

VALUES, RUBBISH, AND WORKPLACE LEARNING

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THE VALUE DILEMMA

In psychology and education, values are usually understood as personal preferences or subjective orientations toward the world. In other words, values are firmly located *inside the individual subject's mind*. While this may correspond to much of our everyday experience, there is also a very different, if not diametrically opposite, way of locating value. This alternative way is illustrated by a bitter letter to the editor, signed by the pseudonym 'A long-term unemployed with three degrees', recently published in the leading Finnish newspaper *Helsingin Sanomat*.

"I would like to finally utilize the education I have received and the experience I have collected through my life, but for both public and private sector employers, *my value* in the labor market seems to be full zero." [italics added]

The author of these lines talks about his or her value in the labor market. In other words, the value is primarily *in the object* – in this case, in the person trying to sell his or her labor power in the market. There is still a subjective element involved, namely the fact that the value of the object is assessed by the employers. But value is definitely not just a personal preference or subjective orientation of an employer; it is something more objective and societal.

In both profit-oriented management guidebooks and critical studies of organizations, work-related values are typically treated as mental and textual constructs of ideology, used primarily for purposes of motivating employees, gaining their commitment, or achieving control. Two books which share the same title, *Values at Work* (Cheney, 2002, Henderson & Thompson, 2003), are a case in point. Cheney's book is a critical analysis of the clash between cooperative and market values in the Mondragon cooperative, Henderson & Thompson's book is a guide for managers for building 'threads between people, performance and profit'. Despite their opposite ideological points of departure, both books treat values essentially as mental and discursive constructs. Paradoxically, even critical organizational studies of value seem at least

as mentalistic and subjectivist as traditional psychology of values (see also Barker, 1993). As Thevenot (2002, p. 52) puts it, they suffer from a “lack of material embedding of political and moral grammars.”

From the point of view of cultural-historical activity theory (Engeström, Miettinen & Punamäki, 1999), this point of departure is misguided. In an activity-theoretical view, values at work are embedded in the object of the activity. Objects are contradictory unities of use value and exchange value, generated materially, mentally and textually. In this view, values are also inseparable from motives. Thus, in medical work, the use value of illness as object generates the motive of healing, while the exchange value of illness generates the motives of treatment-for-profit and cost-cutting.

Being embedded in multiple activity systems simultaneously and successively, objects have lives of their own and resist goal-rational attempts at control and prediction. Negotiations of objects are always also negotiations of values and motives - not just of 'what' but also of 'why', 'for whom' and 'where to'. The doctor and the patient necessarily negotiate not only the diagnosis and treatment but also the consequences (use value) and the expenses (exchange value) of care, for both parties. Such negotiations are highly value-laden, whether their value aspect is openly articulated or not.

The articulation, questioning and expansive transformation of values can eventually only succeed at the level of collective activity systems. Problem solving and reflection-in-action at individual or dyadic levels will not suffice. This requires special kinds of learning actions. In particular, these actions include facing and questioning 'worthless' or 'useless' objects in negotiations and boundary encounters between actors with different power and hierarchical positions.

To get a firmer grip of values, we must first develop a framework for understanding the dynamics of objects as they move through different steps in their life cycles.

THE LIFE OF THE OBJECT: RUBBISH THEORY

Recent critical discussions on the importance of objects for organizational and social theorizing almost invariably emphasize the mobility, restlessness and continuous transformations of objects. While exciting, this rejection of static notions of object is also somewhat

troubling. In recent literature, there seems to be no way to systematically capture and analyze the precise nature, paths, and steps of movement and transformation of objects.

Appadurai's (1986) and Kopytoff's (1986) suggestions of studying the 'cultural biographies of things' were largely limited to the spheres of exchange and consumption, and the movement itself was reduced to the opposite processes of 'commoditization' and 'singularization'. Latour's (1996) suggestion of framing the movement in terms of 'localization' and 'globalization' is intriguing but very vague. Attempts to use models of activity systems for analyzing steps in the movement of objects (see Engeström, 1996) have thus far remained anecdotal.

We have to go twenty-five years back in time to find a rigorous and imaginative attempt to analyze step-by-step the movement of objects. This is Michael Thompson's (1979) book *Rubbish Theory*. Thompson's insight is that with time, objects lose their value and turn into rubbish. Rubbish, however, is not always the end point of an object's life. Out of rubbish, durables emerge. For example, the value of a car decreases each time it is sold, until it no longer appeals to any buyer and becomes rubbish. However, if this rubbish car is for some reason not destroyed but put away and left in a barn for another twenty or thirty years, a connoisseur may find it, and it may instantaneously become a durable collector's item with a high value attached to it.

