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Doing the Right Things or Doing Things Right? Exploring the Relationship Between Professional Autonomy and Resources in Volunteering

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> [I]t is super important to spread spread spread information about their [refugees'] rights in the county care [public health care system] and not to establish a field hospital just because one wants to feel like Che Guevara. Sorry, but anything can happen to the refugees if you make a mistake! They have rights just like us. Right now I try personally to find a balance between encouraging relief efforts—amazing that people want to help—and to ensure that patient safety is secured. (NN33, medical doctor volunteer in a Facebook conversation, Stockholm, 19 September 2015)

This chapter draws on a Swedish case of civil society organizing aimed at health care provision for refugees during the autumn of 2015. During that time, various civil society health care initiatives emerged to meet the needs of the unprecedented numbers of refugees arriving in Sweden. Although undocumented refugees were entitled to care in the public health care

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Z. Kravchenko et al. (eds.), *Resourceful Civil Society*, Palgrave Studies in Third Sector Research, https://doi.org/10.1007/978-3-030-99007-7_10

system, civil society initiatives played an important role in providing swift and flexible care to people who were transiting through Sweden on their way to other countries. Many of these initiatives were organized through social media, primarily Facebook. In this chapter, we examine the shift of a group of medical volunteers moving from highly ad hoc and autonomous organizing to an increasingly bureaucratized structure under the aegis of established civil society organizations. In so doing, we draw attention to the various resources used by these professionals that both enabled and constrained their autonomy in different organizational contexts.

Our study ties into two major trends in the organization of civil society. In the context of medical volunteering in Swedish civil society, these transitions may be viewed as reshaping the conditions under which autonomy can be maintained and resources acquired and used. Firstly, from a Swedish perspective, this chapter relates to the increased plurality of welfare service delivery, enabled through what has been described as a shift from government to governance (Pierre & Peters, 2000; Rhodes, 2000). As part of the proliferation of New Public Management in Sweden, private actors, among them civil society organizations, have been able to provide state-funded welfare services (Dahlberg, 2005; Hasselbladh et al., 2008; Johansson et al., 2015). As public funding permits the state to specify the manner in which welfare services are to be delivered, it may also be viewed as hampering the independence of participating civil society organizations. These developments can be interpreted as a managerialist turn in civil society (Maier et al., 2014), a standardization and formalization of volunteer medical practice and participating civil society actors which may weaken autonomy while potentially providing access to novel resources as well.

Secondly, this study analyzes the complex phenomenon of ad hoc organizing via social media, where established norms for formal civil society organizing are abandoned for the benefit of loosely organized networks (Kaun & Uldam, 2018; Turunen & Weinryb, 2019). This trend can be perceived as contradictory to the formalization of civil society organizations as a forum for state-funded service delivery. Rather than relying on external resources, organizing through social media often builds on the resources pooled by the participating actors (Weinryb et al., 2019), in this

case, medical professionals. This loose form of coordination is yet another aspect that creates novel conditions for autonomy and resource acquisition, which is relevant for the analysis of the case at hand.

By bringing together these two trends—formalization of state-funded private welfare service delivery on one hand and individualized, loosely organized networks with pooled and uncoordinated resources on the other—our study provides fertile ground for understanding how autonomy and the use of resources unfold and interact. As we focus on medical professionals, their specific professional autonomy becomes a focal point where these two trends intersect and present dilemmas on the use of resources in contemporary civil society organizing.

Autonomy and Resource Dependence for Professionals

Theoretically, this chapter centers on the tension between professional autonomy and resource dependence. The study of professions is a classical focus of organization studies, where professional norms serve as a prism and as a driver of various organizational changes (Abbott, 2014; DiMaggio & Powell, 1983). A central element of professions is autonomy, meaning that professional norms and the adherence to these are primarily negotiated and controlled within the profession (Engel, 1969, 1970; Hall, 1968) rather than by "consumers and managers" (Freidson, 2001, p. 12). The medical profession is typically considered a "classical profession" with a high degree of autonomy and less susceptibility to external influences than many other professions (Brante, 1988; Freidson, 1988). In essence, medical professionals can be expected to practice their profession in a reasonably similar way regardless of organizational circumstances, for example, whether they are remunerated or not.

However, according to resource dependence theory, organizations are always dependent on their environments, which perpetually threatens this autonomous status (Pfeffer & Salancik, 1978). Organizations are dependent primarily on resources for their survival, and this dependence

is contingent on an organization's interaction with its environment (ibid.). As professionals often practice their professions in an organizational context, situations entailing various resource dependencies may constrain their autonomy.

As resource dependence theory does give individual agents some degree of agency (see, for example, Pfeffer and Salancik's (1978) discussion of the role of managers), it is a conundrum to discern how professionals may use resources to maintain autonomy while facing environmental constraints. Previous research has shown that the organizational context is key to understanding the impediments to and possibilities for autonomy. As Hall (1968) stated:

> The strong drive for autonomy on the part of a professional may come into direct conflict with organizationally based job requirements. At the same time, the organization may be threatened by strong professional desires on the part of at least some of its members. (pp. 102–103)

Given the tension between professional autonomy and organizational context, this chapter contributes to the existing research by comparatively exploring two contexts with different environmental constraints, focusing on the ways in which autonomy and resource usage unfold and interact. As described above, civil society organizing is currently undergoing two major changes that may reshape the possibilities for maintaining autonomy and for acquiring and using resources. We argue that a strong profession is particularly interesting to study in this context as we can expect there to be well-established norms that influence professionals' perceptions of resources and environmental constraints. Despite the fact that autonomy research dates back many decades within the field of organizational research (Engel, 1969, 1970; Hall, 1968), little contemporary work examines the relationships between autonomy negotiations and the two trends in civil society organizing as regards resource provision.

