ABSTRACT

JASON, KENDRA JEANEL. Supervisors as Aids and Obstacles to Upward Mobility in the Health Care Sector. (Under the direction of Dr. Michael Schwalbe.)

In this dissertation, I examine how supervisors affect the mobility prospects of frontline workers in the healthcare industry. Using data from interviews and focus groups conducted in the late 2000s with 77 supervisors in seven hospital sites in the United States, I look at how supervisors responded to a workforce development program aimed at helping low-wage, frontline workers gain job skills and opportunities for career advancement. I found that some supervisors praised the program and aided workers who participated, while others criticized the program and gave little help to workers who participated. I explain this difference by reference to supervisors’ desires to protect their feelings of job-related competence. When the workforce development program involved supervisors in the planning phase, when it did not strain their already limited resources, and when it gave them roles as teachers, mentors, and coaches, they felt more competent as supervisors and supported the program. When the program excluded supervisors during the planning phase, when it reduced their staff resources and made it harder to meet productivity demands, and when it gave them no clear roles to play, their feelings of job-related competence were threatened and they did not support the program. I also examine how supervisors accounted for the failures of their workers to perform well and to succeed in the workforce development program. I show how supervisors drew on cultural discourses of colorblind racism and neoliberalism to deflect blame from economic and organizational structures onto workers. This study adds to our understanding of how self-concept motives matter for acceptance of and resistance to organizational change, and of how these motives are implicated in behaviors that can affect the mobility prospects of low-wage workers.
Supervisors as Aids and Obstacles to Upward Mobility in the Healthcare Sector

by
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2015

APPROVED BY:

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Michael Schwalbe     Jennifer Craft Morgan
Committee Chair

______________________  ______________________  ______________________
Martha Crowley        Melvin Thomas             Maxine Thompson
DEDICATION

To Henrietta, the first call me Doctor.
Kendra Jeanel Jason was born May 17, 1979 to Rodney and Brenda Jason of Augusta, Georgia. She earned her Bachelor of Science in Sociology from Augusta State University in 2002 and her Master of Science in Sociology from North Carolina State University in 2005. Kendra has taught at the University of North Carolina at Charlotte, North Carolina State University, North Carolina Central University, Wake Technical Community College and the University of Phoenix. She worked at the UNC Chapel Hill Institute on Aging from 2008-2012. In 2012, she began a lecturer position in Sociology at UNC-Charlotte and in fall 2015, she will start as an Assistant Professor. She has one daughter, Kennedy.
ACKNOWLEDGEMENTS

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To Stephanie Helms-Pickett and the Anointed Soles ministry of Wake Chapel Church.

To Arlene Mitchell and the Prayer & Empowerment ministry.

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CHAPTER ONE

INTRODUCTION: WORKFORCE DEVELOPMENT, SUPERVISOR RESISTANCE, AND WORKER MOBILITY

Growing up in a Black working-class family and neighborhood in the 1980s and 90s, I saw how living check-to-check, being underemployed, and being unfairly fired or mistreated at work was the norm for many of the adults in my neighborhood. In my hometown of Augusta, Georgia, limited education meant poor employment options. My parents were lucky. Both had decent jobs at the local power plant (my mom was an administrative assistant and my dad was an electrician). They purchased a modest home and sent my sister and me to a lottery-based magnet school on the other side of town—“the smart school,” as my friends called it. Then, my parents weren’t so lucky. They divorced when I was four. My mom became a single parent of three. My dad lost his job at the plant around that same time, and my mom ended up being laid off during my sophomore year of high school. My dad worked odd jobs until he started driving a cab for a living. My mom found a customer service job at a retail-giant call center and worked there until her retirement, earning nothing close to her previous salary.

I have always understood my parents in the context of their work. Every aspect of our lives was shaped by their income, their availability, their weariness, their frustration, and the meanings they attached to their jobs. Through their lives I also understood the fragility of work and the value of job opportunities. As a kid going to the “smart school,” then returning
home to my neighborhood, it seemed to me that poor and working-class people just needed a chance. If the American Dream taught to me at school was true, the hard-working people I saw around me should have been able to get ahead. But what I saw instead was the frustrating reality of limited time, choices, opportunities, education, and guidance people in my neighborhood experienced. For most them, the chance to get ahead, the chance I was being taught to believe in, never materialized.

Then there is me. I did well in school and am now positioned to earn a PhD in sociology. Someone once asked me, “How’d you make it [out]?” I replied, “I guess I got a chance.” The truth is, I got many chances—for mentorship, scholarships, jobs, and educational experiences along the way, one chance often leading to another. I saw that others who were no less smart or hard-working did not get the same breaks. These experiences and observations fueled my research interests as a sociologist. They also instilled in me a desire to use my academic skills to improve the job opportunities of people coming from backgrounds similar to mine.

In 2005, I completed my master’s thesis, “Organizational Inequality in Job Promotions,” which explored the distribution of promotion opportunities among jobs in a general sample of Australian organizations. Using organizational-level data from the 2002 Australian National Organization Survey, and performing ordinal logistic regression, I found that promotion probability is a function of human capital investment, vacancy chains, status differentials, and organizational context. Although I was excited to connect sociological inquiry with real-world data, and I understood that mechanisms of inequality are generic in
nature (Stainback, Tomaskovic-Devey and Skaggs 2010; Schwalbe et al. 2000), Australian data were far removed from the African American and other U.S. minority communities about which I was concerned. Also, using aggregate-level organizational data, I could not explore the perspectives of the organizational actors whose lives I hoped to affect for the better (Hill Collins 1990; Scott and Lyman 1968).

In 2008, I took advantage of an opportunity to study a unique workforce development program for frontline workers in the healthcare industry. I began a job at a research institute as a member of an evaluation team for a project that included pilot case studies in hospitals and health care systems, community health centers, behavioral health centers, and long-term care facilities across the United States. The program was designed to provide training and/or credentialing to low wage, entry-level workers, with the goal of helping them get higher-paying jobs through upskilling. I was allowed to use the data for my dissertation and chose to focus on hospitals. I thought this would be the best option for understanding how job promotions occur for low-wage workers in complex, bureaucratic organizations.

I decided to focus my attention on supervisors because, when listening to interviews with workers, I heard them complain about supervisors, giving the impression that supervisors greatly influenced their daily experience on the job. I also listened to supervisor interviews. I heard them talk about their challenging jobs and about their workers. There was also a great deal of variation in how supervisors talked about their workers in relation to the workforce development program. I thus began to wonder: How does the relationship between supervisors and their staff influence job opportunities for low-wage frontline workers? Did
supervisor support for the program enhance its effectiveness? If so, how? What kind of support mattered? What determined whether supervisors supported the programs or not? and How does all this matter for staff mobility and the reproduction of inequality more generally? I wanted to try to answer these questions through my dissertation project.

To date, few studies have examined the effectiveness of career programs that directly address the needs of low-wage workers in the healthcare industry. In addition, prior research has neglected to examine the how race, gender, and class matter for labor market disparities in the healthcare industry. Furthermore, the literature lacks a comparative study examining how supervisors influence upward mobility for low-level workers. My research seeks to fill these gaps. I also want to suggest how the challenges faced by low-wage workers in various occupational fields can be overcome.

My goal is to contribute to the understanding of organizational behavior and labor market outcomes more generally by examining key social psychological process underlying employees’ resistance to organizational change. What makes this case interesting is that supervisors are in a contradictory class position, and thus may have correspondingly complex reactions to the opportunities their jobs provide for deriving feelings of competence. It is also interesting because supervisors’ acts of resistance and compliance affect frontline workers’ prospects for upward mobility. Throughout this project, I drew on social psychological theory to explain the relationship between the identity-work of supervisors, organizational change, and low-wage worker mobility. I found that internal and external factors that affected supervisors’ feelings of competence influenced how supervisors
responded to organizational change. How they responded, I will argue, has implications for frontline workers’ prospects for upward mobility.

I also aim to reveal individual and organizational-level processes through which advancement opportunities for low-wage workers are created or denied. This means taking into account the profit-seeking interests of capitalists and managers, and how these interests can manifest in things like high production demands placed on supervisors and poor training provided for frontline workers. The case of supervisors and frontline workers in hospitals provides an opportunity to examine these processes and show how they matter for mobility, in ways that are not easy to see. My analysis will, I hope, reveal more about the conditions under which mobility prospects are diminished and the rarer conditions under which they can be enhanced by workforce development programs.

**CHALLENGES FOR LOW-WAGE WORKERS**

Workforce development is especially important to the mobility prospects of low-wage workers who cannot afford to invest in human capital. Human capital refers to the experience, skills, and education that an individual possesses. Workers invest in human capital for returns in status attainment and income. The higher the attainment level of a job, the higher the level of resources needed to gain access to that job (Sorenson 1977). Limited resources keep low-wage workers from attaining the human capital needed to escape the secondary labor market (Piore 1970). Not surprisingly, these secondary labor market jobs
are usually occupied by ethnic minorities, women, and the less educated (Kalleberg, Reskin and Hudson 2000; Jensen et al. 1999; Tomaskovic-Devey 1993a).

Kanter (1979) argued that women and minorities have low access to opportunity and power in organizations. Previous studies have consistently found that whites receive more supervisory positions, higher authority, and higher pay than Blacks (Pergumit and Veum 1999; Tomaskovic-Devey 1993b; Kanter 1977). Racial segregation limits minority workers’ initial placement on job ladders to positions that ultimately offer relatively little opportunity for further advancement. Moreover, minority workers tend to be isolated from certain jobs accessible to equally qualified whites. Furthermore, Black and minority workers tend to be channeled into “racialized” jobs (Maume 1999; Collins 1997). The channeling of Blacks into these jobs leaves the more visible jobs for whites and they, in turn, have more opportunities to exercise higher-order and reward-relevant job functions (Wilson, Quane and Rankin 1999). The dependence on low-wage labor in American society has created a labor market that supports a closed system of social stratification and mobility.

*The Healthcare Industry and Frontline Worker Mobility*

Despite high rates of unemployment associated with the Great Recession of 2008, healthcare continued to be a fast-growing segment of the labor force. Healthcare will generate 5.6 million jobs between 2012 and 2022—more than any other industry (Bureau of Labor Statistics 2013). Approximately 54% of the total health and healthcare workforce consists of frontline workers (Robert Wood Johnson Foundation 2006). Frontline healthcare workers are low-wage nonprofessional workers. Frontline jobs include jobs such as nurse
assistants, respiratory therapy technicians, social and human service assistants, and home health aides.

The frontline workforce is growing faster (32.6%) than the growth rate of all health and healthcare occupations (28.3%), and significantly faster than the growth rate for all occupations (10.8%) in the United States workforce (Bureau of Labor Statistics Occupational Employment Statistics 2010-2011). National statistics report frontline workers as 79% female, 33% minority, with a bachelor’s degree or less, earning less than $40,000 per year (Robert Wood Johnson Foundation 2006). The frontline worker demographics for all sites in the workforce development program were 91% female, 59% minority, with 33% of minorities being immigrant, 51% high school or less education, earning an average of $26,000 per year. Low-wages, minority status, educational un-readiness, and family responsibilities represent challenges many frontline workers face when considering investing in education and training. These challenges are compounded by local contexts characterized by high rates of poverty, unemployment, and geographical dispersion. Given the opportunity to advance through additional education and training, many are daunted by obstacles such as academic inferiority, poverty, discrimination, unreliable transportation, and family responsibilities.

Hospitals are interesting sites in which to study low-wage worker mobility. The highly stratified occupational structure and formalized internal job ladders in hospitals may seem to offer more advancement opportunities than typical “bad jobs” characterized by low pay, few or no benefits, heavy workloads, and high turnover (Kalleberg, Reskin, and Hudson

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such as retail or food service, that many low-wage workers find themselves in. But hospital job ladders are typically provided for professional staff, not frontline workers. Promotions in hospitals typically require degrees, certification, and/or licensure gained through formal education. It is this kind of career capital that frontline workers lack.

Opportunity through Workforce Development

While mobility prospects for frontline workers are bad in most places in the healthcare industry, some organizations have tried to improve these prospects. During the Great Recession of 2008, many hospitals found it cost effective to retrain or “upskill” incumbent frontline workers who were already doing well in their jobs. This strategy of hiring and training from within was used to meet demands for greater output while facing tight budgets and hiring freezes. These workforce development programs sought to reduce the costs of (new) hiring and turnover, and to give hospitals access to a population of loyal workers with higher levels of skill. Although it did not always happen, these programs had the potential to improve mobility prospects for frontline workers.

The workforce development program examined in the current study was created to help frontline workers improve their chances of getting ahead by providing accessible and affordable education and training. The program was designed to fit the needs of each site and its different entry-level workers. The program provided release time for workers to participate in college courses, clinical simulations, preceptorship training, and/or on-the-job training. The goals were to make frontline workers better in their current jobs, or to provide them with the training necessary to make them good candidates for promotion.
Selection into the program varied at different sites. Participants applied or were recommended and then were or selected based on various criteria. In most cases, only one or a few participants were selected out of a department. In some cases, entire departments required their frontline staff in certain positions to participate. Thus, participation for frontline workers was voluntary in some cases and mandatory in others. Bosses of participants (departmental supervisors, managers, and directors), however, were required to comply with the program as mandated by hospital administration.

Supervisor resistance can be a major challenge when implementing innovations such as new skills training, evidence-based protocols, or workforce reorganization. Immediate supervisors have been found to significantly affect the success of these programs. Previous studies have shown that supervisor support can greatly facilitate implementation (Caldwell, Chatman, O’Reilly, Omiston, and Lapiz 2008). Other studies have shown that a lack of supervisor support can impede and even undermine the effectiveness of career programs (Guth and MacMillan 1986). Degree of supervisor support seems to be positively associated with degree of supervisor involvement in and control over implementation (Chuang, Jason, and Morgan 2011). Very little has been offered, however, by way of a theoretical explanation for these findings. Such an explanation is what I hope to offer.

*Explaining Resistance: A Social Psychological Approach*

Weber ([1921] 1968) saw organizational behavior largely as a consequence of formal roles and rules, though he recognized that struggles for status and power also come into play. Marx, on the other hand, saw class conflict as endemic to capitalism, and saw class conflict
as the basis of resistance. His theory of the labor process focused on capitalists’ exploitation of workers for the maximization of profit, an arrangement that Marx saw as creating misery for workers, hence the likelihood of resistance. According to Marx, this misery, when combined with workers’ awareness of their collective interests, would undermine the legitimacy of capitalist relations of production and inspire revolution. Marx seemingly underestimated the difficulty of generating critical class consciousness and the ease with which capitalists have been able to co-opt workers with wage increases and benefits. A more social psychological approach grants the importance of these factors, but also recognizes the importance of negotiation (Maines 1977), emotion (Hochschild 1983), and identities (Callero 2014; Schwalbe and Mason-Schrock 1996; Snow and Anderson 1987). The approach I take here gives prominence to the self-concept as a motivating force (Gecas 1991, 1982). Much of what people do in organizations, according to this view, stems from efforts to maintain or enhance feelings of self-worth and self-efficacy.

Other scholars have likewise argued for the importance of feelings of self-efficacy and self-worth derived from work (e.g., Schwalbe 1988, 1985; Gecas and Schwalbe 1983; Hughes 1951), feelings that are closely related to pride and dignity. These approaches to understanding work experience remind us that people are not simply members of economic categories, but are individuals whose responses to work are complicated by emotions, interpretations, and self-conceptions. These approaches to the sociology of work are not reductionist or psychological; rather, they aim to understand patterns of individual experience as a result of both internal and external social forces. Both the Marxian and Weberian
perspectives stand to gain from taking this kind of sociological social psychology more seriously.

It is important to see how people respond to workplace conditions not only as members of economic classes but as complex emotional beings. Workers may comply with managerial directives because, under capitalist relations of production, they can lose their jobs if they don’t. But it seems clear that compliance is also based on desires to feel efficacious by performing a job well (Burawoy 1979), to avoid or manage noxious emotions (Leidner 1993; Hochschild 1983), and/or to protect identities on which many “side bets” ride (Schwalbe 2008). Organized resistance can also arise when workers feel that their dignity and important identities are threatened (Fantasia 1988). The point again is that understanding workplace behavior requires attention to what are usually considered social psychological matters.

My argument here is that supervisors’ behavior in response to the workforce development program depended on how they perceived its implications for their work-related self-efficacy. When the program was perceived to bolster supervisors’ feelings of competence by giving them new ways to help their workers succeed, they supported the program. When it threatened their feelings of competence by restricting resources, excluding them, or challenging their workers’ potential, they responded by criticizing and resisting the program. The outcomes of the program, including mobility prospects for frontline workers, can thus be seen as mediated by the self-concept motives on which supervisors acted.
SETTINGS AND METHOD

The workforce development program examined in this study was implemented in four single hospitals and three hospital care systems in seven states, representing all but one region of the United States. Pseudonyms for each site are used in this dissertation. The program was funded by a private foundation, with supplementary funds from a business and management funder and a government source. The formally stated goals were to meet the growing need for healthcare workers, to provide education and training for frontline workers, and to improve the well-being of frontline workers through better working conditions, higher wages, and career advancement. The three-year trial implementation occurred in the late 2000s. Evaluation data were collected in three phases during each year of implementation.

The evaluation team consisted of two senior researchers and four graduate research assistants. We designed the evaluation, created questionnaires, and collected survey data. We interviewed CEOs, hospital executives, managers, supervisors, and participating frontline workers. Two-member teams conducted two-day on-site visits during phases one and three of data collection. The evaluation team collectively participated in telephone interviews during phase two. I conducted interviews at two of the seven hospital sites and numerous phone interviews at these and other sites. We had multiple team meetings about each site throughout the evaluation and shared quantitative and qualitative data analysis and writing responsibilities to ensure reliability and validity of the data. We coded and analyzed data for all sites using the codes developed by the team to provide formative and summative feedback.
for the grantee partnerships and the national program office. All individual and focus group interviews were recorded and transcribed by a professional transcriptionist.

**Data Collection**

The data used here are taken from semi-structured interviews and focus groups conducted on-site or in follow-up telephone interviews with 77 supervisors from seven hospital sites in seven states. Since the evaluation team requested to interview “supervisors of the participants” and did not provide a clear occupational description or role, the interviews yielded data from departmental directors, unit managers, clinical managers, direct supervisors, and nurse managers. In a handful of cases, educators, team leaders, trainers and departmental coordinators were included as associates of the program. We conducted 20 individual supervisor interviews and 13 supervisor focus groups at the hospitals. The interviews focused on supervisors’ management style, their relationships with staff, their perception of the program, problems of implementation, and perceptions of how the program affected their units. Interviews were conducted in person at the beginning of the program (phase I), over the phone in the middle of the program (phase II), and again in person at the end (phase III).

The first phase of baseline data collection from supervisors usually occurred before program implementation began. These were eight focus groups in which the questions explored a range of issues, such as supervisors’ management styles, their relationships with staff, their perceptions of the challenges faced by frontline workers, definitions of a “good worker,” the adequacy of frontline worker training, perceptions of organizational support for
frontline workers, perceptions of higher-level managerial support for supervisors, and beliefs about the likely impact of the jobs program. The second phase of interviewing occurred about a year later with the program well underway (two of the seven sites had one full cohort complete the program by this time). Fourteen individual interviews focused on the supervisors’ job responsibilities, their likes and dislikes about their job, supervisors’ management styles, their relationships with staff, their perceptions of frontline workers’ strengths and weaknesses, the challenges they faced at work, their perception of administration, their involvement with the job training program, their perception of the program, organizational support they need to support the frontline worker participants, and program sustainability. The third phase of interviewing occurred in year three of implementation as the projects were coming to a close. Questions focused on supervisors’ experiences with the program, their perceived successes and failures with the program, perceived and realized outcomes, frontline worker (participants and non-participants) reactions to the program, organizational support they needed to do their jobs well, their overall perception of the program, and expected program sustainability.

