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Designing work organization based on "profession" collectives and "inter-profession" relations

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Abstract. The aim is to show that the design of organizational structure can be enhanced through debates about work among profession-specific collectives and through the development of relations between several professions. We are carrying out several ergonomic interventions in projects with multidisciplinary teams working in occupational health departments. We shall present two cases of occupational health departments whose contexts, in terms of multidisciplinary team composition are different. The intervention-related difficulties encountered during organizational design projects based on collective activity lead us to question future methodologies.

Keywords: collective activity, organization, multidisciplinary, occupational health.

1. Introduction

The aim of this communication is to question the methods to be implemented to enhance the design of work organization, based on debates about work among profession-specific collectives and methods geared towards exchange between several professions. Fostering spaces for debate about activity and the quality of work can contribute to the development of collective activity.

1.1 Theoretical basis

Designing work organization compels the ergonomist not to separate the structural and relational aspects of the organization during their intervention (Petit, Dugué, 2012). These relations also enable the structure to obtain a result, i.e. achieve efficiency, which makes sense for the people who work in the organization. With respect to collective activity, a distinction must be made between collective work and the work collective in order to understand how constant readjustments to work-related rules are resources for the health of individuals and for the vitality of the work collective (Caroly, 2009). It is built up over time, requires cooperation, the sharing of criteria about work quality, the recognition of skills, and trust. In this case, the organization is empowering (Falzon, 2014) to increase the capacities of the individuals making it up, allowing them to respond to the requirements of the organization while at the same time responding to their own requirement to perform quality work (Arnoud, Falzon, 2012).

We believe that carrying out organizational design projects based on collective activity can encourage organizational leeway, increase the empowerment of each professional in the execution of their work and collaboration with other professionals, and

produce new spaces for debate about real work.

1.2 The context of occupational medicine in France and changes to occupational health departments

and the objectives of ergonomics intervention

As part of research on multidisciplinarity in health departments, financed by the ANSES, we are carrying out several intervention projects on the theme of collective work and changes to activity in each of these professions. Our ergonomic actions stem from requests for guidance with the collective design of occupational health projects and organizations with the aim of enhancing collective work and developing the professions involved.

Faced with the shortage of occupational doctors and the alarming increase in occupational diseases and accidents at work, the European legislator has been striving to improve the efficiency of the system that manages work-health relations for over a decade. To this end, it has made multidisciplinarity an obligation. In France, in 2006, this led to the recruitment of occupational risk specialists to back up the work carried out by occupational doctors in companies. When occupational medicine departments were transformed into occupational health departments in 2008, this strengthened the idea of a multidisciplinary team involved in the management of work-health relations and which no longer depended exclusively on the skills of an occupational doctor. In 2012, the multidisciplinary team was made legally responsible for defining priority prevention areas. Furthermore, these teams have been joined by new professionals, such as occupational nurses and occupational health assistants. Occupational doctors have been under much pressure in the accomplishment of their different tasks. These mainly involve medical consultations for new recruits and check-ups on the state of health of employees in relation to their work, with one third of their time spent on prevention actions in companies. Occupational nurses are in charge of checking up on employees between consultations with the occupational doctor. Occupational health assistants have also been taken on to help perform risk assessments in companies. This progression towards greater multidisciplinarity has been accompanied by a certain number of difficulties: relations between these professionals are somewhat tense, in spite of the fact that they are expected to perform collective work in order to improve prevention of alterations to the state of employees' health.

The demand of intervention concerns the means to develop multidisciplinarity organization.

2. Methods

The intervention is based on participatory design approach. The aim of this approach is for the profession-specific collective to express a point of view about the occupational health project prevention themes and their organizational needs, and for the inter-professional groups to design the arrangements and means necessary to manage the prevention themes.

Our methodological approach is based on three steps: first based on building "profession-specific" groups. Participants discuss the traces left by their real activity on their typical work situations (4 or 5 sessions). The second step is to build "inter-professional" groups to define the needs of organization to develop collective work (4 or 5 sessions). The third step is to set up organizational simulations to try out the new forms of work organization with the professionals.

In this paper, this methodology approach used to develop multisciplinarity organization concerns two departments of occupation health: the first department comprises 33 occupational doctors and 5 occupational risk specialists; the second comprises 20 occupational doctors and 13 occupational risk specialists.

3. Results: intervention methods requiring ongoing adaptation

Our results will focus on the way in which our ergonomic research team strove to build their intervention approach and the methodological difficulties in order to develop multidisciplinarity.