The Empirical Case of Health Care Professionals Volunteering in the 2015 Refugee Crisis

In the fall of 2015, Sweden experienced a dramatic increase in the number of incoming refugees; at times, as many as 10,000 arrived each week. This was colloquially referred to as the 2015 refugee crisis. The influx of refugees to Sweden began in early September, as the Dublin Convention broke down, and halted almost completely by late November, when the Swedish border was closed by a bipartisan parliamentary decision. The sudden arrival of refugees gave rise to various voluntary initiatives, many organized through social media, primarily Facebook (Weinryb, 2015). Some groups were intended for those in particular professions, such as doctors, nurses, and lawyers, and focused on assisting refugees in specific matters. The group of health care personnel studied here was set up through Facebook and aimed to complement the public health care system by assisting the so-called transit refugees who were residing illegally in Sweden while on their way to other Nordic countries.

Historically, Swedish civil society has been active primarily in areas outside of the core functions of the welfare state, such as health care provision and social services (Amnå, 2006; Wijkström, 2004); it has traditionally focused on the areas of sports, culture, and recreation, as well as funding research and engaging in adult education and political voice (Lundström & Wijkström, 1995). Yet, as the Swedish welfare state has increasingly come to incorporate private welfare providers through different forms of public procurement, civil society has become more engaged in welfare service delivery (Johansson et al., 2015; Lundström & Wijkström, 2012). These civil society welfare providers have overwhelmingly been paid for, or at least subsidized, by public funds. Until July 1, 2013, however, some populations were not eligible for welfare services delivered by the public system; undocumented immigrants were among them. Until that point in time, health care for these immigrants was primarily provided by volunteering health care personnel. However, since July 1, 2013, undocumented adults have been eligible for non-deferrable public health care services, including various forms of obstetrics and

gynecology care and dental care (SFS, 2013, p. 407); undocumented minors are eligible for all types of public health care services, not only immediate care (Vårdguiden, 2019).

Given the 2013 law, the role of volunteering health care personnel has gradually become less relevant. In 2015, however, the sudden influx of refugees put a serious strain on public administration, recreating a perceived need for volunteer health care initiatives (Turunen & Weinryb, 2017). The group studied in this chapter was initially run and staffed entirely by volunteering health care professionals relying heavily on Facebook for organizing. An underlying premise of this volunteer-based health care provision was that the autonomy of the health care personnel was almost absolute. However, the autonomous initiative was subsequently organized under the aegis of two established civil society organizations supported by public funds to temporarily provide these services. These established civil society organizations were neither specifically nor solely focused on health care provision and did not have the professional mandate on which the independent initiative had been based. It is this transfer, from linking professionals primarily through a free-floating online forum to being bound by an established organizational setting, that is the comparative focus of this chapter.

Theoretical Framework

Previous research has shed some light on professional autonomy and bureaucratic organizational constraints, although it has not focused specifically on the tension between resource dependence and autonomy. In one of the classics in this field, Engel (1969) argued:

> [T]he limiting administrative structure of the bureaucracy restricts the professional's freedom and makes him dependent on the organization which, in turn, controls him and inhibits the application of his knowledge and skills. His association with a bureaucratic organization could therefore prevent the professional from fulfilling a fundamental requisite of professional behavior—serving the best interests of his clients. (Engel, 1969, p. 30)

The limiting role of the organization has also been described as rendering the "professional conception […] challenged and transformed by the requirements of the bureaucratic setting" (Sorensen & Sorensen, 1974, p. 105). However, other studies have shown that professional and organizational commitments can be compatible under certain conditions. For instance, Thornton (1970) demonstrated that the compatibility of two such commitments depends on the extent to which professionals experience and perceive "an organizational situation as reaffirming and exemplifying certain principles of professionalism" (p. 424).

This view has also been supported by studies highlighting the fact that organizationally generated normative systems do not necessarily restrict professionals in their self-regulatory activity (Hall, 1967). In addition, if the profession is dependent on a logistical infrastructure to practice that profession, as in the case of most health care provision (e.g. authorization to prescribe drugs, access to medical equipment, a formal journal system, etc.), it is no longer solely within the purview of the individual professional or group of professionals to establish the very organizational setting in which the autonomy of the profession could be practiced (cf. Engel, 1970). The results of studies investigating the conflict between organizational contingencies and professional autonomy have thus been contradictory to some extent. Nevertheless, they have all centered around one particular argument: the degree of professional autonomy in relation to bureaucracy depends on each particular context. This is in line with ideas regarding resource dependence as contingent on environmental conditions.