I approached my data differently than I would a purely inductive or deductive project because it is a bit of both. By the time I began analyzing data for this dissertation, I had been working on the evaluation team for two years and coded hundreds of pages of transcripts, contributed to numerous professional presentations and reports, and had co-authored one publication. So I was familiar with the themes represented in the data. For my dissertation project, I pulled away from the concerns of the evaluation and engaged in focused coding specific to my interests in supervisors. Questions concerning interpersonal relationships,
supervisors’ feelings about workers, and how the supervisors perceived themselves revealed a story about relationships between supervisors and their frontline staff. In addition to focused line-by-line coding, I also wrote notes-on-notes and analytic memos based on themes emerging in the data.

**Supervisor Demographics**

My sample consists of 77 supervisors from seven hospital sites. The sample includes the job titles direct supervisor, supervisor, manager, and director, with six educators, one lead, one trainer, and one coordinator. Twenty-one are men, forty-eight are women, and eight chose not to identify their sex. The men are mostly supervisors of patient services, while the women are mostly supervisors of direct care. Fifty-three supervisors self-identified as white, fourteen as Black, two as multi-racial or other category, and eight supervisors did not identify their race. Ages ranged from 27-65 years, with an average age of 47. Most of the managers and directors had a four-year degree (or at least sixteen years of education) and earned over $60,000 per year. Lower-level supervisors and coordinators, on average, had a high school education and earned about $30,000-45,000 per year. My sample was weighted toward higher-ranking supervisors, averaging fourteen years of education and earning $60,000-69,000 per year. Supervisors tended to be long-term employees, most having worked in the same hospital for an average of fifteen years, holding several positions as they moved up the job ladder. Table 1 summarizes the characteristics of my sample.

It would be informative to compare the demographics of this sample to national statistics on supervisors in hospitals. This would allow me to speak to the representativeness
of my sample. Unfortunately, no such national data exist. My sample also includes a range of supervisor titles that can mask differences in responsibilities and tasks performed. There could thus be hidden variation in the degree to which some people labeled “supervisors” interacted directly with frontline workers. Despite these limitations, the sample taps a population of organizational actors whose responses to the workforce development program had important implications for the workers who participated.
Table 1: Sample Characteristics

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*Total N= 77
OVERVIEW OF THE DISSERTATION

This project underscores the nature of identity work and the centrality of work-related self-efficacy. When supervisors were able to feel they played an important role in the success of the program, or more specifically, in the accomplishments of their workers, they felt good about their work and themselves. However, there was a continuous threat to their ability to feel efficacious as supervisors: the poor performance of their staff. This project explores how supervisors attempted to protect their feelings of competence under these conditions. My aim is to say something about the conditions under which the self-efficacy motive leads to compliance on the one hand, or to resistance on the other. The next three chapters unpack this analysis.

In chapter two, I explain how supervisors’ responses to the program were motivated by a desire for work-related feelings of competence. These feelings were constantly threatened by high productivity demands and a lack of resources. Yet supervisors invested much in their identities as good supervisors. Their perception of being good at their jobs was closely tied to feelings of respect, dignity, control, and inclusion. Organizational changes either enabled or constrained their feelings of effectiveness. I thus identify workplace conditions and practices that supervisors saw as meaningful in their jobs and to their identities. I then examine how these meanings, being either reinforced or jeopardized, influenced supervisors’ feelings of status and value, and how they responded in ways that mattered for their frontline workers. Drawing on social psychological theories of the self-
concept, I argue that feelings of work-related self-efficacy underlay supervisors’ responses to the program. I then discuss the implications this has for program success.

In chapter three, I consider how organizational culture and practices mattered for supervisors’ willingness to invest in their workers. I identify features of the hospitals that shaped the way supervisors perceived the worth and mobility prospects of their staff. I show how organization culture and practices enhanced or diminished supervisors’ ability to take credit for their workers’ success. I examine how they preserved their feelings of competence by investing in, or distancing themselves from, workers based on their expectations for worker success. Here I argue that supervisors’ desires to feel competent directly influenced the market value and potential growth of frontline workers.

In chapter four, I explain how social inequalities were justified and reproduced by the acceptance of culture of poverty and neoliberal discourses and how supervisors used these discourses to resolve identity-work dilemmas. I demonstrate how supervisors engaged in identity talk that justified deprivation for workers and shielded management from blame. I discuss how supervisors subtly invoked class, race, and gender stereotypes—and thus reproduced ideologies supportive of structural inequalities—as they crafted accounts that drew attention away from economic and organizational problems and focused on the victims. I also examine how supervisors’ perceptions of their staff defined workers’ opportunities and, again, inadvertently reproduced inequality.

In the final chapter, I discuss the sociological implications of this study. Specifically, I consider how self-processes mediate between organizational conditions and supervisor
behavior, especially behavior that has implications for the mobility prospects of low-wage workers. Upper-management must take into account the possible effects of organizational change on supervisors, who play key roles as mentors and supporters of frontline workers. Sociologists who are concerned with organizational change and the reproduction of inequality need to pay attention to the self-processes of mid-level authority figures. Lastly, I reflect on the limitations of this study and offer suggestions for future research.
CHAPTER TWO

SUPERVISORS, SELF-EFFICACY, AND SUPPORT FOR WORKFORCE DEVELOPMENT

In this chapter I identify two general responses supervisors had concerning the workforce development program: support and criticism. In my data, one theme emerged that I believe best explains supervisors’ differing responses to the workforce development programs: work-related self-efficacy. I found that support or criticism for the program depended on how changes in workplace conditions affected supervisors’ work-related self-efficacy. For instance, when organizational changes allowed supervisors to take credit for an increase in service quality and the success of workers under the program, they supported it; but when changes interfered with supervisors’ ability to run their departments well, they were critical of it. I use social psychological theory to explain the external and internal forces that influence supervisor behavior. My aim is to use this approach to better explain organizational behavior in response to innovative programs.

This analysis of self-efficacy as a part of a motivation dynamic contributes to what we know about workplace behavior. The findings presented here suggest people support and more easily adapt to change when the change benefits them, and people will criticize and resist change when they perceive that those changes will make their jobs harder. The process by which people come to their response to change, and how they come to see themselves because of change, however, is more complicated and sociologically relevant. This chapter
contributes to the literature on self-efficacy, organizational behavior, management, and mobility prospects in two distinct ways: (1) it shows how supervisors’ acceptance of organizational change can hinge on how change affects their self-conceptions and; (2) it shows how supervisor self-efficacy mediates between organizational practices and frontline worker mobility prospects.

Work-related self-efficacy is an important determinant of organizational behavior. Self-efficacy has implications for workplace behavior and human resource management (Gist 1987). What seems most useful for my research on supervisors in the healthcare sector purposes is a body of social-psychological theory that identifies the self-concept as a source of motivation (Gecas 1991). Social psychologists usually argue that people derive their self-conceptions from three sources: reflected appraisals (i.e., feedback from others), social comparisons, and self-perceptions (See Gecas 1982 for a review). Behavior is then motivated by desires for positive reflected appraisals, favorable social comparisons, and self-perceptions of competence and morality. Under this theoretical framework, workplace behavior can be understood as driven by desires to elicit positive and avoid negative feedback from (important) others; make favorable and avoid unfavorable social comparisons; and observe oneself acting in competent and moral ways. An implication of this view is that support for organizational change is likely to hinge on whether those changes threaten or bolster people’s feelings of job-related self-efficacy.

Some supervisors in my study were concerned about how the program would affect their ability to manage their departments and staff. I contend that this concern is related to
the program’s threat to a major dimension of their self-concept: self-efficacy at work (Garrett-Peters 2009; Gecas and Schwalbe 1983; Bandura 1977). It seems that support for the program decreased to the extent it was perceived as a threat to supervisors’ self-efficacy or, more simply, their feelings of competence as good supervisors. In order to better understand supervisors’ responses to the newly implemented workforce development program, one should have an idea of the preexisting work conditions which may have influenced supervisor self-efficacy. In the following section, I briefly describe the general working environment, work pressures, and the general characteristics of the staff that the supervisors manage.

**Preexisting Work Conditions**

Supervisors were responsible for getting a high volume of work done, under time pressure, with limited staffing. Direct care is obviously time-sensitive work. Some patients have pressing needs for toileting, turning, catheter care, and medication. Other services, such as food preparation and delivery, facility maintenance, waste disposal, and recreation, are less urgent, but still important in affecting quality of care. Although supervisors’ roles and responsibilities varied by department, all were responsible for managing healthcare workers in “bad jobs”—jobs characterized by low pay, few or no benefits, heavy workloads, and high turnover (Kalleberg, Reskin and Hudson 2000). Bad jobs are dead-end in nature. Low-wage workers have limited opportunities to advance in their task-oriented jobs, limited time off (sick, vacation, personal) and few fringe benefits; and turnover rates are high.

Frontline jobs are numerically dominated by marginalized groups: women, racial/ethnic minorities, immigrants, and the less-educated. Seventy-nine percent of the
frontline healthcare workforce is female and 32 percent is African American, Hispanic, or Asian. Average income is less than $40,000 per year. Most frontline workers have only a high school education (Robert Wood Johnson Foundation 2006) and usually have limited training, experience, and other job skills. Furthermore, bad jobs usually do not have adequate or formal orientation and training for new workers (Tilly 1996).

New hires usually get a generic and brief orientation to the hospital and department. Their departmental training is unstandardized, informal, and often given by a peer worker rather than a certified trainer or supervisor. In many of the hospitals in this study, orientation consisted of a one- to three-day orientation as a new hospital employee with human resources and then one day of orientation in the department consisting of watching safety videos, computer training for that job category, and reviewing policy and procedural videos or manuals. Physical training often consisted of shadowing an experienced peer worker for a week or less. An environmental services supervisor at one hospital describes the minimal training given to new hires:

We do a verbal orientation with them [and] we have [them watch] videos about cleaning procedures. Then, we will place them with [a] supervisor [who will] give them a tour of the facility. Then, they will work with [the supervisor] and [eventually the supervisor] will put them with [a senior worker] who we feel comfortable enough [to] give them the type of training as if a supervisor was there. [T]he supervisor sometimes would forget about that new employee. Well, we need to be careful because we’ve got to pull that new employee back and just reinforce what [the senior] employee had communicated to them to make sure that they understand everything that individual did. I think new employees have failed because we would throw them out there.
Although clinical frontline workers must meet some additional regulatory requirements for training and onboarding, the passage above describes the typical training regimen for most low-wage workers in healthcare. It also suggests that supervisors sometimes felt that this process shortchanged new hires and that they wanted to do a better job of training.

The challenging conditions under which supervisors worked made them weary of changes that could affect scheduling, staffing, budgets, and interpersonal dynamics. As the program began to inherently change things that were related to feelings of self-worth and competence as a good supervisor—either in a positive or negative direction—supervisors responded accordingly: either supporting or criticizing the program’s effects on their daily working experience. In the following section I examine more closely how program changes elicited support in some cases and criticism in others.

Supporters

Hospitals typically provide internal job ladders for professional staff, but few paths for upward mobility exist for frontline healthcare workers. Promotions in hospitals are highly credential-dependent with mid-level skilled positions requiring degrees, certification, and/or licensure. Most of these credentials require formal training through an educational institution such as a community college. Despite the possibility of advancement through additional education and training, obstacles such as poverty, unreliable transportation, and family responsibilities prevent many frontline workers from growing with the industry. Supportive supervisors believed that the program would help workers overcome socioeconomic and
employment barriers to upward mobility. These supervisors understood that many of their workers were motivated and had aspirations for advancement.

The program provided a way for frontline workers to achieve ambitious employment goals, and gave supervisors a way to help. The program bolstered supporters’ feelings of competence by giving them mentorship, training, and job-coaching roles. For example, supervisors at one hospital admitted that before the job program was implemented, they did not give adequate training to new hires. By giving supervisors a formal training role, the program made them feel more connected to their staff and more competent. At another hospital, the program provided a way for the supervisors to become job coaches. Through this role, they had the opportunity to become better career advisers for their staff, providing opportunities to bolster feelings of competence. Supporters were able to engage the program, assist their workers, and benefit from the rewards of compliance. That is, even though the program offered extrinsic benefits to frontline workers, supervisors supported the program because of the intrinsic benefits they received.

*Investment and Assistance*

Supporters valued the professional development of low-ranking staff. These supervisors were sensitive to the fact that their staff were paid poorly and under-appreciated, and wanted to minimize the harm this did to their workers’ work ethic, morale, and aspirations. Supporters knew that their workers often felt powerless because of their low occupational status. One supervisor spoke of trying to encourage his worker(s):
I’ve got a person now that I’ve been working on for two years trying to get them to go back just to get the GED. [I’m] trying to encourage [the worker] and [the worker is] on the verge now of doing that, but it’s taken me two years of keeping [sic] encouraging them that, they can do it. I’m not giving up on [my staff] but I’m just one person and they need to hear that from other people. I’m not so sure if they’re getting that.

Many Supporters claimed they have always encouraged their workers to grow with the organization. They saw the program as giving workers an opportunity to follow this advice and thus, give their support to the program.

The program allowed these encouraging supervisors to take on support roles and offer workers the tools and time to get the training they needed to be good candidates for advancement. As one supervisor put it, “I think everybody would agree [with supporting the program]. It’s kind of like motherhood and apple pie. How could you disagree with providing them the opportunity to advance?” Even so, not all supervisors supported the program, as will be discussed later.

Supporters saw the program as helping their staff overcome barriers and grab hold of an opportunity for advancement. As one nurse supervisor said, “These are basically struggling staff members with very minimal education. So anytime there’s an opportunity for them to better themselves—to move up in life—I welcome that.” Another supervisor said, “I’m supposed to be able to do all I can to help my staff move up the ladder. It is my job to be able to lend that hand and to be able to provide for them.” Others echoed this sentiment when describing some of the basic duties of their job. When asked what they liked most about their jobs, two supervisors commented,
Supervisor 1: [Something I like about my job is] being able to make a difference [and to] see people progress. Going from what they are doing and advance to other departments throughout the facility as a career.

Supervisor 2: I could put it in simple words. I like the opportunity to help people.

Many supervisors cited being able to help their staff as an important motivation. This meant helping not just with daily performance, but also with long-term job advancement.

Supporters understood the complexity of negotiating work and family on a limited income and, when given the opportunity, wanted to assist workers. One supervisor described the struggle many workers faced when trying to move up in the organization:

I’ll talk to them about what their futures are and ask them, “You’ve been doing this for how long?” “What is your future?” “What are you plan[ing] on doing?” And some of them will say, “Well, I want to go to nursing school but I’ve got to wait for one kid to get off to school… I can’t…I’ve got to make sure that I’m [at work] and then I’m home.” They’re juggling a lot of family, personal issues. Along with that, they want to be something different, and then they want that help, so I tell them about this [program] because they’ve known about it for a while. [A] lot of them are looking forward to anything that can help them get where they need to go. And that bridge is severely needed for a lot of entry-level workers.

As this supervisor’s account shows, directing struggling workers onto the path provided by the workforce development program allowed supervisors to feel efficacious. As I will show next, supervisors’ used the program to mentor workers, with the aim of increasing workers’ feelings of self-worth.
Instilling Value

Frontline healthcare workers often become trapped in dead-end jobs. After facing cumulative disadvantages over time as the working poor, these workers tend to lose motivation to progress as their well-being diminishes (Shulman 2005). Although some find dignity and other intrinsic rewards in their jobs, they still deal with a status deficit relative to many coworkers and clients (Farrar, n.d.). One thing that supportive supervisors liked about the workforce development program was that it off set these demoralizing forces by giving frontline workers feelings of value and self-confidence. When supervisors could see and take credit for these boosts in morale, they tended to support the program.

Supervisors stressed repeatedly that they tried to support, motivate, and encourage frontline workers in their everyday jobs. Supervisors did this, they said, to help frontline workers see that their jobs had value. As two supervisors put it:

Supervisor 1: [In] all three of our departments the employees feel as though that they are looked down … you know, because they’re like…

Supervisor 2: Nobody cares…

Supervisor 1: We’re all three lowest paid departments—services departments—so of course, they’re not upbeat most of the time.

One supervisor went on, “I think it’s very important to make [third-shift workers] aware that they are important. They’re just as important as the first shift.” Another supervisor added,

You’re no one’s maid, but we are a service department and the expectations are that we provide that service, because if this hospital was dirty, filthy, [with] germs all of over the place, then we’d have to close our doors. So we
try to encourage our employees that they are important and we need to go to bat for them. Anything we possibly we can do for them, we need to do it.

Supporters said that they liked the fact that workers gained confidence and a more positive attitude as they went through the program. They thought favorably of the program when participants returned to the department with improved skills and better work attitudes.

One laundry services supervisor said:

[My staff worker’s] attitude changed to a positive. Well, it was already positive, but it just went to another level because of her confidence and what she’s doing now [in the program].

Supportive supervisors also discussed how program participants were generally more motivated than their peers. One supervisor spoke of the difference:

The people who come into the program are, I think, a lot more motivated than [those who are not in the program]. You could see a difference in how the people that were in the program actually wanted the opportunity to better themselves.

Supervisors who supported the program often felt that the program helped make their workers better. The program allowed for workers to experience personal attention from others and institutional investment—both of which may increase self-value and motivation.

Supporters tended to be supervisors who identified sympathetically with the class-based struggles of frontline workers. These supervisors wanted to see workers get ahead, or, at least find value in their work. Prior to the implementation of the workforce development program, however, there was little realistic chance that supervisors’ encouragement would
make a difference. The job program, as supervisors perceived it, boosted their workers’ morale and created the possibility of advancement. This was especially important for supervisors who felt responsible for their workers’ morale and success. These supervisors became supporters of the program because it boosted their feelings of competence. As I will show next, however, not all supervisors felt this way. Although the program offered long-term benefits to the workers, the program posed immediate constraints on supervisors. I turn next to examining how supervisors responded to the newfound policies and parameters of the program.

Critics

Supervisors were critical of the workforce development program when they perceived the program as making their jobs harder and threatening to their feelings of competence. One of the greatest challenges as a healthcare supervisor is to manage limited resources. The workforce development program often decreased staff availability, constricted budgets, and complicated scheduling—making some supervisors resistant, or at least hesitant—to follow the program protocol. In the following sections, I describe how supervisors dealt with the loss of control over resources, the lack of communication from superiors, and their feelings of exclusion as a result of the program implementation. I will also describe the acts of resistance supervisors engaged in to assert control over the process.

Loss of Control

Critics of the program already lacked control over many aspects of their work. A program that further diminished supervisors’ control was thus a problem. Knowing that direct care is high-volume, high-demand work, being short-staffed, even temporarily, is a major concern
for supervisors. This fear of being left short-staffed underlay much of the criticism heard from some supervisors. One supervisor put it this way:

[W]hat would happen if [the participant] came out of my [nursing] area? How would that affect me? Would I be able to get another person or another body to replace her so that I won’t be left on the back end? So it puts a bad taste in my mouth. How can I support this, consciously, knowing that I may not get anybody to replace this person? So in essence what I’m doing is training people to leave me, with no guarantee that I’m going to get anybody else.

For some supervisors, turnover was already a big problem, and budget cuts in recent years had left them with no cushion when it came to staffing. Even supervisors who wanted their frontline staff to advance felt conflicted. One supervisor said, “[by supporting this program] I’m not raising somebody to keep, I’m raising them to lose.”

Losing employees threatened department performance. Understandably, then, the prospect of losing their good employees to meet the needs of another department put supervisors on edge. In many cases, a lost employee would not be replaced. As one supervisor explained:

[HR] put a hold on all hiring. [B]efore they put a hold on hiring we had to kind of cut back on staffing. And so we were at the bare minimum on our staffing already. I could not hire anybody else, so I had to already give up one person in the beginning, and now I’m have to deal with giving up another person with no guarantee of getting another body.
Losing employees meant losing some of the resources necessary to run an effective department. It meant, in effect, to lose some of the resources necessary to be seen as a competent supervisor.

