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Erasmus University Rotterdam
Making Minds Matter

Jannine van Schothorst

THE BALANCING ACT

Developing new professional roles against a background of high expectations and tough practices

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The Balancing Act
Developing new professional roles against a background of high expectations and tough practices

De Balanceeract
Het ontwikkelen van nieuwe professionele rollen tegen een achtergrond van hoge verwachtingen en taaie praktijken

Proefschrift

ter verkrijging van de graad van doctor aan de
Erasmus Universiteit Rotterdam
op gezag van de
rector magnificus

Prof.dr. A.L. Bredenoord

en volgens besluit van het College voor Promoties.
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CONTENTS

	Voorwoord	7
Chapter 1	General introduction	11
Chapter 2	The role of emergency physicians in the institutionalization of emergency medicine	41
Chapter 3	Nurses in the lead: a qualitative study on the development of distinct nursing roles in daily nursing practice	57
Chapter 4	The balancing act of organizing professionals and managers: An ethnographic account of nursing role development and unfolding nurse-manager relationships	79
Chapter 5	Role of Dutch internal policy advisors in a hospital quality improvement programme and their influence on nurses' role development: a qualitative study	105
Chapter 6	Discussion: professional role development in everyday practice	125
Chapter 7	Concluding remarks	151
Summary		161
Samenvatting		165
Dankwoord		171
PhD portfolio		173

VOORWOORD

Het is zondagavond 20 maart om 22:45 uur. We staan in het ziekenhuis aan het bed van mijn vader, die kort daarvoor is overleden. Verpleegkundige Benthe, die voor hem verantwoordelijk was in de avonddienst, en haar collega Marit staan bij ons. Mijn zus en ik staan aan de ene kant van het bed, zij staan aan de andere kant. Marit vraagt: “Zouden jullie willen helpen om jouw vader te verzorgen? Haar vraagt geeft mij net het duwtje wat ik nodig heb. We rijden zijn bed naar een éénpersoonskamer, aan het einde van de afdeling. Met z’n vieren staan we om zijn bed en verzorgen we hem. De verpleegkundige reiken mijn zus en mij om de beurt een washandje of een handdoek aan. Ondertussen praten we over hoe het die avond ging. Dat hadden ze daarvoor ook al verteld, in een ‘officieel moment’ met alle gezinsleden. Nu vertellen ze het opnieuw tussen de bedrijven door; ongedwongen vertellen ze nog eens hoe het ging. Waar het gesprek met mijn vader over ging, hoe hij zich voelde in die laatste minuten waarin hij onverwacht benauwd werd. En hoe zij als verpleegkundigen samen dat hectische moment opvingen. De één bleef bij mijn vader, ondersteunde hem en deed verpleegtechnische handelingen. De ander belde de arts, trok medicatie op en stond haar collega bij de nodige verpleegtechnische handelingen bij. Hoe vervolgens mijn vader weer stabiliseerde, de controles goed waren en hij helder was tot het laatste moment. Dat zij vonden dat hij het allemaal zo goed doorstond. Dat hij vertelde dat hij als docent economie op het mbo “met die gasten van 17, 18 jaar leerde om ergens tegen te kunnen”. En hoe hij ineens zijn laatste adem uitblies, terwijl ze met hem bezig waren. We draaien hem, leggen een laken onder hem, draaien hem voorzichtig terug. Iets omhoog. Z’n hoofd ligt iets te ver naar achteren. Een extra kussentje eronder, iets verleggen nog. Zo ligt hij mooi. Ondertussen vertellen wij, hoe hij de dag ervoor onrustig was. En dat hij die zondag zo’n goede dag had, zijn leven in Gods hand kon leggen en hoe dat ons ook troost geeft. Zij begrijpen dat. We praten nog even over ons verpleegkundige vak. En dan is het 00:30 uur. We zijn klaar en merken op dat de dienst van deze twee verpleegkundigen allang afgelopen is. We lopen terug en ik denk: “Dit is waar het om gaat in de zorg.” Ik neem getroost en dankbaar afscheid van mijn vader.

Ik had niet gedacht dit proefschrift te beginnen met een persoonlijke etnografie. Na ruim vier jaar etnografisch onderzoek en het ‘binnen 24 uur maken van thick descriptions’, om de ervaringen en betekenis van zoveel mooie en soms ingewikkelde observatiemomenten vast te leggen. En nu aan den lijve te ervaren hoe het is om, in zeer emotionele omstandigheden, opgevangen te worden door verpleegkundigen. Verpleegkundigen die hun dagelijkse werk haast onzichtbaar combineren met emotionele steun, die helpen bij het begin van verwerken. Maar ook tal van praktische regelzaken doen, terwijl zij ondertussen een verpleegkundige in opleiding de kneepjes van het vak leren.

Ruim vier jaar mocht ik onderzoek doen naar de ontwikkeling van het verpleegkundig en medisch beroep en hoe professionals in de zorgpraktijk zelf invulling geven aan de ontwikkeling van nieuwe rollen. Een complex samenspel binnen de professies, tussen professies, tussen professionals en managers en in interactie met interne beleidsadviseurs. Ik heb genoten van het schaduwen op de verschillende afdelingen en het meedraaien in de organisatorische context. Tot in de late uurtjes zat ik op de SEH, maakte de spanning mee, zag het professioneel handelen in acute situaties. Plakte mijzelf tegen de muur om niet in de weg te lopen en tegelijk het fascinerende werk en de interactie waar te nemen. Soms actief beïnvloedend en spiegelend om in gesprekken met professionals, managers en bestuurders in Rijnstate, HagaZiekenhuis, Isala, Reinier de Graaf Gasthuis en ZuidOostZorg. Vele momenten van samen leren en verbeteren. Ik genoot van de dynamiek, de spanning, het politieke spel met macht en belangen, en de persoonlijke noot. Dit onzichtbare werk, dat op allerlei plekken in zorgorganisaties plaatsvindt, is niet te vatten in rolbeschrijvingen. Het vraagt om vakmanschap en ruimte om de eigen werkomgeving vorm te geven, om te leren en bij te stellen wanneer het niet aansluit bij de complexe dynamiek van professionele praktijken. Een waardevol proces van actie en reflectie, die soms vraagt om vertraging en even afstand nemen. In dit proefschrift laat ik zien hoe dat ingewikkelde proces in de zorgpraktijk vorm krijgt, als een balanceer act. Met hoge verwachtingen en soms taaie praktijken is het een ontwikkelproces dat niet af is. Het is een “ongoing journey without clear routes”.

1

General introduction

1.1 INTRODUCTION

Vignette 1: In the summer of 2019, Dutch nurses unexpectedly rebelled against a proposed law amendment that would make a formal distinction between different training levels in nursing. The nurses' revolt was organized on the shop-floor level and played out on social and conventional media in the midst of a heat wave. It was a powerful, unanticipated response to years of preparation by appointed experts, including professional nursing associations, unions, employers and the Ministry of Health to make a long wished for distinction between in-house, vocational (VN), bachelor's (BN) and master's (NP) levels of education. The planned reform intended to move nursing work onto a higher level and foster nursing role development. Nurses who had not obtained a bachelor's degree objected vociferously, arguing that the new amendment would render them second-rate nurses, no longer allowed to do the complex tasks that they were experienced enough to do, tasks moreover of crucial importance in the light of an ageing population with growing care needs. The protesters succeeded in provoking national debate and concern, and this led to a quick withdrawal of the proposed amendment.

Vignette 2: Only a couple of months later, the Dutch healthcare system faced major challenges due to the outbreak of COVID-19. Unfamiliarity with the virus and the severity of patient infections put intense pressure on hospitals, especially on intensive care units. Regular healthcare was scaled down, and the crisis changed the established task division between physicians and nurses on all educational levels. An exceptional situation arose. Nurses and physicians without relevant training were assigned to acute care and intensive care units. This meant that properly trained nurses and physicians had to delegate complex tasks to colleagues who lacked specific knowledge of intensive care and this led to situations where experienced nurses had to supervise inexperienced physicians. The COVID-19 pandemic led to a political awareness of the need to have a broader, generalist nursing role that would facilitate a fast and effective response for specific care in times of crisis.

Professional role development in healthcare is key to the highly politicized debate on the future of our healthcare systems. The current crises in healthcare, both the sudden, urgent crisis caused by the COVID-19 pandemic and the 'creeping crisis' of decreasing numbers of healthcare professionals available to deal with an ageing population (e.g. van Pijkeren et al. 2021) demand new ways of thinking about the tasks and responsibilities of healthcare professionals. The first vignette illustrates that when a national committee of commissioned experts defines new professional roles, this top-down development often causes resistance and dissent when the new distinctions are rolled out over the profession, (Poitras et al., 2016; Felder et al. 2022). In this nursing case, the new

role distinctions put emphasis on acquiring textbook knowledge and evidence-based practice and rendered on-the-job training in daily practice less important and valuable. Moreover, this example shows how difficult it is to make a meaningful connection between distinct nursing roles, based on educational levels and the tasks each role is allowed to perform.

The second vignette shows that in times of crisis professional boundaries and cultural, hierarchical patterns can get blurred in daily practice. Consequently, outsiders to the profession (e.g. politicians) take up the discussion about the further development of professional roles. Both vignettes raise societal questions. What is a relevant professional role distinction based on educational levels? Who is in charge of healthcare professional role development? And: what influence do external requirements have on role development? Answering these questions requires a thorough understanding of professional role development in daily healthcare practice.

The focus on role development within professions and organizations ties in with a broader trend of transitions in healthcare systems to meet current and future healthcare challenges. First, healthcare has to deal with growing complexity in the systematic organization of care. The complexity of organizational processes and competing logics complicates solving emerging problems in the healthcare system (Greenwood et al., 2011; Rouse & Serban, 2014; Chandler et al., 2016). Among other aspects, this requires a reorganization of tasks, rearrangement of professional roles and raises questions about the required (higher) educational level of professionals. Second, healthcare faces a growing demand for care, because of a growing ageing population (WHO, 2019). The number of clients with multimorbidity amplifies the complexity of care processes (Harvey et al., 2018). Third, due to the ageing population and more (technical and treatment) opportunities in healthcare (Goyen & Debatin, 2009), healthcare costs are rising. These challenges lead to questions about the reallocation of tasks, e.g. from physicians to nurse practitioners, or from nurses to nursing aids. Fourth, shortages in the labour market threaten the feasibility or availability and accessibility of healthcare and increases the workload for professionals, influencing the quality of care and leading to professionals leaving the profession. This reinforces the discussions about the attractiveness of professional roles. These trends require transitions in healthcare systems (e.g. decentralization) and in professional roles, but simultaneously lead to a revaluation of professionals and to reprofessionalization.

This dissertation studies how nursing and medical role development is 'fleshed out' in daily professional practice. To gain a thorough understanding of the complexity of professional role development, I studied role development on three organizational levels – micro, meso and macro – investigating how role development is influenced by the interplay between different (hierarchical) actors, in relation to professional ambitions and organizational needs and in interaction with external stakeholders including

policy makers. To that end, I elaborate on three theoretical fields that enable studying both evolving professional practices and the institutional fields in which professionals act: the sociology of professions, institutional theory and practice theory. The sociology of professions focuses on professional role development within organizations and the political system, often focusing on questions of professional autonomy and jurisdictions (Abbott 1988; Freidson, 2001; Currie, Finn & Martin, 2010; Evetts, 2011; Noordegraaf 2016). Institutional theory sheds light on the formal and informal 'rules of the game'. It studies the influence of law and regulation as well as the role of traditions that shape the playing field of (in our case) professional role development. To deepen insights into how professionals engage in 'doing' their work and how they shape social (inter)actions, organizational structures and professional routines, I use practice theory (see section 1.6).

To set the scene, I will outline the historical context of Dutch nursing and medical role development (1.2), after which I will describe the concept of professional role development (1.3). Then I will further explain the three theoretical foundations (1.4–1.6) and follow that with the research aims and questions (1.7), and the research design and methodology (1.8). The Introduction ends with an outline of the rest of the dissertation (1.9).

1.2 PROFESSIONAL ROLE DEVELOPMENT IN THE NETHERLANDS

From a historical perspective, the development of professions is closely connected to the development of healthcare institutions, initially hospitals, and is strongly influenced by major sociocultural phenomena, such as the development of knowledge and technology and the changing social and gender relationships. Although it is beyond the scope of this thesis to accurately describe these historical influences, providing a rough overview is important to understand the current role division between physicians and nurses. Therefore, I broadly describe the influence of these contextual factors on the development of the medical and nursing profession. This contextualization is relevant to understand the background and developmental differences in medicine and nursing – in medicine the focus is on rational thinking and technology while in nursing the focus is on caring – and to understand the relationship between nurses and physicians.

The system of professions and organizations we know nowadays underwent major transitions in the 20th century. Prior to that, healthcare was seldom institutionalized because of limited knowledge about health and sickness and the adverse outcomes in the 'guest houses' (gasthuizen) as hospitals were then called in the Netherlands. The focus in healthcare lay on caring, generally done by female relatives in the patients' own homes, or – in the case of poverty and illness – by monks and nuns in monasteries or

charitable guest houses. In medicine, numerous scientific findings in the 19th century and early 20th century supported the professional development of physicians, which was based on academic education and clinical research (Lindeboom, 1972). With the development of medical knowledge and instruments, treatment increasingly took place in hospitals. The value given to knowledge and rational thinking and the emphasis on healing prospects increased the physician's key status, leading to their position of physician-directors in the hospital, making them out to be professional, organizational leaders (Boot & Knapen, 2003; Granshaw & Porter, 2012).

The shift from guest houses to hospitals also gave nursing role development a boost. Quality of care was lacking in the first hospitals. Unskilled maids and servants did the caring while wealthy – and often more skilled – women were not allowed to get involved, fuelled by prudishness and gender role perceptions. In line with the institutionalization of health care, nursing and medical associations arose worldwide and set up standardized educational and examination systems to enhance the level of caring and establish nursing as a profession. Two aspects are remarkable in this development. First, internationally, there was a discussion about who was in charge of the care. Was it nurses, with exclusive admission to the associations? Or was it physicians, hospital directors and matrons without nursing experience? This debate on nursing or medical leadership in nursing role development/professionalization also happened in the Netherlands. Second, the importance of the role nurses played in the development of their own profession was identified yet also denounced as "disinterest, apathy, lacking a sense of solidarity and knowledge of social conditions, allowing them to tolerate these issues, without attempting to move forward" (Wiegman, 2012). Today these topics are still present in the discussion on professional role development and the nurse-medical relationship.