An ideal-type way to distinguish between different environmental conditions is to compare a context in which bureaucratic structures are predominant to a context in which professionals are essentially steering themselves. Scott (1965) termed such ideal-type organizational settings *heteronomous* and *autonomous*. A heteronomous organization is described by Scott as one in which

> professional employees are clearly subordinated to an administrative framework, and the amount of autonomy granted professional employees is relatively small. An elaborate set of rules and a system of routine supervision controls many if not most aspects of the tasks performed by professional employees, so that it is often difficult if not impossible to locate or define an arena of activity for which the professional group is responsible individually or collectively. (Scott, 1965, p. 67)

A heteronomous setting may be seen as a proxy for the first trend described above, according to which Swedish civil society actors become formalized and standardized given their dependence on the state for the funding of their welfare service delivery. In contrast, in the autonomous case,

> organizational officials delegate to the group of professional employees considerable responsibility for defining and implementing the goals, for setting performance standards, and for seeing to it that standards are maintained. […] Individual professionals are expected to be highly skilled and motivated and to have internalized professional norms so that little external surveillance is required. If necessary, however, formal or informal sanctions may be applied by the colleague group. (Scott, 1965, p. 66)

An autonomous setting may be seen as a proxy for the second trend described above, according to which professionals pool resources with the help of a digital initiative. In the design of our study, we followed these ideal types to distinguish between two contexts with different environmental constraints that may influence resource usage and professional autonomy. Given recent trends in civil society engagement in the delivery of welfare services (Dahlberg, 2005; Hasselbladh et al., 2008; Johansson et al., 2015; Turunen & Weinryb, 2019), we tied our study to the realm of health care, a classical focus of profession research (Freidson, 1988), as well as to the volunteering context. We thereby suggest that volunteering medical professionals acquire and use resources differently in autonomous and heteronomous organizational settings.

Research Design, Data, and Methods

As stated above, this chapter studies a group of health care professionals that organized to voluntarily help refugees arriving in Stockholm in the fall of 2015. The health care provision took place in temporary venues, yet much of the organizing was accomplished via a Facebook page rather than at the venues themselves. That page, covering the period from September 16 to December 2, 2015, constitutes the main basis for our analysis of resource usage and autonomy negotiation. During this period, the health care professionals interacted on a daily basis about issues pertaining to staffing, medical supplies, and work practices. We view these interactions, in which professionals discuss and negotiate different resources in their work, as an expression of how they interpreted their degree of autonomy as well as the influence of environmental constraints. Web archiving is increasingly recognized as a useful approach to systematically acquiring a fine-grained and chronological understanding of a phenomenon (Lomborg, 2012).

The professionals in the group were all self-identified as health care personnel, and only occasionally, predominantly when signing up for scheduled slots, did they state their specific professions (typically doctor or nurse). The criterion for inclusion in the group was thus self-identification as belonging to the professional group of "health care personnel." At the end of our period of study, this group had 1344 members (including one of the authors). The Facebook group we studied was closed but not secret. The author who was part of the group clicked open all comments that were posted during the period. The material consists of 231 pages in PDF. This entire sequence was important in the analytical work, as its longitudinal nature provided a rich understanding of the case at hand and thus allowed us to obtain a full understanding of the development of the group.

Group administrators granted us permission to use the data. In addition to working with the dataset, we triangulated our key findings by interviewing two health care personnel who were active in the Facebook group, one of whom had a leading role; we were also granted permission by the participants to partake in another online conversation that

informed our contextual understanding of the case studied here. This online conversation was conducted during the same time period by volunteer health care professionals, some of whom were involved in the initiative studied here, which was discussed at length.

The distinction between autonomous and heteronomous organizations allowed us to analytically distinguish between our two cases and to explore them comparatively. Our dataset may be viewed as the result of a natural experiment of professionals encountering a heteronomous organization after a period of organizing in an autonomous context. The group we studied was created on September 16, 2015, by health care personnel who had not been previously coordinated. On October 2, the autonomous organizing was moved to new transit housing, where the provision of health care was run jointly by two heteronomous host organizations (Organizations A and B), neither of which was focused solely or specifically on health care delivery. Both of the established civil society organizations had been contracted by the municipality. In the abovementioned PDF document, 107 pages recorded the initial organizing, which took place between September 16 and October 2. The remaining 124 pages chronicle the organizing after Organization A and Organization B became involved in the health care provision. We coded the first period of organizing as T1. The second period, T2, began when the Facebook group reorganized under the aegis of Organization A and Organization B. In this study, we view the period of the first organizational context, T1, as an autonomous organizational setting and the second context, during T2, as a heteronomous organizational setting. Our labelling of T1 as a period of autonomous organization is intended to contrast with the cooperation with Organization A and Organization B, which were not managed specifically by health care personnel. T1 took place at a venue called *The Club*, and T2 took place at venue called *The School*.

In our analysis of the data, we performed qualitative content analysis using NVivo (Kohlbacher, 2006; Saldaña, 2012) to compare how professionals discussed resources in the two periods. All data were initially coded separately by the two authors, and the codes and interpretations were subsequently developed and corroborated.