In some cases, budgeting was an issue. One of the main complaints supervisors had about the program was the expectation that the funding to cover backfill (on-call or temporary staff) would come out of departmental budgets. Departments were not always compensated when staff took the time to participate in the workforce development program. The problem with this is that the budget, in many cases, had already been expended by the time the program began. The program’s funding was not a part of the planned budget for the fiscal year. In these cases particularly, supervisors wanted human resources to be responsible for backfill and support. As one emergency services director said, “I don’t know, it just seems to me that instead of the departments being held accountable for that extra time that [participants] get off, it should [come out of] the HR budget, instead of our departmental budget.” Other supervisors of budget-strapped departments agreed, as indicated in the following exchange:

Supervisor 1: We’re hiring PRN [per-diem] people to fill in for our employees that are coming out of our budget. We didn’t plan for that; we didn’t budget for it in this budget year… I’m cautious about letting any other employee do this.

Supervisor 2: I think the number one deterrent for other departments in contributing more people to the program is this issue of the money coming out of department budgets to cover it, and it’s to benefit the whole organization. And so there’s an ongoing conflict there for me between not having that money budgeted to cover these people, and yet, being encouraged to put people through the program and wanting to put them through the program.
Supervisor 3: You can’t just work that day with one less employee. You have to fill that position, so then you get into budget problems with your boss... because we’re really held accountable for our budgets.

Supervisor 1: Yeah, [HR] wondering why you need an extra PRN person, you know?

At other sites, supervisors were further stressed by their inability to temporarily fill positions.

One supervisor explained:

The ones of us that have let [participants] go [to train]… our staff are stressed [and] we’re stressed. There isn’t anybody to back fill. The perfect example would be that there’s a cost center that back fills the department with a person, and also the money comes out of that because we are a very cost-center driven organization. So if your budget isn’t exactly right… [If this hospital] is really going to promote this program, they should have a cost center in place for both, and to have people in addition in the float pool. If they know X number of people are going to be in the MA (Medical Assistant) program, then they need to be able to hire to cover that because they still have to cover the sick calls. And it’s not the float pool’s problem. It’s in the fall. It’s in the middle of flu season, right? So we need to remember that we also have other staff who are going to be out during that time. Then holiday season comes right after that, so right now I’m trying to complete the vacation calendar for this time and accommodate for the student that’s going to be out for four weeks. So when she comes back, the people who have been covering her, going to be out on their vacations then, so there’s no continuity of care. There’s no warm hand-off between the student who’s gone and the people who have been covering.

Critics like this supervisor, worried about the ability to cover staffing while workers were absent because of their participation in classes, instruction, and training. The problem was largely one of money and time. When supervisors had no budget for replacement staff, this generated the additional stress of conflict with finance directors and human resources.
Frustration due to the lack of resources generated much criticism about the program’s implementation strategies. Critics thought that issues of backfill were not well thought out (i.e., this is a poorly designed plan) or that supervisors’ difficulties in complying with the program’s requirements were not taken seriously. In a nutshell, supervisors who were critical felt that the program’s implementation for staffing, budgeting, and continuity of care had not been adequately taken into account. The program, in the eyes of critics, posed a threat to their ability to appear competent as supervisors. Another strain that supervisors were forced to deal with was lack of communication with upper management. In the next section, I discuss the impact this had on supervisor’s critique of the workforce development program.

Lack of Communication

In most cases, the program was devised by administrators, without the involvement of supervisors, and an implementation plan was given to supervisors weeks, or just days, before the program was to begin. This left supervisors at a disadvantage when managing their staff and budgets. When the supervisors looked to HR for support, it was not there. The director of food service at one hospital said, “I think the human resource person needs to be involved from the very beginning, so that they can dictate how [the program is] going to happen and then warrant any changes…You’ve got to have somebody that’s going to feed [administrators] information when it comes to staffing.” Complaints like this were common and reflected the gap between how supervisors envisioned effective program implementation and how it was actually imposed by administrators.
Other critics said that HR policies sometimes made it difficult for individuals and departments to realize the benefits promised by the workforce development program. For example, salaries were not always adjusted to compensate for increased responsibility. One supervisor described the problem:

I’m just going through this now with HR where my MAs (Medical Assistants) that have been here a year—usually after a year is when we have changed their job title to surgery scheduler— and I really had to work with HR to say, “Look, they’re not doing this component of being an MA, so you can’t put them in as a surgery scheduler. So now they’re making more but they don’t get their MA cert[ification] pay, so if they’re certified MAs they don’t get that extra fifty cents an hour because they’re surgery schedulers, but they also make more money than a certified MA. And yet it’s really kind of a Catch-22 with that, and I think HR really needs to clean this up and say, you know, if we’re going to do a push for MAs, then we need to change the salaries of things.

As some supervisors saw it, the workforce development program did not always benefit the employee. In some cases, the compensation was so low that it could be deemed not worth the effort. In other cases, it put workers off track to gain advancement in other ways. Some supervisors felt that HR should have foreseen these problems and designed the program differently.

Supervisors also criticized HR personnel for not doing more to help them comply with the program. Critics cited poor administrative communication as a problem. For one food service director good communication was a missing piece in the program:

If [the program] could be started up again, the one piece that I think was missing—because it directly affected my department—is a line of communication between the hospital board—who’s in charge—as well as
the human resource department. Somebody from human resource for that hospital has to be a part of that.

For the supervisors, lack of communication was equivalent to exclusion from involvement in the program. Poor communication left supervisors feeling responsible for key parts of the program, but with no way to get clarification or guidance when problems arose.

Other Critics expressed concerns related to promotion of the program. Here again communication was cited as a problem. As one supervisor put it:

There was a hospital league function we had a week or so ago [that] would have been a perfect opportunity to have a booth out there to generate some more interest. I think you would have gotten a whole lot more exposure [and] more excitement. As [another supervisor] was saying, “The key to this thing is going to always be communication.” We’re not dealing with supervisors who are highly motivated people. We’re dealing with the lower [status] ones who something like this means a lot to them. [I]f we continued to just kind of play it low, not keep them informed… [I]f we’re not going to keep the communication going at the forefront, then there’s no need in trying to make this program, because it’s not going to pass. That’s sad but it’s not going to go. That communication has got to be a number one priority.

Some supervisors spent most of their interview time complaining about the lack of communication between the administrative offices and their departments. This was especially true of supervisors who saw themselves as good communicators:

Supervisor 1: I’m a stickler for communication, and you’re going to hear me say that a lot in this conversation, because I believe that communication is the key to any success that anybody has. I believe also that no supervisor will ever be successful without good people, and good people-communication skill. So I’m a stickler for that. So if you were to ask me, “What is my [management] style?” Well, my style varies. That would be my answer, because I’ve got a
little bit of this, I’ve got a little bit of that, but most of all what holds it together is the ability to communicate.

Supervisor 2: As a leader, I have to be very careful of what I communicate to my staff, because the staff is only going to communicate what the leader is saying. And if the leader [says] yes, we don’t have to do this, we’re such and such a people, and if I continue to harp on positions that we have open, then that’s going to carry out to the other staff members and our patients to result in a negative quality and complaints that come down as far as the cleanliness of their rooms.

For these supervisors, effective communication was important for bolstering feelings of competence. Poor communication with upper-management made it hard to solve program-related problems and impeded supervisors’ ability to use skills on which their feelings of workplace competence rested.

Feeling Left Out

Some supervisors reported feeling anxious when they were uninformed. They also complained that program participants could run into problems if supervisors were left out of the process.

Supervisor 1: [W]hat [participants] need to know is that their supervisors need to know where they are at all times in their program. I’m always asking [the participant], “Where are you and what you doing now?” Sometimes I don’t know unless she tells me. And I just think that somehow we have to know where they are so that we can assist them before it gets too late. Because when it came down for her to take her test and stuff, I could tell that she was frustrated, and I didn’t want her to fail. I wanted her to make it. I just felt like if I could—if I knew where she was in the program and had some input—that I could probably help her through that, because it’s got to be a partnership between the worker and the supervisors.
Supervisor 2: If [program administrators] gave us an outline, itinerary, agenda, or schedule as to where [the participant is] going to be in week one—she’ll be studying this, or he’ll be doing this, and that kind of stuff—then the supervisors can be aware of that and ask questions. Now face it, if somebody is struggling, they’re not going to tell you that. You know what I’m saying? Number one, they’re going to be embarrassed. If you just happen to have a good supervisor, that supervisor is going to ask you some questions. But how can they ask you questions if they don’t know where you are? So it’s just better, I think, if the supervisors had something, even if they just got the same program that the students have, so they can kind of follow along with them.

Supervisors wanted to help participants get through the process. Impeding supervisors’ ability to provide this help threatened their feelings of competence as supervisors. As a result, they criticized upper-management’s communication efforts, or lack thereof. As critics, they not only complained about supervisors being uninformed about their staff’s whereabouts during work hours, they also protested that they could not give their staff the benefit of guidance or encouragement.

When supervisors felt left out of the process, they blamed the program administrators. In the situations presented, supervisors felt unable to help their frontline workers, and further felt they had been denied a supervisor’s right to know what is going on. Adding to their frustration was the fact that they were still responsible for staffing and scheduling, despite the intrusions of the job program, as this exchange demonstrates:

Supervisor 1: [W]e’re not supposed to know the certain people that actually turned in the application [for the job training program].

Supervisor 2: And that’s one thing that I disagree with. I mean, it’s nothing wrong with us knowing the individuals. We don’t know anyway…

Supervisor 1: We have to schedule them all.
Supervisor 2: And we can encourage them. Let me know if there’s anything that I can do. I don’t think it should be a secret.

Supervisor 3: I was going to say, it’s almost like it’s holding them back still.

Supervisor 2: It’s a secret. Don’t tell nobody.

Supervisor 3: [It gives the participants the impression that] you should be ashamed that you’ve been [chosen], or you might be chosen, or that you’re requesting to do this.

Supervisor 2: Right, and we as the workers, we have a right. I mean it’s no secret. I want my employees to progress. I encourage that if they want to. That makes all of us look good. You know we hate to lose good employees, but if it’s for a better opportunity, we’ve opened doors. It sounds like this grant is going to open doors for our employees. I think we should [know], because that’s the only way we’re going to encourage them to move forward. Some are going to get down because of the homework and all of that. They need someone that they can lean on or come talk to. You know, I may not be able to help them, but then I’m an ear and I can encourage them. [Then they can be] communicating with their other peers, like, “Hey, the class is going good!” You know?

Besides the staffing issues and the perceived inability to help their frontline workers be successful in the program, Critics were annoyed that the program violated their right (as they saw it) to know what was going on with their subordinates. When high-level managers failed to keep supervisors informed, supervisors’ ability to manage their staff members was impeded. If there was one component of the program most disliked by supervisors, this was it.

*Other Acts of Resistance*

Watson and Korcynski define sabotage as “the deliberate disruption of work flow within an organization” whereby “realities are negotiated, interests are defended, and the problems of ‘getting through’ the day at work are coped with” (2008:321).
Organizational mischief (e.g., joking, sexual activity, resistance, destroying property, withholding information) thus should not been seen as senseless but as part of how workers deal with conflict and control. This was true of some (a few) critics, who went so far as to sabotage participants by intimidating them through confrontation and questioning, and by refusing to participate in training. At one hospital, a worker from nutrition services (i.e., kitchen staff) was the first participant in the program who was training to become a health care assistant (HCA). As part of her on-the-job training, she was assigned to work with RNs and learn patient care skills, primarily by shadowing and assisting. The training experience, however, was not what it was supposed to be. An RN trainer described what happened:

Well, there was no RN with her. She was with HCAs and she was getting upset. She was getting these ten patients without the knowledge base. So everybody started talking. You know, “Why is [the participant] hired and she can’t do anything?” So they just started dogging her. And then, I hate to say it, [but] my supervisor was like, “Why doesn’t she know what she’s doing?”

Later in this interview, the RN trainer insisted that, at this hospital, “people need to [be in the] know” and “be on the same page.” She meant that until the program was thoroughly explained to RN supervisors, they would be resistant. In the case described above, supervisors did not train the participant as they were assigned to do— they passed her off to unqualified entry-level workers. Supervisors in this case so much resented being uninformed about the purpose and operation of the program that they sabotaged it.
As supervisors adjusted schedules, manipulated departmental budgets, listened to coworker complaints about covering shifts for participants, and agonized about being short-staffed, they sometimes got to the point of threatening to withhold cooperation entirely. One supervisor cited rumors of nonparticipation from other supervisors:

I’ve heard other supervisors say, “I can’t let [participants] go for four to six weeks.” I don’t know what I’ll do [if I faced that situation]. I think what would be helpful is to have a policy where [supervisors] can’t really refuse to let our staff do this. I’ve heard—and I don’t know firsthand, of course—but I have heard from supervisors saying, “I won’t. I don’t have the time to let the staff [participate in training].”

This supervisor’s account reflects the conflict that some supervisors were experiencing. They claimed some supervisors were prepared to outright reject the implementation if they felt they could not get their jobs done. Similarly, at another site a supervisor said his hands were so tightly tied that he could not let anyone else participate.

If another employee should come to me and want me to support them to be in this program, I couldn’t do it. I couldn’t do it. I could not support another person no matter how I wanted to. [I]f I felt they were going to be an excellent nurse or whatever, I couldn’t. I can’t do it. I can’t run the department with less people.

Although some administrators and workers reported supervisors not allowing workers to take release time, supervisors themselves did not admit this. (It is possible that supervisors who obstructed the program in this way simply were not selected for evaluation interviews. It is also possible that they were in the interview sample but chose not to say they obstructed the program in these ways.)
Reports of sabotage were rare. But it is telling that some supervisors, the most actively resistant of the Critics, went this far. They clearly felt strapped and strained in trying to manage their departments. Being encouraged to allow staff members to participate in the workforce development program added more strain— and so many resisted, understandably. They did so, however, at the expense of the frontline workers who were trying to get ahead. The findings presented here show how social mobility in the workplace for low-wage workers is mediated between organizational practices and supervisor self-efficacy. When supervisors did not feel supported, involved, or communicated with about their work experience in relation to the program they resisted and carried out these acts of resistance on the floor with participating workers in an attempt to preserve work order without directly challenging management practices.

CONCLUSION

Work-related self-efficacy was a key factor underlying supervisors’ support for, or resistance to, the workforce development program. Supervisors’ perceptions of how the program would affect their ability to perform their jobs competently mattered for determining support or resistance. Supporters wanted their workers to succeed and saw the program as helping them to achieve this goal. It was thus perceived as a potential enhancer of feelings of competence. Those who saw the program as likely to interfere with day-to-day work, and thus make them look less competent as supervisors, became critics and resisters.
Competence at work, how people achieve competence, and the consequences of threats to feelings of competence are relevant to the sociology of work more generally. The adoption of a social psychological perspective, as I have used here, connects individual motives to objective work conditions. This research shows that in highly stratified organizations, supervisors (i.e., mid-level authority figures) may attach greater importance either to relationships (with staff) or resources, depending on the implications for self-perceived competence. Which is more important would also seem to depend on which is subject to greater control. In this case, supervisors had more control over relationships than over organizational resources, and so support and resistance manifested largely in their relationships with frontline workers.

In her 2013 Presidential Address at the annual meetings of the American Sociological Association, Cecilia Ridgeway connected control over resources and access to positions of power in organizations to social status. She warned us not to limit our understanding of “inequality as … a structural struggle for power and resources,” but to consider “how much people care about their sense of being valued by others” (2014:79). The supervisors in this study cared about being valued by others; they wanted status and respect in the eyes of their peers, bosses, and frontline workers. When the workforce program did not diminish their apparent value in the eyes of their peers and bosses, but increased their value in the eyes of the frontline workers whom they could help, they supported the program. When they thought, often because of resource limitations, that the program might diminish their status as competent supervisors in the eyes of their peers and managers, and it did not give them a clear, promising way to help frontline workers, they resisted the program. What this suggests
is that both kinds of struggles, for power and resources on the one hand, and for status and respect on the other, must be taken into account.

The workforce development program had as one of its goals career advancement for frontline staff. In sociological terms, the program aimed to improve the mobility prospects of low-wage workers. Studying the program and supervisors’ responses to it thus offers a way to see how an improvement in mobility prospects might occur. Perhaps most relevant to the processes examined here is the literature on mentoring. This literature has shown the importance of mentoring for the career advancement of professionals (Ely and Thomas 2001; Wright and Wright 1987). It has also shown that the quality of the mentoring relationship matters greatly (Whitley, Dougherty, and Dreher 1992). Little attention has been given, however, to “mentoring” low-wage workers in what are often thought of as dead-end jobs, or to the question of why some people are willing to mentor and others are not.

My findings and analysis begin to shed light on how organization culture and practices matter for improving the mobility prospects of low-wage workers (more about this in chapter 3). There is a vast literature on organizational readiness for change (ORC) that looks at how institutional resources, organizational climate, and attributes of organizational actors affect new program implementation (Lehman, Greener, and Simpson 2002). Previous research has identified motivation (Simpson 2002), efficacy (Judge et al. 1999), (Brown, Ganesan, and Challagalla 2001) influence (Hall 1968), and adaptability (Fishbein 1995) as the attributes of organizational actors that have the greatest impact on ORC. The idea of “attributes,” however, suggests that there are fixed personality traits that determine readiness
for change. My research suggests that what matters are not fixed attributes of individuals, but rather a set of shifting perceptions—under particular organizational conditions—of how change is likely to enhance or undermine feelings of job-related competence. I am thus offering a more sociological social-psychological way of understanding what underlies organizational readiness for change.

What this chapter shows is that, for frontline workers, supervisors are key actors in the process. If supervisors supported the workforce development program, their workers were at least more likely to have a chance at upward mobility. If supervisors resisted the program, their workers were less likely to be encouraged to participate or to receive support if they did, thus reducing their mobility prospects. But, again, being a critic or a supporter of the program—which often translated into being a mentor or not being a mentor—did not seem to stem from personality traits. What mattered were the conditions under which supervisors worked and whether they perceived organizational change as likely to enhance or diminish their own feelings of self-efficacy.

In sum, my analysis suggests that there are conditions under which supervisors will act in ways that increase or decrease the mobility prospects of low-wage workers. Supervisors who saw the workforce development program as enhancing their feelings of competence by giving them mentoring, coaching, and training roles supported the program, thus potentially improving their workers’ chances of getting ahead. Supervisors who felt excluded from program planning and implementation, and who felt that implementation threatened their ability to perform their own jobs well, resisted the program, thus potentially
reducing their workers’ chances of getting ahead. How the process of implementing the
program was carried out mattered, and so did the demanding conditions under which
supervisors worked. But the crucial “intervening variable,” my analysis suggests, is how this
process and prevailing organizational conditions affected supervisors’ feelings of job-related
competence. This analysis begins to offer a more complete picture of the processes through
which organizational life can affect mobility outcomes. In the next chapter, I will continue to
examine how supervisors’ perceptions and behavior had consequences for workers’ job
outcomes by examining which type of workers supervisors identified as valuable and
investment worthy.
CHAPTER THREE
DETERMINING WORTH
AND MOBILITY PROSPECTS FOR LOW-SKILL WORKERS

The aim of this chapter is to understand the conditions under which supervisors considered workers investment-worthy. Examining investment is important to the study of inequality and work because supervisors are in a position to significantly determine the career outcomes of lower-ranking staff. Ideally, I would have observed supervisors engaged in training, or even recommending workers for training. But not all supervisors interviewed were responsible for training, so I do not have the “hands-on” indicators of supervisors’ investment. Instead, I look at how supervisors talked about their workers based on the type of training environment in which they worked. In this way I am able to indirectly capture investment-worthiness and answer the question, “Under what conditions did supervisors see their workers as investment-worthy?”

