collective process that took place within the clinical base of the hospital organizational hierarchy. Glouberman and Mintzberg (2001) argue that as long as there is friction in terms of different conceptions of the organizational reality and different ways of organizing work based on the four different worlds (mindsets), nothing fundamental will change (Glouberman & Mintzberg, 2001). In the present study, it was clear that such friction could contribute to an undeveloped coworkership over professional boundaries, as well in relationship to the overall organization. However, according to Hällstén and Tengblad (2006), important preconditions for the development of coworkership include trust and openness, community spirit and cooperation, engagement and meaningfulness, and responsibility and initiative. Velten et al. (2017) have also pointed out the importance of communication being characterized with dialogue in order to develop coworkership (Velten et al., 2017). The categories formed from the employees' conceptions in the present study (*Group coherence and striving toward a common goal, cooperation over professional and organizational boundaries*, *work experience and trusting each other's competence*, *social climate and sense of community*, and *participation and influence*) are in line with the preconditions described in the model of development of coworkership (Hällstén & Tengblad, 2006). This affirmative result contributes important knowledge about coworkership from the employee's point of view that can be useful both in promoting efficiency, quality, and a healthy work environment within organizations, and in further research focusing on such questions.

The results from this study indicate certain normative preconditions that not only contribute to the development of coworkership but also strengthen a health-promoting workplace (Bringsén et al., 2012). The concept of workplace health promotion is based on the World Health Organization's health promotion approach (Eriksson & Lindström, 2008) and Antonowsky's theory of salutogenesis (Antonovsky, 1996). The workplace is often regarded as one of the most important arenas for health promotion (Shain & Kramer, 2004). The employees in the present study stated that coworkership as a collective process was dependent on mutual reliance and confidence in each other's competence. Another study aimed at identifying and analyzing experiential determinants of healthy working conditions highlighted confidence and respect for each other's knowledge as favorable conditions for creating a health-promoting workplace; managers and employees described a positive link between social support at work and healthy working life (Nilsson et al., 2005). Social support in the present study was related to helping each other when needed, both emotionally and practically,

as well as promoting a social climate in terms of a positive and familiar atmosphere. The results also indicated that the collective process took place at the bottom of the organizational hierarchy. According to this, participation and influence were mostly expressed in employees' clinical work, not in overall organizational issues. Participation and influence are preconditions for increased responsibility, and are a central part of the definition of coworkership (Hällstén & Tengblad, 2006). However, in line with an earlier qualitative study (Kilhammar, 2011), the employees' views of participation and influence were not explicitly linked to taking responsibility.

Methodological considerations

Some methodological considerations should be noted. The selection procedure was performed by the managers, who either requested or selected employees to participate in the study. This may have resulted in sampling bias if the managers had selected those employees they knew would give a positive view of their workplace. However, we found nothing to indicate this in the results. With regard to the selection process, it is also important to mention that those ward managers who declined to participate in the study with employees from their workplace could have encouraged employees with an especially interesting experience of coworkership to take part in this study. However, there were only three managers who declined (for reasons that were explained), and in the end, the large participant group, with as many as 68 employees from different clinical settings, was a strength of the study.

The focus group interviews were carried out by two different moderators (CB, KS), meaning that the questions could have been asked in different ways. On the other hand, the moderators used the same main open question: 'What does the concept of coworkership mean to you?' In addition, both of the moderators were involved in every phase of the study, and the possible impact on the findings was discussed together with the comoderator (AH), which strengthened the credibility of the findings.

During the focus group interviews, the employees did not explicitly describe their relationship with their managers as a central part of coworkership, and the moderators did not ask any specific questions about who was included or not included in the participants' relationships. The main reason why the employees pointed out their relationship with colleagues could have been to do with their experiences of coworkership in relation to the context of health care, where cooperation between professions is fundamental. These conceptions are in line with the aim of phenomenography (Marton, 1981), which in this case was to describe the different ways in which the employees experienced and understood the phenomenon of coworkership in the context of health care, which constituted their 'surrounding world'.

The number of participants in each focus group ranged from two to eight. Research has shown that the number of participants can affect the communication process (Bergman et al., 2016). In the present study, the number of participants could have affected the discussion in certain way, for example, with some of the participants talking more than others. In order to encourage those who were quiet, the moderator took a more active role and used follow-up questions directed to these employees. In addition, one central aspect of phenomenography is that there are no right or wrong answers (Alexandersson, 1994), which the moderators pointed out during the focus group interviews.