The nurses' level of influence differed across the world. In the United Kingdom, Florence Nightingale, for example, played an essential role as the founder of the nursing profession, as well as in the reorganization of a small London hospital. In the Netherlands, the physician-directors were accompanied by matrons, wealthy women who had not always worked or had been educated as nurses themselves. They were more likely to maintain a good relationship with the directorate and to keep nurses as the labour force rather than supporting nurses in professional improvement. At the same time, due to their low social status and backgrounds, nursing groups seldom operated homogeneously, taking on a joint position or view. The empowerment and professional attitude of Dutch nurses lagged behind their American and British colleagues, for example. In the Netherlands, the professional background of nurses, influenced by social-cultural gender relationships and loyalty to medical orders, resulted in a long-lasting subordinate position, power inequities and lack of autonomy (Chua & Clegg, 1990; Van Oostveen, Matthijsen & Vermeulen, 2015).

Where physicians historically possess an academic level of education, successfully displacing the surgeons (chirurgijns) with their limited and practical knowledge, nurses historically possess a vocational level of education and expertise. This is related to the view on caring as an extension of domestic work, the social-cultural position and supported by national policy and legislation (Ayala, 2019; Brockman, Clarke & Winch, 2008; Chua & Clegg, 1990) that hindered the development of an own, well-defined, institutionalized and specialized nursing body of knowledge. The introduction of higher (bachelor's or master's) degrees differed worldwide, demonstrating a different duration for nursing role development and resulting in specific country levels of education (Brockman et al., 2008; Francis & Humphreys 1999, Gunn et al., 2019). The Netherlands, for example, started in-house (diploma) training in 1921, while the United States established a university-based School of Nursing (Duijvestein-Ockeloen, 2016). In the Netherlands, it became possible to obtain a bachelor's degree in nursing in the 1970s, with the introduction of the vocational and bachelor educational system. Diploma education continued up to 2000.

Nursing in the Netherlands does not hold a unique position. In several countries across the world, registered nurses are educated at various levels: with a baccalaureate degree (BS), an associate degree (AD) or a diploma training. The diversity in education, however, does not translate into (differentiated) practices. In several countries the question still lives if and how a distinction should be made in nursing, based on an educational level (Matthias, 2017; Endacott et al., 2018; Van Kraaij, 2022).

In the 20th century, the healthcare sector grew enormously with the rise in knowledge, wealth and social legislation. This led to the growth of specialized institutions, in psychiatry or elderly care, for example. In nursing and medicine, it led to further specializations in distinct professional domains (Jones, 2005; Castiglioni, 2019) and the establishment of distinct professional profiles and legal jurisdictions. Nowadays, medicine is a broadly, master's educated profession, supplemented by specialist training in a distinct field of medicine. Dutch nursing now comprises three differently educated groups: vocationally trained nurses (VNs) and nurses with a Bachelor of Science degree (BNs). Both VNs and BNs may have supplementary specialist education or fulfil senior roles that include organizational-managerial tasks. The third group comprises nurses with a Master of Science degree who operate as nurse practitioners (NPs), physician's assistants (PAs) or nurse scientists (NS), who are employed as 'pure scientists' by the university or operate in close connection with nursing practice in the development of the professional field (Taylor & Wiseman, 2020). Generally inspired by shortages in the medical workforce, nurses have enhanced their roles, taking over such medical tasks as diagnosing and treating patients. However, the degree of autonomy and final responsibility of nurses on all levels (VNs, BNS, NPs and PAs) has been contested.

Nowadays, nurses are expected to respond to current challenges in the organization and delivery of healthcare, possessing competence in communication, organization and care quality improvement. Together with the internal professional developmental demands, this requires the further development of nursing roles. However, the national discussion on nursing role distinctions mainly concerns professional jurisdictions and the lack of autonomy and unwanted hierarchy between nurses mutually, and between nurses and physicians (see also Abbott, 1988).

This section showed how nursing roles have developed in relation to medical roles. Nursing roles are strongly influenced by their focus on caring, a longstanding tradition of vocational training and a subordinate position, all of which hinders the development of a well-defined, institutionalized body of knowledge. This raises questions on what would happen if nurses were given and took responsibility for developing their own profession and what this would means for the division of labour and the relationship, in our case, between nurses and physicians, given the strong intertwinement of these professions in daily healthcare practice.

1.3 CONCEPTUALIZING PROFESSIONAL ROLE DEVELOPMENT

The concept of 'professional role' is widely used in the healthcare and professional literature but is seldom defined or operationalized (de Bont et al. 2016). Professional roles can be based on specific characteristics (van Gestel, Kuiper & Hendrikx, 2019) or a set of principles (Noordegraaf, 2015), such as the degree of autonomy, legitimacy, knowledge and skills. In their scoping review, Poitras et al. (2016:9) define a professional nursing role as a function modulated by professional norms, a legislative framework, the scope of practice and a social system. They show that a professional role comprises certain domains, which in turn includes a series of activities. To describe these domains and activities, professional bodies generally use a framework or classification model, such as the CanMEDS model originally developed for medical education (Frank & Danoff, 2007; Van der Lee et al., 2013). The nursing profession has adopted the CanMEDS model to describe the distinct roles nurses play in meeting the needs of clients (e.g. Terpstra et al., 2015; Lambregts et al., 2016). The CanMEDS model describes the key competencies of care provision linked to seven professional roles for nurses: caregiver, organizer, professional and quality enhancer, communicator, collaborative partner, reflective professional and health promoter. The Netherlands had adopted the CanMEDS model to distinguish the new role of the highly educated, director nurse (regieverpleegkundige) from the nurse with intermediate education. The CanMEDS model defines different areas of expertise with distinct forms of knowledge, skills and attitude (Terpstra et al., 2015).

This dissertation defines role development broadly as the development of a comprehensive set of activities and responsibilities, based on knowledge, modulated by professional norms, a legislative framework, the scope of practice and a social system.

The literature describes various forms of professional role development. In the professional and sociological literature, we discern three lenses on professional role development. First, it can be described in terms of division of labour, which means the division of tasks, skills and responsibility structures or more broadly defined, ‘professional jurisdictions’ (Abbott 1988; Dubois & Singh, 2009). These professional jurisdictions are defined both intra- and interprofessionally. Within a profession (‘intra’), tasks and responsibilities can be relocated horizontally, involving specialization and differentiation. A specialist is an expert in a specific domain of professional practice (Ranchal et al., 2015). Differentiation concerns “the creation of jobs with different tasks, responsibilities and authorizations within the same professional group” (Sermeus et al., 2015:14).

The interprofessional division of labour involves substitution and delegation of professional labour. In the case of substitution, specific tasks and responsibilities shift from one professional domain to another or are shared between different domains. In both cases, professional boundaries are blurred and involve negotiation which may lead to formal regulation such as guidelines and laws (Dubois & Singh, 2009). Delegation, in turn, is generally seen as the transfer of tasks to other (subordinate) professions but keeping them under the first profession’s supervision (Maier et al., 2018). Abbott (1988) and others (e.g., Allen, 1997) argue that the division of tasks and responsibilities often works out well on the work floor level where the focus lies on ‘getting the job done’. Things get more problematic, however, when role divisions are formalized on the level of professional associations and policy decision-making.

Professional role development in terms of division of labour supplies guidelines to discuss the division of labour. It also creates drawbacks. First, it gives the opportunity to discuss the division of labour outside or without the profession, at a policy level, using it as an instrument to deal with shortages in the labour market and increasing costs in healthcare. It is mainly used as an instrument to make clear distinctions between professional roles at the policy and legal level, leaving role distinctions blurry in everyday professional practice (Abbott, 1988; 2005). Second, defining role development in terms of the division of labour turns the spotlight on dividing instead of sharing, for example, which consequently leads to struggle and domain discussions within and between professions. It keeps the eyes on the division of isolated tasks – even separating the reallocation of tasks from the reallocation of responsibilities – instead of discussing professional roles as a set of probably overlaying tasks with corresponding jurisdictions.

The second lens describes role development in terms of the **professional hierarchy**, developed to retain intraprofessional power and protect intraprofessional interests. This phenomenon has been termed restratification (Freidson 1984; Waring, 2014; McDonald

et al., 2009), indicating the emergence of new intraprofessional hierarchies, segments or strata differentiated from the rank-and-file professionals. The elite groups operate as practice elites (sub-specialties), knowledge elites, managerial-organizational elites or political and governance elites, represented in national and professional bodies. The restratification concept originates from the 1980s, a period in which bureaucratic and managerial influences restricted professional power. For the 'greater good' of retaining professional power and interests, professionals give up a certain amount of (individual) professional autonomy and accept some hierarchy within the profession. It also shows how stratification is primarily not meant for personal growth, but to protect the profession's power and interests, connecting the different professional, organizational and political worlds. For this purpose, the elite groups remain strongly connected with the very core of professional work. However, there are some limitations to this view on the development of professional roles. On the one hand, the strong focus on the medical profession and differentiating roles within the profession leaves aside the interdependence with other professions in the healthcare system. For example, the literature describes how physicians took on a managerial role (Waring & Currie, 2009; Spyridonidis et al., 2015; Berghout et al., 2017). On the other hand, the unity in the profession during or after restratification can be questioned (Adams, 2020) and lastly, the focus on power and interests neglects the influence of elites on changing professional cultures and identities (Waring, 2014).

The third lens situates professional role development in the complex process of **role negotiation** in an institutional context. The sociological and institutional literature on professions shows that role development is not done without effort and that role distinctions are not easily made. On the one hand, professionals, especially physicians, heavily debate the reallocation of tasks and responsibilities, protecting existing jurisdictions, both intra- and interprofessionally (Currie et al, 2010; Currie et al., 2012; McGivern et al., 2015; Currie & Spyridonidis, 2016; Noordegraaf, 2016). On the other hand, healthcare organizations are characterized as longstanding, durable institutional arrangements, in which professional roles are not easily transformed (Zucker, 1987; Scott, 2013). Lastly, management and boards also influence professional role development. It generally leads to resistance and (successful) protection within the medical profession (Waring, 2004; Waring & Currie, 2009; Currie, Finn & Martin, 2009). In nursing, managers play a vital role in the design of and decisions on role differentiation, more than nursing professionals themselves (Van Dam et al., 2004; Currie & Spyridonidis, 2019).

These three views on professional role development highlight both a technical-political approach and a sociological-institutional approach, both of which are often discussed in the literature and in professional/scientific debates. What is lacking is a more coherent view that connects the distinct aspects of role development and considers the daily actions and interactions that give shape to these roles. In this dissertation,

I present the findings of an empirical investigation of these various aspects of professional role development in everyday professional practice.

1.4 A SOCIOLOGICAL PERSPECTIVE ON PROFESSIONS AND ORGANIZATIONS IN ROLE DEVELOPMENT

A sociological perspective aims to understand how professions develop themselves as occupations with well-defined bodies of knowledge, structures, power and autonomy and how they relate to each other, protecting and enhancing their professional domain. The sociological perspective gives insight into relationships of professions with other social groups, such as managers in healthcare organizations. This perspective is relevant to understand how physicians and nurses develop their own profession in relationship to each other and to management, and to understand how conflicts between professional groups arise and develop over time.

A profession can be defined as “a knowledge-based category of occupation which usually follows a period of tertiary education and vocational training and experience; at least in part, that knowledge comes from science” (Ayala, 2020: vii). In contrast to medicine, the nursing profession still struggles to incorporate scientific, evidence-based knowledge in daily tasks (Fineout-Overholt, 2005; Nilsen et al., 2017; Renolen et al., 2018). Referring to the work of Evetts (2013), Ayala describes professions as “structural, occupational and institutional arrangements for work associated with the uncertainties of modern life in risk societies.” (Ayala 2019: vii). These definitions reflect elements of the structural and functionalist approach to professionalism in the last century. In this structural, functionalist approach, the development of a specific body of knowledge and expertise and the strengthening of the professional internal traits are central elements of a profession and professionalization (Saks 2012). In this, professionalism is a matter of (self)controlled content whereby professional self-control is executed inside professional domains, also to protect these domains against outside forces (see also Abbott, 1988; Freidson, 2001). In the systemic, neo-Weberian approach, professionalization is considered as the negotiation of roles and jurisdictions within a political, societal and professional-organizational context, often accompanied by internal and external conflicts. From this perspective, professionalism is strongly influenced and defined by what professions do instead of how they are structured (Abbott 1988; Noordegraaf 2016). Professionalism and professionalization are then influenced by external forces, such as the degree of legitimacy provided by society, and during the legal jurisdictions provided by the state (Abbott 1988) and internal forces, in the negotiation of professional jurisdictions, in a professional interdependency in the workplace (ibid.). In workplace interdependency, power and autonomy differences between nurses and physicians

are manifest in differences in formal organizational and policy-influencing positions, the access to and possession of (financial) resources, expectations of the change and implementation capabilities. Physicians are expected to take the lead, with managers supporting and facilitating physicians in change trajectories, and nurses following managers and physicians in the implementation of healthcare policy (Currie & Spyridonis, 2016).

The sociological literature shows the shift in attention from structures, defining what a profession is, to the negotiation of professional roles at an organizational and professional level, and in the workplace. The negotiation of professional roles in the workplace has been influenced by the perspectives on professional jurisdictions which have changed over time. In the 1980s, affected by the New Public Management (NPM) movement, the view on professions shifted from 'pure professionalism', in which professionals are autonomous in the organization and delivery of care (Abbott, 1988; Freidson, 2001) to 'controlled professionalism', in which managers control the quality and organization of professional work. However, the dualistic and often conflicting approach caused an ongoing struggle to bridge the gap between professional and organizational logics in healthcare (Noordegraaf, 2007; Evetts, 2009; Noordegraaf, 2011). This ongoing struggle about conflicting logics led to the development of hybrid roles, in which professionals take on managerial roles, enabling them to move between different organizational groups (Reay and Hinings, 2009; Blomgren and Waks 2015; Andersson and Liff 2018; Breit, Fossestøl and Andreassen 2018). Noordegraaf argues that hybridized professionalism is also a new way "to bridge expertise-induced gaps between professional control and managerial control – to control ways in which expertise is controlled" (Noordegraaf 2007:776). The notion of control, however, remains in the conceptualization of hybrid professionalism.