Comparing Autonomous and Heteronomous Organizational Settings

Resources and Professional Autonomy in the Autonomous Organizational Setting

In the autonomous organizational setting, there were essentially no organizational officials delegating responsibility to the professionals (cf. Scott, 1965); rather, the health care volunteers themselves constituted the organizational setting. No one was formally in charge, and everyone was free to take the initiative. Although two individuals were particularly active in highlighting the need for additional volunteers during certain hours or on certain days and in answering questions from first-time volunteers, there were no signs that their engagement was based on formal appointment. The schedule, in Excel format, was available for everyone in the Facebook group to read and fill in. Similarly, various volunteers reported on shortages of material resources, such as drugs and medical equipment, by publishing posts in the group. Supplies were sometimes paid for by the individual volunteers and sometimes provided by the volunteers' respective workplaces. Various first-time volunteers raised the question of whether they should verify their medical degrees before beginning their work, but the practice was that while awaiting guidelines from the National Board of Health and Welfare, everyone was responsible for working within their own area of competence. Though it was decided at some point (it is unclear when and by whom) that volunteers then undergoing schooling to obtain their degrees were not to work on their own, there was no oversight to confirm that this direction was being followed. On some occasions, for practical reasons, volunteers took their children with them to The Club. Some volunteers first posed a question about doing so in the Facebook group, and some of the more active volunteers responded by stating: "You are not the first to do so." As compared to practices of health care provision in established contexts, then, this organizational setting was characterized by a large degree of autonomy in the acquisition and use of human and material resources. There was, however, also a demand for norms and for guidelines as to how to use some

of these resources. Several first-time volunteers requested introductory guidelines or asked to work together with more experienced volunteers. With time, questions also arose in the Facebook group concerning, for instance, how to use drugs and other medical supplies, or when to refer refugees to the established Swedish health care system instead of providing care at The Club. Norms and guidelines thus emerged as an important resource in addition to the more tangible human and material resources. These intangible resources were acquired in somewhat varying ways, as illustrated below.

One example concerns the medical examination of small children. One day, a volunteer published a post in the Facebook group asking for equipment to measure blood pressure in small children. This request was gently rebuffed by another volunteer, who referred to *Pediatric Early Warning System* (PEWS) as a much better way to examine children, explaining that blood pressure is a rather late sign of illness in small children. The volunteer who had posted the question appeared truly thankful for this advice. Here, established professional guidelines were used as a resource for guiding work in the group. Another example concerns the treatment of colds and coughing. One of the volunteers—a medical doctor—argued that non-prescription drugs only worked as placebos. She furthermore stated that prescription drugs containing opiates had serious side effects, such as dizziness and nausea, that had already affected some of the volunteers' patients. Although the entire conversation sprung from one volunteer's questioning of other volunteers' administering of certain drugs as inappropriate, the critical volunteer emphasized that she was not finding fault with the work of her colleagues. Rather, she framed her criticism as a sharing of thoughts in order to improve routines for the benefit of the patients. Unlike the example of the conversation about examining small children, no established guidelines were referred to in these posts, but the advice appears to have been received as useful and was gladly accepted without conflict, possibly because the question fell rather clearly within the purview of medical doctors.

However, some discussions of norms and guidelines included more divergent views. These primarily concerned what we here call "boundary items." With this term, we refer to items that may be used in medical

practice as well as by laypeople in everyday life without medical consultation. Our examples are milk substitute for infants and fluid replacement for small children. In the case of milk substitute, some volunteers emphasized its benefits for mothers and babies without stable residences (as in the cases of some refugees), while others pointed out the risks that using milk substitute poses for nursing mothers. A lengthy debate ensued among a large number of volunteers on just how risky milk substitute is for nursing, whether any universal advice on the issue is actually justified, and how important the element of travel was in this discussion, given that the patients in question were refugees. In these contestations over the boundary item of milk substitute, professionals explicitly self-identified their specific professional roles (which was rare in this group) with greater frequency than in the debates on the usage of medical equipment and drugs, and they referred to these roles when legitimating their arguments. Eventually, it was suggested that the main takeaways of this debate be used in the creation of written guidelines for volunteers. In the absence of any clear consensus, other than that established practices from different medical professions offer different takes on the dilemma, it remained unclear what these guidelines should state. When the written guidelines sourced from the group conversation were offered as a solution, however, they were not contested by the debating volunteers and seemed to be accepted as guidelines created among peers.

Whereas the discussion on milk substitute primarily relates to the professional expertise of those in different types of medical professions—midwives, pediatric nurses, and pediatric doctors—the discussion on fluid replacement for small children tended toward organizational-level arguments. Like milk substitute, fluid replacement is a boundary item in terms of medical practice, but here, rather than mentioning their specific health care roles, professionals primarily referred to their "home" organizations when offering opinions as to how to best self-organize. In this case, the main debate concerned whether fluid replacement for small children should be bought readymade or cooked by the volunteers themselves. It became apparent that this practice varied in the pediatric units of different Stockholm hospitals. One volunteer argued that the benefit of the readymade replacement was its more precise dosage, whereas the

"homecooked" version was riskier as its ingredients could be mixed in the wrong proportions during preparation, which might be detrimental to the health of dehydrated young patients. However, a volunteer who was an experienced "home cooker" pointed out that error is also possible when using the readymade mix, as it must be accurately mixed with the correct amount of water.

Hence, in comparison to the norms regarding the use of drugs and equipment, the discussions surrounding norms for the use of milk substitute and fluid replacement contained more debate, possibly because they related to several areas of expertise. Nevertheless, both types of discussions were aimed at ensuring patients' safety, and norms and guidelines were seen as resources rather than as constraints. One important explanation for this is likely the fact that these norms and guidelines were largely arrived at through peer discussions, that is, from the inside rather than from the outside, and were thus in line with the idea of professional autonomy.