Thompson calls the object in circulation a *transient*. There are two possible steps of qualitative transformation in the life of an object in circulation: (1) a transient becomes rubbish, (2) rubbish becomes a durable. Rubbish, the necessary middle point, is largely invisible, kept out of sight.

For Thompson, individual actions of buying and selling are not themselves particularly interesting (as they might be for Appadurai and Kopytoff). They represent only *quantitative* reductions of the object's value. What is interesting is the *qualitative* step from transient to rubbish, or from rubbish to durable.

Thompson's basic scheme focuses on circulation, or exchange. This is its basic weakness. Thompson does acknowledge that the spheres of production and consumption are equally important, but he fails to characterize in detail (indeed, even to name) the transitions of the object connected to those spheres. This is clear when one looks at the basic diagram in which Thompson summarizes his theory (Figure 1).

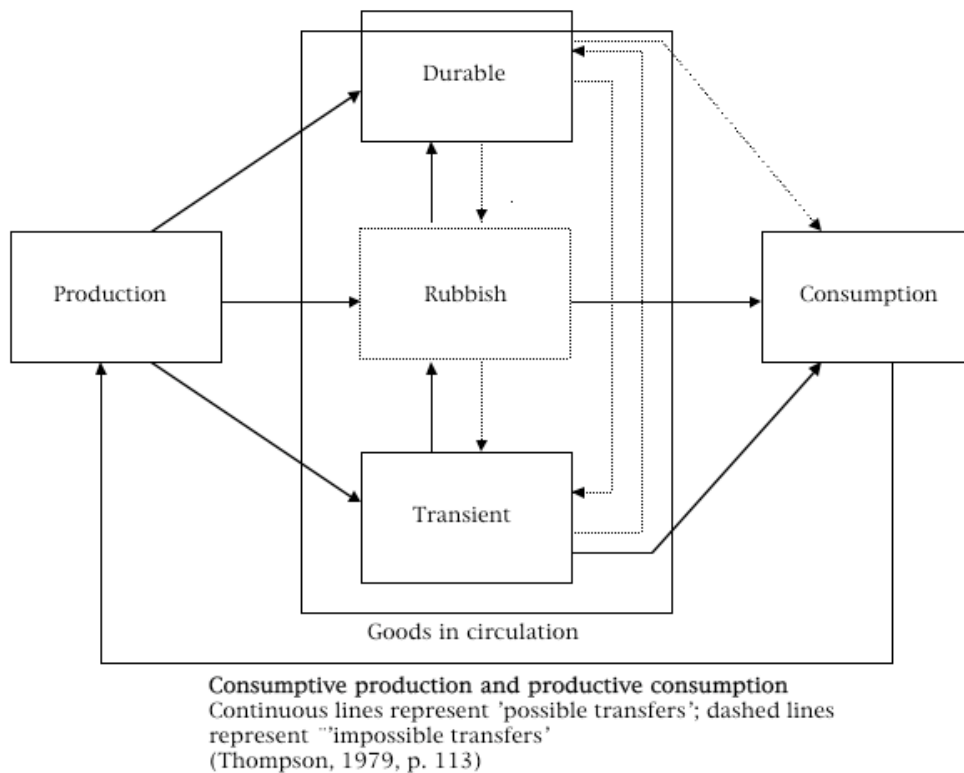


Figure 1. Thompson's basic model of transitions in the life of an object

OPENING UP PRODUCTION AND CONSUMPTION

I suggest that the spheres of production and consumption can very well be opened up for analysis at the same level of detail that Thompson devoted to exchange.

In Thompson's model (Figure 1), the bottom element of the exchange or circulation sphere consists of transients, publicly visible objects that are actively manipulated by selling and buying. One might characterize this part of the model as the *layer of public manipulation*. In the sphere of production, this layer is occupied by raw materials (including parts, or whatever ingredients the producer needs to put together a finished product). Raw materials are actively and publicly manipulated as they are turned into marketable products. In the sphere of consumption, this layer is occupied by objects in use – products being actively consumed by their so called 'end users'.

In Figure 1, the middle element in the sphere of circulation consists of rubbish - invisible, poorly controlled, and surprising.

“But of course the fact that the boundary between rubbish and non-rubbish is not fixed but moves in response to social pressures means that new elements may suddenly appear within his [the economist’s] field, whilst others may suddenly disappear in an equally distressing and inexplicable manner.” (Thompson, 1979, p. 12)

This middle part of the model may be called the *layer of invisible resistance and emergence*. In the sphere of production, this layer is occupied by products in repair, those products which have been returned to the producer from circulation or consumption because they have been found faulty or broken down before their warranty has expired. The producers are not keen on disclosing and discussing these troublesome items, yet they have to deal with them all the time as if in the shadows. In the sphere of consumption, this layer is occupied by objects being serviced, or maintained. Here the users themselves have to engage in the fixing and servicing of their objects in order to keep them usable. Again, this is not the favorite aspect of consumption we consumers like to discuss, except when engaged in the discourse of complaining.