In nursing, managers took on organizational tasks, while nurses developed a strong focus on (holistic) direct patient care and the nurse-patient relationship (Allen, 2018). In turn, nursing careers often developed within a managerial discourse (Carvalho, 2014), given that as nurses move into managerial and hierarchical positions they move away 'from the bedside'. The organizing work in nursing, which functioned as a 'glue in the system', faded into the background and became invisible (Allen, 2014). In the last decade, the organizing work of nurses regained (scientific) attention, and is described as articulation work (Postma, Oldenhof & Putters, 2015), organizing work (Allen, 2014) and organizing professionalism (Noordegraaf, 2015). These concepts involve the intertwinement of professions and organizations, which draws attention to new developments in the field of professional roles. Allen (2014: xiii) describes the organizing role of nurses as "making connections across occupational, departmental and organizational boundaries and mediating the 'needs' of individual patients with the needs of the whole population." Allen (2014, 2018) shows how nurses are enrolled in bed management to match

the patient's need of proper care while maximizing bed utilization to ensure corporate efficiency. Noordegraaf (2015) provides a broader theoretical lens, describing the organizing role of professionals at three levels: 1) treating cases, to streamline the patient's process through the organization; 2) treating case treatment, selecting and prioritizing between patient cases to organize caseloads; and 3) treating the treatment of case treatment, taking responsibility for the quality of care, e.g. when professionals do quality and safety measurements themselves. Noordegraaf theoretically offers the possibility to discern various levels of organizing work. However, his theory has not been empirically explored. Our study will show how levels of organizing play out in daily nursing, and how they contribute to the development of an organizing nurse role.

The recent studies on professionalism are looking for the relationship between professions and organizations, aiming to go beyond the dichotomy in logics, looking for ways to combine professional and organizational logics in a professional role. This led to the concept of organizing professionalism (Noordegraaf, 2015; Postma et al., 2015). Current research reveals that professionals and managers are not turned against each other. Instead, it shows that professionals increasingly have to embrace organizational aims. New professional roles are being developed to answer organizational issues. This creates openings to develop professional roles in organizing, for example. The literature shows how professionals develop these new roles themselves, "actively reconfiguring their professional work and reshaping organizational policies" (Postma, Oldenhof and Putters 2015: 64). On the other hand, managers empower professionals to consider organizing a natural part of their professional work (Noordegraaf, 2015). According to Noordegraaf (2015) and Postma, Oldenhof & Putters (2015) development requires coordination, both between professionals (intra- and interprofessionally) and between professionals and managers, as organizing professionalism does not mean "a strict return to autonomous or un-organized professional practice" (Noordegraaf 2016: 792). Other scholars also describe how managers engage in the development of organizing work and, at times withhold giving space to professionals to craft new roles (Oldenhof, Stoopendaal and Putters, 2016); Van Wieringen, Groenewegen and Broese van Groenou, 2017). Our study contributes to the further understanding of how nurses take up this organizing role and how it affects their interactions with managers in daily nursing practice.

The interaction between professionals and managers in role development takes place in a longstanding organizational-institutional and professional-institutional context to which professionals actively contribute. To explore this further, we need to understand the concept of institutions, institutional change and institutional work.

1.5 INSTITUTIONS, INSTITUTIONAL CHANGE AND WORK

The second theoretical strand we draw upon is institutionalism. Institutional theory helps us to understand how organizations and professions function based on vested ways of thinking and doing, both formal (regulated) and anchored in traditions (Jepperson, 1991; Scott, 2013). For a long time, the emphasis in institutional theory has lain on structures with little agency from actors: institutions were decisive for the 'rules of the game'. Hence, the focus was on structures instead of agency. In this macro-level perspective the central, formal elements of institutions, such as law and regulations, structure how people think and act (Powell & DiMaggio, 2012; Finn et al., 2010). The institutional elements are stable and maintain over time as they are produced and reproduced (Scott 2013; Smets et al., 2015) by people who 'inhabit the institutions' (Hallett & Ventresca, 2006), without further justification or elaboration (Zucker 1987). An institution then functions as a social order or pattern that has achieved a certain state and that becomes taken for granted by the environment (Jepperson, 1991).

Rather than accepting institutions as enduring and immutable, the sociological-institutional literature has shifted its focus onto a micro-level perspective, paying more attention to the actor's endeavours and agency to influence existing institutions. The role of actors in institutions comes together in the concept of institutional work. This concept initially was developed by the academic community as "the purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions" (Lawrence & Suddaby, 2006:215). In this definition, as well as in other studies, the actions of individual actors are central. Individual actors are seen as institutional entrepreneurs, who try to influence existing and upcoming institutional configurations (Battilana et al., 2009; Van der Scheer et al., 2011; Lockett et al., 2012). This perspective shifted with the insight that actors can also operate as a group, especially visible in professions. Currie et al. (2012), for example, show how medical specialists act as a homogeneous group, using their power and position to protect, maintain and extend their interests, co-opting less powerful actors to protect their domain and interests. More recently, institutional agency has been discussed as collective, distributed actions that can act in diverse ways (Clark & Newell, 2013; Dorado, 2013). In a critical examination of studies, such as the one by Currie et al. (2012), who focus on powerful professionals as actors who are 'on the winning side', Hampel, Lawrence & Tracey (2017) argue that the further conceptualization of institutional work would benefit from more balanced accounts which consider the perspectives of all actors, including the role of actors other than professionals. In our study it means that we also pay attention to the managers, directors and internal advisors who play their roles in professional role development.

Beside the role of individual or collective actors, scholars also pay attention to the position of actors in the field, which is related to their degree of embeddedness in or-

ganizations. Embeddedness is the degree to which actors and their actions are linked to their social context (Reay, Golden-Biddle & Germann, 2006:978 – based on papers by Baum & Dutton, 1996; Lee, Mitchell, Sablynski, Burton, & Holtom, 2004; Mitchell, Holtom, Lee, Sablynski, & Erez, 2001; Powell, 1996). Embeddedness is also described as possessing a position at the centre, or periphery of an organizational field. Different researchers describe the embeddedness of actors as a constraint on acting and creating changes in existing institutions (Greenwood & Suddaby, 2006; Zilber, 2002; Leblebici et al., 1991; Maguire et al., 2004; Currie et al., 2009; Nancarrow & Borthwick, 2005). Other authors show that embeddedness of actors is both a constraint and an opportunity for change (Baum & Dutton, 1996; Dacin et al., 1999; Powell, 1996). Locket et al. (2012) argue that actors in a subject position are able to enact institutional change. From this perspective we would shed light on the role of upcoming professionals and how they – purposefully or not – interact in an institutional complexity of agents' sharing and competing interests (Wallenburg, 2012; Reay et al., 2017; Andersson & Gadolin, 2020). Between vested and upcoming professions, the relationship between power and institutions is undisputed, but how their relationship plays out in an empirical context is underexamined (Lawrence, Leca & Zilber, 2013). To gain insight into the relationship and shaping of social interactions, I applied a practice-based approach.

In sum, institutional theory helps us to understand how organizations and professions function based on vested ways of thinking and doing, both formal (regulated) attitudes and anchored in traditions. Whereas before, institutional theory emphasized structures, the sociological-institutional literature has shifted attention to the micro-level perspective, where social actors seek to influence and change existing institutions. This comes together in the concept of institutional work. The literature describes various constellations of actions of powerful actors. However, the role of upcoming and less powerful actors deserves more attention. That is the object of this study.

1.6 PRACTICE-BASED APPROACH, ROUTINES AND EXPERIMENTS

Practice theory is used to investigate institutional practices at the micro-level – how people engage in 'doing' their work and shape the social interaction and structure they are part of (Smets, Greenwood & Lounsbury, 2015). Far more than a single theory, practice theory is a broad intellectual landscape covering several features. For example, practitioners are not central, but practices are as "coherent and complex forms of socially established cooperative human activities" (MacIntyre, 1981:187). In a practice-based approach (PBA) the social world is not regarded as separate from agents, or as constructed by agents, but as "brought into being by everyday activity" (Feldman & Orlikowski, 2011:1241). The everyday activities do not stand on their own but are embedded or

'produced and reproduced' in a historical and social context (Nicolini, 2012). The recurrent actions constitute structure, and the enacted structure constitutes the ongoing actions, accompanied however by intended and unintended consequences (Feldman & Orlikowski, 2011; Gherardi, 2012; Nicolini, 2012). To gain insight into these actions, scholars put routines at the centre of (re)production of practices (Feldman, 2000; Kuiper, 2018), because practices can also be considered as shared routines (Whittington, 2006).

Organizational routines are crucial to the performance of people in organizations. Routines are "recognizable, repetitive patterns of interdependent action carried out by multiple actors" that structure work and are a basic necessity to carry out complex work in organizations (Feldman et al., 2016, p. 505). Instead of focused on individual actions, routines are considered collective actions because they belong to social groups (Zietsma & Lawrence, 2010; Dionysiou & Tsoukas, 2013) and organizations constitute a full range of interdependent practices (Nicolini, 2009). These actions are formerly seen as repeated, unconscious actions, but nowadays they are generally considered as conscious, deliberate actions, enacted by knowledgeable actors (Giddens, 1976; Bygballe & Swärd, 2019; Feldman, 2000).

Originally, routines were seen as stable, unchanging features of organizations and practices. Feldman (2000), however, shows that routines are a resource for both stability and change. Change can be caused by external shocks, but routines also have the potential for endogenous change, "as a result of participants' reflections on and reactions to various outcomes of previous iterations of the routine" (Feldman, 2000:611). She shows that routines can produce unintended or undesirable outcomes, to which actors can respond by repairing, expanding, or striving to change routines (ibid). However, there is a gap between the potential for change (the ostensive aspect of a routine) and the performative aspect of specific actions that constitute the routine – the routine in practice. In other words, how do actions constitute or change routines in practices and how do (changed) routines constitute actors' actions and performance? Although we theoretically understand how routines can be 'isolated', replaced or revised, relatively little is known of how these changes are enacted in practice, especially as collective action (Rerup & Feldman, 2011). To gain insight into the actors' collective actions undertaken in practice, we rely upon an experimental approach.

When organizations strive for change, the question will be how change can be brought into action, into daily practice. Authors in the field of organizational change and practice-based research refer to the potential of organizational learning. Organizational learning is "a process of positive change in an organization's collective knowledge, cognition and actions, which enhances the organization's ability to achieve its desired outcomes" (Lyman, Hammond & Cox, 2018:10). Organizational learning can be divided into adaptive and developmental learning (Ellström, 2001; Nilsen et al., 2017). Adaptive learning concerns learning new skills, while developmental learning concerns

the disruption of existing habits. For example (Nilsen et al., 2017) shows in the case of implementing evidence-based practice (EBP) that developmental learning is needed to embed EBP interventions in routine practice. Developmental learning can be supported by an experimental approach.

Experimenting – not to be confused with an experiment in a trial setting but in experimental spaces or places – provides the opportunity for developmental learning in daily practice and to create minor changes in everyday routines. Experiments are series of slight changes, based on action and appraisal. They involve non-linear, iterative change processes responding to emerging problems (Bohmer, 2016; Clegg et al., 2005; Ellström, 2001; Lyman et al., 2018). These responses are also emergent accomplishments (Feldman, 2000) that create change through learning and doing, by trial and error (Levitt & March, 1988). Through experimenting, design and implementation become connected processes of probing and tinkering ('doing') rather than planning 'upfront' (Hacking, 1992; Gherardi, 2012). Hence, experimenting does not focus on a planned process or a stepwise implementation of predefined interventions as would be the case in a more linear approach, but on an ongoing, emergent process of ideas and (small) interventions, which introduces these interventions step by step. The results are evaluated over time, allowing for adjustments in the course of experimenting (Reynolds, 2011; Nilsen & Ellström, 2012; Goulet et al., 2016; Anvik et al., 2020). In our study, we investigate experiments on role development in daily professional practices, shedding light on the role of professionals and 'mid-level actors' (Canales, 2016), like team managers, in changing practices to develop new professional roles.

In conclusion, with the three theories described above, we can study professional (nursing and medical) role development as the negotiation of roles and jurisdictions within a political, sociological and professional-organizational context, often accompanied by conflict. The institutional theory helps us be aware of the stable structures and vested ways of thinking and doing, anchored in traditions, that make it hard to change professional roles. Although the role of actors receives more attention in the concept of institutional work, which was long ignored in institutional theory, practice theory takes it a step further, studying how people collectively – not as individual actors – engage in 'doing' their work, shaping the social interaction and structure. Bringing these theorical insights together helps us to unravel the microprocesses and complexities of professional role development.

1.7 RESEARCH AIM AND QUESTIONS

The overall research aim is to reveal how professional role development is shaped in a dynamic environment of daily professional practices and is enacted in the interplay

between various internal and external (f)actors. The intention is to come to a dynamic understanding of professional role development and how this touches upon the organization of healthcare.

The central question we address in this study is:

How do professionals in continuous interaction with their organizational context shape new professional roles in everyday healthcare practices?

The following questions lead our research and analyses:

1) How do professionals enact new professional roles in everyday healthcare practice and what type of roles are developed?
2) How do healthcare professionals interact with other organizational actors (managers, directors, consultants) in creating new professional roles?
3) How does the institutionalized healthcare context impact new professional role development?
4) What does a practice-based approach offer when studying new professional role development?

1.8 METHODOLOGY: AN ETHNOGRAPHIC MULTIPLE-CASE STUDY

In line with the practice-based approach, we conducted an ethnographic multiple-case study to observe professional role development in healthcare practice. Ethnography is characterized by the investigation of people's actions and accounts in everyday contexts, using an array of data resources, focusing on a few cases to facilitate in-depth study (Atkinson & Hammersley, 2007). In the in-depth study, ethnographic cases provide the opportunity to shed light on professional, organizational, cultural and structural aspects and, taking these aspects into account, on how professionals shape their practices as well as how these aspects influence professional work (Leslie et al., 2014). During the research period we travelled between various organizational entities (i.e. the emergency wards of three hospitals, in a nursing home and several nursing wards in a hospital), observing professional practices, participating in team meetings, workgroups, project group and management meetings, and interviewing the actors involved. Investigating multiple cases gives the opportunity to gather and analyse data in-depth within and between cases, providing a cross-case analysis (Gustafsson, 2017).

This dissertation draws on three distinct, but closely connected research projects on nursing and medical role development in the Netherlands. First, from February to April 2013, we investigated the development of a newly introduced role called emergency physicians (EPs) in three top clinical teaching hospitals (EP patients numbered between

24000 and 42000 per hospital). The three cases were selected with the ‘maximum variation’ method (Creswell et al., 2014) on such topics as the work carried out by EPs, the autonomy and responsibility they possessed and the geographical distribution across rural and urban regions, giving insight into the inter- organizational and structural factors of patient admissions and the impact on EP role development. Every case study lasted a month and consisted of observations of the EPs’ work in the emergency departments (8, 5 and 6 EPs), their encounters with other practitioners and their role in professional and organizational meetings. In addition, we conducted 22 interviews with EPs and key stakeholders, such as other medical professionals, (medical) managers and board members.

Second, from February to December 2017, we investigated the role development of NPs in a nursing home organization (13 locations, total 1747 employees), who as members of the medical team partly replaced elderly care physicians (ECPs). Doing ethnography enabled us to study the NP’s role development in a healthcare organization, paying attention to intra- and interprofessional relationships, including relationships with management, and the embedding of roles in the organizational context. As an observer-as-participants we joined in all kind of activities related to role development. We gathered distinct types of data based on observations, informal conversations and semi-structured interviews, and several types of meetings. We shadowed NPs and ECPs in their daily practice, joining general team meetings on medical-organizational issues and team meetings in which the NPs’ role and responsibilities were discussed. We held conversations with NPs, ECPs and top management as well.