In sum, in the context of autonomous organizing, the use of both human and material resources was negotiated and regulated through discussions among volunteers. Most frequently subject to discussion was the use of material resources, that is, drugs, medical equipment, and other supplies. The use of human resources was not explicitly debated to the same extent, though questions were raised (but not discussed) regarding, for instance, medical licenses. This extreme autonomy had its shortcomings as well—for instance, the volunteers often had to pay for medical supplies themselves—but few were highlighted. The norms and guidelines emerging from the discussions were typically regarded as resources rather than environmental constraints. Regardless of whether these stemmed from emergent norms (as in the case of boundary items) or more established guidelines (as in the case of medical equipment and drugs), they served to ensure patient safety and seemed to strengthen a sense of professional autonomy rather than threaten it. In essence, norms and guidelines appeared to serve to enact a form of organizing that we call "doing things right."

Resources and Professional Autonomy in the Heteronomous Organizational Setting

As the autonomous organization of the group of health care personnel moved in under the aegis of the heteronomous organizations, the acquisition and use of resources and the conditions for doing so began to change. First of all, the heteronomous organizations ensured the stable provision of material resources, such as drugs and equipment, thus relieving the volunteers of an economic burden. Second, when filling in the schedule, volunteers were asked to indicate whether they were already licensed to practice, and they were subject to identity checks by security guards upon entering the building. Security guards also checked whether each individual was on the schedule. Human resources thus became significantly more subject to guidelines, not to say regulations, introduced by the heteronomous organizations. Professional secrecy also became regulated. Furthermore—in fact starting already during the initial period but gaining importance in the heteronomous setting—the number of hours of health care provision per day was reduced and volunteers were increasingly encouraged to fill the empty slots in the schedule instead of signing up together with other volunteers. The latter practice was, however, initiated by the volunteers themselves.

Overall, the introduction and emergence of further rules and norms was appreciated by the volunteers. As mentioned in the previous section, the verification of licenses had already been subject to discussion, and several volunteers had expressed a wish for more guidelines concerning everything from the storage of drugs to what types of health care should be referred to the public health care system. Even though the organizing of the autonomous setting did revolve around "doing things right," there now seemed to be increasing awareness that rules, norms, and guidelines are important resources and that the absence of such resources risks putting significant strain on the human resources. One of the volunteers referred to her previous experience as a medical volunteer, underlining the importance of clearly delineating work scope and responsibilities so as to avoid overloading and stressing helpful people. Also, just as in the autonomous context, the value of rules and norms was emphasized from

the perspective of patient safety. It was pointed out that some of the practices carried out in September should never have been undertaken in the autonomous organizational setting, as some types of treatment that patients had received would have been much more safely administered in a hospital setting (in which they were eligible to be treated). Examples mentioned of this misdirected and implicitly dangerous form of medical practice were the provision of intravenous fluid to a patient as well as the provision of insulin to a diabetic.

However, as the situation in the heteronomous setting unfolded, it became clear that some of its norms and guidelines were perceived by the professionals as constraints rather than resources. Some of the volunteers seemed to view the collaboration as being primarily based on their own contributions of skills and licenses to the hosts rather than on the hosts' contribution of better organization to the volunteers' health care provision for refugees. There was indeed pride in and strong identification with the autonomous organizational setting, which in retrospect appeared highly flexible to the volunteers. Some of them used the term "gray-area health care" in laudatory terms, testifying to a perceived need to retain some amount of flexibility in their work. At the core of this contention lay a clash as to which norms should prevail when the health care professionals organized to help refugees—"doing things right" or "doing the right things"—but also how these norms should be negotiated, that is, among peers or with the external environment. As negotiations of "doing things right" increasingly took place in a larger context (the heteronomous setting), "doing things right," as elaborated below, was juxtaposed with the idea of "doing the right things."

There was an outpouring of anger when, one day, a volunteer was stopped at the entrance as they were not on the schedule for that day. Discussions arose regarding the need for a flexible schedule according to which volunteers would be permitted to appear on short notice when their regular work allowed rather than always being scheduled in advance. Volunteers were especially upset by the contrast between their will to do good and the questioning imposed by the seemingly irrelevant routines of the heteronomous host organizations. However, some volunteers continued to emphasize the safety they experienced in the routines set up by the host organizations, thus revealing tensions among the health care

professionals. Some volunteers were so angry at the host organizations that they warned of quitting volunteering altogether. It was pointed out that they were volunteering out of good will and that they were already strained by the requirements of their paid regular jobs, implying that they as purely volunteer health care providers deserved gratitude from the host organizations. It was made clear that many volunteers considered themselves invaluable human resources that should not be hindered or regulated by the imposition of burdensome security routines, as any regulation that hampered their volunteering might come at the patients' expense.