Interview transcripts revealed patterns suggesting that workplace culture and certain organization practices affected how supervisors perceived the investment-worthiness of their workers. Supervisors in hospitals with strong training programs felt empowered and spoke highly about the potential of their workers (e.g., encouraging them to participate in training or education, describing them as valuable, and recommending that they pursue advancement). Supervisors in hospitals that lacked critical training components seemed to lack confidence and had low expectations for their workers’ performance and program outcomes. My interpretation of these patterns is that something like a Pygmalion effect is induced by organization culture and practice.
The idea that expectations can translate into self-fulfilling prophecies (Merton 1948) was unproven until Rosenthal and Jacobson’s (1968) classic study of the so-called Pygmalion effect. This refers to the idea that a person’s (perceiver) expectation of another (target) may influence the target’s achievement level. Rosenthal and Jacobson led teachers to believe that some students tested as “high” performers and others did not. The students were actually randomly selected and there were no real differences between the two groups. Students whom teachers expected to do well, performed well, and the ones who were not expected to do well, did not. The Pygmalion hypothesis was thus supported.

Using this model, social scientists had the means to test self-fulfilling prophecies empirically (see McNatt 2000 and Kierein and Gold 2000 for meta-analysis; Rosenthal and Rubin 1978), though critics of the Pygmalion argument cited methodological, theoretical, and generalization concerns. McNatt (2000) summarized these criticisms:

Since the original Pygmalion experiment, literally hundreds of related studies have been completed (Rosenthal 1994). Some researchers have also raised criticisms about the validity of initial findings (as well as on meta-analytic studies that summarized those findings). These criticisms included noting that some of the original studies had methodological problems (e.g., Elahoff and Snow 1971), that many expectancy manipulations were weak and not validated (contained no manipulation check; Eden and Shani 1982), and that some early studies have capitalized on chance by selecting findings to emphasize ex post facto (Barber 1978; Braun 1976). The majority of questions, however, cited the lack of theory and findings explaining how, when, and for whom the Pygmalion effect worked (e.g., Adair 1978; Ellsworth 1978; Johnson 1978).

In response to these critiques, studies were designed to better explain how the Pygmalion effect occurs. The most famous of these in the management literature is Eden’s
(1994, 1984) study of the self-fulfilling prophecy at work, which connected self-fulfilling prophecies, leadership, and expectations. Eden built on the work of Livingston (1969), who was among the first to apply the Pygmalion effect to management. Livingstone wrote that what managers expect of their workers and how they treat them greatly influence their workers’ performance and career. He found that effective managers could create and transfer high expectations onto staff, thereby improving performance. Based on previous findings that subordinates’ achievements are linked to superiors’ expectations (e.g., Eden and Ravid 1982; Eden and Shani 1982; King 1971), it is plausible to suppose that frontline staff will perform better in hospitals with supervisors who convey high expectations.

In part because the phenomenon had been demonstrated again and again, research on self-fulfilling prophecies began to wane by the mid-1990s. Yet there is still much to be understood when it comes to managerial expectations and workplace performance (Livingstone 2003). There is a need for further theoretical specification of how and why the Pygmalion effect occurs (Kierein and Gold 2000; Goddard 1985). The current study aims to help fill these gaps by (1) demonstrating how organization characteristics influence supervisor expectations; (2) presenting an empirical and theoretical model (including supervisor self-efficacy as a previously unexamined factor) of self-fulfilling prophecies at work; (3) and explaining how supervisor expectations shape perceptions of their workers and why these perceptions can have consequences for disadvantaged workers.

This is also the first study that examines the Pygmalion effect in hospital settings. Previous Pygmalion studies in work organizations have focused on military and business settings. This study is one of only two that examine self-fulfilling prophecies without
deceiving perceivers (see Crawford, Thomas, and Fink 1980 for another example). Finally, Pygmalion research is predominately quantitative, measuring effects to estimate outcomes. This study, being qualitative, uses the accounts of the supervisor—an authority figure with limited power—to help demystify how expectations are shaped for key organizational players. Using this approach, I was able to better capture organization culture, practices, and outcomes previously understudied in Pygmalion, organizational behavior, and work organization research.

ORGANIZATION CULTURE AND PRACTICES

This study uses the concepts of organization culture and practices to help understand the conditions that led to favorable or unfavorable outcomes for frontline workers. Organization culture consists of the norms and values regarding people’s behavior and expectations for how things are customarily done. It is this body of shared norms and values that patterns how business is carried out in an organization (Kunda 1992). Those concerned with organization culture seek to understand the consequences of culture on workplace outcomes and/or how culture works to control how people interact with each other. Organization culture promotes social functions to control member behavior, maintain social order, and define social identities. It also may introduce variability in organization behavior, given that norms and values are sometimes contested.

Based on multiple sources of data (see below), I identify five organization practices that seemed to shape supervisor perceptions of the workforce development program, and thus of frontline workers. They were: (1) formal roles for supervisors in the program; (2) formal
supervisor meetings concerning the program; (3) training for supervisors; (4) directing
workers to job openings after training; and (5) communication between managers and
supervisors. These organization practices influenced supervisors’ expectations of their
workers’ performance during training and expectations for outcomes after training. These
practices were objectively documented apart from supervisors’ reports.

I assessed organization culture by documenting contextual variation between sites
from summative reports. Summative reports were written by the evaluation team to assess the
overall effectiveness and outcomes of the workforce development programs. There were six
members of the evaluation team. Each site was visited by two team members at least two
times, and each site engaged in at least one round of telephone interviews with various team
members over the three-year evaluation period. Team members collected data and performed
analysis for each site. We had multiple team meetings about each site throughout the
evaluation, and shared quantitative and qualitative data analysis and writing responsibilities
to ensure reliability and validity of the data.

We wrote summative reports after each physical and virtual site visit and wrote
another at the end of the evaluation period to report. Our goal was to identify the effects of
the implementation and provide data and insight for future funding considerations. These
reports synthesized data from grant proposals, interviews with hospital administrators, nurse
educators and trainers, unit directors, supervisors, and frontline workers, and the U.S.
Census. We also drew on data from focus group interviews with supervisors and frontline
workers.
I was able to document organization culture and practices through these summative reports. Individual and group interviews captured people’s perceptions of their workplaces and revealed much about their norms, values, expectations, and customary practices. I was able to identify other organization characteristics from the hospitals’ publicized materials and descriptions of the workforce development programs. I verified the existence of these characteristics using data from the summative reports, interviews, and focus groups. Organization culture and customary practices constituted the environment that supervisors had to negotiate in deciding which workers to support. In the following section, I describe how organization culture and practices shaped supervisors’ expectations and the investment-worthiness of workers at each site.

TRAINING, SUPERVISORS, AND THE PYGMALION EFFECT

Strong Training Programs Foster High Expectations

Supervisors at two sites spoke of the high value, potential, and mobility of their frontline staff. The first was Long Valley General Hospital, where some frontline workers from various departments were given training and, upon completion of training, received a certificate in “Health Care Informatics.” The second site was Mid Atlantic Hospital, where frontline workers from a variety of low-skill occupations studied to become Certified Nurse Assistants (CNAs). Another training program at this site was for CNAs to become Nurse Extenders (also called Patient Care Technicians or PCTs) so they could pass the national certification exam. Within these organizations, supervisors said they embraced a “grow your
own” culture that promoted career advancement and team-oriented learning. Supervisors also had formal and supported roles in the workforce development program.

The general philosophy about workers and training at these sites is reflected in the excerpts below. At Long Valley General Hospital, a supervisor linked educational opportunities to training and worker promotion:

We care about [education]. We all strongly believe in giving people the tools to do the job. And if you don’t step up and do it, then nobody’s going to do it for you ... Where on earth are you going to find the opportunity to retain your job, get paid for two days a week and go to school, and come out the other end (chuckling)? Yeah! So whether they immediately move into a new position, or we have to kind of work through getting these positions, we know that [with] the direction healthcare’s moving, there’s going to be an increased need. It’s just a matter of time.

At Mid Atlantic Hospital, a supervisor explained why she liked the workforce development program. Her answer reflected the culture of workforce development present at this job site, with its multiple training programs:

Oh, well, why would I support the workforce development program? It’s based on training and new structures for frontline workers. I mean, everybody has wings. Growing. One new way of development is changing [into] a position. We’re here to grow. I mean, we don’t want [anybody] left hanging in one spot. You don’t have to be at a dead-end job. You can move on, be successful, and you can grow in that position.

These excerpts can be taken as indicators of a culture of organization support for frontline workers. Both sites had regular and accessible training prior to the implementation of the workforce development program. Most supervisors at these sites spoke of frontline jobs as
entry-level jobs with the possibility of promotion, not entry-level dead-end jobs. For example, at Long Valley General Hospital, a supervisor explained why the hospital decided to train frontline workers for the highly specialized job of Laboratory Informatics Specialist (LIS), citing the costly mistake of not considering incumbent workers sooner:

We have huge shortages. I had a job posted for over fifteen months and ended up not finding anybody. We primed somebody from within and just said, “Well, we’re going to invest the time and train [incumbent frontline workers].” Had I done that originally, I’d been ahead. But we went fifteen months looking for somebody. [We] advertised all over, hired recruiters and headhunters.

A supervisor at Mid Atlantic Hospital explained that entry-level and mid-level positions were filled because the outside perception that the hospital promotes from within attracts workers from the community:

[Potential workers] basically fill out the [frontline] application just to get in the door. Once you get in the door, you move up. [The hospital has] a lot of programs that let you [advance]. [There are] a lot of classes. They have an LPN class going on right now, I think, about to start up. So you can move up in the hospital. You don’t have to stay [at one level].

Supervisors at these sites spoke of the mobility potential of frontline workers. They also implied that their organizations were widely viewed as recognizing and nurturing this potential. Another supervisor at Long Valley General Hospital suggested that administrators understood that using incumbent workers would decrease training time and costs:

From an organization point of view it doesn’t make sense having the high-paid person resetting passwords and fixing printers and telling people, “Yes! The PC really does need power in order to work.” So it makes perfect sense to
send people up that literally are 50% of the cost and have them doing a lot of these frontline things. And we’ve kind of played with the idea of just hiring IT Support Techs. The issue with that is they don’t have the clinical bent.

One of the main values of incumbent workers is that they have institutional knowledge and they understand the work process. This supervisor suggests that upskilling such workers will have better long-term benefits for the organization. In the same focus group, another supervisor explained why he thought incumbent workers should be considered for advancement:

We want incumbent workers. We want people with that healthcare background, that language, that understanding of workflow. And there’s a certain level of understanding…level of workflow is crucial…and there’s a certain level of empathy that people in healthcare tend to have, where the folks…and I said this right in front of the IT [Information Technology] people, so I’m not talking out of school…but true IT people—they come out and they look at things differently.

At Long Valley General Hospital and Mid Atlantic Hospital, supervisors generally described their workers as valuable. Workers were said to have access to tools, training, and education, as long as they aspired to upward mobility. Supervisors did acknowledge that training leads to staffing shortages, but they said they still supported the advancement of good workers whom they would lose, as these Mid Atlantic Hospital supervisors noted:

Supervisor 1: You lose a lot of good employees [through promotion]. But then again, you know they’re advancing.

These supervisors could talk knowledgably about training, continuing education, certification programs, and formalized job ladders because they participated in the workforce development program as mentors, coaches, or preceptors. At both sites, supervisors with participants in the workforce development program and/or those who served in mentoring roles attended meetings to keep them updated. This support may have encouraged some supervisors to think about ways to create more formalized and accelerated pathways for their workers. Consider this excerpt from a laboratory supervisor at Long Valley General Hospital:

If we could train [the LIS workers] with that one-year certificate, we are circumventing five years of experience into one year of training and we’re kind of supercharging them. But we’re also going to be pulling [positions such as] couriers, processors, and phlebotomists. In the laboratory, really, my goal is a very clear-cut career ladder where they start out with the clinical lab assistant, which is a two semester course, which grows into the processor registrar or phlebotomist, which grows into an MLT, which grows into an MT, or into an informatist, into an associate degree. And from there if they want to continue they have the opportunity to get a bachelors and either go back into the clinical area, or to move into an LIS technical position.

Supervisors like this one believed that with training and support, workers could get ahead. This is further evident in how a supervisor at Long Valley General Hospital, and another at Mid Atlantic Hospital, described worker training:

We’re training these people. We have the opportunity to give them the formal theory behind it in a structured environment … not missing any pieces (of
knowledge). The ability to help us set up competencies and really focus what our actual needs are and then adapt them to our work so that we get exactly the end result we’re looking for—a well-rounded clinical person with great IT skills.

As he went on, this supervisor linked the needs of the organization to the training the workers receive:

Our orientation starts out with more of a classroom setting, and I have a nurse educator that does that. Then they are assigned to what’s called a “preceptor,” who works with them for the remainder of their orientation. They follow the same schedule together, and the goal is that the preceptor is training them on what the job expectations are. [The preceptors are] going to function overseeing [the workers] performing the skills that they have learned in training so that they are competent to do them on the units.

By emphasizing the close guidance of the preceptor, the supervisor points out the confidence they have in trained senior workers (i.e., preceptors) in training frontline workers. After initial training, these supervisors said they followed up and supported workers as needed.

Another Mid Atlantic Hospital supervisor noted the improvement she observed after workers entered the training program:

[After training, there is a change in] their attitude. I think they are positive. They [realize that] it’s hard out here and they’re more eager to do their job because they know out here the work world is not as effective. They see that we’re right there with them as far as their training. We’re up here on the floors helping them out. If they feel where they’re lacking, we may retrain them. If they need to be retrained, we’ll help them out. Help them out any way we can.
Optimistic accounts of this kind were consistently associated with strong training programs that seemed to lead supervisors to see upward mobility for their workers as either already achieved or entirely possible.

These sites had an established learning culture prior to implementation of the workforce development program. A learning culture promotes the development of its members and continuously transforms itself through innovative behavior. It is characterized by a culture involving open communication, reflection on action, and collaborative or team learning (Chuang, Morgan, and Jason 2011). These sites provided training for supervisors, formal roles for supervisors, and job opportunities for staff. These features in turn seemed to bolster supervisors’ confidence that their workers could be successful. For example, at Long Valley General Hospital 65% of frontline participants received math remediation and 6% received literacy remediation as a part of their training in Heath Care Informatics. At Mid Atlantic Hospital, less than one percent needed literacy remediation and no frontline participants needed math remediation to become Certified Nurse Assistants or Patient Care Technicians. Supervisors nonetheless spoke highly of the value and potential of workers at both sites. This suggests that worker-preparedness was not a major factor in determining investment-worthiness. Rather, organizational context seemed to be the key factor.

Weak Training Programs Foster Low Expectations

Supervisors at two sites, Delta River Medical Center and St. Valentine Healthcare, spoke of the limited potential and mobility of workers. At Delta River Medical Center, two training directives were being pursued: to prepare workers from transportation, dietary and nutrition, and environmental services to become unit clerks; and to improve work-related
skills such as conflict management, teamwork, and effective communication so that nursing assistants and unit clerks could achieve higher performance evaluations. At St. Valentine Healthcare, training was provided for workers in environmental and nutrition positions to become Health Care Associates (HCAs) and Unit Clerks (UCs). Supervisors at these sites had low expectations. They did not expect failure, but they did not expect high producers or great advancement for workers, either.

At these sites, supervisor resistance to training was the highest. Supervisors seemed to imply that workers showed potential, but had low expectations for workers because the hospital did not provide good training and the supervisors did not support the training offered. For instance, at St. Valentine Healthcare nurses who were supposed to help train participants in the program complained about wasting their time training frontline workers. A nurse, who was also a trainer, tried to explain the overwhelming resistance to training HCAs among her fellow nurses:

I guess it’s the learning. Everybody needs to be on the same page. Once you tell an RN, or a group of RNs, why we’re doing what we’re doing, they’re in. They’re really, really in. But I think when the program first came out a couple of months ago, when they did the first group [of frontline participants, the RNs] didn’t know why they were there, and the RNs were not going to waste their time training an HCA because they just didn’t have the understanding (about the program), nor did they have the time, basically. Managers now at [the hospitals] had no problem hiring this group of kids (participants). In fact, the student I just finished is going to be working on my floor. So yeah, it’s nice. They interact well with the other HCAs on the floor. That’s not a problem. It’s just that point when we get to the floor when we’re doing our clinicals, [RNs say], “Why are they doing that? Why are they with you? And why are…, why, why, why?” So once they get the whys—they’re onboard.
This RN was in charge of facilitating training for workers in dietary and nutrition services to become HCAs, but she needed the training support of other RNs at the hospital. As she scrambled to explain her coworkers’ resistant behavior, she was quick to point out that although the inquiries were centered on the worker (i.e., Why are they doing that?), the problem was a lack of information from administrators about what was going on in their units. She then explained that once the workers were trained, they fared well in their new placements and did not have problems with other workers.

Supervisors’ expectations for their staff were often limited and doubtful. This can be observed in the way a St. Valentine Healthcare supervisor discussed the difference between technical skills and skills that she considers more innate:

When I do an interview, I have two expectations. One is to show up when you’re scheduled. Two is to treat the patient like a member of your family. If they don’t have that inside their heart, I can’t give them that. I can train them on any machine, any protocol and procedure that we have. Basically, [they need] to look at the patient like a member of their family, and to give the care like that.

The emphasis on what is “inside [the workers’] hearts” partially reveals the weakness of the training program. In strong training programs, innate qualities were less important. In weak training programs, these qualities may make a great deal of difference in compensating for poor training.

Supervisors at Delta River Medical Center were not concerned about workers’ innate qualities, but did express reservations about the potential for mismatching workers in
promotions. For example, this supervisor explained why promoting an environmental service worker into a supervisory position might not be a good idea:

Supervisor 1: [There’s] an opportunity to [advance out of] environmental services. The only way up [is] if there was an opportunity for a supervisory position to come open, or a manager position. But you could be a good cleaner, but are you actually [capable of] leadership? I think a lot of people have made that mistake. [They think], “Hey, this is a good cleaner. Let’s move her on into [a] supervisor [position],” and then [the worker] fail[s]. It’s not their fault but…

Supervisor 2: But there’s no training…

Supervisor 1: But, you know, there is training…

Supervisor 2: They’re trying to figure that out.

Supervisor 1: You can train a person as much as you want, but still if they don’t have that leadership capability inside, I think it’d be very difficult. You can train them all you want, you know? I can’t train you how to go out there and talk, open your mouth and talk. You’ve got to want to. If you want to do it, then, yes.

In both cases, supervisors questioned the ability of frontline workers to succeed due to what they saw as professional shortcomings. As the above-quoted supervisors from Delta River Medical Center discussed the leadership potential of the environmental services worker, one mentioned how a job lattice could have helped overcome this shortcoming and facilitated success for unprepared workers:

Supervisor 1: I personally think that there ought to be another position in between the regular staff and a supervisor. I think it needs to be a lead position. That way we could see if that person is ready for supervision and train them to become a supervisor. Most of them that we say “that’s going to be a supervisor,” often times they could be just a lead person, and not a
supervisor. But we throw them in the role as a supervisor and they’re not quite ready yet.

Supervisor 2: I was going to say, it’s hard to take somebody that’s just a regular employee and just throw them in a supervisory position.