Third, from July 2017 to January 2019, we participated in a case study on nursing role development in a teaching hospital (481 beds, 2600 employees including 800 nurses), following nurses in four wards in the development of distinct VN and BN roles. We shadowed ward nurses in their daily nursing practice, observing first their existing and subsequently their changing roles in the professional and organizational-institutional context. We held informal conversations and semi-structured interviews to deepen the insight into opinions, behaviour, underlying choices and convictions and any intra- or interprofessional behaviour and tensions. Following the project structure in the hospital’s programme on nursing role development, we attended ward meetings, interdepartmental meetings and project group meetings, to get insight into nursing role development, interactions between nurses and among nurses, managers and the internal advisors in the project group.

In total, we did approximately 300 hours of observations, 33 hours of conversations, held 54 interviews and participated in 47 diverse types of meetings. We conducted an abductive analysis of nursing and medical role development. Abductive analysis involves both inductive and deductive analysis, combining a rich understanding of empirical phenomena – codes from the data – with codes based on theory (Tavory and

Timmermans, 2014). In our study we used abductive analysis to obtain deeper insight into the role of professionals and other actors in a complex institutional environment. To that end we conducted interviews with key actors, participated in meetings and did our observations in the institutional context. We used the theoretical insights into professional role development, interactions with both intra- and interprofessional and with other stakeholders, and the insights into institutional change to interpret our findings. As is common in abductive analysis, we went back and forth between data and theory (Dubois & Gadde, 2002), comparing and contrasting the findings from the multiple cases to obtain a rich understanding of patterns in professional role development (Cresswell 2014; Polit & Beck, 2008).

1.9 OUTLINE OF THIS THESIS

The empirical chapters (2–5) have been published as individual academic articles, which explains why there is some overlap in the methods sections and description of the research setting. Together, these chapters reveal the complexity of professional role development in a healthcare organization, influenced by internal and external (f)actors.

Chapter 2. The role of emergency physicians in the institutionalization of emergency medicine is an ethnographic study on medical role development. We investigated the role of emergency physicians (EPs), an upcoming specialism in Dutch hospitals, in the highly institutionalized environment of both the hospitals themselves and the medical profession. Based on a cross-case ethnographic study, comprising document analysis, observations and in-depth interviews, we show how vested medical specialists, medical managers, and also EPs as upcoming professionals all conduct institutional work to give shape to the tasks and responsibilities of the new EP role. The occasionally strategic and other times unintentional actions both restrict and enlarge the EP domain and shape the EP role, redistributing task and responsibilities in acute care delivery.

Chapter 3. Nurses in the lead: a qualitative study on the development of distinct nursing roles in daily nursing practice investigates what nurses do themselves to create a new role, something that has scarcely been investigated. Using a range of qualitative research methods (i.e. shadowing, interviews, participation in meetings and organizing focus groups) provided the opportunity to gain in-depth insight into patterns of actions and interactions in nursing role development, learning how roles are shaped experimentally in everyday nursing practice, considering the invisible knowledge and invisible practicalities of everyday nursing work. We show how the experimental, practice-based approach fosters personal and professional nursing leadership.

Chapter 4. The balancing act of organizing professionals and managers: An ethnographic account of nursing role development and unfolding nurse-manager relationships describes the relationship between nurses and physicians in the development of nursing roles, and their interaction with management. Relying on theoretical notions of organizing professionalism we show how nurses shape their role in interaction with these actors and with their own ambitions, aimed at more nurse-driven care, organizational needs and external requirements. We show how the development of a nursing role is a balancing act between nurses and managers. Nurses play a significant role in this developmental process but can be hindered by professional power differences and managerial interests.

Chapter 5. Role of Dutch internal policy advisors in a hospital quality improvement programme and their influence on nurses' role development: a qualitative study focuses on the role of internal policy advisors and how they contribute to the development of new professional roles. The healthcare or quality management literature seldom describes the internal policy advisor's role. Relying on business and management literature on consultancy roles we show how internal policy advisors are key in the development of a nursing quality improvement role and simultaneously struggle with putting the responsibility for role development in the right place.

Chapters 6 and 7. Discussion & concluding remarks: professional role development in everyday practice reflect on the empirical findings and answers the research questions, discussing the findings in the light of the theoretical debate on professional (nursing and medical) role development in an institutionalized context, using a practice-based approach. We argue that role development is not the straightforward, simple implementation of a pre-designed distinction in tasks and roles. Rather, professional role development arises in a complex intra- and interprofessional interplay between professionals, between professionals and managers, directors and internal advisors. Influenced by external parties, professional role development is shaped and reshaped, back and forth, in practices and routines. Therefore we argue that role development should be considered a practice, given that professional role development constitutes practice and practice constitutes professions and their development. We conclude that there is a high degree of dependence between professions and organizations in professional role development, as new roles are undeniably intended to fulfil an organizational need.

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The role of emergency physicians in the institutionalization of emergency medicine

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ABSTRACT

Objectives: Emergency medicine is a fast-growing medical profession. Nevertheless, the clinical activities emergency physicians (EPs) carry out and the responsibilities they have differ considerably between hospitals. This article addresses the question how the role of EPs is shaped and institutionalized in the everyday context of acute care in hospitals.
Methods: A cross-case ethnographic study was conducted, comprising observations, document analysis and in-depth interviews in three emergency departments in the Netherlands.
Results: Drawing on the theoretical concept of institutional work, we show that managers, already established medical specialties and EPs all conduct institutional work to enhance private interests, which both restricts and enlarges EPs' work domain. These actions are strategic and intentional, as well as unintentional and part of EPs' everyday work in acute care delivery. It is in this very process that tasks and responsibilities are redistributed and the role of the EP is shaped.
Discussion: In contemporary literature it is often argued that the role and status of EPs should be enhanced by strengthening regulation and improving training programs. This article shows that attention should also be paid to the more subtle everyday processes of role development.

Keywords: emergency medicine, emergency physician, institutional work, professional role development

INTRODUCTION

Emergency medicine (EM) is a fast growing medical profession in Europe (Gaakeer, van den Brand & Patka, 2012; Kurland & Graham, 2014). In the Netherlands, where this study is based, EM has been introduced in the late 1990s. In the early days, Emergency Physicians (EPs) were employed in only a small number of hospitals. Nevertheless, to date almost 450 trained and registered EPs work in 80% of the 90 Dutch Emergency Medicine Departments (Eds) (Gaakeer et al., 2012; Gaakeer, van den Brand, Bracey, et al., 2013). Their positioning in hospital organizations, the clinical activities EPs carry out at the ED, and the autonomous responsibilities EPs possess, however, differ significantly among hospitals. How did these differences evolve? In what way is the role of the EP as a new medical profession shaped, expanded, and institutionally embedded in the everyday context? To our knowledge, no study has addressed this matter. However, such knowledge will provide deeper insight into the processes of task reallocation and quality improvement in hospital care, as intended by the introduction of EPs in the first place. In this article we examine, based on a comparative ethnographic study, the micro processes that fashion the role of EPs in the Dutch landscape of hospital-based medicine. More specifically, we aim to provide insight into the evolvement of the role, clinical tasks, and responsibilities of EPs in acute care. We use institutional theory, and more in particular the theoretical concept of institutional work, to draw attention to the work EPs carry out to achieve this.

INSTITUTIONAL THEORY AND INSTITUTIONAL WORK

Organizational practices – such as the work of EPs at the ED – are shaped by numerous, often contradictory institutional forces within the field they operate (DiMaggio & Powell, 1983; Finn, Currie & Martin, 2010). Jepperson (1991) defines an institution as 'a social order or pattern that has achieved a certain state and that becomes taken for granted by the environment'. Institutions can both be formal (e.g., laws and regulations) and informal (e.g., customs, traditions and codes of conduct). Institutions create rules, shared meanings and expectations and, as a result, postulate certain courses of action and behavior (Currie & Suhomlinova, 2006).

The concept of institutional work explores how actors create, maintain and disrupt institutions (Lawrence & Suddaby, 2006). It refers to the relatively invisible micro-processes of actions that individuals engage to further their own interests (Harrington, 2015). Actions become institutional work when they simultaneously contribute, although often in unanticipated ways, to advance institutional projects (Thorton, Ocasio & Lounsbury, 2012; Lounsbury & Crumley, 2007). A particular stream within institutional

theory studies the role of professions as “institutional agents” (Scott, 2008) that possess the ability to both enable and constrain institutional change (Suddaby & Viale, 2011). These studies describe the changing interprofessional relationships, articulating the establishment and defense of jurisdictional claims, as well as the construction and legitimization of new professional roles and identities. These studies often point out how traditional medical specialties succeed in maintaining its dominant status and, as such, maintain power, by using all types of strategies to counteract shifts of jurisdictional boundaries (Currie, Lockett, Finn et al., 2012). Others, however, have criticized this rather strategic and purposive perspective. They point at the existence of a more messy and disorderly everyday world in which less powerful and less well-resourced actors may conduct institutional work as well to further extent their own interests by using various experimental activities that help them to navigate established work practices (Lawrence, Suddaby & Leca, 2011).

METHODS

This paper draws on an ethnographic study in three Dutch hospitals (February- April 2013). A cross-case analysis was conducted to gain insight into the factors that play a role in the positioning of EPs at the ED (Sanders & Harrison, 2008). Ethnography is concerned with trying to understand a cultural or social phenomenon from the perspective of someone who is part of that particular phenomenon. It is a qualitative research method that is increasingly used in medical settings (Pope, 2005; Wallenburg, Bont, Heineman et al., 2013). Ethnography encompasses a series of methods, including document study, interviews, and participatory observations. Ethnography aims to gain in-depth knowledge of everyday (work) practices and interactions. It typically involves lengthy participation or immersion in the everyday life of a chosen setting (Pope, 2005). The ethnographer, in our case the first author [J.v.S.], observes the behavior and interactions of the targeted group, also taking into account the organizational context. Observational data were supplemented by informal interviews to explore participants’ work, skills and knowledge involved, as well as the ways they make sense of what they actually do (Merriam, 1998).

We conducted three case studies, following the method of ‘maximum variation’ (Creswell & Clark, 2007). Case studies were selected on basis of substantial differences on those aspects that are expected to matter to the study’s aim - in this case the work EPs carry out and the autonomy and responsibilities they possess. In addition, geographical location was taken into account to enhance the richness of the findings. Case selection was carried out by the second and third author [C.L.B. and M.I.G.] in close interaction with the other two authors. C.L.B. and M.I.G. are president and immediate

Table 1. Key characteristics of emergency hospitals per hospitals

Key characteristics (2012)	Hospital A	Hospital B	Hospital C
Number of ED-patients	37.000	24.000	42.000
Percentage of hospital admissions from the ED	33	37	30
Percentage of nonreferred patients (by another medical doctor)	30	15	47
Medical management (Head) ED	Surgeon	Tripartite (Surgeon, Internist, EP)	Intensivist
Start of the EP residency training program	2005	2007	2001
Number of certified EPs specialists in EM working	8	5	6
Presence of EP's at the ED (h/day, 7 days a week)	24/7	16/7 No presence of certified EP's at night	16/7 No presence of certified EP's at night

ED, emergency department; EM, emergency medicine; EP, emergency physician.

past president of the Netherlands Society of Emergency Physicians, respectively, and, as a consequence, have in-depth knowledge about the status of the EP in various hospitals. Key characteristics of the three hospitals are displayed in Table 1.

Each case study lasted 1 month. Observations and semistructured interviews were conducted by J.v.S. and supervised by I.W. During the case study, daily practices at the ED were observed, paying particular attention to the work of EPs and their interactions with other practitioners and patients. Observations and informal interviews were worked out in detailed observation reports shortly after (at least within 24 h). In addition, interviews were held with key stakeholders. Interviewees were selected on basis of their (organizational) involvement in EP training program, their position at the ED, and their interaction with EPs at the ED. For overview see Table 2. Interviews lasted between 45 and 60 minutes. After permission of the interviewees (none of them refused), interviews were audio-recorded and transcribed verbatim.

Both in the observations and the interviews, a topic list was used listing the items we wanted to discuss or observe to enable comparison between hospital sites and to objectify data collection. The interviews and observation reports together with the documents constituted the input for the analysis. Documents were used as background information to enhance understanding. Transcripts (i.e. observation reports and transcribed interviews) were coded based on factors that emerged of the data (grounded theory) (Glaser & Strauss, 1967), as well as based on the literature on institutional work. This method of coding, known as 'abduction' (Stoopendaal & Bal, 2013; Tavory & Timmermans, 2014), provided situational and theoretically based generalizations of our findings. Codes were debated among J.v.S. and I.W. until consensus was reached.

Table 2 – Interviews with key stakeholders in management and acute care per hospital

	Hospital A	Hospital B	Hospital C
1	Hospital executive	Hospital executive	Hospital executive
2	Chair medical board	Chair medical board	Chair medical board
3		Operational director	
4	Division manager	Division manager	Division manager
5	Managers ED		Manager ED
6	Emergency physician/ Chairman EPs	Emergency physician/ vice-trainer	Emergency physician/ trainer
7	Gastrointestinal physician	Emergency physician	Emergency physician
8	Surgeon – former trainer and founder of EM in this hospital	Surgeon – trainer/ medical manager	Surgeon – former trainer
9	Internist/ intensivist	Internist vice-trainer/ medical manager	Medical chief EM department/ intensivist
10	Neurologist		Internist/ intensivist
11			Internist- acute medicine

ED, emergency department; EM, emergency medicine; EP, emergency physician

Table 3. Empirical findings about the responsibilities, clinical tasks, and roles of emergency physicians per hospital

Differences in organizational factors and responsibilities EPs (2013)	Hospital A	Hospital B	Hospital C
Responsibility of EPs in medical care for nonreferred patients	EPs are responsible for medical treatment of nonreferred patients.	EPs are responsible for medical treatment of nonreferred patients.	EPs are responsible for the medical treatment of nonreferred surgical patients.
Responsibility of EPs in medical care for referred patients	EPs are allowed to treat all referred surgical patients, and other patients under end-responsibility of vested specialism.	EPs are allowed to treat all referred chirurgical and internal patients, and patients of some (small) specialism on request (i.e. pediatrics, dermatology).	EPs are allowed to treat referred surgical patients, and patients of some (small) specialism on request – that is, at night. (urology, E.N.T.)
Coordination of medical care at the ED	EPs coordinate care at the ED	EPs coordinate care at the ED	Coordination of care shared between EPs and nurses. EPs focus on own patient category
Trauma care	EP coordinates trauma patients	Formally, EPs coordinate trauma care, in practice a supervisory role of medical specialists	Formally, EPs coordinate trauma care, in practice a supervisory role of medical specialists
Supervision	EPs supervise EP residents and interns at the ED, as well as interns from other specialisms	EPs supervise EP residents and interns at the ED	EPs supervise EP residents and interns at the ED
EP training	Trained by a certified EP	Shared traineeship (surgeon, internist and EP)	Trained by a certified EP
Medical management	Surgeon	Tripartite medical management (surgeon, internist and EP)	Intensivist

ED, emergency department; EM, emergency medicine; EP, emergency physician.