The top element of circulation in Figure 1 consists of durables with increasing value. Durables are definitely public, but they are typically not supposed to be actively manipulated after they reach their status as durables. In effect, they are supposed to sit still and let their value grow as people observe, reflect, discuss and speculate about them – until the price is right and another exchange takes place. This top part may be called the *layer of public reflection*. In production, this layer is occupied by models which represent and guide the creation of the future products, in reflective dialogue with manipulative actions on raw materials. In consumption, this layer is occupied by objects displayed and admired, such as collectibles in galleries.

I will now put forward a diagram which completes the work started by Thompson (Figure 2). Each cell in the diagram may be understood as a distinctive state of the object.

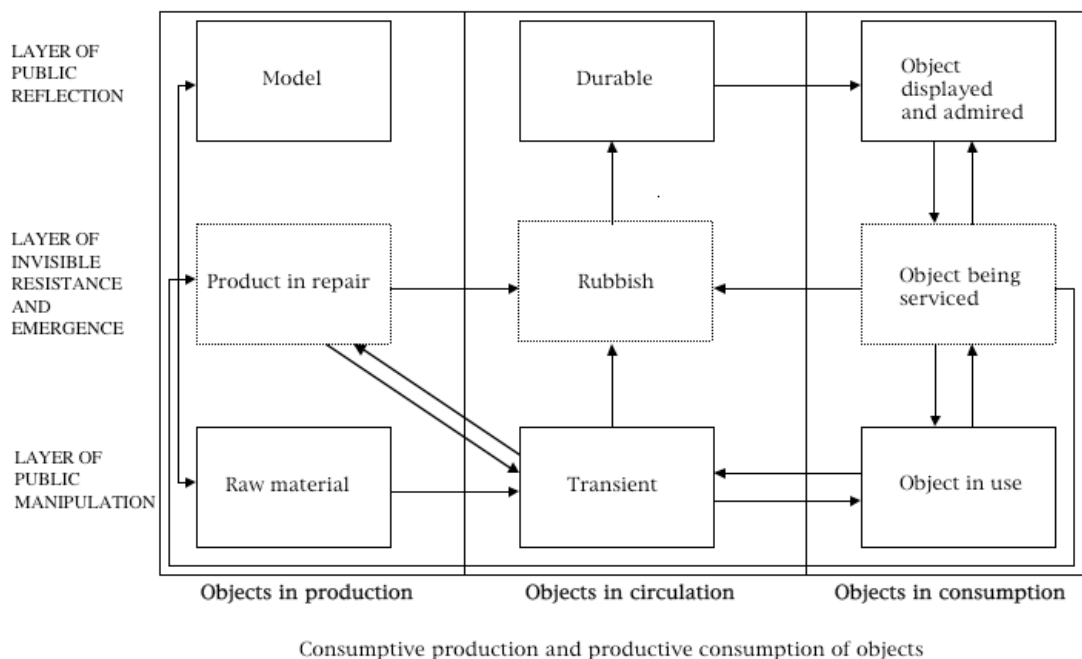


Figure 2. Spheres, layers and states in the life of an object

ACTIONS ON THE OBJECT

It is not enough to identify the spheres, layers and states of the object. The main task is to identify the transitions, or actions, that take place as the object moves between the different states.

As Figure 3 shows, I have identified sixteen possible actions that change the state of the object. To elaborate on the potentials of the framework, I will now briefly examine these actions.

As a concrete case, I will examine transformations in the life of a set of objects encountered on a daily basis in medical work in primary health care settings. This set of objects consists of patients and health problems increasingly 'dumped' on primary care clinics, at least in Finland. These include cases of alcohol and drug abuse, chronic pain, dependency on medications, chronic mental health problems, and more generally cases of multiple simultaneous chronic illnesses, especially in elderly patients. This vaguely defined and ill-bounded set of objects is sometimes characterized as 'difficult patients', 'demanding patients' or 'complex patients', but there is no general agreement or theory about what exactly makes them 'difficult', 'demanding' or 'complex'.