The supervisors acknowledged that the hospital could better support and promote these workers by creating job ladders or lattices, in this case, a lead position. Job lattices allow workers to move laterally rather than just upward, as in the traditional job ladder. This allows workers to diversify as they explore other work roles in their organizations. They suggested this could allow workers to take on more responsibility, yet not overwhelm them with supervisory responsibilities they were not ready for. The supervisors also admitted to “just throw(ing) them” into the new position. Not providing the training to support workers in their new position set them up for failure. The Delta River Medical Center supervisors went on to describe why follow up is so important:

The most important [step in training] is you follow up. Don’t take anybody’s word for it. You follow up. But oftentimes we miss that fourth step, which is follow up. Whether it be supervisors, management, or whoever. We don’t do enough of follow up, because we don’t know for sure if that person knows what they should know, or that whatever it is that we tried to tell them to do. We’ll make sure that they get with somebody who’s supposed to show them, or we’ll make sure they’ll get with somebody that’s supposed to know what they’re supposed to know. But oftentimes whether it be a supervisor or management person who will miss that fourth step, which is in my mind the most important part of the training. And I just think that that’s something that probably in this program is going to be a key to the success… is follow up.
These supervisors admitted to a kind of organizational failure. If frontline workers did not succeed, it wasn’t necessarily because of their shortcomings. It was because follow-up was lacking or, in the previous case, unprepared workers getting promoted.

Supervisors admitted to promoting (or recommending for promotion) workers who were not ready. They also admitted to not completing training protocols for new hires. These, too, can be construed as organizational failures. In a focus group at Delta River Medical Center, the supervisors discussed training that supervisors need to get better results from their staff:

Superior 1: Our staff need more on motivation…training on motivation. I’m talking supervisors now. Because we’re here…we’re managing it okay…but we’re not here.

Supervisor 2: Yeah, you know who drives the morale of this hospital? Our supervisors. They’re it. They’re the ones that are driving the morale—if it’s going to go down or it’s going to go up. That’s why I said that we need something…and that’s a piece of the puzzle of any organization…where you don’t get enough training in those supervisors.

The limited potential and job outcomes for frontline staff were explained in two different ways at these hospitals. At Delta River Medical Center, the supervisors cited a lack of supervisor accountability when it came to training and a lack of job ladders. In St. Valentine Healthcare, supervisors claimed that they did not understand the program, or understand why they should be assisting program participants through training. This led to criticism and resistance. Supervisors described poor training coordination by the organization
and, admittedly, poor supervision on their part. The supervisors here recognized that the shortcomings in training were real and consequential for their staff.

Other Conditions that Foster Low Expectations

At South Derby Regional Hospital, South End Medical Center, and Star Memorial Center, supervisors doubted their staff’s ability to move up in the organization because, they claimed, there were either too many social barriers that discouraged pursuing mobility, workers did not perform well after they were trained, or supervisors did not feel knowledgeable and equipped to deliver good training. In South Derby Regional Hospital, frontline workers from various departments trained to receive their Associates in Nursing degree and technical training in nursing practicum. At South End Medical Center, workers from various frontline positions were trained to become Patient Access Representatives (PAR) or Clinical Technicians (CT). Finally, at Star Memorial Center, training was provided to Clinical Service Representatives (CSRs) and other non-clinical entry-level staff to become licensed Medical Assistants (MAs).

At these three sites, supervisors noted that training needed improvement, but that there were bigger problems due to the challenges frontline workers faced in their personal lives that training could not overcome. For instance, at Star Memorial Center, where the work process changed from a team medicine approach to a protocol driven production-type system, senior workers were resistant to change. A supervisor explained:

We actually have quite a few tenured folks. People who have been here for a long time— twenty-plus years working in the same clinical setting… and having those folks gone through our transition of team medicine and protocol
 driven business...we still see struggles with them. [The transition took place] eight years ago... probably the last four years have been just very stringent on standard work, very structured in the way they train and deliver that care... and there are still folks that we encounter, not just in pediatrics, but other places you go that [have] trouble [with this and say,] “this isn’t how I was [originally] trained.”

At South End Medical Center, work-and-family balance issues seemed to keep some workers from pursuing employment opportunities. This supervisor advocated for a flexible curriculum to meet the needs of those who work nonstandard hours:

I think [that the] education we provide [has] got to be flexible...online to evening [and] maybe on the weekends, because a lot of these people are single parents or have [older] parents and have to work, or this person has to work. I have a gal that’s very interested in this (training), but she’s a single parent. She has two kids and she works Monday through Friday night shift. She only works nights because she can make ninety cents more an hour or whatever it is, and it’s just sad.

Another issue noted by supervisors at South End Medical Center was workers’ misconceptions about what working in healthcare is really like. Supervisors questioned whether some staff could handle its emotional, mental, and physical demands. A supervisor gave an example:

I’ve got a clinical assistant that is in school trying [to go] to nursing school. When we interview people on our floor, we don’t mince any words about how difficult it is. You are sometimes not going to get a lunch break, you’ll cry the first three months, and the patient turnover is high. You are going to be busy. You are going to leave here tired...and you tell them that...put them through orientation...spend the money training them. And I’m not kidding, [a female trainee] cried every single day for three months that she worked on our floor. And she finally said, “I can’t take it.” And I thought, “Well, I don’t know how...
she’s going to be a nurse. I really don’t.” So she transferred to another unit. Healthcare. Not a lot of people have an idea of what exactly a nurse does…

At Star Memorial Center, a supervisor shared a similar view of certified surgical (CS) technicians who do not work directly with patients. He argued that although technical training is provided, the workers still do not understand important techniques:

We have CS techs in our area because we have sterile instruments that have to be processed and scopes that need to be processed, and in the past we had sent [techs] downtown to train for just a day or two to see the big picture. It’s a hard job to train people for because a lot of people don’t have any experience and they don’t really know what they’re coming into. A lot of times they don’t understand sterile technique and things like that. And then at one point I didn’t have any one of my CSs, and the nurses had to do the job. I had nurses washing scopes, which is not a good utilization of nurses, but you do what you’ve got to do.

In these examples, supervisors did not contend that the training provided by their organizations was inadequate, but rather, that frontline workers faced other kinds of barriers. According to these supervisors, even though good training was present, its outcomes were in doubt, leading supervisors to fear investing much time and energy in workers. A South Derby Regional Hospital supervisor cited the lack of educational pathways for respiratory technicians:

[To become a respiratory technician] you pretty much need to go to respiratory school. There are some programs out like [at the local college] where they would provide the educational training, but then you’d have to hire that person and basically train them yourself clinically…which you don’t want to spend that much time and effort with somebody unless you know they’re going to be a very good employee. Because a lot of times if they’re not, [and
then] you’ve spent all that time for nothing. Or they’ll go on…go ahead and leave you.

These excerpts suggest that concerns over workers’ barriers influenced supervisors’ training considerations.

Another organization-level obstacle was the lack of training given to supervisors. At South End Medical Center, supervisors expressed doubts about their capabilities as leaders and trainers:

Nurse Educator: [The hospital administrators] don’t give you that regular period in the training. [They will say], “Okay we’re going to go live in three weeks—get your nurses trained.” You are learning that train-the-trainer technique that we love at [a partner hospital] is not the best. If I’m just learning an application, how good am I to somebody that I’m trying [to train]? I’m like, “I know about this and this, but don’t ask me about that button because I don’t know what it does either.” It gets very frustrating, and you don’t have the answers to give someone you’re training. Sometimes you don’t find out before, [so] six weeks later when you’re like, “Oh, that was what it does.” And yet you put [the new worker] in a situation that they need to know it for their job [and] you’re holding them accountable for them to do it for their job, though you yourself don’t know.

When trainers expressed a lack of confidence about their own abilities, they were well-aware that their lack of knowledge or skills would negatively affect new workers they trained:

Supervisor 1: [Our staffs’] expectation [is] as an educator, a supervisor, [or] a trainer, that if they come to you, you need to know how to answer that question. And they lose when you can’t.
Nurse Educator: Oh, my God, you know? And all the people who have received that training were just like, “I don’t know what I am doing.” It took them weeks, if not months, to actually fully feel comfortable with what they were doing because they had to take a Web-based training module, which I hate modules as an educator, and then go to, like, a four hour in-service (training) by people who just took a small little class and they’re like, “Okay, now you have to teach it.”

Supervisors’ and trainers’ alike expressed concerns about being ill-prepared to help their trainees when needed. These concerns led some supervisors to distance themselves from their so-called expert status because they were not confident in their training they received:

Supervisor 2: We went to the confidence training. We wear these purple badges that said [inaudible job title]. I had to take mine off because the doctors kept coming up to me [saying], “Come here! You’re a purple [inaudible job title]. You should show me how to do this,” and I’m like, “I don’t remember how to do that.” I had to take my badge off.

In work environments with weak training programs, the pressure supervisors feel is evident:

Supervisor 1: And it’s really rough on the employee because you ask anybody how they want to learn [and they will say], “Well, I want training.” “What do you expect from your supervisor or management within the first ninety days that you come on?” is an interview question. [The applicant will say], “Well, I expect to be trained.” Well, I’m like, “Are you self-motivated to learn, or do I have to hold you? Because I can’t say that we provide good training, and if you tell a person that you have to learn by learning your errors and correcting your errors, I probably would have wanted to quit, too.

This exchange at South End Medical Center illuminates another major training issue.

Supervisors and trainers need good training. This was another area not focused on by the
workforce development program but seemingly an important part of the story. A lack of training undermined the supervisors’ self-efficacy and reduced their motivation to train others.

South Derby Regional Hospital, South End Medical Center, and Star Memorial Center had different organization characteristics, but supervisors’ perceptions of their workers had much in common. Supervisors were reluctant to invest in their workers despite workers’ access to training. Supervisors were critical of training at times, but also felt that the challenges and barriers faced by their workers were too much for the training to overcome. Supervisors at these sites had low expectations for staff performance post-training and critically questioned workers’ ability to move up, despite their more favorable impressions about the quality of the training provided.

**SHIFTING EXPECTATIONS THROUGH ADAPTIVE TRAINING PRACTICES**

Overall, supervisors at weak training sites seemed unattached to their frontline workers and doubted a high return after training; but interestingly, they but did not speak negatively about the potential and value of the staff when talking about cross training and teamwork. Talk about these two approaches to training was revealing of supervisors’ perceptions of the investment-worthiness of their workers. The first excerpt is from St. Valentine Healthcare and the second is from Delta River Medical Center:

**Supervisor 1:** Well, now I would say that one of the strengths that [frontline workers] have, or the staff that I have now, is the fact that they’re team players. They’re willing to work together and that was not one of the strengths
in the beginning, but it has now come together, and they’re more of a team player, more willing to help one another [and] complete their task when somebody is out. We won’t miss a beat, because they’re able to do those things. Because, number one, they’ve been cross trained, and, number two, they have a willingness to learn.

Supervisor 2: [The] CNA that took the class to become a unit secretary wears two hats. She functions as both. When the need is on the floor, she functions on the floor; and when the need is a secretary, she functions as a secretary. And this other person that’s in the class as well wears a triple hat. She can work. [She] used to work as a CNA, was trained as a monitor tech, and she primarily works in the monitor room. She wanted to take the class. From my standpoint, the more things you can do, the more valuable you are. And so that’s kind of where I am with that.

Training alone, however, did not resolve the uncertainty supervisors felt about the growth and potential of frontline staff. Training had to be complemented with communication to yield the buy-in administration needed from supervisors. This is demonstrated by an RN supervisor at St. Valentine Healthcare who described strategies for implementing the workforce development program:

I could just think of just one thing (that would help training be more supported). Maybe they could have just a meeting at each hospital and let them know what this program… even though you know what it’s about… this is what it’s about again. Just something reinforcing what we’re doing and why they’re going to be the best HCAs when they get them to work on their floor because they’re going to know. They’re going to have the background and the ability to function. I really think that’s it.

This RN noted that, even though the training had already been explained to the hospital supervisors, it would help to explain it again. She then described how this strategy made a difference from the first round to the second round of implementation:
The managers of the floors downtown [were saying], “Is there anything we can do for you? Do you need any help? Are there any assignments you need to take?” They were very, very open to having us on the floor—versus the first round where they weren’t quite sure what we were doing. I think they just thought we were kind of there being in the way. [In] the second round [the program administrator] did a lot of teaching with the managers [and] told them what we were there for. At the second round we were a valuable, valuable part of their staff for the day.

As revealed in these excerpts, workers were not seen as unworthy. But their potential seemed to be in question even after they had completed program training until at least one of four conditions was met: (1) they were successfully cross trained; (2) there was a team-approach to job tasks; (3) there was a job ladder or lattice to support advancement; or (4) supervisors were informed about the program implementation. Under these conditions, supervisors would speak favorably about the potential of their frontline workers. Many of the workers at the weak training sites were in the low-ranking service positions of transportation, dietary and nutrition, and environmental services, more commonly known as orderlies, kitchen staff, and housekeeping. These sites did not have learning or job ladder cultures. Frontline workers were hired in dead-end entry-level jobs and there was little expectation or support for their mobility.

At these sites, supervisors were not given formal roles in the workforce development program and they were not incorporated in the planning or execution of the program. Supervisors complained about the lack of communication between themselves, upper management, and human resources. Indifferent and noncommittal treatment, in this case being uncommunicative, contributes to an organization culture that produces low
performance (Livingstone 2003). These supervisors were the most resistant to the program in the beginning, but upper management was able to get buy-in from many of them by the end. As communication improved, expectations rose. This, coupled with seeing the effects of team training and cross training, led supervisors to begin to see participants in the program as valuable and worthy of investment. This suggests that organization characteristics are an important influence on how supervisors perceive what their workers are capable of. It also demonstrates that supervisors can change their perceptions and expectations of staff. This is an important finding. Previous research has contended that changing organization culture is a way to foster high expectations (Eden 1992), but no research has shown the specific changes in practice necessary to accomplish this.

SELF-EFFICACY AND THE PYGMALION EFFECT

Features of organizations shape the way supervisors perceive the worth and mobility prospects of their frontline staff. I found that supervisors’ perception of the ability and potential of frontline workers was influenced by organization culture more so than by some general disregard for low-skilled workers. My analysis suggests that supervisors were more likely to perceive the workers as investment-worthy in organizations with effective training for low-skilled workers, regardless of the workers’ background. When organizational practices were poor, supervisors spoke of the workers’ limited value and potential in the organization. Organization characteristics seemed to influence how well they believed their workers could perform. These characteristics are (1) presence of a learning culture; (2)
supervisor inclusion (e.g., roles, training, meetings, communication); and (3) job placement for staff.

Figure 1 is a model that suggests how organization characteristics and social environments interact to shape supervisors’ perceptions of their workers in the context of a workforce development program of the kind examined here. Organization practices that are inclusive and value supervisor input are at the core of the process. These practices are supported by a learning culture that values education, training, communication, and innovative action. Equally important is the real or perceived opportunity for subordinate advancement or growth. Taken together, these conditions are conducive to supervisor perceptions that their workers are valuable, worthy of investment, and able to benefit from training.
Figure 1: Supervisor Expectancy and Investment in Workers
Organization culture and practices are mutually reinforcing. Supervisors in learning cultures, for instance, benefited from organization flexibility and task modifications that promoted collaborative learning, job sharing and cross-training to cover staff shortages. Soliciting supervisors’ participation and input were key practices that impacted supervisor buy-in. Buy-in was also encouraged by the existence of job ladders or lattices. Job placement possibilities were clearly important in shaping the perceptions supervisors had of their workers. When training practices were solid, when organization culture valued worker mobility, and when job ladders existed, supervisors saw their workers as investment-worthy.

To further explicate the Pygmalion effect, I have extended the model to suggest how supervisors’ self-efficacy comes into play. Self-efficacy, according to Bandura (1997, 1986, 1977), refers to an individual’s belief that s/he can competently perform some kind of task. Bandura also distinguishes between efficacy expectations—that is, belief that one can competently perform a task or type of task—and outcome expectations. The latter refers to believing that some type of action, competently performed, will produce a desired outcome. It is possible, Bandura argues, for actors to believe in their own competence but doubt that their action will lead to the goals they are seeking. As I will explain below, both efficacy expectations and outcome expectations mattered for supervisor behavior.

My argument also depends on understanding the self-concept as a source of motivation. Gecas (1991) argues that the desire to experience oneself as capable and competent is a basic human motivation. By implication, we would expect workers—including supervisors—to gravitate toward activities that bolster feelings of self-efficacy and avoid (if possible) activities that undermine these feelings. Consistent with this line of
thinking, I observed that supervisors who were well trained and helped to feel competent as trainers, mentors, and program collaborators invested more effort in trying to make the program work. This included putting more effort into training and supporting their workers. It might also be possible that supervisors who expected themselves to be effective passed along these expectations to their workers.

It seemed clear that supervisors in strong training programs displayed more confidence and had higher expectations for their workers than supervisors in weak programs. The workers’ education, skill level, and social background in strong programs were not considered barriers because the organization had already developed resources to bridge these gaps. Supervisors in strong training programs seemed to experience greater work-related self-efficacy and expect higher performance from their staff. Feeling unsupported and excluded from the program left supervisors in weak training programs feeling less competent and more resistant—though when communication, supervisor training, and supervisor involvement improved, so did support for the program. This suggests that supervisor self-efficacy, perceptions of their workers’ worth, and expectations for positive outcomes depend on organization culture and practices. This supports my argument that organizational characteristics helped shape supervisors’ sense of efficacy and perception of their workers’ value, in spite of workers’ characteristics.

In the present study, it thus seemed clear that the training supervisors received made a difference for their feelings of competence when it came to training their workers. Supervisors who received less training seemed to feel less competent when it came to training workers, and consequently invested less effort in the process and had lower
expectations for their workers’ success. But organization culture and practices were also important. Without other supports for worker advancement, it seems that supervisors’ *outcome expectations* were low, also leading to less investment in workers. I am thus suggesting that investment-worthiness in the eyes of supervisors depends on both supervisors’ feelings of self-efficacy (confidence in their competence as trainers) and on outcome expectations (confidence that other conditions give workers a good chance to succeed).
Figure 2: A General Model of Supervisor Self-efficacy and Worker Outcomes
Figure 2 outlines this argument, suggesting how features of the organization shape supervisors’ expectations for their workers, in turn fostering behaviors that promote worker success. This is a more social-psychological model of how the Pygmalion effect was generated in the organizations that adopted the workforce development program. The model incorporates not only supervisors’ self-efficacy as part of the process, but links supervisor self-efficacy to organization culture and practices. It also distinguishes between efficacy expectations and outcome expectations. High expectations and investment in workers depend not just on whether supervisors feel competent, but on whether they see local conditions as making worker success likely. I would argue that this model can be applied to other settings in which organizational actors can choose to invest maximally or minimally in the growth and success of their subordinates.

CONCLUSION

Previous studies of self-fulfilling prophecies at work have typically begun by manipulating supervisor (or manager) expectations and then trying to measure changes in subordinate self-expectancy and/or performance (McNatt 2000). Some studies have also looked at how interventions such as expectation training (Crawford, Thomas, and Fink 1980), job redesign (Chen and Klimoski 2003; Eden 1990, 1984), and training to change leadership styles can influence subordinate self-efficacy and raise self-expectations (Eden 1992). My study adds to this tradition by identifying organizational conditions that influence supervisors’ expectations for their workers. I showed how supervisor investment in the workforce development program and their perceptions of workers’ investment-worthiness
varied depending on organization culture and practices. Supervisor perceptions might thus be said to have been “manipulated” by conditions naturally existing in their work organizations. My analysis showed evidence of a Pygmalion effect linked to aspects of organization culture (valuation of training and employee growth) and to organization practices (solid training programs, involvement of supervisors in innovation, good communication between supervisors and upper management). This analysis has several implications for improving organizational practices more generally.

First, supervisors are often overlooked as a valuable resource. As demonstrated in previous Pygmalion studies, supervisors may have the power to unlock great potential in their workers by promoting learning and raising performance goals. Supervisors may be an underappreciated resource in these regards because they are generally seen as lacking organizational power; they are low-level managers holding authority over low-ranking staff, and have little ability to set policy. They are perhaps also seen as already knowing how to do their jobs. But it seems clear that, given the power of supervisors to communicate expectations to frontline workers, organizations would be wise to invest more resources in training supervisors to themselves be better trainers.