Data collection took place in the Dutch language. Quotes were translated in English for the purpose of this paper. Ethical permission for this study was reviewed by the ethical committee of one of the participating hospitals and was deemed exempt.

RESULTS

From the cross-case analysis, three categories of factors emerged that play a role in the positioning of EPs: (a) the reform of acute care delivery; (b) the distribution of patients; and (c) the expanding working domain of EPs. In Table 3, we present the various nonclassified factors per hospital, which provided the background for the cross-case analysis.

Reform of acute care delivery

Hospital executives played an important role in the introduction of EPs. In Hospitals A, hospital executives, middle managers, and a group of physicians acted in close alignment to encourage the enrollment of EPs, despite severe objections among groups of established medical specialists.

> 'We had a very enthusiastic medical manager, (…) who was able to convince others and was accepted by the medical staff. He was able to alter relationships. And so, by having many conversations, he gradually gained support for the concept. He really played a crucial role' (Strategic manager, Hospital A).

Management's medical expertise appeared crucial for having this connecting role, just like the coordinated and active support of key actors at different levels within the organization. In Hospital C, this condition was lacking. Compared to Hospitals A and B, the position and status of the EP developed rather slowly in hospital C. EPs in Hospital C only had a marginal role in acute care delivery. For a long time, they missed the active support of a prominent medical figure. The appointed manager did not have a medical background and was unable to overcome resistance among existing medical specialties. In 2012, an internist was appointed to enhance the status of EPs. In contrast to the former manager, he adopted the clinical point of view as a starting point:

> 'I would stimulate them [EPs] to treat more patients for an internal medical specialty, particularly because I think that these patients are the ones who are most severe (…) That's why it is important we look at those patients together. And I think it's also important that the EPs develop themselves; it is part of their job. (…) There is space enough, I suppose, for both specialties [EM and internal

medicine] to profile themselves (…) just each with a different focus' (Medical manager and internist Hospital C).

Financial regulations appeared to be another important aspect of the negations between already established medical specialists and the hospital board on the introduction of EPs at the ED. In the Netherlands, a majority of medical doctors work in entrepreneurial partnerships (maatschappen) in association with a hospital. They are paid on the basis of the DRG system as well as on the basis of agreements among the hospital board and medical staff. The introduction of a new occupational group in EM embarked upon existing financial regulations. In Hospital A, despite initial enthusiasm, physicians' support for the incorporation of EPs in acute care was withdrawn until financial regulations were settled. In Hospital C, it took almost a decade to reach consensus on the distribution of costs and income. In all three hospitals, it was finally decided that the hospital would employ – and thus pay – the EPs. They were only partly compensated by the specialists who directly benefitted financially from the extra staff. Hospitals, in turn, benefited from national financial regulations for the training of medical residents.

A third aspect was the establishment of a skilled, knowledgeable and matured group of EPs. In all three hospitals the hospital training system was an important facilitating condition for the development of EM. The training program for EPs entailed components (internships) of existing residency training programs, such as surgery training, and anesthesiology training. This allowed for a quick start of the new EP training program. Initially, the surgeons supervised interns and residents. In Hospital A and C, this task was quickly taken over by a certified EP, enabling EM to grow up to a 'real' and less-dependent occupational group. With an extended staff, EPs were able to combine different tasks, such as supervising residents and interns, further developing the training program, and participating in various hospital-wide governing bodies and project groups:

> 'All together it means that we are treated "as adults"; we are now full member of the medical staff. We all participate in [hospital] committees, so we do the same things as other medical specialists do. We participate in all meetings, and one of us is part of the medical board' (Emergency physician, Hospital A).

Distribution of patients

In all three hospitals, surgeons have played an entrepreneurial role in the development of EPs. During interviews, they articulated the need to improve the quality of acute care delivery. Others, however, being more skeptical, highlighted the interest of surgeons to leave the ED to EPs:

> ‘Look, the surgeons had the incentives (…) they realized what the EP could bring them and then, they think, okay, that’s attractive, we can hire them, they’re useful. [Now] the surgeon doesn’t need to treat ankle injuries after soccer on Saturday afternoon anymore’ (Internist, Hospital B).

This internal specialist points at the advantage surgeons have by delegating the work to EPs. Surgeons do not lose out on ‘interesting patient cases’. If needed, patients will end up in the operating theatre anyway. Moreover, surgeons will not financially suffer from the presence of EPs as they will still be reimbursed for the patients they operate on. The internists, in turn, acted much more defensively. They felt that the introduction of EPs threatened their status and position at the ED.

> ‘You have to know that it’s a power game (…). In the Netherlands, the internal medical specialists have grossly neglected the development of acute care for a long time. And then the EPs stepped in. And then, I think at ‘five to twelve’, or maybe even ‘five past twelve’, anyway, at a given moment they [internists] realized: ‘Oh we got to act right now.’ And now they’re setting up emergency care. Now they want to reclaim that domain’ (Medical manager, Hospital C).

In both Hospitals A and C, internists attempted to strengthen their position in acute care. They allocated more residents and internists to the ED and enforced supervision of interns and residents.

> ‘The EPs don’t treat our referred patients anymore. In the past this sometimes happened, but then we lacked sufficient manpower. But now we have extended our workforce’ (Internist, Hospital C).

By extending their occupational group, internists attempted to continue have control over their patients, marginalizing the role of EPs to the first aid of surgical patients and the triage of nonreferred patients. Discussions particularly concentrated on the referred patients. These are the patients who are sent in by another medical doctor, usually a GP. Referred patients are seen as more complex or more severely ill, and therefore more important. Internists argued that an experienced internist should always see these patients:

> ‘It’s a problem, especially to us, because we also think that much work can’t easily be done by EPs (…). It is just about the subtle things, which may mean that [you need to think in] another direction [of diagnoses and treatment]. You should not miss on that. (…)’ (Neurologist, Hospital A).

With the introduction of the EPs, a debate started on the expertise of internal medicine in acute care. During the observations, one of the internists in Hospital B co-authored an article in a popular medical professional journal, arguing that EPs should refer patients with undifferentiated and multimorbidity to an acute internist immediately, as these physicians have the embodied knowledge to assess possible severely ill patients. Stressing the importance of embodied knowledge and skills aimed to legitimize the exclusiveness of a specific occupational group to deal with specific patients, excluding the EPs.

Expanding working domain of EPs

In Hospitals A and B, EPs urged to expand and safeguard their position. These actions were embedded in the daily work at the ED. This was also recognized by one of the hospital executives:

> 'Now they [existing medical specialists] see how EPs work, I see they [EPs] gain their trust. (…) They've to struggle for their position; they have to show their competence, and demonstrate that they're skilled doctors and that they are of added value' (CEO Hospital B).

EPs have to convince 'traditional' specialists that they possess the necessary skills and knowledge, and that they can be entrusted with 'their' patients. By closely working together and building up a personal relationship, which is rather similar to the process of student socialization during medical residency training (Wallenburg et al., 2013), existing medical specialists learned what to expect of EPs, and whether EPs could be entrusted with 'their' patients.

In hospital C, where the EPs were struggling with their position in acute care delivery, strategies to build up trust were hardly visible. Here, EPs lacked shared working spaces to demonstrate their competences and trustworthiness:

> 'They [EPs] aren't always taken seriously. (…) They're employed for only a short period of time. They're too young, and their training is too short. They also have a quality deficiency with regard to some clinical aspects, and there are just too little EPs employed. (…) I mean, you will only be taken seriously when you're also in at three o'clock at night, when a very ill patient comes in (…)' (Internist, Hospital C).

This physician points at a crucial aspect of medical work, professional dedication. To be trusted and respected as 'real' doctors, EPs need to be in 24/7. This was well recognized in Hospital A:

> ‘So there is a shift from refusing to co-operate with EPs to perceiving the quality of something very scarce, and everybody is willing to take advantage of it. We’re here 24 h a day, so we’re also here at night. Each medical specialist hates working at night’ (Emergency physician, Hospital A).

> ‘Our aim has always been a 24/7 presence of EPs. This is an account of quality (…). Otherwise during day-time residents are at the ED and then they act in a particular way, and at night things are different. During daytime there is supervision, and at night there isn’t. That’s impossible. When you’re developing a new role, you have to do it right from the start’ (Surgeon, Hospital A).

By working at night, EPs won the sympathy of other medical specialists, as they now acted as ‘real’ medical doctors. The surgeon quoted above points at another important feature: the aim of autonomy. At night, only a few medical doctors are around. Hence, if EPs do night shifts, they must possess the clinical knowledge to act autonomously. By treating patients with different diseases and injuries, EPs enlarged their knowledge and skills and, as a result, expanded their working domain:

> ‘The specialist [in this case, an E.N.T. specialist] couldn’t deal with the caseload for that specific moment. It’s our challenge to “jump in”. Our legitimacy is built up by providing such forms of support’ (EP, Hospital B).

During the observations and interviews, it was nicely shown how moments of ‘jumping in’ and ‘helping out’ other specialists at the ED were not restricted to specific moments, but rather part of the strategy of EPs to enhance legitimacy and expand their working domain. This was particularly clear at moments of formalization. In Hospital A, for example, GPs had started to refer their patients to the ED instead of sending them to a particular medical specialty. The EPs proposed to formalize this new procedure; however, other specialists objected this. The EPs, in turn, refused to give up their obtained competences. It was finally agreed upon that EPs would treat patients autonomously and that patient cases were discussed during the morning report so that the medical specialists could keep an eye on the work being carried out. Hence, new work routines emerged that gradually institutionalized, enlarging EPs’ working domain and their position at the ED.

DISCUSSION

This research aimed to provide insight on the evolvement of the clinical tasks, and the role and responsibilities of EPs in Dutch acute care. The study shows that the establishment of EM as a new profession within hospitals requires institutional work. This institutional work takes place at various organizational levels and is conducted by a wide variety of stakeholders – that is, EPs, managers, hospital executives, governing bodies, and already established medical specialists. Our comparative ethnographic study reveals that it is particularly the interplay of organizational features (e.g., the introduction of an appropriate finance system) and day-to-day professional interactions that shape the role and position of EPs in hospitals. We have shown that the active support of a respected and high-placed medical specialist is crucial to win credibility among colleague medical specialists and, in doing so, extend working space.

At the same time, however, EPs are also counteracted in their ambitions by existing medical specialties that fear to lose out on their working domain and related authority to EPs. It is this back and forth lingering - underscoring the lack of a linear development of EPs' role and position - that characterizes the establishment of a new profession.

Moreover, our research has shown that EPs themselves conduct institutional work to enhance their role and position in both clinical care delivery and the hospital organization. This institutional work, we pointed out, is both strategic and intentional (e.g. staffing the ED at night) and unintentional and part of EPs' everyday work of acute care delivery. By 'getting the daily work done" and seeing patients of a wider range of medical specialties, EPs extend their skills and obtain trust from existing medical specialists to treat patients autonomously. In addition, EPs have obtained a position in hospital's governing bodies. Taking part in management discussions is an important condition in becoming a 'real' or mature profession. It enables us to influence hospital's policies and to bring to the fore EPs' private interests. These activities reshape existing organizational structures, and help to establish the role and position of EPs in acute hospital care. On the basis of our findings we argue that the role and status of EPs in acute care cannot only be encouraged by enhancing training programs and strengthening regulations as is often argued (González Armengol, Oscar & Graham, 2013; Plunkett, 2006), but attention should also be paid to the more subtle and micro-processes of role development and the negotiations on work that takes place in everyday acute care delivery as well - both in practice and in research.

Although our ethnographic approach has revealed new insights on the development and institutionalization of EPs, it also has some limitations. First, due to the intensity of the research methods and time restrictions, only a restricted number of case studies were conducted just in one country. Hence, in-depth insight was valued above generalizability. A more extensive research, however, may have revealed additional factors that

influence the institutionalization of EPs. Second, ethnography as a research method has an important drawback as outcomes are difficult to replicate – and thus to check upon – as the observed event takes place in a natural setting and cannot be reproduced. Moreover, observations were conducted by only one researcher, who had to judge upon what to note down, and what not to. Although observations and subsequent transcripts were shared, debated, and coded among researchers, this hampers the validity of the research. Nevertheless, ethnography offers the advantage to gain in-depth understanding of how organizational and professional processes evolve 'in real life' and such understanding may contribute to the further development of EM. Furthermore, diverging national institutional contexts (e.g. financial structure and government regulation) may reveal other external processes influencing new profession development. These limitations strengthen our argument to conduct more qualitative, and, in particular, ethnographic research in EM.

CONCLUSION

This research aimed to provide insight into the evolvement of the role, clinical tasks, and responsibilities of EPs in the organization and delivery of acute care. Informed by the theoretical concept of institutional work, we have shown how the development of EPs and EM is shaped by the institutionalized practices of acute healthcare delivery. Managers, traditional medical specialists, and EPs conduct institutional work to protect established work practices and accompanied power relationships, or, conversely, open up established practices to create room for the development of EM. This research has shown that EPs act as institutional agents to extend their work domain by demonstrating competences and claiming expertise and autonomy, and, as such, contribute to the institutionalization of EM. Our findings give a first and in-depth insight on the microprocesses that fashion the positioning of EPs in the Dutch landscape of hospital-based medicine. In our opinion more attention is needed for this. Better insight can pave the path and accelerate the processes of task reallocation and quality improvement in hospital care, as was intended by the introduction of EPs in the first place.