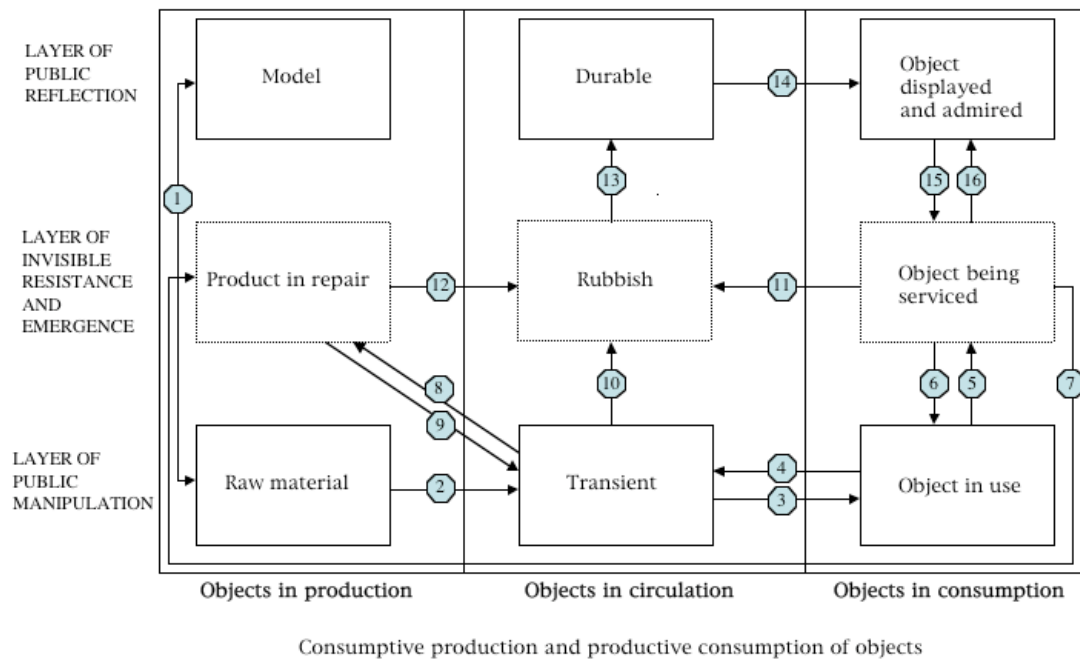


Figure 3. Possible actions that transform the object

The first action in Figure 3 is the naming of the object, which in medicine takes place by means of diagnosis and testing. More generally, this first action may be called *stabilization*. It involves separating the object from its background, giving shape to and defining the object as an identifiable entity. In medicine, accepted stabilizing names are listed in official classifications of diseases. These classifications are oriented to specific singular diagnoses based on biomedical data. They are notoriously useless for the characterization of cases in which multiple biomedical conditions, or worse yet, biomedical, social and psychological issues are intertwined. Thus, the very first action on these objects tends to be taken in a fragmenting mode, isolating one or more biomedically acceptable diagnoses from the messy totality of the patient's condition.

If the patient is diagnosed with medical condition that needs hospitalization, the object will be immediately placed in its appropriate Diagnosis Related Group (DRG). The DRG framework is defined as “a system for classifying patient care by relating common characteristics such as diagnosis, treatment, and age to an expected consumption of hospital resources and length of stay; its purpose is to provide a

framework for specifying case mix and to *reduce hospital costs and reimbursements and it forms the cornerstone of the prospective payment system.*” (Agency for Healthcare Research and Quality, <http://www.ahcpr.gov/>, emphasis added) In other words, the DRG system puts a price tag on the object. The price is based on statistical data on average costs of cases in the same DRG category (for a profit-oriented discussion of the DRG system, see Block & Press, 1986, for a critical study of the same phenomenon, see Geist & Hardesty, 1992).

Mean length of stay (LOS) is calculated by dividing the sum of inpatient days by the number of patients within the DRG category. Mean total charge is calculated by dividing the sum of patient charges by the number of patients within the DRG category. Total charges represent the dollar amount charged for the hospitalization rather than the amount paid or the actual costs to provide the care. Patients who are more seriously ill tend to require more hospital resources than patients who are less seriously ill, even though they are admitted to the hospital for the same reason. Recognizing this, the DRG grouper splits certain DRGs based on the presence of secondary diagnoses for specific complications or comorbidities (CC).

The use of the DRG system exemplifies the second action in Figure 3, the entrance of the object into the sphere of circulation and exchange. While this event is mundanely called as selling or buying, I call this the action of *commoditization*. The object enters the sphere of circulation and exchange with a price tag on it. This action is brought to conclusion when the patient, or whoever represents the patient, is for the first time charged or billed for the care. That is when the disease truly becomes a transient.

From the point of view of the patient, his or her condition is not anymore just his or her personal source of discomfort, suffering, and fear. It has become a package where the illness and the care are inseparably intertwined and constitute each other. How does this object enter the sphere of consumption?