A second implication is that better results could be obtained by changing organization practices to support supervisors and frontline workers than by emphasizing individual “leadership qualities,” as is often popular in managerial circles. As my analysis suggests, what matters are the organizational conditions that foster high expectations, the latter being unlikely without the former. To simply lay blame on supervisors for a lack of investment or positivity is a mistake. No less than their subordinates, supervisors respond positively or
negatively to the opportunities for growth and success that organizational policies and practices make possible.

A third implication is that it is entirely possible to create high expectations. This was observed in several of the hospitals examined in this study. Just as these hospitals did, other organizations could shift their cultures and change their practices to bolster supervisor self-efficacy and expectations for their subordinates. If supervisors are themselves well trained, if they believe that their organizations will provide equally good training to frontline workers, and if they believe that these workers will be given real opportunities to advance, then supervisors are likely to see their workers as investment-worthy and to raise their expectations accordingly. As observed in the case of the workforce development program, supervisors with low expectations raised those expectations when organizational changes made higher expectations seem realistic.

In this chapter I have sought to understand the conditions under which supervisors considered workers investment-worthy. Examining investment is important to the study of inequality and work because supervisors are in positions of power relative to frontline workers and can greatly influence these workers’ career outcomes. It is therefore important both sociologically and practically to try to understand how organization cultures and practices can shape supervisors’ expectations and, through this process, affect workers’ prospects for mobility. By showing how organizations can enhance or diminish supervisors’ confidence in themselves and in their frontline workers, I have shown that how organizations work matters for how workers see themselves and their own investment-worthiness.
CHAPTER FOUR

VICTIM-BLAMING IN DISGUISE?

SUPERVISORS’ ACCOUNTS OF PROBLEMS IN HEALTHCARE DELIVERY

In this chapter, I examine the accounts supervisors provided during individual interviews and focus groups conducted as part of evaluating the workforce development program to explain why their jobs were so hard. Sociologically, it is important to consider what these accounts accomplished. The evaluation team, hired by the national funder, was charged with studying program implementation and effectiveness, and providing the program funder with information bearing on decisions about future funding. As an integral part of this evaluation, supervisors, many of whom had frontline workers participating in the workforce programs, were asked to discuss the strengths and weaknesses of their organization, management style, staff, training practices, and the newly implemented workforce development program at their hospitals. Supervisors were also expected to explain why current training models were deficient, why their workers failed, what organizational supports were lacking, and what their role was when it came to training and worker retention. They were expected to recall and explain why they had failed—either individually or as a part of a system.

In their classic *American Sociological Review* article “Accounts,” Scott and Lyman (1968) urged social scientists to examine how social actors use talk to protect and repair identities by excusing or justifying behavior. Sherryl Kleinman also has written about the power of language to reproduce inequalities, “even as the words seem benign or positive” (2007:13). Kleinman reminds us, as qualitative researchers, that we “must take words
seriously” and analyze how legitimating rhetorics of the powerful are used to “explain” their harmful behavior (pp.13-14). Here, I examine how language—in the form of supervisors’ accounts for problems at work and the difficulty of their jobs—had the consequence of justifying unfair treatment for low-status workers and protecting management from blame. Later I will consider how this language is connected to larger cultural and political discourses that blame the victims of capitalism without seeming to do so.

The supervisors in this project expressed a range of feelings—from extreme pride to indifference to stark disappointment—when describing their staff and daily work experience in the individual interviews and focus groups. Some supervisors seemed to be candid, and others a bit more cautious, when talking to our evaluation team about their work experiences. As the questioning explored training practices, work issues, and frontline workers’ needs and mobility challenges, supervisors may have been put in an uncomfortable spot. Most of the supervisors were white, middle class, and female. They were college-educated, with specialized training in nursing, management, or some other relevant professional background. As evidenced by their lengthy (or planned) time-on-the-job, they valued job security and organizational loyalty. They were very different from their frontline workers, who were typically minimally-educated ethnic minorities from working-poor or working-class backgrounds, known for jumping jobs when a nominal pay increase was involved. When asked to talk about the vulnerabilities of these workers and the barriers they faced, some supervisors may have felt that they were getting onto shaky ground beyond their personal experience.
From their accounts, I came to understand that the supervision and management of frontline healthcare is hard. Supervisors were often constrained with limited staffing and resources while trying to meet high demands. Yet, supervisors generally spoke favorably about their organizations, including opportunities for career advancement, support for workers, and team-based approaches. Also, many boasted of their growth, promotion, and time-on-the-job. Supervisors were critical, however, when talking about the characteristics of their frontline staff. Take this supervisor’s impression for example:

[This is] something that my generation and maybe the next one after me did to our children. We have done this. We have turned out this generation, or generations, of individuals that feel like the world owes them something and that everything is supposed to just come their way without any kind of an effort. We have created these monsters.

The generation this supervisor is referring to is group of frontline staff that some supervisors have labeled the “new generation.” New generation workers were typically a generation or two younger than the supervisors, new to the field of healthcare, and were raised in the communities that the hospitals resided. According to supervisors, the new generation of workers hired for frontline jobs lacked a strong work ethic. They were described as immature, unprepared, and unprofessional.

Supervisors contended that their jobs were challenging because they lacked the resources to do their jobs well. But what made their jobs especially hard, they said, was the additional load of dealing with these workers. I was surprised at how negatively some supervisors talked about their subordinates. I was also intrigued by how supervisors spoke
favorably, or at least without blame, about upper management as they detailed organizational shortcomings such as training, supervisor support, and worker pay.

ELICITING SUPERVISORS’ ACCOUNTS

In individual and focus group interviews, all supervisors were asked the same questions about their daily work experience. Two questions in particular led supervisors to label their workers as “new generation” and to criticize their work ethic: What are the biggest issues that your frontline workers face? and, What kinds of [organizational] supports do you think the [workforce development] program could put in place that could help frontline supervisors or frontline workers succeed? In answering these questions, supervisors often complained about workers. Evaluators also asked supervisors to explain their supervisory styles, describe their relationships with workers and administrators, and to identify problematic organizational practices.

Despite being invited to talk about problems, supervisors knew they were expected by upper management to represent their organizations well and to be advocates for their workers. The evaluation team tried to create a safe and comfortable space in which supervisors could speak freely about their work experiences. We assured supervisors of confidentiality and made it clear that we were charged with evaluating the workforce development program, not their superiors. Despite our assurances, supervisors might have worried about critical remarks being traced back to them because only one or two supervisors were interviewed per department, and management was aware of which supervisors participated. It is also possible that supervisors felt they had been selected to participate in
the evaluation because upper-management saw them as especially good supervisors. In these regards, even though managers were not present as an audience, they were, possibly, an imagined audience.

In focus groups, confidentiality and anonymity could not be guaranteed. In these situations, supervisors had to trust their peers to maintain confidentiality. Fellow supervisors also constituted a reference group who’s reflected appraisals likely mattered a great deal for how supervisors thought of themselves, at least in the workplace. Supervisors were also aware that the evaluation team consisted of Ph.D.-level social scientists affiliated with a prestigious university. This might have inclined supervisors to try to “speak the language” of the evaluators by referencing (as they did) culture and social institutions. Thus, despite good methodological practices, the conditions of the evaluation study meant that a great deal was at stake for supervisors. They had to be concerned with the impressions they were making on the evaluators, each other, and, potentially, those outside the interview or focus group situation.

All this put supervisors in a tough spot; they were, in Scott and Lyman’s terms, subjected to “valuative inquiry,” and they may have sought to “prevent conflict by verbally bridging the gap between action and expectation” (1968:46). Goffman (1963) argues that when people need to explain unanticipated or improper behavior, including those which attempt to lessen responsibility, they offer accounts to show that they are simply responding in a way that reflects the values or culture of their social group. Accounts often reflect defensive strategies (Berard 1998) or disclaimers (Hewitt and Stokes 1975) that minimize or deflect blame (Atkinson and Drew 1979). The supervisors in this study surely did not want
to imply their own incompetence by blaming themselves for problems with frontline
workers. Nor did they want to risk getting in trouble for blaming upper management. Nor did
they want to seem to prejudicially blame the least powerful people in the system— the
frontline workers, many of whom were women of color.

From one methodological perspective, the social desirability biases operating in the
interview and focus group situations can be seen as problems. These biases could raise
doubts about the truthfulness of supervisors’ reports. But all reports by research subjects,
especially those given in person, are affected to some degree by social desirability;
anticipated audience reactions always affect what people say and how they say it. Schostak
(2002) explains this methodological complication when capturing respondent accounts:

‘What is going on here?’ is a key question to ask of any situation. Asking it
assumes there is an ‘answer.’ Whether or not respondents claim to have the
answer, what results is an account of what they think they ‘know’, or what they
claim to believe, or the reasons why they do not know, or do not care about
knowing, believing and so on. During accounts, respondents may ramble,
change the subject, and attempt to please the researcher by providing ‘answers’
they think are ‘wanted’ by the researcher. In any case, the account does more
than try to explain, convince or deceive someone about a situation it is also a
negotiation of identities as between the questioner and the answerer and can
‘cover up’ as much as uncover.

From another methodological perspective, this is not a limitation but an inherent quality of
the data—something to be analyzed rather than ignored. That is the approach taken here.
Rather than treat supervisors’ implicit concerns with impression management as distorting
what supervisors said, I analyze their reports as accounts. I, thus, do not treat supervisors’
talk as if it provides a window to another reality, but as a reality itself to be analyzed.
RHETORICS OF BLAME

Since supervisors did not want to be thought badly of when responding to the interview questions, they offered accounts that downplayed their unsuccessful efforts and bolstered an image of competence. By providing these accounts, supervisors sought to manage the impressions they made on the evaluation team, their peers, and, potentially, their bosses. Supervisors’ account-giving can thus be seen as a form of identity work for multiple real and imagined audiences. Schwalbe and Mason-Schrock (1996:115) defined identity work as “anything people do, individually and collectively, to give meaning to themselves or others.” How, then, did supervisors deal with the identity-work dilemmas in which they were put by the program evaluation process? They did so by using rhetorics of blame that targeted neither themselves nor their bosses—nor frontline workers, at least not directly. Yet, as I will suggest, their rhetorics of blame can be seen as victim-blaming in disguise.

In one key regard, supervisors did blame their organizations. Supervisors often said that frontline workers were not given adequate orientation and training to do their jobs well. For example, supervisors complained that workers received poor training because so little time was allocated for it. Supervisors described the training new hires received as brief and superficial. They noted the training process typically involved hospital orientation (1-3 days), departmental orientation (1-2 days), followed by the viewing of procedural video tapes, reading workplace manuals, and shadowing a senior worker for 5 minutes to 1 week, depending on the job. But rather than pointedly blaming managers for cutting corners on
training, supervisors cited “limited budgets” that led to hiring unskilled workers coming from backgrounds in retail, fast food, and low-level customer service.

Supervisors seemed to understand the economic logic at work here. Some explained that since the turnover rate in most of these entry-level jobs was moderate to high, the decision was made to continuously bring in batches of workers and provide them with the minimal training necessary to do their jobs. They did this knowing full well that many would not stick around for long, since the work was hard and the wages were low. A soft labor market also meant that it was possible to hire new people as soon as others left. Some supervisors seemed to understand that low wages, high turnover, and easy replacement were factors that made their jobs harder. Yet they never explicitly blamed upper management for paying low wages, scrimping on training, or exploiting a labor market glut.

*Blaming Schools*

The first type of account that supervisors commonly provided was to blame schools. Supervisors often complained that “new generation” workers—by which they usually meant workers under thirty—were unprepared for the job, that they lacked basic education and skills, or that they simply did not have the talent needed to do the job well. For these workers, human capital investment was generally very low. Most had earned only a high school diploma or GED and had no vocational training. Supervisors tended not to blame workers for being poorly educated, but rather blamed schools or the education system for doing a bad job. For example, supervisors at one site, a former steel town, discussed the inability of the education system to properly educate its citizens:
The main challenge that I found was most of my staff didn’t have the basic education required for them to move out of the city. We saw a few succeed, but most just did not have the reading, the writing, and the math at even a basic level. I think some of that comes back to the city’s public schools. My ex-wife has worked twenty-five, thirty years in them, and even though I’m a graduate of them, I have a pretty low opinion of the product they’re putting out nowadays. I don’t know if that’s the students’ fault, the parents’ fault or the school system’s fault, or all of the above. It’s difficult sometimes when you have to really start two steps back to bring them up to fulfill that education piece.

This supervisor cited what he saw as a broken school, indicative of the poor education system, as failing to produce quality students and workers. He did not claim to know the ultimate source of the problem, but what matters, for him at least, is the end result: unprepared workers.

This was a common frustration expressed in the interviews. Two other supervisors chimed in on the same matter but shifted the conversation to the lack of professionalism and what they saw as a lowering of standards with regard to workplace presentations of self:

Supervisor 1: I think sometimes you can look at the education system. You wonder how these people have come in for an interview the way they dress. Way back when, before females went out, they wanted to make sure they looked nice—before they went out the door. It’s not like that anymore. You see different types of people coming in wearing flip flops for an interview, jeans, short pants, and all that. A first impression goes a long way.

Supervisor 2: Tank tops.

Supervisor 1: Absolutely, or chewing a toothpick and all of that while they’re interviewing.
Blaming schools extended to higher education as well. Supervisors also criticized the quality of education and the graduates of the local technical schools and community colleges:

[Students] pay a lot of money for those tech schools, and it’s a very short period of time, and I think it’s sad that the curriculum does not include more on professionalism for the amount of money these folks pay when they’re in a job. The whole thing seems to be, “Let’s get them in, get them out as quick as possible, so they can get into the workforce,” and that’s how they advertise. Their advertisements definitely focus on a certain type of person—it’s get in there and get it done—and that’s the piece that gets missed. And then I often find when we interview some of these externs or even folks I’ve hired, they’re caught off guard by this whole concept. “What do you mean I can’t have my cell phone?” You know, they’re just shocked that we have this expectation [that] you have to act a certain way in the workplace.

At another hospital in a different city, two supervisors echoed a similar frustration:

Supervisor 1: Just emphasize professionalism. It’s the training, the technical skills they can get. Teach professionalism. Here’s somebody who came in for an interview in flip flops looking like she was going to the beach. Show up on time.

Supervisor 2: And their résumés are atrocious.

Supervisor 1: Back to the basics…It shouldn’t be that hard.

The data segments above show supervisors complaining openly about the lack of training and preparation students get in the public school system and as young adults (or adult-learners) in technical schools. While most of the frontline workers in this study averaged a high school education or general equivalency, many went to community colleges or technical schools to gain experience, education, and training to pursue healthcare-related
jobs, if not some other occupation. In the end, however, supervisors may not have been able to distinguish between workers who went through vocational training and those who did not.

The data also show that supervisors did not deny that there was a problem. They acknowledged that new hires for frontline jobs were not likely to do well. By blaming schools, supervisors exempted themselves and management from blame, and upheld an impression of themselves as competent and professional in the eyes of the program evaluators. Through these accounts, low-waged workers in health care were not presented as lazy and unmotivated as many low-waged workers are often stereotyped. No overtly racist beliefs or sentiments were expressed. Supervisors thus avoided appearing prejudiced. Complaints about broken education systems gave evaluators societal-level reasons why low-waged workers were hard to employ and retain.

**Blaming Cultural Deficits**

The second type of account provided by supervisors was blaming cultural deficits. As noted earlier, some supervisors felt that professionalism was a missing quality in new generation workers. In these accounts, supervisors claimed that new generation workers were not professional. Workers violated formal and informal rules of interaction and did not meet the supervisors’ standards of workplace behavior. The problem, as supervisors described it, was a failure of the younger workers to learn, somewhere along the way, what everyone should know about being a good worker. Not only this, but new generation workers were said to be too self-centered and financially-motivated to be good healthcare providers.
Supervisors’ claims that new generation workers did not meet expectations, violated norms, and dishonored values in the workplace were at the core of many supervisor complaints. According to one supervisor:

I think it really comes down to training and professionalism. Our biggest problem is that there is this huge lack of awareness of how to [or] what being a responsible worker is about. It’s about coming to work on time. It’s about coming to work at all. It’s about [the] basic stuff! It would be about the way you communicate with your peers. It’s about the way you express yourself if you’re not having a good day. It’s about, you know, all of these things, which for some, it’s inherent. You don’t have to train people on some of this stuff! But our, or my, experience is that I’ve had to let people go. I’ve asked people to leave because they don’t show up for work and they don’t call or they’re consistently late or they call in sick three, four weeks out of the year. I mean it’s the attitude, the pride that they take in what they do.

When the supervisor exclaimed, “You don’t have to train people on some of this stuff!” he was referencing what he felt were basic principles of responsibility and interaction at work. He felt that there are rules or norms that all workers should just know—for example, that one is expected to show up on time. Younger, new generation workers were said to create problems because they lacked these understandings.

The supervisor quoted below explained how the actions of a new generation worker did not match the expectations and norms of the healthcare field:

I had someone with a patient and it was five o’clock, so [the frontline worker] just walked out. The doctor comes out looking for somebody to help her and she’s gone. I said [to her], “You can’t do that. You can’t put a patient and the doctor in a room and not even tell them, ‘I’m leaving now.’ If you have to go, you have to say, ‘I have child care, or whatever,’ but you can’t just walk out the door. I just think this is the new generation, because it’s not the kind of
stuff that I ever came from before, and I started out as a nurse’s aide. I just don’t understand it. But I see that, and then when I told her about it she said, “Oh, okay, I’ll do that.” And what ended up happening was the next time—I was walking out and I said, “Now you’re going to stay until you know the doctor is finished right?” And she said, “Oh, yeah.” So I walk out, and she went out the back door. And as I’m pulling around, because I went around the building to go out a different way, I see her getting in her car. Obviously, she didn’t work with us for very much longer. You try so hard to make people realize just how important their position is. I don’t know, sometimes they look at it like it’s just a means to a paycheck, or they get upset because they feel that the nurses aren’t treating them fairly.

In this supervisor’s account, the younger worker violated several workplace norms. Although the worker was leaving work at her scheduled time, she left a patient unattended and did not consult with the doctor on duty. When she was confronted by the supervisor about leaving, she promised not to leave early again without following the protocol expected of her. However, when the situation presented itself again, she left again. For the supervisor, this was intolerable, unprofessional behavior and resulted in termination.

Supervisors were especially annoyed at the immature attitude they argued some new generation workers projected. Not only were workers accused of having a poor work ethic, they were described as being self-centered, impatient, and immature. Supervisors complained that these immature attitudes were often paired with apathy or arrogance. Supervisors said this made management harder and more frustrating. Some supervisors challenged what they saw as workers’ failure to take responsibility for themselves:

You’ve got people calling in with, “Well, I’ve got a flat tire. I can’t come to work.” You know, back then you found a way to come to work. They’re using the excuse, “Well, my Ride’s car is broke.” I provided you a job. It’s up to you to get here. That’s not my responsibility to see that you get to work.
As this excerpt illustrates, supervisors felt that new generation workers’ general sense of responsibility did not meet their standards.

Many supervisors cited age to account for this problem. In the words of two supervisors:

Supervisor 1: You’ve got [Generation Xers] that think you should be glad that they’re here no matter what time that they come to work, or you should be glad that [they’ve accomplished some of the work but not the whole task]. That’s not only a challenge for their peers, it’s a challenge for management. I think we’re dealing with a different group of individuals compared to when we were growing up.

Supervisor 2: This generation that we have now wants immediate gratification. [They believe], “If I don’t like it here I’ll go somewhere else and I’ll get it there, whatever I want.” And I know [the hospital] provides us with the ongoing education [to understand] the Generation Xers, so you can learn how to deal with the individuals a little bit better.

The latter supervisor noted that her workplace provided training specifically for the management of Generation Xers (This was the only time such training was mentioned in my study). The former supervisor contended that the egotistical attitude of new generation workers is a problem for coworkers and managers alike.