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3

Nurses in the lead: a qualitative study on the development of distinct nursing roles in daily nursing practice

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ABSTRACT

Background: Transitions in healthcare delivery, such as the rapidly growing numbers of older people and increasing social and healthcare needs, combined with nursing shortages has sparked renewed interest in differentiations in nursing staff and skill mix. Policy attempts to implement new competency frameworks and job profiles often fails for not serving existing nursing practices. This study is aimed to understand how licensed vocational nurses (VNs) and nurses with a Bachelor of Science degree (BNs) shape distinct nursing roles in daily practice.
Methods: A qualitative study was conducted in four wards (neurology, oncology, pneumatology and surgery) of a Dutch teaching hospital. Various ethnographic methods were used: shadowing nurses in daily practice (56 hrs), observations and participation in relevant meetings (15 hrs), informal conversations (up to 15 hrs), 22 semi-structured interviews and member-checking with four focus groups (19 nurses in total). Data was analyzed using thematic analysis.
Results: Hospital nurses developed new role distinctions in a series of small-change experiments, based on action and appraisal. Our findings show that: (1) this developmental approach incorporated the nurses' invisible work; (2) nurses' roles evolved through the accumulation of small changes that included embedding the new routines in organizational structures; (3) the experimental approach supported the professionalization of nurses, enabling them to translate national legislation into hospital policies and supporting the nurses' (bottom-up) evolution of practices. The new roles required the special knowledge and skills of Bachelor-trained nurses to support healthcare quality improvement and connect the patients' needs to organizational capacity.
Conclusion: Conducting small-change experiments, anchored by *action and appraisal* rather than by *design*, clarified the distinctions between vocational and Bachelor-trained nurses. The process stimulated personal leadership and boosted the responsibility nurses feel for their own development and the nursing profession in general. This study indicates that experimental nursing role development provides opportunities for nursing professionalization and gives nurses, managers and policymakers the opportunity of a 'two-way-window' in nursing role development, aligning policy initiatives with daily nursing practices.

Keywords: Evidence-based practice, nursing practice, policy, registered nurses, vocational-trained nurses, role development, role distinctions, skill mix, qualitative study

BACKGROUND

The aging population and mounting social and healthcare needs are challenging both healthcare delivery and the financial sustainability of healthcare systems (Allen, 2015; NHS, 2016). Nurses play an important role in facing these contemporary challenges (IOM, 2011; WHO, 2016). However, nursing shortages increase the workload which, in turn, boosts resignation numbers of nurses (Dawson, Stasa, Roche et al., 2014; Hayes, O'Brien-Pallas, Duffield et al., 2012). Research shows that nurses resign because they feel undervalued and have insufficient control over their professional practice and organization (Persson & Carlson, 2019; Senek, Robertson, Ryan et al., 2020). This issue has sparked renewed interest in nursing role development (de Bont, van Exel, Coretti et al., 2016; Jacob, McKenna & D'Amore, 2015; Sermeus, Aiken, Van den Heede et al., 2011). A role can be defined by the activities assumed by one person, based on knowledge, modulated by professional norms, a legislative framework, the scope of practice and a social system (Poitras, Chouinard, Fortin et al., 2016:9).

New nursing roles usually arise through task specialization (Jones, 2005; Ranchal, Jolley, Keogh et al., 2015) and the development of advanced nursing roles (Fealy, Ceasy, O'Leary et al., 2018; Lowe, Plummer, O'Brien et al., 2012). Increasing attention is drawn to role distinction within nursing teams by differentiating the staff and skill mix to meet the challenges of nursing shortages, quality of care and low job satisfaction (Aiken, Sermeus, Van den Heede et al., 2012; Lu & Zhao, 2019). The staff and skill mix include the roles of enrolled nurses, registered nurses, and nurse assistants (Chua, Legido-Quigley, Ng et al., 2019; Duffield, Roche, Twigg et al., 2018). Studies on differentiation in staff and skill mix reveal that several countries struggle with the composition of nursing teams (Van Oostveen, Matthijssen & Vermeulen, 2015; Saville, Griffiths, Ball et al., 2019; Vatnøy, Sundlisæter Skinner, Karlsen et al., 2020).

Role distinctions between licensed vocational-trained nurses (VNs) and Bachelor of Science-trained nurses (BNs) has been heavily debated since the introduction of the higher nurse education in the early 1970s, not only in the Netherlands (De Jong, Kerstens, Sesink et al., 2003; Lalleman, Stalpers, Goossens et al., 2020) but also in Australia (Endacott, O'Connor, Williams et al., 2018; Jacob, Sellick & McKenna, 2012), Singapore (Chua et al., 2019) and the United States of America (Boston-Fleischhauer, 2019; Matthias, 2017). Current debates have focused on the difficulty of designing distinct nursing roles. For example, Gardner et al. (2016) revealed that registered nursing roles are not well defined and that job profiles focus on direct patient care. Even when distinct nursing roles are described, there are no proper guidelines on how these roles should be differentiated and integrated into daily practice. Although the value of differentiating nursing roles has been recognized, it is still not clear how this should be done or how new nursing roles should be embedded in daily nursing practice. Furthermore, the con-

sequences of these roles on nursing work has been insufficiently investigated (Duffield, Twigg, Roche et al., 2019).

This study reports on a study of nursing teams developing new roles in daily nursing hospital practice. In 2010, the Dutch Ministry of Health announced a law amendment (the Individual Health Care Professions Act) to formalize the distinction between VNs and BNs. The law amendment made a distinction in responsibilities regarding complexity of care, coordination of care, and quality improvement. Professional roles are usually developed top-down at policy level, through competency frameworks and job profiles that are subsequently implemented in nursing practice. In the Dutch case, a national expert committee made two distinct job profiles (Terpstra, van den Berg & van Mierlo, 2015). Instead of prescribing role implementation, however, healthcare organizations were granted the opportunity to develop these new nursing roles in practice, aiming for a more practice-based approach to reforming the nursing workforce. This study investigates a Dutch teaching hospital that used an experimental development process in which the nurses developed role distinctions by 'doing and appraising'. This iterative process evolved in small changes (Bohmer, 2016; Ellström, 2001; van Schothorst-van Roekel, 2020), based on nurses' thorough knowledge of professional practices (Reay, Golden-Biddle & Germann, 2006) and leadership role (Boamah, 2019; Mannix, Wilkes & Jackson, 2013; Nelson-Brantley & Ford, 2017).

According to Abbott, the constitution of a new role is a competitive action, as it always leads to negotiation of new openings for one profession and/or degradation of adjacent professions (Abbott, 2005). Additionally, role differentiation requires negotiation between different professionals, which always takes place in the background of historical professionalization processes and vested interests resulting in power-related issues (Ayala, 2020; Chua & Clegg, 1990; Hughes, 2017). Recent studies have described the differentiation of nursing roles to other professionals, such as nurse practitioners and nurse assistants, but have focused on evaluating shifts in nursing tasks and roles (Duffield et al., 2019). Limited research has been conducted on differentiating between the different roles of registered nurses and the involvement of nurses themselves in developing new nursing roles. An ethnographic study was conducted to shed light on the nurses' work of seeking openings and negotiating roles and responsibilities and the consequences of role distinctions, against a background of historically shaped relationships and patterns.

METHODS

Aim

The study aimed to understand the formulation of nursing role distinctions between different educational levels in a development process involving experimental action (doing) and appraisal.

Design

We conducted an ethnographic case study. This design was commonly used in nursing studies in researching changing professional practices (Polit & Beck, 2008; Roper & Shapira, 2000). The researchers gained detailed insights into the nurses' actions and into the finetuning of their new roles in daily practice, including the meanings, beliefs and values nurses give to their roles (Atkinson & Hammersley, 2007; Draper, 2015). This study complied with the consolidated criteria for reporting qualitative research (COREQ) checklist.

Setting and participants

Our study took place in a purposefully selected Dutch teaching hospital (481 beds, 2,600 employees including 800 nurses). Historically, nurses in Dutch hospitals have vocational training. The introduction of higher nursing education in 1972 prompted debates about distinguishing between vocational-trained nurses (VNs) and bachelor-trained nurses (BNs). For a long time, VNs resisted a role distinction, arguing that their work experience rendered them equally capable to take care of patients and deal with complex needs. As a result, VNs and BNs carry out the same duties and bear equal responsibility. To experiment with role distinctions in daily practice, the hospital management and project team selected a convenience but representative sample of wards. Two general (neurology and surgery) and two specific care (oncology and pneumatology) wards were selected as they represent the different compositions of nursing educational levels (VN, BN and additional specialized training). The demographic profile for the nursing teams is shown in Table 1. The project team, comprising nursing policy staff, coaches and HR staff (N=7), supported the four (nursing) teams of the wards in their experimental development process (131 nurses; 32% BNs and 68% VNs, including seven senior nurses with an organizational role). We also studied the interactions between nurses and team managers (N=4), and the CEO (N=1) in the meetings.

Data collection

Data was collected between July 2017 and January 2019. A broad selection of respondents was made based on the different roles they performed. Respondents were personally approached by the first author, after close consultation with the team managers.

Table 1. Demographics of the study participants*

Variables		Numbers
Wards	Oncology	22
	Neurology	19
	Surgery	15
	Pulmonology	16
Age	younger than 25	14
	25 till 34	28
	35 till 44	10
	45 till 54	15
	55+	5
	Average	35
Gender	male	4
	female	68
Education level	VN	46
	BN	26
Current role	VN	44
	BN	25
	Senior	3
Work hours	<28	11
	≥28	61
Years of experience	<3 years	23
	≥3 and < 5 years	9
	≥ 5 and < 10 years	11
	≥ 10 years	29

* Demographic data derived from a quantitative study that was conducted in parallel on the same sample (72 respondents, 55% of the study participants, representative for the total sample).

Four qualitative research methods were used iteratively combining collection and analysis, as is common in ethnographic studies (Roper & Shapira, 2000) (see Table 2).

1) Shadowing nurses (i.e. observations and questioning nurses about their work) on shift (65 hours in total) was conducted to observe behavior in detail in the nurses' organizational and social setting (Allen, 2014; Lalleman, Bouma, Smid et al., 2017), both in existing practices and in the messy fragmented process of developing distinct nursing roles. The notes taken during shadowing were worked up in thick descriptions (Polit & Beck, 2008).
2) Observation and participation in four types of meetings. The first and second authors attended: 1) kick-off meetings for the nursing teams (n=2); 2) bi-monthly meetings (n=10) between BNs and the project team to share experiences and reflect on the challenges, successes and failures; and 3) project group meetings at which the

nursing role developmental processes was discussed (n=20). Additionally, the first author observed nurses in ward meetings discussing the nursing role distinctions in daily practice (n=15). Minutes and detailed notes also produced thick descriptions (Atkins, Lewin, Smith et al., 2008). This fieldwork provided a clear understanding of the experimental development process and how the respondents made sense of the challenges/problems, the chosen solutions and the changes to their work routines and organizational structures. During the fieldwork, informal conversations took place with nurses, nursing managers, project group members and the CEO (app. 15 hours), which enabled us to reflect on the daily experiences and thus gain in-depth insights into practices and their meanings. The notes taken during the conversations were also written up in the thick description reports, shortly after, to ensure data validity (Houghton, Casey, Shaw et al., 2013). These were completed with organizational documents, such as policy documents, activity plans, communication bulletins, formal minutes and in-house presentations.

3) Semi-structured interviews lasting 60–90 minutes were held by the first author with 22 respondents: the CEO (n=1), middle managers (n=4), VNs (n=6), BNs (n=9, including four senior nurses), paramedics (n=2) using a predefined topic list based on the shadowing, observations and informal conversations findings. In the interviews, questions were asked about task distinctions, different stakeholder roles (i.e., nurses, managers, project group), experimental approach, and added value of the different roles and how they influence other roles. General open questions were asked, including: "How do you distinguish between tasks in daily practice?". As the conversation proceeded, the researcher asked more specific questions about what role differentiation meant to the respondent and their opinions and feelings. For example: "what does differentiation mean for you as a professional?", and "what does it mean for you daily work?", and "what does role distinction mean for collaboration in your team?" The interviews were tape-recorded (with permission), transcribed verbatim and anonymized.
4) The fieldwork period ended with four focus groups held by the first author on each of the four nursing wards (N=19 nurses in total: nine BNs, eight VNs, and two senior nurses). The groups discussed the findings, such as (nurses' perceptions on) the emergence of role distinctions, the consequences of these role distinctions for nursing, experimenting as a strategy, the elements of a supportive environment and leadership. Questions were discussed like: "which distinctions are made between VN and BN roles?", and "what does it mean for VNs, BNs and senior nurses?". During these meetings, statements were also used to provoke opinions and discussion, e.g., "The role of the manager in developing distinct nursing roles is...". With permission, all focus groups were audio recorded and the recordings were transcribed verbatim. The focus groups also served for member-checking and enriched data collection,

together with the reflection meetings, in which the researchers reflected with the leader and a member of the project group members on program, progress, roles of actors and project outcomes. Finally, the researchers shared a report of the findings with all participants to check the credibility of the analysis.

Table 2. Data collection methods for both cases, excluding document study

Hospital wards	Participants	Shadowing nurses	Conversations	Interviews	Meetings
* neurology * surgery * oncology *pulmonology	Ward nurses: VNs, BSNs, Senior nurses (n=131) Managers (n=4) Project group (n=7) Top manager (n=1)	65 hours approx.	15 hours approx.	Top manager (n=1), Nurse managers (n=4) VNs (n=6) BSNs (n=9) Paramedics (n=2) Total interviews n=22 60-90 minutes each	Kick-off meeting: nursing team, manager, project group members (n=2) Ward meetings: BSNs, VNs, senior nurses, manager (n=15) Interdepartmental meetings: 2 nurses per team, team managers, project group members (n=10) Project group meetings: nurse project leader, nurse project member, teachers/ coaches, HR staff, researchers (n=20) Team focus groups (n=4; 19 nurses in total) Reflection meetings: project leader and member of the Nurse Advisory dept, 2 researchers (n=9) Total meetings n=60

Data analysis

Data collection and inductive thematic analysis took place iteratively (Denzin & Lincoln, 2011; Roper & Shapira, 2000). The first author coded the data (i.e. observation reports, interview and focus group transcripts), basing the codes on the research question and theoretical notions on nursing role development and distinctions. In the next step, the research team discussed the codes until consensus was reached. Next, the first author did the thematic coding, based on actions and interactions in the nursing teams, the organizational consequences of their experimental development process, and relevant opinions that steered the development of nurse role distinctions (see additional file). Iteratively, the research team developed preliminary findings, which were fed back to the respondents to validate our analysis and deepen our insights (Creswell & Miller, 2000). After the analysis of the additional data gained in these validating discussions, codes were organized and re-organized until we had a coherent view.

Rigor

Ethnography acknowledges the influence of the researcher, whose own (expert) knowledge, beliefs and values form part of the research process (Draper, 2015). The first author was involved in the teams and meetings as an observer-as-participant, to gain in-depth insight, but remained research-oriented (Baker, 2006). The focus was on the study of nursing actions, routines and accounts, asking questions to obtain insights into underlying assumptions, which the whole research group discussed to prevent 'going native' (Dwyer & Buckle, 2009; Kanuha, 2000). Rigor was further ensured by triangulating the various data resources (i.e. participants and research methods), purposefully gathered over time to secure consistency of findings and until saturation on a specific topic was reached (Creswell & Miller, 2000). The meetings in which the researchers shared the preliminary findings enabled nurses to make explicit their understanding of what works and why, how they perceived the nursing role distinctions and their views on experimental development processes.