Another example of the antiregulatory stance was a debate concerning a medical volunteer who took their child along while volunteering in the heteronomous organizational setting and was barred from seeing patients while the child was present. This resulted in much anger and resentment against the heteronomous hosts, whose decision not to allow children to be present while their parents practiced medicine was portrayed as unprofessional. It was acknowledged that minors should not practice medicine [*sic*], but it was also argued that they might well provide good company for the refugee children present. The autonomy of the health care personnel was thus interpreted as strong enough to sustain the renegotiation of formal standards of medical practice, shifting from "doing things right" to "doing the right things." Here it was especially emphasized that the will to help should supersede any burdensome formal requirements by the host organizations, allowing the volunteers to put patient needs first.

As the above instances occurred, many volunteers began to clearly identify with their previous autonomous organizational setting. The preservation of their autonomy became an imperative in their relationships to the heteronomous organizations, and the introduction of rules that had not been collectively negotiated was seen as a provocation. This is interesting given the fact that health care personnel, among other things, normally wear name tags and do not take their children along to their daily practice at hospitals and health clinics. Rules were not merely invented by the heteronomous organizations; rather, they mirrored established medical practice. The volunteers were especially offended by the guards telling them that they did not want large numbers of people "running around" the facilities. There were apparently also other volunteers (who were not medical professionals) loitering near the building and wanting to help;

the health care volunteers were offended by being treated like layman volunteers. The hurt feelings also seemed to include a sense that the heteronomous organizations did not understand the strong community feel and gray-zone working routines of the autonomous group. Clearly, the heteronomous organizations began to be viewed as a serious environmental constraint by some health care volunteers, although this view was not unanimous.

In the heteronomous setting, then, the presence of increasingly divergent viewpoints within the group reflected a tension between established medical practice and the ad hoc practice conceived by some of the professionals. Rather than aiming to ensure established knowledge of medical practice, professional autonomy (cf. Engel's (1970) definition) was interpreted as the freedom not to be regulated as human resources, and this lack of regulation was emphasized as the main route to "doing the right things." As the period of heteronomous organizing progressed, it appeared not only that the ideal of "doing things right" was challenged by the ideal of "doing the right things," but also that the latter took on more significance in the collective memory of the autonomous period.

In sum, as the organizational settings changed, both material and human resources became significantly more regulated, and regulation was rarely achieved by means of discussions among volunteers; more often, it came by means of direct instruction from the heteronomous organizations. These norms and rules were to some extent perceived as important resources that would support other resources, namely the human resources. The norms and rules were, however, also perceived as environmental constraints when they compromised the volunteers' capability to "do the right things," as this ideal grew increasingly important vis-à-vis "doing things right."

Concluding Discussion

As can be seen in Table 10.1, we found that material resources were the most discussed resources in the autonomous organizational setting. In the heteronomous organizational setting, by contrast, debates primarily concerned human resources. Moreover, during the first stage of

Table 10.1 Usage of resources in different organizational settings

	September 16–October 2	October 3–December 2
Organizational form	Autonomous	Heteronomous
Examples of resources debated in the two periods	Regulation of material resources such as: • Medical equipment • Drugs • Boundary items (milk substitute, fluid replacement)	Regulation of human resources by demanding: • Identity cards • Minors not to be present while their parents see patients
Means of regulating resources	Peer discussions resulting in norms and guidelines	Instructions from host organizations, sometimes connected to sanctions
Ideal for organizing advocated among health care professionals	"Doing things right"	"Doing the right things"

organizing, the professionals collaboratively defined and accepted norms and guidelines for the regulation of their acquisition and use of resources, thus largely in keeping with the idea of professional autonomy. During the later stage, however, norms and guidelines—rules, essentially—were imposed by the heteronomous hosts on a seemingly non-negotiable basis. In this situation, a striving for autonomy can be seen, reflected in protests against norms and guidelines similar to those that were embraced in the autonomous setting. In the context of heteronomous organizing, "doing the right things" emerged as a competing ideal to that of "doing things right," which had been prevalent earlier.

The emphasis on "doing the right things" rather than "doing things right" in the heteronomous organization is striking, as the latter was central in the autonomous context. The transfer from an autonomous to a heteronomous organizational setting seemed to trigger a reaction in which the primary arguments shifted from mainly leaning on the desirability of norms and guidelines to opposing those norms and guidelines when the human resources of the medical professionals themselves were being regulated. This sudden shift in ideals of conduct can be related to previous research on bureaucracy and professionalism. Hall (1967)

described how the transfer from autonomous to heteronomous organization may cause discord in a professional group:

> A potential source of conflict for the professional may come from changes within the professional group itself. If there is actually an equilibrium between professional and organizational norms, then changes in the degree of professionalism or bureaucratization would lead to conflict. (p. 477)

More bluntly put: "if the level of bureaucratization is increased, conflict would ensue" (ibid., p. 478). Hall's ideas are largely in line with our findings in terms of it being easier to be autonomous when autonomy is freely contested in a professional community and when the relevant resource usage is decided upon by that community (see also Engel, 1970). In contrast, when resource use is regulated from outside a professional community, it may trigger a striving for autonomy even at the price of abandoning previously embraced ideals (cf. Engel's (1970) definition of professional autonomy). It then becomes more important to "do the right things" than to "do things right."

Interestingly, in the heteronomous setting in our study, the important marker of professional autonomy was the "we" of the health care personnel against the ideals advocated by "them," the heteronomous hosts. In this type of binary conceptualization, the boundaries between professions inside the group of health care professionals are largely obliterated. Here, the autonomy of the previous organizational setting was coupled with the imperative of health care personnel to help those in need, that is, an argument of altruism. This was contrasted with the demands by the heteronomous host organizations to regulate human resources, such as using identity cards and not taking along minors when practicing medicine. Yet, the dilemma of "doing the right things" at the expense of "doing things right" was in fact not emphasized in the retrospectively idealized autonomous context.