As the patient receives care from the care provider, he or she typically begins to consume the care immediately. This is most obvious in the taking of medicine – a central action in almost all medical care. But even the less tangible aspects of care, such as instructions for the diet and physical exercise, must be actively used and implemented to produce an effect. The notion of ‘productive consumption’ is indeed very appropriate here. The third action in Figure 3 may simply be called *using*.

Often the patient’s condition and medication need to be checked and assessed regularly. When this requires a visit or some other billable

transaction with a care provider, the object returns to the sphere of exchange and appears as a transient once again. In a way, the value of this particular illness case is reassessed. For lack of a better term, I call this the action of *consumption-initiated recommoditization*.

Of course not all actions of care require a re-entry to the sphere of exchange. In chronic illnesses, a large amount of service work is done by the patient on him- or herself. These are examples of the fifth and sixth actions in Figure 3. The fifth action may be called *maintaining*. The sixth one is typically tightly coupled to the fifth one and may be called *reusing*.

When a patient's condition deteriorates significantly, often through the appearance of new, related diseases, the object typically re-enters the sphere of production. In a way, all chronic illness is riddled with continuous product recalls. After a while, the prescribed care regime proves insufficient, so new diagnoses and care regimes are needed (Wiener, Fagerhaugh, Strauss & Suczek, 1984). This re-entry to production may be initiated from consumption, that is by the patient him-or herself (action 7), or from exchange, that is by a caregiver organization (action 8). I call these actions *consumption-initiated* and *exchange-initiated restabilization*, respectively. Action 9 in Figure 3 represents the *production-initiated recommoditization* of the object.

Two major questions remain. How do these patient cases become rubbish? And how might they become durables?

There are three ways in which a disease may become rubbish. The first one is pretty obvious: the patient is so poor, and the medical insurance arrangements are so weak or non-existent, that the patient's care is not anymore billed, which means that the patient is not anymore given care, or receives care as a charity only. The second alternative is that the patient becomes so old and/or weak that the care providers begin to see the care as useless or too costly for the limited benefits gained. The third alternative is the most subtle, and very possibly the most common one. The patient's illness may become a trivial routine or disturbing nuisance and abuse of medical services for the medical care providers, which leads them to see the object as rubbish, to be avoided and sent away as soon and with as little expense be as possible.

The third alternative has been extensively studied by Mizrahi (1986) in her perceptive book *Getting Rid of Patients*. On the basis on extensive

ethnographic fieldwork in a hospital, Mizrahi describes the invisible classifications at play.

“Within the house staff culture there were two major systems of social classification. The first depended on the disease of the patient – ‘interesting’ versus ‘uninteresting’ – with the latter category predominating during the house staff’s graduate medical training. This system of categorization is basically devoid of reference to the external social structure and to some degree independent of the personal and social characteristics of the patient. It is almost solely determined by professional criteria related to diagnosis; that is, the symptoms are the primary basis of valuation, and outcome of the disease – whether it is curable – is the secondary basis.

The second system of social classification begins with the ideal patient and ends with the despised patient. The ideal patient is described in terms such as ‘clean,’ ‘articulate,’ ‘cooperative,’ and so forth – most of which closely conform to external systems of social status. Despised patients are defined as abusers – of themselves, the system, house staff – and as such are subject to counterabuse.” (Mizrahi, 1986, p. 70)

However, the final determinant of rubbish is economical: the ‘bottom line’ in patient calculation, as Mizrahi points out.

“When the house staff did raise the issue of costs, it was almost always in regard to patients who were wasting taxpayers’ money by inappropriate use of the medical or hospital facilities. This assessment of patients who ‘abused’ the system clearly supported their desire to GROOP [get rid of patients] those who, in their estimation, were costing the taxpaying public millions of dollars for unwarranted care.” (Mizrahi, 1986, p. 79)

Here is a poignant quote that concerns diabetes, taken from an interview with one of Mizrahi’s subjects.

“We get tired of it ... if it’s the fifty-seventh [hospital] admission for somebody who is diabetic who gets drunk and doesn’t take insulin and then has to be intubated in the intensive care unit. ... Everybody says along the way, ‘Why are we spending all this money on this guy who is trying to kill himself?’” (Mizrahi, 1986, p. 80)

Figure 3 shows that an object may enter the state of rubbishness through three actions (10, 11, and 12). The first route (action 10) is through a exchange in which a transient is found to possess minimal or no value. In medicine, this might happen when a care provider tries to hand over a patient (such as the one described by Mizrahi’s informant in the quote above) to another care provider. The second route (action 11) is initiated in a maintenance effort, when an object in consumption is found hopelessly worn out and thus discarded as rubbish. This might be what the patient in Mizrahi’s quote above had actually done to his own illness and to himself. Finally, the third route (action 12) is initiated in a repair effort within production, when repair of the product is found too costly. If the care prodvider in Mizrahi’s example

simply abandons the patient for all practical purposes, it performs this action. I call these three actions *devaluation in exchange*, *devaluation in maintenance*, and *devaluation in repair*, respectively.