Ethical considerations

All participants received verbal and written information, ensuring that they understood the study goals and role of the researcher (Draper, 2015). Participants were informed about their voluntary participation and their right to end their contribution to the study. All gave informed consent. The study was performed in accordance with the Declaration of Helsinki and was approved by the Erasmus Medical Ethical Assessment Committee in Rotterdam (MEC-2019-0215), which also assessed the compliance with GDPR.

RESULTS

Our findings reveal how nurses gradually shaped new nursing role distinctions in an experimental process of action and appraisal and how the new BN nursing roles became embedded in new nursing routines, organizational routines and structures. Three empirical appeared from the systematic coding: 1) distinction based on complexity of care; 2) organizing hospital care; and 3) evidence-based practices (EBP) in quality improvement work.

Distinction based on complexity of care

Initially, nurses distinguished the VN and BN roles based on the complexity of patient care, as stated in national job profiles (Terpstra et al., 2015). BNs were supposed to take care of clinically complex patients, rather than VNs, although both VNs and BNs had been equally taking care of every patient category. To distinguish between highly and less complex patient care, nurses developed a complexity measurement tool. This tool

enabled classification of the predictability of care, patient's degree of self-reliance, care intensity, technical nursing procedures and involvement of other disciplines. However, in practice, BNs questioned the validity of assessing a patient's care complexity, because the assessments of different nurses often led to different outcomes. Furthermore, allocating complex patient care to BNs impacted negatively on the nurses' job satisfaction, organizational routines and ultimately the quality of care. VNs experienced the shift of complex patient care to BNs as a diminution of their professional expertise. They continuously stressed their competencies and questioned the assigned levels of complexity, aiming to prevent losses to their professional tasks:

> 'Now we're only allowed to take care of COPD patients and people with pneumonia, so no more young boys with a pneumothorax drain. Suddenly we are not allowed to do that. (…) So, your [professional] world is getting smaller. We don't like that at all. So, we said: We used to be competent, so why aren't we anymore?' (Interview VN1, in-service trained nurse)

In discussing complexity of care, both VNs and BNs (re)discovered the competencies VNs possess in providing complex daily care. BNs acknowledged the contestability of the distinction between VN and BN roles related to patient care complexity, as the next quote shows:

> 'Complexity, they always make such a fuss about it. (...) At a given moment you're an expert in just one certain area; try then to stand out on your ward. (...) When I go to GE [gastroenterology] I think how complex care is in here! (...) But it's also the other way around, when I'm the expert and know what to expect after an angioplasty, or a bypass, or a laparoscopic cholecystectomy (…) When I've mastered it, then I no longer think it's complex, because I know what to expect!' (Interview BN1, 19-07-2017)

This quote illustrates how complexity was shaped through clinical experience. What complex care *is*, is influenced by the years of doing nursing work and hence is individual and remains invisible. It is not formally valued (Star & Strauss, 1999) because it is not included in the BN-VN competency model. This caused dissatisfaction and feelings of demotion among VNs. The distinction in complexities of care was also problematic for BNs. Following the complexity tool, recently graduated BNs were supposed to look after highly complex patients. However, they often felt insecure and needed the support of more experienced (VN) colleagues – which the VNs perceived as a recognition of their added value and evidence of the failure of the complexity tool to guide division of tasks. Also, mundane issues like holidays, sickness or pregnancy leave further complicated

the use of the complexity tool as a way of allocating patients, as it decreased flexibility in taking over and swapping shifts, causing dissatisfaction with the work schedule and leading to problems in the continuity of care during evening, night and weekend shifts. Hence, the complexity tool disturbed the flexibility in organizing the ward and held possible consequences for the quality and safety of care (e.g. inexperienced BNs providing complex care), Ultimately, the complexity tool upset traditional teamwork, in which nurses more implicitly complemented each other's competencies and ability to 'get the work done' (Allen & Lyne, 1997). As a result, role distinction based on 'quantifiable' complexity of care was abolished. Attention shifted to the development of an organizational and quality-enhancing role, seeking to highlight the added value of BNs – which we will elaborate on in the next section.

Organizing hospital care

Nurses increasingly fulfill a coordinating role in healthcare, making connections across occupational, departmental and organizational boundaries, and 'mediating' individual patient needs, which Allen describes as organizing work (Allen, 2014). Attempting to make a valuable distinction between nursing roles, BNs adopted coordinating management tasks at the ward level, taking over this task from senior nurses and team managers. BNs sought to connect the coordinating management tasks with their clinical role and expertise. An example is bed management, which involves comparing a ward's bed capacity with nursing staff capacity (Allen, 2015; 2018). At first, BNs accompanied middle managers to the hospital bed review meeting to discuss and assess patient transfers. On the wards where this coordination task used to be assigned to senior nurses, the process of transferring this task to BNs was complicated. Senior nurses were reluctant to hand over coordinating tasks as this might undermine their position in the near future. Initially, BNs were hesitant to take over this task, but found a strategy to overcome their uncertainty. This is reflected in the next excerpt from fieldnotes:

> Senior nurse: 'First we have to figure out if it will work, don't we? I mean, all three of us [middle manager, senior nurse, BN] can't just turn up at the bed review meeting, can we? The BN has to know what to do first, otherwise she won't be able to coordinate properly. We can't just do it.' BN: 'I think we should keep things small, just start doing it, step by step. (…) If we don't try it out, we don't know if it works.' (Field notes, 24-05-2018)

This excerpt shows that nurses gradually developed new roles as a series of matching tasks. Trying out and evaluating each step of development in the process overcame the uncertainty and discomfort all parties held (Arrowsmith et al., 2016). Moreover, carrying out the new tasks made the role distinctions become apparent. The coordinating role in

bed management, for instance, became increasingly embedded in the new BN nursing role. Experimenting with coordination allowed BNs prove their added value (Apker et al., 2006) and contributed to overall hospital performance as it combined daily working routines with their ability to manage bed occupancy, patient flow, staffing issues and workload. This was not an easy task. The next quote shows the complexity of creating room for this organizing role:

> The BNs decide to let the VNs help coordinate the daily care, as some VNs want to do this task. One BN explains: 'It's very hard to say, you're not allowed.' The middle manager looks surprised and says that daily coordination is a chance to draw a clear distinction and further shape the role of BNs. The project group leader replies: 'Being a BN means that you dare to make a difference [in distinctive roles]. We're all newbies in this field, but we can use our shared knowledge. You can derive support from this task for your new role.' (Field notes, 09-01-2018)

This excerpt reveals the BNs' thinking on crafting their organizational role, turning down the VNs wishes to bear equal responsibility for coordinating tasks. Taking up this role touched on nurse identity as BNs had to overcome the delicate issue of equity (Currie et al., 2009), which has long been a core element of the Dutch nursing profession. Taking over an organization role caused discomfort among BNs, but at the same time provided legitimation for a role distinction.

Legitimation for this task was also gained from external sources, as the law amendment and the expert committee's job descriptions both mentioned coordinating tasks. However, taking over coordinating tasks and having an organizing role in hospital care was not done as an 'implementation'; rather it required a process of actively crafting and carving out this new role. We observed BNs choosing not to disclose that they were experimenting with taking over the coordinating tasks as they anticipated a lack of support from VNs:

> BN: 'We shouldn't tell the VNs everything. We just need this time to give shape to our new role. And we all know who [of the colleagues] won't agree with it. In my opinion, we'd be better off hinting at it at lunchtime, for example, to figure out what colleagues think about it. And then go on as usual.' (Field notes, 12-06-2018)

BNs stayed 'under the radar', not talking explicitly about their fragile new role to protect the small coordination tasks they had already gained. By deliberately keeping the evaluation of their new task to themselves, they protected the transition they had set into motion. Thus, nurses collected small changes in their daily routines, developing a new role distinction step by step. Changes to single tasks accumulated in a new role

distinction between BNs, VNs and senior nurses, and gave BNs a more hybrid nursing management role.

Evidence-based practices in quality improvement work

Quality improvement appeared to be another key concern in the development of the new BN role. Quality improvement work used to be carried out by groups of senior nurses, middle managers and quality advisory staff. Not involved in daily routines, the working group focused on nursing procedures (e.g. changing infusion system and wound treatment protocols). In taking on this new role BNs tried different ways of incorporating EBP in their routines, an aspect that had long been neglected in the Netherlands. As a first step, BNs rearranged the routines of the working group. For example, a team of BNs conducted a quality improvement investigation of a patient's formal's complaint:

> Twenty-two patients registered a pain score of seven or higher and were still discharged. The question for BNs was: how and why did this bad care happen? The BNs used electronic patient record to study data on the relations between pain, medication and treatment. Their investigation concluded: nurses do not always follow the protocols for high pain scores. Their improvement plan covered standard medication policy, clinical lessons on pain management and revisions to the patient information folder. One BN said: 'I really loved investigating this improvement.' (Field notes, 28-05-2018)

This fieldnote shows the joy quality improvement work can bring. During interviews, nurses said that it had given them a better grip on the outcome of nursing work. BNs felt the need to enhance their quality improvement tasks with their EBP skills, e.g. using clinical reasoning in bedside teaching, formulating and answering research questions in clinical lessons and in multi-disciplinary patient rounds to render nursing work more evidence based. The BNs blended EBP-related education into shift handovers and ward meetings, to show VNs the value of doing EBP [64]. In doing so, they integrated and fostered an EBP infrastructure of care provision, reflecting a new sense of professionalism and responsibility for quality of care.

However, learning how to blend EPB quality work in daily routines – 'learning in practice' –requires attention and steering. Although the BNs had a Bachelor's degree, they had no experience of a quality-enhancing role in hospital practice (Skela-Savič, 2017). In our case, the interplay between team members' previous education and experienced shortcomings in knowledge and skills uncovered the need for further EBP training. This training established the BNs' role as quality improvers in daily work and at the same time supported the further professionalization of both BNs and VNs. Although introducing the EBP approach was initially restricted to the BNs, it was soon realized

that VNs should be involved as well, as nursing is a collaborative endeavor (Allen, 2015), as one team member (the trainer) put it:

> 'I think that collaboration between BNs and VNs would add lots of value, because both add something different to quality work. I'd suggest that BNs could introduce the process-oriented, theoretical scope, while VNs could maybe focus on the patients' interest.' (Fieldnote, informal conversation, 11-06-2018)

During reflection sessions on the ward level and in the project team meetings BNs, informed by their previous experience with the complexity tool, revealed that they found it a struggle to do justice to everyone's competencies. They wanted to use everyone's expertise to improve the quality of patient care. They were for VNs being involved in the quality work, e.g. in preparing a clinical lesson, conducting small surveys, asking VNs to pose EBP questions and encourage VNs to write down their thoughts on flip over charts as means of engaging all team members.

These findings show that applying EPB in quality improvement is a relational practice driven by mutual recognition of one another's competencies. This relational practice blended the BNs' theoretical competence in EBP (Stokke, Olsen & Espehaug, 2014) with the VNs' practical approach to the improvement work they did together. As a result, the blend enhanced the quality of daily nursing work and thus improved the quality of patient care and the further professionalization of the whole nursing team.

DISCUSSION

This study aimed to understand how an experimental approach enables differently educated nurses to develop new, distinct professional roles. Our findings show that roles cannot be distinguished by complexity of care; VNs and BNs are both able to provide care to patients with complex healthcare needs based on their knowledge and experience. However, role distinctions can be made on organizing care and quality improvement. BNs have an important role organizing care, for example arranging the patient flow on and across wards at bed management meetings, while VNs contribute more to organizing at the individual patient level. BNs play a key role in starting and steering quality improvement work, especially blending EBP in with daily nursing tasks, while VNs are involved but not in the lead. Working together on quality improvement boosts nursing professionalization and team development.

Our findings also show that the role development process is greatly supported by a series of small-change experiments, based on action and appraisal. This experimental approach supported role development in three ways. First, it incorporates both formal

tasks and the invisible, unconscious elements of nursing work (Allen, 2014). Usually, invisible work gets no formal recognition, for example in policy documents (Baker, 2006), whereas it is crucial in daily routines and organizational structures (Allen, 2014; 2018). Second, experimenting triggers an accumulation of small changes (Bohmer, 2016; Lyman et al., 2019) leading to the embeddedness of role distinctions in new nursing routines, allowing nurses to influence the organization of care. This finding confirms the observations of Reay et al. that nurses can create small changes in daily activities to craft a new nursing role, based on their thorough knowledge of their own practice and that of the other involved professional groups (Reay et al., 2006). Although these changes are accompanied by tension and uncertainty, the process of developing roles generates a certain joy. Third, experimenting stimulated nursing professionalization, enabling the nurses to translate national legislation into hospital policy and supporting the nurses' own (bottom-up) evolution of practices. Historically, nursing professionalization is strongly influenced by gender and education level (Ayala, 2020) resulting in a subordinate position, power inequity and lack of autonomy (Chua & Clegg, 1990). Giving nurses the lead in developing distinct roles enables them to 'engage in acts of power' and obtain more control over their work. Fourth, experimenting contributes to role definition and clarification. In line with Poitras et al. (2016) we showed that identifying and differentiating daily nursing tasks led to the development of two distinct and complementary roles. We have also shown that the knowledge base of roles and tasks includes both previous and additional education, as well as nursing experience.

Our study contributes to the literature on the development of distinct nursing roles (de Bont et al., 2016; Jacob et al, 2015; Sermeus et al., 2011) by showing that delineating new roles in formal job descriptions is not enough. Evidence shows that this formal distinction led particularly to the non-recognition, non-use and degradation (Abbott, 2005) of VN competencies and discomforted recently graduated BNs. The workplace-based experimental approach in the hospital includes negotiation between professionals, the adoption process of distinct roles and the way nurses handle formal policy boundaries stipulated by legislation, national job profiles, and hospital documents, leading to clear role distinctions. In addition to Hughes (2017) and Abbott (1988) who showed that the delineation of formal work boundaries does not fit the blurred professional practices or individual differences in the profession, we show how the experimental approach leads to the clarification and shape of distinct professional practices.

Thus, an important implication of our study is that the professionals concerned should be given a key role in creating change (Boamah, 2019; Nelson-Brantley & Ford, 2017; Reay et al., 2006). Adding to Mannix et al. (2013), our study showed that BNs fulfill a leadership role, which allows them to build on their professional role and identity. Through the experiments, BNs and VNs filled the gap between what they had learned in formal education, and what they do in daily practice (Furåker, 2008; Skela-Savič et al.,

2017). Experimenting integrates learning, appraising and doing much like going on 'a journey with no fixed routes' (Clegg et al., 2005; Ellström, 2001) and no fixed job description, resulting in the enlargement of their roles.