The use of focus group interviews as the data collection strategy was suitable for this study, because coworkership remains a phenomenon with many different and diffuse definitions. Through their group interactions, the employees shared their experiences, and further knowledge of the phenomenon emerged. The different professions provided a variety of conceptions of coworkership, and enriched the known data. The majority of the employees were nurses and assistant nurses, and one possible disadvantage was that some professions were under-represented: for example, there were only five physicians, two occupational therapists, and three physiotherapists. However, this reflects the distribution of professions both in the organization under study and in several other Swedish health care organizations. Based on this, we suggest that it is possible to transfer our findings on employees' conceptions of coworkership to other health care organizations in Sweden, as well as to those in the other Nordic countries where coworkership has evolved from a long working life tradition.

Conclusion

Employees' conceptions of coworkership in a health care organization were mainly expressed as a collective process formed around the patient. This collective process included colleagues but not explicitly managers. The collective process in terms of cooperation is closely related to team climate, which in turn influences the quality of both patient care and a health-promoting work environment. There were some obvious differences in conceptions between the professions, related to conflicts of interest, ability to exert influence, and belonging to a group, as well as to the overall organization. These differences may be an obstacle to developing coworkership over boundaries, both horizontally between professions and vertically between different levels in the overall organization. Overall, a well-functioning communication climate seems to be important for coworkership in terms of promoting a climate of trust, opportunities to speak up, better cooperation between employees with different professional roles, and improved relationships with the manager, and the organization at large.

References

Alexandersson, M. 1994. Den fenomenografiska forskningsansatsens fokus [The phenomenographic research approach]. *In:* B, S. & P-G, S. (eds.) *Kvalitativ metod och vetenskapsteori*. Lund: Studentlitteratur.

Anderson, N. R. & West, M. A. 1998. Measuring climate for work group innovation: development and validation of the team climate inventory. *Journal of Organizational Behavior,* 19, 235–258.

Andersson, K. 2013a. *Lärande och utveckling av medarbetarskap i vård och omsorg [Learning and development of coworkership in healthcare]*. Dissertation thesis, Örebro universitet.

Andersson, T. 2013b. Förutsättningar för förbättringsarbete i vården [Conditions for improvement work in healthcare]. *In:* NOMIE ERIKSSON, K.-M. H. T. M. (ed.) *Att utveckla vården : Erfarenheter av kvalitet, verksamhetsutveckling och förbättringsarbete*. 1 ed. Lund: Studentlitteratur.

Andersson, T. 2018. Followership: An Important Social Resource for Organizational Resilience. *The Resilience Framework*. Springer.