While it is true that the transition to heteronomous organizing triggered new ideals and stronger identity claims, there was, simultaneously, a growing awareness of the importance of regulating human resources and an appreciation of such initiatives taken by the heteronomous organizations. The tension between "doing things right" and "doing the right

things" was thus also evident within the group. Although our empirical material reveals little about the rationale behind the introduction of rules from the heteronomous organizations' side, these initiatives were interpreted by many of the volunteers as beneficial both for patient safety and for the sake of the volunteers themselves. In a sense, many volunteers viewed the heteronomous organizations as vital for the long-term survival of the group (cf. Pfeffer & Salancik, 1978), precisely because they would ensure the provision of material resources as well as more guidelines that would better define the volunteering and make it less burdensome. In that regard, our findings diverge from the longstanding idea of a tension between professional and bureaucratic ideals (Engel, 1970; Hall, 1967). These rather different findings cut to the core of civil society engagement, namely altruism.

Altruism is an espoused value for civil society engagement (Smith, 1981), and in the context of volunteering it may be defined as "any activity in which time is given freely to benefit another person, group or cause" (Wilson, 2000, p. 215). Altruism has also been considered an important component of the ethos of health care professions, here interpreted in terms of empathy and humanity (Blomgren, 2003; Burks & Kobus, 2012; Dunn & Jones, 2010). Among volunteering health care professionals, ideals of altruism may surface more than in any other context. However, as seen in our analyzed case, behaving altruistically in a civil society context may necessitate both supporting norms and guidelines *and* having the autonomy to operate without the constraints imposed by such norms and guidelines. In order for human resources to give freely of their time, they may not only need additional resources in the form of delimiting and efficiency-enhancing guidelines, but may simultaneously benefit from some amount of freedom to undertake practices that would not be acceptable in an established health care setting.

The simultaneous need for autonomy on one hand and guidelines on the other also points to the importance of balancing different sources for resource acquisition. As stated by Pfeffer and Salancik (1978), resources are acquired in interaction with the environment, and in our case, we see at least two different environmental contexts from which resources were acquired: one more profession-based and one more bureaucratic. Whereas the former is important for creating a sense of autonomy (cf. Engel, 1970;

Freidson, 2001), the latter seems necessary for "putting one's foot down" when difficult questions arise, such as those around staffing, referral to the public health care system, etc. However, as evidenced by some volunteers' striving for the rather extreme form of autonomy stretching beyond the profession, neither the profession-based nor the bureaucratic environment can provide all necessary resources. Our case reveals an interesting area (or gray zone, to use the parlance of some of the volunteers) of Swedish civil society emerging at the intersection between increased formalization of welfare service delivery and loosely organized networks of volunteers via social media.

In both time periods analyzed here, the health care professionals were volunteers in a sector of Swedish civil society in which little volunteering occurs. Whereas there was some local know-how surrounding health care volunteering prior to 2013, this did not seem to be prevalent in the broader population of health care volunteers. In fact, many of the volunteers who continuously advocated for stricter guidelines and more referrals to the public health care system referred to their experience from the organization that had led the clinic for undocumented migrants before 2013. Apart from this, there seemed to be very little specific health care volunteering know-how in the group, although there was a great deal of health care provision know-how from both the professions and the regular workplace settings of these professionals. This may be because civil society health care provision in Sweden, as described in the introduction, is normally highly regulated and also paid for by public funds. We can thus see that the conflict that emerged in the different interpretations of how to enable altruism may have stemmed from a lack of experience and professional consensus as to what health care professionals' volunteering in a Swedish context may actually entail. While all involved agreed that altruism, that is, a voluntary dedication of time and effort by health care professionals for the benefit of patients, is good and important in and of itself, there was no consensus on how to best channel it. The second trend mentioned in the introduction—the swift and flexible organization of volunteers via social media—implies both opportunities and difficulties in this regard. With a possibly larger and broader influx of volunteers, reaching consensus may be even more difficult. Social media could, however, provide an important arena for discussions and, ultimately, for

approaching consensus. The negotiations illustrated in this chapter represent a potential first step in achieving such a consensus in the face of future scenarios in which health care volunteers may be in demand.

References

Abbott, A. (2014). *The system of professions: An essay on the division of expert labor*. University of Chicago Press.

Amnå, E. (2006). Still a trustworthy ally? Civil society and the transformation of Scandinavian democracy. *Journal of Civil Society, 2*(1), 1–20.

Blomgren, M. (2003). Ordering a profession: Swedish nurses encounter New Public Management reforms. *Financial Accountability and Management, 19*(1), 45–71.

Brante, T. (1988). Sociological approaches to the professions. *Acta sociologica, 31*(2), 119–142.

Burks, D. J., & Kobus, A. M. (2012). The legacy of altruism in health care: The promotion of empathy, prosociality and humanism. *Medical Education, 46*(3), 317–325.

Dahlberg, L. (2005). Interaction between voluntary and statutory social service provision in Sweden: A matter of welfare pluralism, substitution or complementarity? *Social Policy & Administration, 39*(7), 740–763.