One major complaint about new generation workers was the constant affirmation required to keep them motivated. As another supervisor put it:
To me [the challenge is] a generation issue. There is a sense of not wanting to be responsible for anything. [The workers] don’t care. They can do it, but they don’t want to do it. They have the talent and the ability to do it, but they have to stay motivated. I know I do. I spend most of my time—not necessarily teaching them their job—but actually trying to keep them motivated. They want to hear all the good stuff that they’re doing. They don’t necessarily want to hear the bad stuff. But if you do more, spend more time patting them on the shoulders on the stuff that they do well, they want to continuously get that. They feed off of that. And when you find yourself not doing that, that’s when they’ll retract back to what they used to do or not do.

Like this supervisor, others were also frustrated when new generation workers fell below their standards. Supervisors complained about having to manage workers who were professionally immature and needed constant praise. Supervisors were especially annoyed by the sense of entitlement, apathy, and arrogance they argued that new generation workers displayed. Some supervisors went deeper in their complaints about new generation workers by questioning their motivation for working in healthcare:

Unfortunately, there’s a generation of a very different work ethic. I hate to say that. I kind of fit that borderline on aging, but are people always just doing it for the money…or are they doing it because they have a passion to want to help people? It seems like [after they get acclimated to the job you can] get a feel for them to know whether that’s going to be a really good fit and [if] that’s a person who really wants to be here, or is it somebody who’s just showing up because they want to get a job that pays a little better.

These supervisors thought that new generation workers did not care about patients. They saw young workers as uncaring and money-driven. Along with this, another issue that supervisors had with new generation workers was their sense of entitlement. As some supervisors saw it, new generation workers were unwilling to pay their dues:
The other thing too with that is that [a newly hired frontline worker] might come and say, “I’m going to start as a Medical Assistant (MA) but I really want to be [in a higher position].” But they can’t even cut it as an MA. So, from a manager’s perspective, we’re saying we’ll do what we can to promote you. They actually, they come out of school thinking that they can run the joint. Paying dues doesn’t exist in this generation. It’s hard because we said, “We were planning on promoting you, but you can’t even come to work on time. How am I going to get you to the next level?” But starting out they think that they’re too good for what they’re doing to begin with.

This excerpt shows the supervisor’s amusement with the unrealistic expectations of unconsciously incompetent new generation workers. These unrealistic expectations were further evidence, as supervisors saw it, that new generation workers failed to understand basic things about work, employment, and mobility.

In these accounts, supervisors brought neither their competence as supervisors nor organizational policy into question. The problem resided, rather, in the raw material (the novice frontline workers) they were given to work with. For instance, discipline was another issue for some supervisors:

When you have people with different work ethics it really creates a lot of resentment, especially if you’re within the same unit. As managers, we are responsible for disciplining and calling people out on their behaviors—which I think we do a pretty good job at—but we can’t—we’re limited because we can’t communicate to those other co-workers because of confidentiality. Which I think is fine. But they see [other frontline workers say], “Well, she comes to work late every day. She doesn’t do half of what she is supposed to and she constantly makes mistakes—so what are you doing about it?” And all I can say to them is, “Well, we are doing something about it. It is being addressed. Thank you for letting me know.” But by that time they say, “Oh, she’s going to get away with this? Well then, I’m going to act the same way.”
The example above illustrates the supervisor’s inability to effectively discipline the new generation worker. She also contended that this situation threatened the control she had over other workers.

Supervisors saw the weak work ethic of new generation workers as contagious—something that would infect other workers and undermine productivity. This was a major concern for other supervisors as well:

Supervisor 1: I think the challenge in my particular department is not only time management but I think its peer pressure as well. You’ve got individuals that want to do a good job—are doing a good job—but then they see their peers and their work ethic … and I think that is so big right now. Probably over the last five years, maybe longer.

Supervisor 2: It’s longer than that.

Supervisor 1: You’re seeing a different work ethic that’s coming into the work environment.

This excerpt suggests why the poor work ethic of a few individuals threatened supervisors: there was, it seemed, fear of a contamination effect. Some supervisors imagined that by failing to embrace a proper work ethic, new generation workers might lower standards and decrease job commitment on the part of other workers. It’s possible, then, that by “othering” new generation workers, portraying them as essentially different from themselves and from older workers, supervisors could alleviate their fears of contamination.

Again, it’s important to note that supervisors did not attribute workers’ problematic attitudes and behavior to deficiencies inherent in categories of people defined by race,
Although their complaints pointed toward frontline workers, supervisors did not blame workers *per se*, but rather invoked large, outside forces, mainly culture and educational institutions. In doing this, supervisors presented themselves as understanding, tolerant, patient, and socially aware. This also allowed supervisors to justify the exhaustion of their patience because the root problems were too big and intractable for them to deal with.

By giving the accounts they did, supervisors left themselves blameless for the negative work experiences and job outcomes of their frontline staff. Recall that supervisors were in charge of the staff targeted for help by the workforce development program. They were responsible not only for workers’ daily performance but, in part, for workers’ success in the program. Supervisors’ competence was thus on the line in at least two ways when they were being interviewed by evaluators. Supervisors also wanted to avoid appearing elitist, racist, sexist, or egotistical when discussing the shortcomings of their low-level staff. And, finally, while they sometimes alluded to bad organizational policies, they avoided blaming upper management for the problems caused by under-trained, underpaid workers.

**DRAWING ON LARGER CULTURAL DISCOURSES**

During the focus groups and interviews, supervisors had to manage several kinds of impressions, and they did this by drawing on cultural discourse. They needed to create an impression of being good team players in the eyes of administrators and peers. They also needed to create the impression that they were fair to their staff and worked to meet their needs. Finally, they needed to impress upon the evaluation team that they were competent in
their jobs and as participants in the workforce development program. Moreover, they had to do all this while being asked to discuss problems in their jobs.

Supervisors upheld an image of themselves as competent—that is, they engaged in identity talk, a form of identity work—by blaming schools and cultural deficiencies for the negative work experiences and job outcomes of their frontline staff. When doing identity talk, people make verbal claims to identities for themselves or impose them on others (Snow and Anderson 1987; Hadden and Lester 1978). When voicing complaints, supervisors blamed outside forces, rather than themselves, their bosses, or powerless workers. In doing this identity work, supervisors drew on currently popular discourses; that is, ways of talking about a topic or issue that rest on a set of shared assumptions about social reality. The manner in which they presented themselves was, in other words, connected to—and ultimately served to reinforce—a set of pervasive cultural understandings about who or what is the source of a problem. In this case, the problem was that of poor workers. These themes are discussed in the following sections.

*Culture of Poverty Discourse*

In the mid-1960s, Daniel Moynihan used the term “culture of poverty” (originally coined by anthropologist Oscar Lewis in 1959) in a public report titled “The Negro Family: The Case for National Action,” written for the U.S. Department of Labor. In the report, Moynihan claimed that some African American families were trapped in a “tangle of pathology” of welfare dependence and self-destructive behaviors that perpetuated poverty. The report powerfully influenced policy agendas and led to the creation of government programs such as VISTA, Job CORPS, Head Start, and the Office of Economic Opportunity.
Thirty years later, the enduring appeal of the “culture of poverty” idea led President Bill Clinton to sign the 1996 Personal Responsibility and Work Opportunity Act, which replaced Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF), the latter program adding time limits and mandatory workforce participation.

Although many sociologists are wary of invoking culture to explain poverty—preferring instead to see poverty as a consequence of the structure and functioning of the economy—the idea that poor people cause and perpetuate their own misfortunes because of bad attitudes and values continues to resonate with the general public. The achievement ideology contends that America is a meritocracy in which anyone with brains and ambition can be successful. This widespread and deeply held ideology complements the culture of poverty theory, supporting a kind of disguised victim-blaming. It seems clear that supervisors were using both the culture of poverty and achievement ideology discourses in fashioning their accounts.

Most supervisors we interviewed had probably not read Oscar Lewis, Daniel Patrick Moynihan, or even Cornel West. But given the wide circulation of culture of poverty ideas and the achievement ideology (even the popular comedian, actor, and activist Bill Cosby has criticized how poor Blacks dress, behave, and name their children), it is not surprising that their accounts drew upon these discourses. Supervisors were put on the spot in interviews and focus groups; they needed somehow to account for unfavorable worker outcomes without blaming themselves or their bosses—and without appearing racist. Blaming culture was a solution. Individuals, after all, cannot be blamed for being products of their (deficient)
culture. Moreover, pointing to “culture” does not imply inherent flaws in a whole category of people, as is the case with racist ideologies. Pointing to culture as the culprit also suggests compassion and social awareness on the part of the pointer.

Neoliberal Discourse

In *Racism Without Racists*, Eduardo Bonilla-Silva (2003/2014) shows how whites have largely abandoned overt expression of racist sentiments. Today, Bonilla-Silva argues, racist sentiments are expressed in more subtle and indirect ways. For example, the new racist discourse opposes affirmative action because it is not color-blind and is thus unfair. It also attributes poverty to the bad choices of individuals, such as dropping out of school, using drugs, committing crimes, and having children outside of marriage. By using this rhetoric, which does not explicitly mention race, whites can ignore structural racism and blame minorities for their plight, without “sounding racist.” The problems of residential segregation, urban deindustrialization, educational disparities, wage inequality, and job discrimination thus remain invisible and protected from challenge.

The ideology of color-blindness is an important one for my study. In the interviews, there were clear allusions to class and to the achievement ideology (anyone can get ahead by working hard), but race was not directly mentioned by *anyone*. The middle-class, mostly white supervisors also spoke about their staff members in a seemingly compassionate and caring way. And while I believe their expressions of caring were genuine, it nonetheless seems clear that their accounts of the mobility problems experienced by the low-income women of color who constituted the frontline staff were shaped by color-blind racist discourses.
Two forms of color-blind racism were evident in supervisors’ accounts: abstract liberalism and cultural racism. Abstract liberalism abstracts the individual from his or her social context and emphasizes supposedly free choices on a supposedly level field of vast opportunities. This view is associated with free-market fundamentalism, or what is often called “neoliberalism.” Abstract liberalism holds that individuals can and should take responsibility for their futures by making smart choices in the marketplace of life, yet it fails to acknowledge how such choices are often limited by social forces beyond individual control. For instance, a supervisor said:

I often hear a person will [go from one job to the next] for twenty-five cents more…not having a long term career path. They’re just looking day to day [and] that can hurt you because a job-hopper type of resume doesn’t go very far.

This supervisor was drawing on a larger discourse of abstract liberalism. He criticized low-wage workers’ job jumping behavior without considering that this behavior was driven by economic necessity and limited opportunity.

Cultural racism was evident in supervisors’ references to “new generation” workers. Supervisors did not say, “These women of color from low-income backgrounds are stupid and lazy.” Such a statement would have been easily construed as racist. But by labeling the same group of workers, who varied widely in age, as members of a single generation, they could lump them all into one deficient category. Their common failing, as supervisors put it, was a “poor work ethic” or “lack of professionalism,” which was said to characterize a whole generation of workers. But supervisors clearly did not mean that all people under 30 in the
United States had a poor work ethic because of some society-wide failure. They meant that this generation of this group of workers was deficient. Who constituted this group? Women of color from low-income backgrounds. It thus seems that supervisors were using a coded form of a culture-of-poverty argument. It is also telling that, as noted earlier, “new generation” rhetoric was most prevalent at hospitals located in economically-depressed, urban, and racially-stratified communities.

When supervisors pointed to “broken schools” as responsible for the poor quality of the raw material they were given to work with, they were again drawing on a larger cultural discourse. Blaming schools for social problems has a long history in the United States (Berliner and Biddle 1995). But this blame has been fueled in recent years by free-market fundamentalists who have pointed to the problem of underperforming public schools and touted vouchers and private (for-profit) schools as the solution (Ravitch 2013). It would not be surprising if supervisors, especially those in economically depressed areas, picked up this rhetoric and used it to explain deficiencies they saw in younger workers. As noted earlier, this way of attributing blame does not imply that a category or group of people is defective; in fact, it appears sociological in saying that the problem lies with institutions and organizations. It might be the case, then, that some supervisors used this discourse because they thought (or felt) that it would favorably impress the social scientists on the evaluation team. If the “broken schools” discourse is a mask for racism, its perhaps mainly because the solution is usually said to be more parental choice rather than more funding for schools that serve students of color.
It’s also possible that the healthcare environment encouraged supervisors to use a discourse that invoked schools. The medical world is highly stratified, rewarding merit, mainly on the basis of educational credentials. It is widely understood that to get ahead in the medical world one must go to school and acquire degrees and certifications. Given the importance of schooling for achieving status in the healthcare field, the emphasis the workforce development program placed on education, and the presence of Ph.D.-level evaluators, supervisors were probably cued to think of schools. The “broken schools” discourse was then readily available for weaving together a sense of the importance of education with an explanation for frontline workers’ shortcomings.

To say that culture-of-poverty or neoliberal discourses can mask racism and were evident in supervisors’ accounts is not to say that supervisors consciously used these discourses for this purpose. Supervisors were asked to discuss problems in their jobs, problems with their frontline workers, and problems in the workforce development program. When they responded, they used language that exempted themselves and their bosses from blame, and that did not appear to blame their frontline workers in a racist manner. The language they used was the language that had currency in the culture and that seemed reasonable to them—as middle-class whites. The few minority supervisors in the study used similar discourses, perhaps underscoring the point that assimilation to the middle class often entails embracing color-blind rhetoric and distancing from low-status minorities (Milton 1964).

The discourses picked up and used by supervisors matter because they can have the consequence of reproducing inequality. As noted, these discourses can mask not only racism
but structural problems that limit minority-group access to economic opportunity. Then there is the matter of deciding who deserves support in pursuing the limited opportunities that do exist (see Cassiman 2008 for discussion of the impact of neoliberal and conservative discourse on poverty policy). Using a moral evaluation of the poor promotes poverty as an individual failing, rather than a social one. It also reinforces negative stereotypes of poor women, which most frontline workers are, thus promoting the idea that the “undeserving poor” are hurting society and unworthy of assistance (Seccombe, James, and Waters 1998).

If new hires are perceived as lacking the right values and attitudes to succeed in the workplace, if they are perceived as incapable of proper professional behavior, and if they are perceived as badly educated, then it would seem like a waste of time to offer much support. Color-blind racist discourses help to reproduce inequality by legitimating this withdrawal or limitation of support (Gallagher 2003).

Again, I am not suggesting that supervisors invented these discourses to mask racism or to justify a pre-determined unwillingness to lend help. By many other indications, they genuinely wanted to help their frontline workers do well. Yet they were constrained by management’s refusal to pay decent wages and engage in serious training. Supervisors also had heavy workload demands of their own to contend with. Outside forces—including underperforming schools and depressed economic conditions meant that a lot of new hires had minimal job experience, further limiting what well-meaning supervisors could accomplish. Under these conditions, it is not surprising that supervisors made use of widely available cultural discourses that allowed them to account for on-the-job problems with
minority-group workers, without blaming themselves or their bosses, and without appearing racist.

CONCLUSION

Supervisors wanted to be good managers by effectively managing their staff and team performance. But they were constrained because workers were often poorly trained and hospital departments were understaffed. Supervisors were in a difficult position because they were responsible for meeting the production and patient-satisfaction goals of the hospital as they managed the characteristic shortcomings of their staff. When interviewed by the evaluation team, they were required to discuss the problems they had at work. This, again, put them in a hard spot. They needed to account for the poor performance of their staff, but they did not want to point blame at any stakeholders in the organization, including themselves, their management, or their workers.

An additional concern for supervisors was self-image. They wanted to maintain the impression that they were good at their jobs and not whiners—all while they were exposing their professional and organizational weaknesses. They wanted to present themselves as being advocates for their staff, team players to their peers, and as loyal workers to the organization. They could not do this by demonizing their staff, exposing neglectful peers, and calling out the exploitative nature of their workplaces. To fashion accounts that absolved organizational actors, these middle-class supervisors drew on hegemonic cultural discourses about the causes of poverty and inequality. As educated and engaged citizens, they were aware of the social and structural components of society that shaped lives, but they were
invested (as most Americans are) in the achievement ideology and neoliberal claims that individuals are responsible for their own destiny.

Blaming broken schools and deficient cultures, both of which supervisors claim their low-ranking frontline staff were the products of, allowed them to exempt organizational players from blame. Blaming schools and culture also protected supervisors’ feelings of competence by implying they could be responsible only for things they had control over or the means to improve. They suggested that workers were in such a bad condition when it came to job preparation, education, and training that a mere supervisor could not be responsible for the poor performance of their staff. Finally, blaming schools and culture conveniently accounted for workers’ life conditions without invoking race and racism.

This analysis helps us, as sociologists, better understand how victim-blaming works under the new racism. Over forty years ago Ryan (1971) criticized the “cultural deprivation” arguments used to explain socio-political and economic failures of “socially deprived” children in inner-city schools by blaming the child for his own miseducation or his parents for not valuing education. He aptly identified this as blaming the victim. Under the new racism, neither the child nor his parents are necessarily mentioned explicitly. The disaster that is the educational system is. The trappings of the ghetto are to blame. Blaming the victim, even implicitly, is an ideological process that involves looking sympathetically at those that “have” the problem and defining them as different from the general population (Ryan 1971).

Supervisors in my study were not saying that all workers under the age of 30 had a poor work ethic. The supervisors argued that their subset of low-wage minority workers had
never been taught the value of work because of these inadequate and sustained outside forces. In the current day of the new racism it is not appropriate to identify race as the cause of individuals’ life outcomes; life outcomes are, thus, based in merit, hard work, and chance (See Gallagher 2003 for a full discussion). Supervisors were engaging in disguised victim-blaming when they detailed individual anecdotes and disguised the systemic attack on minorities and the poor by masking the fact that their workers’ life outcomes are based in racialized hierarchies. They were, in effect, masking the structural racism evident in their workers’ lives as exemplified by poor education systems and the collective lack of access and opportunity in their communities.

This research complements recent work on Welfare-to-Work program managers and welfare recipients. Seale, Buck, and Parrotta (2012) demonstrate that program managers engage in identity talk to construct images of themselves as effective workers despite a list of identity contradictions. Turgeon, Taylor, and Niehaus’s (2014) article on welfare discourse shows that program managers use classtalk—a discourse rooted in bureaucratic production and gendered and racialized images reflective of US meritocracy and neoliberalism—that invokes a culture of poverty ideology and ignores structural conditions. Classtalk supports inferences that are made about good and bad clients with assumptions about the amount of effort clients make. My findings add to this line of research by documenting the use of classtalk to account for problems at work. My research also addresses the effect this may have on the staff’s work outcomes in the healthcare sector and the low-wage market.

In this chapter, I looked at how supervisors relied on blaming rhetoric when discussing problems in the workplace, especially those related to frontline workers. I argued
that blaming rhetoric arises from and helps to reproduce inequality. This research extends the work of Bonilla-Silva (2014) on racism without racists and Gallagher (2003) on colorblind racism. The accounts examined here used coded language to blame the poor and protect the powerful. But more than just coded terms, these accounts also revealed the use of larger cultural discourses to account for poverty and inequality. The longer-term consequences are to reduce the mobility prospects of workers, perpetuate the profitable status quo for hospitals, and to reinforce ideologies that blame individuals for failing to get ahead. Supervisors are of course not to blame for this; they are limited in their organizational power and in what they can do for their frontline workers. The point is that we see here how accounts can be fashioned to avoid scrutiny of exploitive social arrangements while allowing people to feel moral and competent, even as they continue to reproduce those arrangements.
CHAPTER FIVE

CONCLUSION: SELF-PROCESSES, MOBILITY, AND ORGANIZATIONAL CHANGE

The supervisors in this study often complained about not being able to do their jobs well because they were overworked and under-resourced. These supervisors were not bad at their jobs, they did not have poor management skills, nor were they apathetic about their workers. The challenges they faced that led to poor performance and negative job outcomes for their staff were the result of problems common to industries that depend on low-wage labor. Despite these limitations, most supervisors wanted to be advocates for their workers and wanted their workers to advance. They also wanted to be good supervisors, but struggled to feel competent as their workers fell victim to off-work barriers and precarious work conditions, in spite of being engaged in the workforce development program.