3.1 Work collectives in the making

The first observation that can be made is that the occupational doctors do not really constitute a work collective given their heterogeneous practices and different conceptions of work. This might be explained by the history of the profession in terms of autonomy and independence. Occupational doctors' professional stances are marked by how much leeway they have to act in companies and with employees. Nevertheless, they do share a number of invariants linked to their professional practices, in relation to the other professionals: establishing a link between the health of employees and their work. It is to provide a consultation service, where they help employees to become actors, guiding them towards the means of acting on the health-work link. They may move from an individual approach to a collective approach, by triggering company-wide actions based on the information they collect during consultation work. They act as preventers more than intervention specialists and shoulder the responsibility of declaring employees fit for work. They consider that occupational risk specialists play more of a technical and metrological role. Faced with the changes to occupational health departments, they are afraid of losing this health-work link. But the collective expression of what is to become of them is disorganized and reflected in a range of different stances. Some, for example, bury themselves in their consultation work, refusing to work with the nurses and failing to delegate work to the occupational risk specialists. The organization desired by the doctors oscillates between two models: either "*everything must go via the doctor*" since everything is centralized at medical level, hence allowing them to maintain control over health-work links, or "*the specialists are there to lend a helping hand to doctors who no longer have time to do all their company work*". In the latter model, the doctors do not see the specialists as encroaching on their own domain. This conception of multidisciplinarity is relatively poor in relation to the model we propose, where each person might develop their activity using others' activity as a springboard to further develop their own. Indeed, the type of multidisciplinarity outlined in the legal texts is understandably not welcomed by the occupational doctors. It strikes them as something that might prevent them from comprehending the employee's work context and make it more difficult to build their employee occupational health diagnosis. As far as they see it, there is a risk that they might only see employees whose state of health is very bad.

Likewise, the occupational risk specialists and the occupational health assistants also find it difficult to build a work collective. This can partly be explained by the fact that their positions are relatively recent and partly by the fact that they come from different professions: ergonomists, occupational psychologists, risk prevention engineers, chemists, health, safety and environment officers, etc. They do not share the same reference frameworks when it comes to intervention, health and the individual at work. Furthermore, within each profession there are controversies about the way a job should be done. For example, one ergonomist may adopt the position of "occupational conditions expert" while

the other ergonomists see themselves more as providing guidance with the change process. The occupational psychologist may play the role of "expert in individuals at work" (focusing on perception and behavior) or feel more involved in "understanding the relationship between work and subjective commitment". The risk prevention engineer may either be an "expert in safety or exposure factor specialist" or feel more involved in risk management, striving to integrate prevention into the company's other logical approaches (production, quality, etc.). However, during their collective exchange within the group of professional risk specialists they were able to pinpoint what was specific to them in relation to the other occupational health service professionals. According to them, their skills come from their level of expertise. This is what allows them to make risk assessments and put forward recommendations for prevention. Their difficulty lies in convincing the employer to take professional risks into account. They wonder what use the doctors are during in-company visits. From time to time they are involved in procedural work with the doctors (e.g. requests for intervention). They systematically provide the doctors with their reports and the doctors in turn hand the reports over to the employer (broad variety of occupational doctor practices). They do not fully understand how priority professional branches are defined by the occupational doctors and wonder how well the effectiveness of their own actions is assessed (no feedback about the recommendations they make or any implementation by the company following their intervention). The progression of occupational health departments towards a bigger obligation to produce company data sheets in order to meet regulatory requirements is likely to limit their work to a technical approach when in fact some of them would prefer to provide companies with greater guidance in the implementation of risk prevention.

The occupational health nurses, who have only been in the departments for two years, are supposed to carry out consultations between two periodically programmed consultations with an occupational doctor. Some find themselves in a situation of under-activity since what is expected of them is badly defined by the occupational health department managers and by the occupational doctors. Others, on the contrary, are involved in a certain number of consultations (between 6 and 8 a day), as part of a procedure-heavy framework requiring them to use an interview guide drawn up by the doctor. Their difficulty when performing this consultation work is twofold. On the one hand, they lack knowledge about the work being carried out and the company context. This makes it difficult for them to draw up the medico-professional diagnosis expected of them by the doctors when they report back on their consultation work. On the other hand, they find it difficult to have their own role as nurses recognized. Moreover, they see this role as being based on an overall approach to the employee's state of health (including in relation to their personal life and lifestyle, without necessarily being linked directly to work). The progression of occupational health departments towards more nurses' consultations in order to meet medical requirements is likely to make the development of this nursing profession difficult as the nurses in question do not yet form a work collective.

3.2 Developing an inter-professional approach using a methodology based on experimentation

Given the challenges involved in building work collectives, we had to question the intervention work initially planned. We noted that each professional group was able to provide the others with what seemed to them to be essential in their work in relation to the others. They were also able to express what they expected of the others and describe the organizational means needed to support their own activity as well as that of the others.