Now what about diabetes becoming a durable? In medicine, objects become durable when they are hailed and immortalized as breakthroughs. It used to be so that after a heart disease had progressed beyond a certain point, it was considered incurable and became in effect rubbish. When Christiaan Barnard performed the first open heart transplant surgery in 1967 with great international press coverage, certain variants of heart disease rubbish became objects of heroic breakthrough medicine. The event, the technique, and Barnard himself became durables, standard icons in medical history texts.

Few people remember that the first patient to receive a heart transplant was Louis Washkansky, a 55 years old man suffering from diabetes and heart disease. Of course diabetes did not reach the echelons of durability. It remained a sidetrack of the story that may be retrieved from the rubbish dumps of medical history.

The thirteenth action in Figure 3, the transition from rubbish to durable, may be called the action of *revaluation*. When a durable is placed into the sphere of consumption (action 14), the action may be called *freezing*. Finally, when a frozen object – such as the iconic representation of Barnard and his transplant surgery – needs maintenance (e.g., the forthcoming celebration of the 50th anniversary of the first open heart transplant in the year 2017), the actions of *retouching* (action 15) and *refreezing* (action 16) are initiated.

HOW VALUE IS SHAPED

The life of the object is also the life of value. In the production sphere, the object takes its shape and acquires its value by virtue of being transformed by human labor. The amount and kind of labor invested in the production of the object represents the foundational ‘hard core’ of value. The action of commoditization (the second action in Figure 3) is the anticipatory definition of the exchange value of the object. This is a critical step, as observed by Leont’ev.

“The doctor who buys a practice in some little provincial place may be very seriously trying to reduce his fellow citizens’ suffering from illness, and may see his calling in just that. He must, however, want the number of the sick to

increase, because his life and practical opportunity to follow his calling depend on that.

This dualism distorts man's most elementary feelings. Even love proves capable of acquiring the most ugly forms, not to mention love of money, which can become a veritable passion." (Leont'ev, 1981, p. 255; see also Rodwin, 1993, for a recent collection on physicians' conflicts of interest)

In the sphere of exchange, the object is sold and bought. One might say that the sphere of exchange is the sphere of negotiated value, where fluctuation and situational factors play an important role. But at the same time, there is something fatefully pre-determined in the evolution of value in the sphere of exchange. In the longer run, each resale of the object is tendentially a step further toward becoming rubbish. The eventual critical action of devaluation (action 10 in Figure 3) involves some kind of conclusive declaration of the worthlessness of the object. Becoming rubbish has thus a sense of finality. When a person is declared 'chronic', or 'disturbed', or 'alcoholic', or 'uninsured', or 'troublemaker', the stigmatic definition is very difficult to eliminate or transform. In terms of exchange value, this status means that there are very few or no buyers: the expenditure of dealing with rubbish is considered greater than any possible gain or revenue. In this sense, rubbishness is a state of inaction, of decaying in a limbo. Only very few lucky objects find their way into revaluation and durability.

The 'softness' and malleability of value is revealed in the sphere of consumption. Each user of the object finds it easy to decrease its value: just use it, or easier yet, just let it sit and become old. This eating away of value in consumption seems innocent enough as long as the user does not have to face the fateful transition of the object into rubbish.

Now these observations have an uncomfortably deterministic sound. They may help us see critical steps in the formation of object and value, but they also seem to exclude the possibility of reversals and deviating courses of action. This is why I think the theory is severely incomplete and biased in the form presented thus far. The task of the next section is to show how this bias may be corrected.

THE INTENTIONAL RESHAPING OF VALUE

Consider physicians, nurses, assistants and receptionists working at a primary care health center, responsible for providing health care services to the local population for no or nominal fee. A very significant portion of their clients are the types of ‘complex’ or ‘demanding’ patients described earlier. By now it should be clear that these are patients who are either already declared or rapidly becoming rubbish.

In fact, it seems clear that dealing with these rubbish or near-rubbish cases is the characteristic that distinguishes this type of public health centers from other medical providers, such as private clinics or hospitals. These professionals are doomed to deal with rubbish as the core object of their activity.

For neoliberal ideologists, politicians and entrepreneurs, the decline of public health into a marginal rubbish dump is of course welcome. On the other hand, among practitioners it evokes various reactions of denial, defense and escape.