Antonovsky, A. 1996. The salutogenic model as a theory to guide health promotion. *Health promotion international,* 11, 11–18.
Arneson, H. & Ekberg, K. 2006. Measuring empowerment in working life: A review. *Work,* 26, 37–46.
Baker, D. P., Day, R. & Salas, E. 2006. Teamwork as an essential component of high-reliability organizations. *Health Services Research,* 41, 1576–1598.
Baker, S. D. 2007. Followership: the theoretical foundation of a contemporary construct. *Journal of Leadership & Organizational Studies,* 14, 50.
Bergman, C., Dellve, L. & Skagert, K. 2016. Exploring communication processes in workplace meetings: A mixed methods study in a Swedish healthcare organization. *Work* 54, 533–541.
Bertlett, J. 2011. *An employeeship model and its relation to psychological climate: a study of congruence in the behavior of leaders and followers.* Dissertation/Thesis, Department of Psychology, Work and Organizational Psychology Division, Lund University.
Bertlett, J., Johansson, C. R., Arvidsson, M. & Jern, S. 2011. A two-way approach of congruent behavior between leaders and staff in the employeeship concept. *Leadership & Organization Development Journal,* 33, 428–446.
Bringsén, Å., Andersson, H. I., Ejlertsson, G. & Troein, M. 2012. Exploring workplace related health resources from a salutogenic perspective. Results from a focus group study among healthcare workers in Sweden. *Work,* 42, 403.
Cummings, G. G., Macgregor, T., Davey, M., Lee, H., Wong, C. A., Lo, E., Muise, M. & Stafford, E. 2010. Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International Journal of Nursing Studies,* 47, 363–385.
Eriksson, M. & Lindström, B. 2008. A salutogenic interpretation of the Ottawa Charter. *Health Promotion International,* 23, 190–199.
Glouberman, S. & Mintzberg, H. 2001. Managing the care of health and the cure of disease - Part I: Differentiation. *Health Care Management Review,* 26, 56–69.
Heide, M. & Simonsson, C. 2011. Putting co-workers in the limelight: New challenges for communication professionals. *International Journal of Strategic Communication,* 5, 201–220.
Hällstén, F. & Tengblad, S. 2006. *Medarbetarskap i praktiken [Coworkership in practice],* Lund, Studentlitteratur.
Kilhammar, K. 2011. *Idén om medarbetarskap: en studie av en idés resa in i och genom två organisationer [The idea of coworkership. A study of an idea's journey into and through two organizations].* 539 Dissertation/Thesis, Linköpings universitet, Institutionen för beteendevetenskap och lärande.
Kilhammar, K. & Ellström, E. 2015. Coworkership in practice: a study of two Swedish organizations. *Human Resource Development International,* 18, 328.
Krueger, R. A. 1994. *Focus groups: a practical guide for applied research,* Thousand Oaks, Calif, Sage.
Lindgren, Å., Bååthe, F. & Dellve, L. 2013. Why risk professional fulfilment: a grounded theory of physician engagement in healthcare development. *The International Journal of Health Planning and Management,* 28, 138–157.
Mamman, A., Kamoche, K. & Bakuwa, R. 2012. Diversity, organizational commitment and organizational citizenship behavior: An organizing framework. *Human Resource Management Review,* 22, 285–302.
Marks, M. A., Mathieu, J. E. & Zaccaro, S. J. 2001. A temporally based framework and taxonomy of team purposes. *Academy of Management Review,* 26, 356.
Marton, F. 1981. Phenomenography - Describing conceptions of the world around us. *Instructional Science,* 10, 177–200.

Mintzberg, H. 1983. *Structure in fives: designing effective organizations,* Englewood Cliffs, N. J, Prentice-Hall.
Morgan, D. L. 1997. *Focus groups as qualitative research,* Thousand Oaks, Calif;London;, SAGE.
Møller, C. 1994. Employeeship: The Necessary Prerequisite for Empowerment. *Empowerment in Organizations,* 2, 4–13.
Nilsson, K., Hertting, A., Petterson, I.-L. & Theorell, T. 2005. Pride and confidence at work: potential predictors of occupational health in a hospital setting. *BMC public health,* 5, 92.
Shain, M. & Kramer, D. M. 2004. Health promotion in the workplace: framing the concept; reviewing the evidence. *Occupational and environmental medicine,* 61, 585–648.
Sinokki, M., Hinkka, K., Ahola, K., Koskinen, S., Klaukka, T., Kivimäki, M., Puukka, P., Lönnqvist, J. & Virtanen, M. 2009. The association between team climate at work and mental health in the Finnish Health 2000 Study. *Occupational and Environmental Medicine,* 66, 523.
Thylefors, I. 2012. All professionals are equal but some professionals are more equal than others? Dominance, status and efficiency in Swedish interprofessional teams. *Scandinavian Journal of Caring Sciences,* 26, 505–512.
Velten, J., Tengblad, S. & Heggen, R. 2017. *Medarbetarskap: så får du dina medarbetare att ta initiativ och känna ansvar [Coworkership: to get your employees to take initiative and feel responsible]*, Stockholm: Liber.
Wheelan, S. A., Burchill, C. N. & Tilin, F. 2003. The link between teamwork and patients' outcomes in intensive care units. *American journal of critical care: an official publication, American Association of Critical-Care Nurses,* 12, 527.
Wikström, E. & Dellve, L. 2009. Contemporary leadership in healthcare organizations: fragmented or concurrent leadership. *Journal of Health Organization and Management,* 23, 411–428.
Ylipaavalniemi, J., Kivimäki, M., Elovainio, M., Virtanen, M., Keltikangas-Järvinen, L. & Vahtera, J. 2005. Psychosocial work characteristics and incidence of newly diagnosed depression: a prospective cohort study of three different models. *Social Science & amp; Medicine,* 61, 111–122.
Yukl, G. A. 2002. *Leadership in organizations,* Upper Saddle River, NJ, Prentice Hall.