When I started this project my aim was to examine how supervisors negotiated the demands of innovative workforce development programs and, in some cases, resisted implementing these programs. What I found was that key social psychological processes related to the self-concept underlay supervisor perceptions and behavior and affected the possibility of organizational change. I have identified conditions under which the self-efficacy motive leads to behavior meant to protect supervisors’ feelings of job-related competence. My findings extend previous research by developing a better understanding of how supervisors engage in identity-work, how mid-level authority figures understand
themselves as organizational actors, and how supervisors can influence the mobility prospects of their low-wage staff. I have contributed to the inequality-at-work literature by examining supervisors and their efforts to feel efficacious and competent. This is presented in the preceding chapters.

In chapter 2, I showed how supervisors’ feelings about their jobs were shaped by their perceptions of the program. Supervisors’ supported the program when they were able to derive a sense of competence through mentoring, coaching, and training roles. In these roles, supervisors felt connected to the program, more valued by their superiors, and helpful to their staff. They also felt they could take credit for participant success in the program, allowing them to feel more like an advocate and supporter for their workers. These conditions made them feel like good supervisors. When the program fostered conditions that denied them the opportunity to help their staff or excluded them from implementation, their sense of competence was diminished and they responded by resisting the program in subtle or overt ways. These findings suggest that supervisor response to the program was affected by self-concept motives.

In chapter 3, I showed how supervisors determined the investment-worthiness of their workers. Supervisors sought to empower their low-ranking staff who they believed would be successful in training, whereas they built distance between themselves and those who would not. In doing this they could take credit for worker successes and explain away worker failure. Organizational culture and practices empowered or diminished supervisors’ confidence in their ability to produce high performers. This directly shaped supervisors’
sense of self, shaped their expectations for worker success, and influenced their investment in staff.

Facing resource constraints, weak training practices, a poor low-wage labor market, and their everyday work demands, supervisors were limited in their ability to make the workforce development program succeed. In chapter 4, I showed how supervisors used rhetorical strategies to blame outside forces for their limited success and to preserve their sense of competence. Supervisors needed to portray themselves, their organizations, and the frontline workers as blameless for whatever poor work their staff might do or the unfavorable career outcomes they experienced. In an attempt to show empathy towards their workers and rationalize what they claimed to be class-based inequities, supervisors engaged in colorblind racist discourse. These strategies left their sense of competence intact, freed them from the responsibility to make change, and shielded them from scrutiny.

In this final chapter, I will draw out the implications of these findings for understanding the relationship between work-related self-efficacy, organizational identities, and organizational change more generally. The processes I captured at seven hospital sites across the United States seem to be generic. Similar processes are likely to occur in other service-sector organizations that rely on overburdened supervisors to manage a low-wage workforce facing a limited opportunity structure. My analyses add to the existing literature by more fully illuminating the role of identity in mediating between supervisor self-interests and organizational change. Supervisors support change, I argue, when workplace conditions
allow them to see change as likely to enhance, or at least not threaten, their feelings of competence.

*The Roots of Resistance*

Wright and his colleagues (1982: 715) define supervisors as having sanctioning authority but no decision-making control, or as having lower-level task authority. This puts supervisors, according to Wright (2009: 108), in a paradoxical position, exercising “many of the powers of domination, [while also being] subordinate to [management].” My findings extend these ideas, showing how the strains associated with being in this position can lead supervisors to be less than reliably compliant with managerial directives. It is not just that supervisors may feel more in solidarity with frontline workers than with executives. It is that supervisors’ feelings of competence are often precarious, and when managerial directives put those feelings at risk, supervisors resist.

The sociology of work and organizations has recently taken a turn toward focusing more on power relations (Ridgeway 2014; Avent-Holt and Tomaskovic-Devey 2010; Roscigno, Lopez, and Hodson 2009; Tilly 2000, Smith-Lovin 1999). How these power relations play out, researchers have argued, has important consequences for personal dignity and material livelihood (Hodson 2001). Hodson contends, “in the workplace, dignity is realized through countless small acts of resistance against abuse and an equally strong drive to take pride in one’s daily work” (1991: 3). My research complements the work of Hodson and other social psychological theorists who contend that workers strive to perceive themselves as competent, generate positive reflected appraisals through their job
performance, and make favorable comparisons between themselves and other workers (Schwalbe 1988, 1985).

In this research, I have shown how supervisors struggled to feel and appear competent when it seemed that they were not being treated respectfully by upper-level management. These efforts to maintain an impression of competence sometimes included resisting program implementation. Similar to the work of Link and Phelan (2001) and Schwalbe and Shay (2014), this study shows how organizational actors engage in identity work to deflect stigma or uphold a positive image of themselves. My study advances our understanding of how this kind of identity work can have consequences not only for individuals but also for organizational change. It can also have consequences, as I have argued, for the mobility prospects of frontline workers. This latter phenomenon has received relatively little attention in the sociology of work.

Identity, Inequality, and Investment

In the late 1970s, social researchers began to focus on how differences in organizational structures can shape workers’ experiences in ways that in turn affect labor market outcomes (e.g., Baron and Bigby 1980, Stolenzberg 1978, Pfeffer 1977, Doeringer and Piore 1971). In the early 1990s, Baron and Pfeffer (1994) called for researchers to “bring the firm back in” and pushed for a social psychological analysis of how interaction in organizations produced inequality. More recently, a new body of theorizing has pointed to “relational inequality” within organizations to understand differences in labor market returns (Tomaskovic-Devey 2014; Avent-Holt and Tomaskovic-Devey 2010). My research joins this
tradition by examining how one relationship—between managers and supervisors—can affect another relationship—between supervisors and workers—in ways that affect workers’ mobility prospects. My research goes beyond this, however, by showing how organization culture and practices condition both sets of relationships.

My findings accord with those of Katherine Kellogg’s (2011, 2009) ethnographic study of the training of surgical residents. Kellogg looked at organizational changes that occurred after a mandate from the American Council of Graduate Medical Education in 2003 limited residents to an 80-hour work week. Kellogg sought to identify the conditions under which institutional changes were accepted or resisted. She found that change occurred when surgeon residents were willing to break from tradition. This “willingness” required, however, solidarity on the part of other organization members who sought change, and a willingness on their part to challenge surgeons who resisted change. Surgeons nonetheless continued to resist change when it had negative identity implications for them, or when they were in the minority and feared retaliation from their peer surgeons.

Similar to Kellogg, my study examined organizational change that had implications for identity. Ideally, I would have been able, as Kellogg did with surgeons, to examine the effects of peer culture among supervisors. I was able, however, to identify how supervisors valued other organizational actors—especially their bosses and their frontline workers—and to examine how supervisors’ feelings about themselves affected these relationships. Most importantly, when supervisors saw organizational change as enhancing their self-perceived competence, they made extra efforts to help their workers succeed. When their feelings of
competence were threatened, they withheld effort. What this adds to Kellogg’s study is the point that resistance to change can be anticipated by taking into accounts how it might negatively affect the ability of organizational actors to derive feelings of competence and worth from their jobs.

Organizations equip their members with norms, values, customs, and meanings that stabilize the organization. Current work on organizational analysis does consider the fluidity of these elements (i.e., meanings change in interaction), but sociologists’ understanding of organizational change could benefit from giving more attention to how these elements of organization culture are shaped by internal struggles over resources and identity rewards. As I have shown, there is a dynamic relationship between organization members’ identity needs and organizational investment in workers. As organizational members seek to affirm valued identities, they resist managerial directives that threaten their efficacy and support those that bolster it. Efforts at organizational change that do not take this dynamic into account are unlikely to succeed.

The Persistence of Inequality in the Workplace

Understanding how the workplace is gendered and racialized commands significant attention from sociologists of work (Wharton 2015). As demographic changes are reshaping the workplace, what remains constant is that the lowest status, least skilled, and lowest paying jobs in the secondary labor market (Piore 1970)—or what Kalleberg et al. (2000) refer to as “bad jobs”—are occupied by gender, racial, and ethnic minorities (Charles and Gruksy 2004), like the frontline workers in this study. The continued association between
jobs and workers of a particular gender, racial, or ethnic background suggests that these social categories are as powerful in shaping life inside the workplace as they are in shaping social institutions more generally (Acker 2008; Tilly 1998). Sociologists have argued that the structure and organization of work also reflect the influences of gender, race, and ethnicity.

From this perspective, gender, race, and ethnicity are not just characteristics of workers, but can also be considered characteristics of work roles and jobs, or seen as embedded in organizations (Acker 1991). This underscores the point made by relational inequality scholars (see, e.g., Tomaskovic-Devey 2014:1) that inequalities are not lodged in people, races, or genders, but in the relationships between people and between status categories. Relational inequalities can be examined through though interactional processes found in cognitive bases of distinction, the creation of status expectations, and the dramaturgical production of inequality (Tomaskovic-Devey 2014; Schwalbe and Shay 2014). The question arises, however, of how extra-organizational processes create the distinctions and categories that then become relevant to workplace interaction.

In chapter 4, I showed how supervisors used a larger cultural discourse, influenced by neoliberal ideology, to maintain social distance between themselves and “new generation” workers. Supervisors described themselves as being responsible, committed, and hardworking, while claiming that younger workers, in contrast, lacked a proper work ethic. Supervisors saw themselves as different from their staff and as role models for how frontline workers should behave. The supervisors used this social comparison to legitimize their low
opinion of new generation worker behavior and to decide who was worthy of investment. But they did not invent the ideology that aided these actions; they imported it to the organization.

Culture of poverty arguments and the achievement ideology allowed victim-blaming to reinforce attitudes, norms, values, and practices that excuse and normalize racism. This process was evident in supervisors’ coded victim blaming. Terms such as “new generation,” “work ethic,” “bad schools,” and “culture” were used to implicate the poor and powerless in creating their own problems. In their efforts to justify the poor performance of workers by blaming outside forces, supervisors masked problems stemming from the organization of healthcare to generate profits. If bad schools and deficient culture were the problems, capitalism and greed were not. The “relational” reproduction of inequality at work can thus be understood only by understanding relations of inequality, and the ideologies that legitimate them, in the surrounding society.

In this study I was able to show how the new racism is reproduced invisibly. Supervisors did not negatively characterize anyone based on race. In fact, they avoided mentioning race at all when talking about frontline workers. Yet supervisors used a discourse that shifted blame for poor worker outcomes away from themselves, away from management, away from the organization, and away from the economy. The rhetorics of blame they used, while not explicitly racist, lodged the problem in deficits workers brought with them to the job. This line of thought implies that neither supervisors nor their employers are to blame for unequal outcomes. The problem lies, rather, in the raw material they have to work with.
When supervisors use “new generation” or other colorblind racist discourse to cast minority-group workers as deficient, it means that these workers are less likely to get good training, less likely to get support for participating in the workforce development program, and less likely to get opportunities for advancement. Criticizing the younger generation is of course nothing new. It matters, however, that it is being used in this case, and perhaps in many similar cases, to legitimate a lack of effort to overcome inequalities. This analysis shows how culture and ideology reproduce inequality in organizations by providing legitimating frames (Roscigno 2011) imported from outside organizations. What it also shows is how the desire to preserve feelings of competence in an organizational environment can make certain kinds of legitimating frames especially compelling.

IMPLICATIONS

Why do skilled and educated people stay in stressful jobs? A large part of the answer has to do with economic necessity. In a capitalist society, people need jobs to meet their survival needs. But many of the supervisors in the present study had sufficient human capital to have found alternative employment. So why were they apparently committed to remaining hospital supervisors? I want to suggest that another part of the answer has to do with what have been called “moral wages” (Kolb 2014).

Based on a study of victim advocates and counselors at a domestic violence and sexual assault (DV and SA) center, Kenneth Kolb (2014) argues that earning moral wages—
symbolic rewards as compensation for the emotional dilemmas and low extrinsic rewards associated with low-status work—explains why workers in difficult and emotionally draining work conditions stay in their jobs: they want to feel that they are good and moral. Moral wages are earned when workers affirm their moral identities. He argues that moral wages do not apply to those in bad jobs, since there is no expectation of return for hard work, or in better jobs which offer extrinsic rewards. Supervisors in the current study were, once again, in the middle.

Strong training sites allowed supervisors to maintain feelings of competence. These supervisors saw themselves as helping workers overcome their limited education and barriers of poverty, and they saw workers gain feelings of worth and self-confidence. They could feel that they were actively combating the demoralizing stigma of low-wage work. In this way, they earned high moral wages. Weak training sites did not equip supervisors to feel like they could make a real, positive difference for their frontline staff; in these sites, supervisors felt that there was little they could do to help their workers get ahead. Instead they sought to feel good about themselves by trying harder to meet production goals and service demands. This strategy allowed them to justify their reluctance to help vulnerable workers because they claimed it was beyond their power to make change and, besides, they were just doing what was best for the hospital. As a result, the mobility of prospects of their workers were diminished.

The concept of moral wages captures an idea helpful for understanding behavior in challenging jobs. It also helps us see how organization culture and practices matter. When
culture encourages and practices allow, moral wages are attainable and can promote commitment to a tough job. When organization culture and practices are not supportive, moral wages might be unattainable (or less attainable) and commitment to the job weaker. As shown with the hospital supervisors, when moral wages were less attainable, they turned to following rules and striving to meet formal production demands, while devoting less effort to getting rewards from helping workers get ahead. The workforce development program asked supervisors to go “above and beyond the call of duty,” but only those who could derive moral wages from participating, without putting their feelings of competence at risk, were willing to do it.

This study was intended to help bridge the gap in understanding how self-processes influence organization change. I have shown how self-concept motives are involved as individuals navigate their organizational surroundings. There is a great deal of research that looks at how self-conceptions are implicated in organizational behavior. But there is little that shows how self-concept motives operate to shape the behavior of one set of organizational actors—in this case, supervisors—such that the mobility prospects of another group—in this case, frontline workers—are affected. This analysis has implications not only for how sociologists understand mobility-relevant behavior in organizations, but for how organizations can change to promote mobility.

A basic principle observed here is that macro-level change—such as the workforce development program—is likely to fall short of its goals because of micro-level resistance—arose in settings where the workforce development program threatened supervisors’ feelings
of competence. One practical implication would thus seem to be that efforts to change organizations must take into account the ways in which existing culture and practices will amplify or dampen micro-level resistance. One simple question to ask might be: How will a proposed change affect the ability of key actors to feel competent in their jobs and to derive positive feelings about themselves as they do their jobs? It is clearly hard to know for sure in advance of change. But failing to ask the question and to consider the perspectives of people who will be affected by change is asking for trouble later.

In hospital settings like those examined here, frontline workers who do not get good training or opportunities for advancement will continue being stigmatized as inferior. Their dignity and mobility prospects will thus continue to suffer. Supervisors who do not receive adequate support from upper management will continue to justify status differentials and legitimate their negative judgments of poorly trained workers. Those same supervisors will fail to make significant investments in the advancement of their frontline workers. And if upper managers continue to cut corners on training, pay low wages, and operate on a high-turnover business model, the systematic exploitation of low-wage workers at the hands of threatened middle management will continue. The following recommendations recognize these limitations, but presume that change is possible.

First, change efforts should be visible, accessible, and understood by organizational constituents at all levels. Attempted innovations must be supported by upper management, and direct supervisors of low-ranking staff must be involved in planning, not just told what to do later. Supporters of proposed changes should meet regularly to keep lines of
communication open between administrators and supervisors; reciprocal dialogue is essential. There should also be formal and informal meetings to discuss concerns, grievances, and resistance on the part of those who want to maintain the status quo. This is best done in “free spaces” (Kellogg 2009; Fantasia 1998) that can be physical or virtual, and perhaps even outside the workplace itself. These suggestions take into account organization culture, organization practices, supervisor dignity and self-efficacy, and power relations. Successful change depends on taking this kind of holistic view and not presuming that it can simply be ordered from the top down.

LIMITATIONS AND FUTURE RESEARCH

The workforce development program I studied is unusual in the healthcare industry, as well as in the low-wage labor market. The hospitals I looked at are a minority when it comes to developing skill, offering education and credentialing, and training on-site with the goal of helping workers achieve upward mobility. Future research should examine how these processes unfold in other types of healthcare contexts, such as nursing homes and community clinics. In these workplaces, supervisors face similar demands with similar types of frontline workers, but the options for mobility are reduced due to simplified organizational structures (which provide short job ladders and narrow job lattices). Further insight could be gained from comparative studies in other low-wage industries.
A limitation of the present study is that it did not document individual-level job outcomes for program participants and non-participants. Although aggregate level outcomes were considered, there was no matching of supervisor-to-participant such that I could argue that the actions of a particular supervisor had a direct effect on the career outcomes of a particular worker. Future research should examine how individual-level outcomes may differ based on context and worker-supervisor matching. Such research could also draw upon and contribute to the literature on mentoring.

My study is also limited by the possible effects of bias in selecting the supervisors who were interviewed. Supervisors were chosen by upper-level managers to meet with the evaluation team to discuss their experiences with the workforce development program. But it was unknown to the evaluation team why the selected supervisors were chosen, other than the stated reason that particular supervisors were unavailable due to work obligations or scheduling conflicts. Managers might have been choosing supervisors who they felt would give a favorable impression of the implementation, or those who had better experiences than others. It is thus possible that a random sample of supervisors would have yielded a different picture.

The methodological implications of interviewing under such conditions should also be considered. In evaluation studies, researchers should be alert for the possibilities of bias and coercion. Possible solutions are insistence on evaluator selection of interviewees and private, absolutely confidential interviewing (rather than using focus groups). The practice of using periodic “site visits” is also a potential problem, in that it does not allow time to build
trust and rapport, or to acquire familiarity with organization culture. Researchers might thus press for opportunities to spend more time in the field and more time getting to know the perspectives of employees, be they supervisors or frontline workers. The present study was limited by the design for the evaluation study, a design that was in place before I joined the research team.

Finally, I should note again that I did not have the opportunity to create interview questions. The questions asked were intended to capture evaluation data, and although the evaluation team created questions, the interview questions were written by the time I conducted site visits and interviews. Since the focus of the evaluation was not on supervisors, I was not able to probe the interactional and social psychological processes through in-depth interviewing. In coding transcripts from focus-group and individual interviews with supervisors, I saw many occasions that would have warranted probing. However, because of time and resource constraints, and the pre-established design of the evaluation, this probing was not possible.

Despite these limitations, this study is built on a unique opportunity to study processes that can influence the mobility prospects of low-wage workers. Future research should extend these findings by looking more closely at the self-processes that shape the behavior of supervisors and other low- to mid-level managers. Much attention has been given to how organizational characteristics, on the one hand, and the personalities of leaders, on the other, can promote or impede organizational change. Future research could benefit from looking at how self-processes are implicated in the kind of change that matters for mobility.
Ideally, the data used in this study would not have been collected as a part of an evaluation of a grant-funded project. There were powerful stakeholders (e.g., hospital CEOs, executive board members, managers, directors) with interests in continued funding, and this may have led to highlighting positive aspects of the program and downplaying negative aspects. This is not an uncommon problem in mid-stream evaluation research. Also, interview conditions did not allow for absolute confidentiality. The generalizability of this study is thus limited. Nonetheless, it provides substantial evidence that obstacles to upward mobility for low-wage workers can be overcome. It also suggests how social psychological processes, which are often less obvious, come into play. More attention to such processes, which arise at the intersection of the individual and the organization, is crucial to understanding how work experience matters for getting ahead or getting left behind.
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