Expanding on the theory presented in this paper makes it clear that there are much more optimistic and exhilarating alternative courses of action available for practitioners.

The theory, as presented thus far, depicts the state of rubbishness as the inevitable end point of most objects. The only alternative to rubbishness is the equally final and closed end point of becoming a durable. Both rubbish and durables are essentially dead ends, domains of inaction and immutability. This leaves the nature – understood as resources not yet molded by humans – as the only source of new raw materials for objects. Human activity looks like an endless process of exploiting nature, of turning natural resources into artefactual objects and eventually into useless rubbish.

There are three types of significant actions that are not accounted for by this limited version of the theory. First, there are actions of *playful conversion* which basically search and pick up rubbish to turn it into newly defined raw materials (action 17 in Figure 4). Secondly, there are actions of *caring revitalization* which pick up rubbish and turn it into newly conceptualized transients (action 18 in Figure 4). Finally, there are actions of *engrossed appropriation* which turn rubbish into enjoyable

objects in use (action 19 in Figure 4). I will briefly examine each one of these three expanded action types.

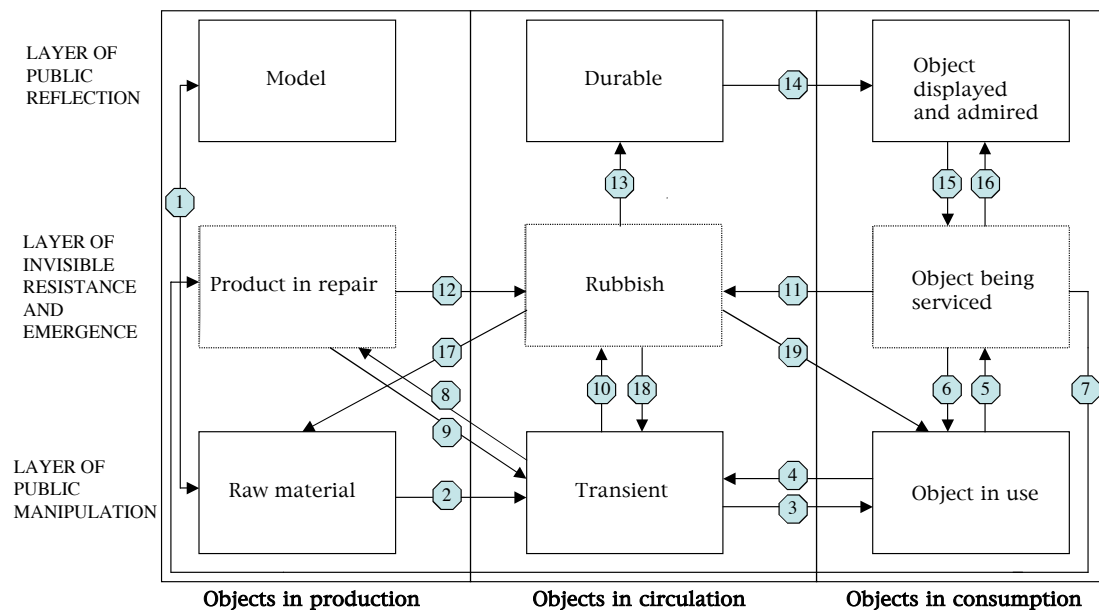


Figure 4. Expanded model of actions on the object

Actions 17, 18 and 19 are peculiar in that they do not seem necessary for standard rational-choice economics, yet they undeniably take place all the time. Let us first take a look at action 17, playful conversion.

It is well known that inventors and artists look for and use pieces of rubbish as raw material for their works, sometimes with astonishing results. Children and teachers of the innovative educational practices of Reggio Emilia in Italy use items of rubbish and convert them into toys for productive play. The most obvious case of conversion is the recycling movement in its different manifestations, from local voluntary efforts to nationwide programs promoted and administered by states and municipalities. What is playful about all these examples, including recycling, is the idea that useless junk may be converted into something unexpectedly useful, even beautiful.

How could this action apply to rubbish patients in public health care? How might complicated or demanding patients be converted into rawmaterials for something quite different?

There is a relatively simple answer to this. Many of the patient groups mentioned earlier are in fact left in the shadows of medical research, so that there is actually very little knowledge and understanding of the nature of their problems and needs. Patients with multiple overlapping medications – and potential dependencies on medications – are a case in point. Excessive medication is clearly an economic and medical problem. To tackle it effectively, we need more in-depth knowledge from the field. Few would be better equipped to generate this knowledge than the general practitioners working at public health centers. Rubbish patients, such as those with excessive medications, and their stories may thus be converted into ethnographically grounded research knowledge, which in turn will serve as raw material for designing new tools, policies and practices for changing the situation. What is playful about this kind of conversion is that it involves experimenting with new genres of research, for instance bringing together practice-bound case narratives, locally grounded theorizing, and statistical generalizations.