DiMaggio, P., & Powell, W. (1983). The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. *American Sociological Review, 48*(2), 147–160.

Dunn, M. B., & Jones, C. (2010). Institutional logics and institutional pluralism: The contestation of care and science logics in medical education, 1967–2005. *Administrative Science Quarterly, 55*(1), 114–149.

Engel, G. V. (1969). The effect of bureaucracy on the professional autonomy of the physician. *Journal of Health and Social Behavior, 10*(1), 30–41.

Engel, G. V. (1970). Professional autonomy and bureaucratic organization. *Administrative Science Quarterly, 15*(1), 12–21.

Freidson, E. (1988). *Profession of medicine: A study of the sociology of applied knowledge*. University of Chicago Press.

Freidson, E. (2001). *Professionalism, the third logic: On the practice of knowledge*. University of Chicago Press.

Hall, R. H. (1967). Some organizational considerations in the professional-organizational relationship. *Administrative Science Quarterly, 12*(3), 461–478.

Hall, R. H. (1968). Professionalization and bureaucratization. *American Sociological Review, 33*(1), 92–104.

Hasselbladh, H., Bejerot, E., & Gustafsson, R. Å. (2008). *Bortom new public management: Institutionell transformation i svensk sjukvård*. Academia adacta.

Johansson, H., Arvidson, M., & Johansson, S. (2015). Welfare mix as a contested terrain: Political positions on government–non-profit relations at national and local levels in a social democratic welfare state. *International Journal of Voluntary and Nonprofit Organizations, 26*(5), 1601–1619.

Kaun, A., & Uldam, J. (2018). 'Volunteering is like any other business': Civic participation and social media. *New Media & Society, 20*(6), 2186–2207.

Kohlbacher, F. (2006). The use of qualitative content analysis in case study research. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 7*(1).

Lomborg, S. (2012). Researching communicative practice: Web archiving in qualitative social media research. *Journal of Technology in Human Services, 30*(3–4), 219–231.

Lundström, T., & Wijkström, F. (1995). *Från röst till service?: Den svenska ideella sektorn i förändring*. Sköndalsinstitutet.

Lundström, T., & Wijkström, F. (2012). Från röst till service: Vad hände sedan? In F. Wijkström (Ed.), *Civilsamhället i samhällskontraktet*. European Civil Society Press.

Maier, F., Meyer, M., & Steinbereithner, M. (2014). Nonprofit organizations becoming business-like: A systematic review. *Nonprofit and Voluntary Sector Quarterly, 45*(1), 64–86.

Pfeffer, J., & Salancik, G. R. (1978). *The external control of organizations: A resource dependence perspective*. Harper & Row.

Pierre, J., & Peters, G. B. (2000). *Governance, politics and the state*. Macmillan.

Rhodes, R. A. W. (2000). Governance and public administration. In J. Pierre (Ed.), *Debating governance* (pp. 54–90). Oxford University Press.

Saldaña, J. (2012). *The coding manual for qualitative researchers*. Sage.

Scott, W. R. (1965). Reactions to supervision in a heteronomous professional organization. *Administrative Science Quarterly, 10*(1), 65–81.

SFS. (2013). *Lag om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd* (p. 407).

Smith, D. H. (1981). Altruism, volunteers, and volunteerism. *Journal of Voluntary Action Research, 10*(1), 21–36.

Sorensen, J. E., & Sorensen, T. L. (1974). The conflict of professionals in bureaucratic organizations. *Administrative Science Quarterly, 19*(1), 98–106.

Thornton, R. (1970). Organizational involvement and commitment to organization and profession. *Administrative Science Quarterly, 15*(4), 417–426.
Turunen, J., & Weinryb, N. (2017). Volontärer i välfärdsstaten—socialt arbete med transitflyktingar som politisk handling. In R. Scaramuzzino & S. Linde (Eds.), *Socialt arbete i civilsamhället—aktörer, former och funktioner* (pp. 175–200). Studentlitteratur.
Turunen, J., & Weinryb, N. (2019). Organizing service delivery on social media platforms? Loosely organized networks, co-optation, and the welfare state. *Public Management Review, 22*(6), 857–876.
Vårdguiden. (2019). Personer som saknar tillstånd. Retrieved May 05, 2020, from https://vardgivarguiden.se/administration/patientadministration/patientavgifter/asyl_utan_tillstand/handbokforpersonerutantillstand/artiklar/personer-som-saknar-tillstand/
Weinryb, N. (2015). Flyktingkrisen omdefinierar civilsamhällets roll. *Kurage, 18*, 12–17.
Weinryb, N., Gullberg, C., & Turunen, J. (2019). Collective action through social media: Possibilities and challenges of partial organizing. In G. Ahrne & N. Brunsson (Eds.), *Organization outside organizations: The abundance of partial organization in social life* (pp. 334–356). Cambridge University Press.
Wijkström, F. (2004). Changing focus or changing role? The Swedish nonprofit sector in the new millennium. In A. E. Zimmer & C. Stecker (Eds.), *Strategy mix for nonprofit organisations* (pp. 15–40). Springer.
Wilson, J. (2000). Volunteering. *Annual Review of Sociology, 26*(1), 215–240.