Following the work carried out with each professional group, the results were collectively overviewed enabling each individual to say what they believed to be their core

work and what they might expect from the others to be able to develop their activity. The occupational doctors expressed the need to maintain the quality of their medical visits (medical interview time and delegation of technical matters to the professional risk specialists). The nurses expressed their need to be able to improve the way they carried out medico-professional interviews, without losing sight of their own role and being able to perform workstation studies in order to better understand the work carried out in the company. The occupational risk specialists and the occupational health assistants expressed the need to develop their prevention actions, by responding to employers' requests with targeted actions to be monitored over time.

What the departments' employees begin to collectively express in terms of what makes sense, what is efficient and what is effective in the way they do their job, is out of kilter with the changes to work organization, which reflect specifications rather than their actual activity. The tension felt converges around the occupational health department project areas. Indeed, the definition of the collective working of the project teams makes health department multidisciplinarity appear as an "offer" to employers and employees. This "offer" appears to be structured around cross-cutting themes, which are hardly linked up with the definition and the actual workings of the multidisciplinary field teams, who are more focused on building responses to help the employees and meeting different "requests".

Our intervention approach and methodologies promoting a multidisciplinarity model based on collective action as a means of designing an empowering organization had to compete with the model defined by the legal texts and occupational health department practices. These difficulties made us wonder several times whether we could continue with our intervention work. Given the debates about work and the impossibility of expressing possible choices relating to future work, we wondered whether it was worthwhile continuing to impose this intervention model. We wondered whether the professionals' ability to question the project, in relation to the requirements they had to fulfill, was not a result of our intervention methodologies.

Today, after many discussions with the occupational health department managers and the employees, in order to adjust our intervention methods to this paradoxical context, we believe it was difficult to further the laying out of profession-specific rules in order to include multidisciplinarity in the work organization. On the other hand, we are performing a number of experiments on inter-professional aspects with the aim of developing collective work practices that would trigger positive changes. For example, in order to improve nurse-doctor collaboration, we are exploring the practical methods that might be applied when nurses report on their consultations with a group of volunteer doctors and nurses. We are also studying how the working hours of a nurse might be shared between two doctors so that the nurse can intervene at company level.

The objective of this limited experimentation is not to question the basis of our overall approach but instead to think about future methodology and how the professionals and management might see this.

3.3 The tensions between employee expression and management project invite us to question managers' activity

The tensions between what the employees say about their actual activity – with the difficulty of applying a collective viewpoint to employee expression, but also considering inter-professional needs in terms of multidisciplinarity – and the occupational health department managements' project, which seeks to meet medical and legal regulatory requirements, made us realize the importance of taking managers into account in the

intervention process. These actors are also subject to deep-reaching changes affecting their activity, which we underestimated in terms of the important role they play in intervention projects. Managers are caught between the logic of their board of directors wishing to satisfy their members, the specific requirements of occupational health department regulations (application of new employment classification grids, deadlines for department accreditation by higher insurance and prevention authorities, etc.), and what the professionals have to say about their jobs. Today, we are convinced that we need to change our methodologies and focus more on analyzing the activity of department managers. An initiative has been taken in relation to the employer body in charge of occupational health departments to see whether this methodology would be feasible. This may help us to better understand the ways in which we might intervene on the design of work organization in a context of tension where there is a contradiction between what the legal texts say, the way these are applied (which varies according to department management), and the actual practices of occupational health department employees. In the cases described above, our difficulties stemmed from the contradiction between the changes operated by management and the limited time we had to develop collective activity. Adjusting our methodologies as described would enable us to fine-tune our approaches and possibly overstep the difficulties encountered in the performance of our intervention work.

4. Discussion and Conclusion

The changes to occupational health departments carry with them the risk of doing less and less occupational health and focusing instead on medical hygiene and technical matters. Our two intervention cases, which are based on the idea that it is necessary to build collective activity in order to design work organization, show us through the first results that this methodology is not easy to implement in a context of deep-reaching change and requires constant adjustments. This suggests that the methodological ingredients to be used in intervention projects should be adjusted to make collective activity possible.

The building of multidisciplinary is not easy when collective work is required and the activity contexts are not conducive to the building of a profession-specific collective. Inter-professional relations are limited when there is no shared collective viewpoint about the way a job should be done. Experimenting with or simulating collective work organization appears to offer an opportunity for professionals and managers to commence discussions about real work. Particular attention must be paid to management. These findings may fuel thinking about possible organizational choices, which may become a resource for developing the activity of professionals.

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