The second new action depicted in Figure 4 is caring revitalization (action 18). This action implies turning rubbish back into transients within the sphere of exchange. In everyday life, we witness such salvaging actions all the time. The typical scenario is the following. A person throws away or abandons an object as rubbish. Another person sees the object and exclaims: “Please, don’t throw it away, give (or sell) it to me, I can still find good use for it!” The object changes hands and – simultaneously – returns from the abyss of rubbishness to the land of living transients. What is caring about such an action is that it necessarily involves compassion for something already condemned. What is revitalizing about it is that it literally gives new life, a new hope, to the object. This typically happens by means of reconceptualizing the object. The new user has a slightly (or radically) different idea for the use of the object: the object is about to receive not only new life, but also new identity.

Again, how could this action apply to rubbish patients in public health care? How might difficult or demanding or hopeless patients be redefined as interesting transients?

The very act of changing hands may offer a key to an answer. The treatment of patients in a busy health center typically takes place in dyadic form, between the individual physician (or nurse) and the individual patient. Practitioners seldom have a chance to look at their colleagues' cases. And it is even more rare that patients get a chance to discuss each others' problems and care. To make space for actions of caring revitalization, collaborative reconceptualization sessions between multiple practitioners – and eventually multiple patients – might be an effective way to go. For a start, each practitioner might simply select a difficult or hopeless case, put together the data available on the case, and present it in a joint session of the practitioners at the center. A more demanding step would be to involve the patient him- or herself in such a session. The most demanding format would bring in multiple patients who have been similarly categorized.

The potential of such sessions lies in the shifting and cross-breeding of perspectives. At the same time, such sessions represent a new type of caring. The patient is taken as a person who has a voice that is worth listening to.

The third new action depicted in Figure 4 is engrossed appropriation (action 19). This action involves turning rubbish into enjoyable objects in use. This implies a concept of consumption and pleasure very different from neoliberal notions.

“When market theorists think about a pleasurable, rewarding experience, the root image they have in mind seems to be eating food (‘consumption’) - and not in the context of a public or private feast, either, but apparently, food eaten by oneself. The idea seems to be of an almost furtive appropriation, in which objects that had been parts of the outside world are completely incorporated into the consumer’s self. (...) one need only imagine how different the theory might look like if it set off from almost any other kind of enjoyable experience: say, from making love, or from being at a concert, or even from playing a game.” (Graeber, 2001, p. 260)

An everyday example of the action of engrossed appropriation is that of listening to a story told by an unlikely narrator who opens up a window into his or her world of the downtrodden. This is the simple secret behind the influence of entire genres of books and

films, from Franz Fanon to Studs Terkel, from Luis Bunuel to Aki Kaurismäki.

It is not too difficult to see the implications of this for the care of rubbish patients in public health care. Eliciting and listening to the patients' stories is of course easier said than done. Time pressure and output demands are heavy. Therefore, it seems necessary to combine the actions of engrossed appropriation with the actions of caring revitalization and playful conversion discussed above. Together, these three actions represent a significant new component to be introduced into the work of primary care practitioners. This component consists of research, listening, and collaborative reconceptualization. Such a reflective component of work will eventually generate new diagnostic categories and new methods of care. Such a component is worth fighting for. It requires administrative and political recognition and allocation of appropriate resources in terms of time, space, and tools.

THE LEARNING CHALLENGE

Coping with rubbish or, more exactly, revaluing rubbish is a challenge to workplace learning. It does not concern only public medical care. In our studies of postal work, we witnessed the same contradictions when mail carriers discussed their relationship to 'junk mail' (Engeström, Virkkunen, Helle, Pihlaja & Poikela, 1996). The same phenomenon appeared in a study of firefighters facing the increasingly prevalent 'useless calls' from people with non-serious emergencies (Mankkinen, 2002). And it came up again recently in our study of investment managers in a bank, discussing what they called the 'unproductive mass' of relatively passive clients (Engeström, Toiviainen, Pasanen & Haavisto, 2004). To condense, the challenge consists in turning rubbish into gems. The gems are not to be understood as dead durables, but as live raw materials, transients, and enjoyable objects in use.

The three expansive actions identified above - playful conversion, caring revitalization and engrossed appropriation - are actually demanding actions of learning. They expand the 'normal' life process of the object, adding a reflective and creative layer to it.

This is the very meaning of learning actions (see Engeström, 1999).

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