Our study suggests that role development should involve professionalization at different educational levels, highlighting and valuing specific roles rather than distinguishing higher and lower level skills and competencies. Further research is needed to investigate what experimenting can yield for nurses trained at different educational levels in the context of changing healthcare practices, and which interventions (e.g., in process planning, leadership, or ownership) are needed to keep the development of nursing roles moving ahead. Furthermore, more attention should be paid to how role distinction and role differentiation influence nurse capacity, quality of care (e.g., patient-centered care and patient satisfaction), and nurses' job satisfaction.

LIMITATIONS

Our study was conducted on four wards of one teaching hospital in the Netherlands. This might limit the potential of generalizing our findings to other contexts. However, the ethnographic nature of our study gave us unique understanding and in-depth knowledge of nurses' role development and distinctions, both of which have broader relevance. As always in ethnographic studies, the chances of 'going native' were apparent, and we tried to prevent this with ongoing reflection in the research team. Also, the interpretation of research findings within the Dutch context of nurse professionalization contributed to a more in-depth understanding of how nursing roles develop, as well as the importance of involving nurses themselves in the development of these roles to foster and support professional development.

We focused on role distinctions between VNs and BNs and paid less attention to (the collaboration with) other professionals or management. Further research is needed to investigate how nursing role development takes place in a broader professional and managerial constellation and what the consequences are on role development and healthcare delivery.

CONCLUSION

This paper described how nurses crafted and shaped new roles with an experimental process. It revealed the implications of developing a distinct VN role and the possibility to enhance the BN role in coordination tasks and in steering and supporting EBP quality improvement work. Embedding the new roles in daily practice occurred through an ac-

cumulation of small changes. Anchored by action and appraisal rather than by design, the changes fostered by experiments have led to a distinction between BNs and VNs in the Netherlands. Furthermore, experimenting with nursing role development has also fostered the professionalization of nurses, encouraging nurses to translate knowledge into practice, educating the team and stimulating collaborative quality improvement activities.

This paper addressed the enduring challenge of developing distinct nursing roles at both the vocational and Bachelor's educational level. It shows the importance of experimental nursing role development as it provides opportunities for the professionalization of nurses at different educational levels, valuing specific roles and tasks rather than distinguishing between higher and lower levels of skills and competencies. Besides, nurses, managers and policymakers can embrace the opportunity of a 'two-way window' in (nursing) role development, whereby distinct roles are outlined in general at policy levels, and finetuned in daily practice in a process of small experiments to determine the best way to collaborate in diverse contexts.

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4

The balancing act of organizing professionals and managers: An ethnographic account of nursing role development and unfolding nurse-manager relationships

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ABSTRACT

Scholars describe organizing professionalism as 'the intertwinement of professional and organizational logics in one professional role'. Organizing professionalism bridges the gap between the often-described conflicting relationship between professionals and managers. However, the ways in which professionals shape this organizing role in daily practice, and how it impacts on their relationship with managers has gained little attention. This ethnographic study reveals how nurses shape and differentiate themselves in organizing roles. We show that developing a new nurse organizing role is a balancing act as it involves resolving various tensions concerning professional authority, task prioritization, alignment of both intra- and interprofessional interests, and internal versus external requirements. Managers play an important yet ambiguous role in this development process as they both cooperate with nurses in aligning organizational and nursing professional aims, and sometimes hamper the development of an independent organizing nursing role due to conflicting organizational concerns.

Keywords: nursing role development; division of labor; ethnographic study; organizing professionalism; management; professional and organizational logics.

INTRODUCTION

Healthcare organizations worldwide face a crisis in the increasing shortage of nurses, due to insufficient numbers of nurses entering the profession and many nurses leaving prematurely (Altman et al. 2016; WHO 2020). Reasons for leaving include heavy workload, limited career opportunities, insufficient use of nursing competencies, and limited opportunity to influence daily practices (Camerino et al. 2006; Hayes et al. 2012). Healthcare organizations might stop nurses leaving by giving them more of a key role in the organization of the care they provide (Chiu et al. 2009; Heinen et al. 2013; Rondeau et al. 2008).

In this article, we study how nurses shape a more central role in the organization of care using the concept of organizing professionalism (Noordegraaf 2015). This concept stresses the intertwinement of professional and organizational logics within a professional role (Evetts 2009). Noordegraaf (2015:16) argues that "the coming together of professional and organizational elements is no longer 'unnatural' – organizing is part of the job". He criticizes the dualistic perspective, which understands these logics as opposites often causing conflict between professionals and managers (Evetts 2009; Noordegraaf 2011). According to Noordegraaf (2015), professionals should be empowered to deal with contradictory roles and actions that underpin professional organizing work as a natural phenomenon, instead of giving rise to tensions (ibid.). In this article, we are interested in how the organizing professionalism of nurses plays out in their relationship with managers (Evetts 2011; Muzio &Kirkpatrick 2011). Managers are neglected in the literature on organizing professionalism as it focuses on practitioners taking up organizing roles. Postma et al. (2015) suggest that organizing professionalism encompasses coordination between professionals and managers, but do not explain how this works in healthcare practice. There is little insight into when tensions arise, what these tensions comprise, and how professionals and managers deal with them. Hence, a better understanding of the managerial role in shaping an organizing nursing role is relevant to the understanding of how nurses develop it. Drawing on an ethnographic study on new nursing roles in the Netherlands, this study provides insight into the development of organizing professionalism in nursing, the resolution of arising tensions and the consequences for daily nursing practice. It adds a better understanding of how organizing professional roles are crafted in everyday work, and how this development of a new role is shaped through and negotiated with managers.

We explore two empirical cases on nurse role development for: 1) nurse practitioners (NPs) in elderly care who partly replace elderly care physicians (ECPs) in nursing homes; and 2) nurses with a bachelor's degree (BSNs) in a general hospital obtaining a more prominent role in organizing and providing hospital care. We examine the mundane mi-

crolevel processes of daily practices, asking 'How do nurses give shape to an organizing role in healthcare practice?'

This paper contributes to the literature on organizing professionalism by revealing the balancing act professionals and managers engage in when crafting a new organizing role. Building on our ethnographic findings, we take the debate on the role of nurses and managers in organizing professionalism a step further, visualizing a variety of tensions concerning professional authority, task prioritization, alignment of both intra- and interprofessional interests, and internal versus external requirements. We show how nurses shape their roles in interaction with their own ambitions, organizational needs, the aim of more nurse-driven care and external requirements. We reveal how managers play an active yet ambiguous role in this process, both contributing to and hampering the further professionalization of nurses.

The paper proceeds as follows. We first review the literature on organizing professionalism, especially on nurses in professions and organization studies. Next, we present our findings, discussing how nurses shape an organizing professional role through microlevel processes of role development and care provision in interaction with managers in everyday practice. In conclusion, we discuss our contribution to the literature on organizing professionalism and consider the developing nursing role in contemporary healthcare systems.

PROFESSIONALS AND MANAGERS IN HEALTHCARE ORGANIZATIONS

The role of professionals in the organization of care has been theorized in several ways. In 'pure' or occupational professionalism, professional work is generally seen as coordination of knowledgeable, skillful tasks by autonomous workers, gaining authority in trust-based patient and collegial relationships and profession-led training and regulation systems (Abbott 1988; Evetts 2009; Freidson 2001; Noordegraaf 2007). In this literature stream, doctors are postulated as the 'real' or 'classic' profession, while nurses are described as semi-professionals or 'lower status professionals' as they lack a strong and autonomous professional status (Freidson 2001). Davies (2003) points out that this resembles the traditional view on nursing as 'mothering', stressing how a certain type of femininity has been woven into the construction of the occupation (see also Dent 2003). Davies (2003) underscores how the caring/mothering view on nursing has contributed to the invisibility of nursing work, contrasting highly with the visibility and hence more appreciated work of doctors.

The early 1990s saw the introduction of a new form of controlled or 'organizational' professionalism, informed by the New Public Management (NPM) movement. In this perspective, professionals are governed top-down by managers who control and

regulate professionals with external forms of regulation, standardized procedures, and measurable targets and performances (Evetts 2010; Numerato et al. 2012). The relationship between professionals and managers is seen as highly conflictual, based on the assumption that professional and organizational logics inherently compete and are accompanied by tensions between professional and organizational demands (Abbott 1988; Cohen et al. 2002; Greenwood et al. 2011). To bridge the gap between these competing logics and deal with both the shared interests and responsibilities dispersed among managers and professionals, scholars use the concept of hybrid professionalism. Hybrid professionalism refers to a range of professional and managerial roles and strategies in which 'pure' professionalism and managerialism become more entangled. Hybrid professionalism demonstrates how professionals take on managerial roles, forcing them to move between different organizational groups (Andersson & Liff 2018; Blomgren & Waks 2015; Breit et al. 2018; Reay & Hinings 2009). Witman et al. (2011) show how physicians must balance between the organizational and professional worlds and derive their managerial legitimacy from their up-to-date clinical experience. Others have described that physicians can play a key role in organizational change by supporting innovation and fostering legitimacy, underscoring the importance of clinical leadership roles in organizational transition (Currie & Spyridonidis 2016). Carvalho (2014) points out that nurses' careers often develop within a managerial discourse given that as nurses move into managerial and hierarchical positions they move away 'from the bedside'. Drawing on a study of nurses in Portugal, Carvalho (2014) states that the nursing discourse is shifting from 'caring' and 'nurturing' to the knowledge, skills and organizational features of nursing organizational work, and how this fosters their status. Others show that career nurses incorporate managerial tasks and develop new professional identities by assuming managerialism as part of their professional practice, hence positioning themselves as 'apart' from field-level nurses (Allen 2018; Lalleman 2016). Bresnen et al. (2019) point to the emergent hybrid professional/management identity, revealing a more variegated, situated and dynamic interpretation of hybrid managerial identities in which hybrid professionals act as boundary-spanners connecting clinical and management practice. These forms of hybridization thus underscore the coexistence and distinctive nature of organizational and professional activities between and across professional and managerial domains, rather than providing insight into how professionals incorporate organizing activities and managerial responsibilities in their work and professional identity. The integrated organizing role is worked out further in the literature on organizing professionalism (Noordegraaf 2015; Kristiansen et al. 2015; Olakivi & Niska 2017).

ORGANIZING PROFESSIONALISM

Organizing professionalism is a relatively new concept to describe the role of professionals in streamlining processes aimed at better service provision, intertwining the professional and organizational logics as natural aspects of professional action (Noordegraaf 2011, 2015). The growing body of literature on organizing or organized professionalism (both terms seem to be used interchangeably) presents various practices of intertwining professional and organizational logics. Postma et al. (2015) use 'articulation work' to show that coordination of clients and professionals meshes the professional and organizational tasks as part of nursing work. Similarly, Allen (2014: xiii) describes the organizing role of nurses as "making connections across occupational, departmental and organizational boundaries and mediating the 'needs' of individual patients with the needs of the whole population". Allen (2014, 2018) shows how nurses are enrolled in bed management to match the patient's need of proper care with maximizing bed utilization to ensure corporate efficiency. While Allen connects an organizing nursing role across occupational, departmental and organizational boundaries, Noordegraaf (2015) provides a broader theoretical lens, describing the organizing role of professionals at three levels: 1) *treating cases*, to streamline the patient's process through the organization; 2) *treating case treatment*, selecting and prioritizing between patient cases to organize caseloads; and 3) *treating the treatment of case treatment*, taking responsibility for the quality of care, e.g., when professionals do quality and safety measurements themselves. While Noordegraaf offers the possibility to discern different levels of organizing work, his theory has not been empirically explored. Our study will show how levels of organizing play out in daily nursing, and how they contribute to the development of an organizing nurse role.

Beside the theme of organizing levels, two other issues require attention. First, to what extent is organizing 'new' to professionalism? Noordegraaf (2015), who focuses on physicians, calls organizing professionalism something new, while Postma et al. (2015) argue that it has long been part of the nursing role, albeit underexposed or neglected (see also Allen 2018). On the one hand, organizing work in nursing is largely taken for granted or neglected as the focus is on the direct patient-nurse relationship. On the other hand, scholars argue that organizing work has been 'captured' by managers, leaving the question of (the degree of) 'newness' undecided (Allen 2018; Newman & Lawler 2009). Second, how do professionals take up an organizing role, or what is needed to do so? Organizing professionalism pays special attention to professionals "actively reconfiguring their professional work and reshaping organizational policies" (Postma et al. 2015, 64). Meanwhile, Noordegraaf (2015) argues that professionals should be empowered to consider organizing a natural part of their work. Noordegraaf (2015) and Postma et al. (2015) both suggest that managers could facilitate the uptake of an organizing profes-

sional role. It would require coordination, both between professionals (intra- and inter-professionally) and between nurses and managers, as organizing professionalism does not mean "a strict return to autonomous or un-organized professional practice" (Noordegraaf 2016, 792). Oldenhof et al. (2016) and Van Wieringen et al. (2017) elaborate on this management role in developing and fostering professionalism by organizing tasks. Describing decoupling practices, Van Wieringen et al. (2017) discuss how managers sometimes engage in professional work-level practices and at other times refrain from intervening to provide space to ground-level workers to craft a new role. Oldenhof et al. (2016) similarly show how middle managers engage in shaping new professional roles, reconfiguring professional practice through professional talk. Our study contributes to the further understanding of how nurses take up this organizing role and how it affects their interactions with managers in daily nursing practice.

METHODS

Setting

We build on two ethnographic studies of nursing role development in the Netherlands, in a nursing home and a hospital. In both settings nurses had to obtain a more prominent role in organizing care. In the nursing home organization (13 locations, total 1,747 employees), the top manager aimed to develop an organization focused on 'care' rather than 'cure' in the light of the changing resident population. In the Netherlands, as elsewhere, healthcare policies are targeted at keeping the elderly at home when possible and so nursing homes are increasingly populated by the elderly facing end-of-life issues. In the nursing home, six NPs developed their role in the medical team (including five ECPs). In the hospital (481 beds, 2,600 employees including 800 nurses) the top manager aimed to create a more central role for nurses in the organization of care in nursing departments. As part of a national plan to formalize the distinction between nurses trained at different levels – anticipating an announced amendment to the law – the hospital sought to make a formal (practical) distinction between vocationally trained nurses (VN) and nurses with a bachelor degree (BSN). In the Netherlands, despite the availability of different training levels, nurses carry out similar tasks and bear equal responsibilities.

In both nursing home and hospital, nurses were put in the lead to develop their new roles. In the nursing home NPs developed their role "on the way" in close collaboration with the ECPs and top manager. In the hospital, two general wards (neurology and surgery) and two specialist wards (oncology and pulmonology) were appointed as 'experimental spaces' for developing organizational nursing roles. A local project group of nursing policy staff, teachers/coaches and HR staff supported this transition. The

project group periodically met to discuss progress and the consequences for nursing as a profession and the hospital as a whole.

Ethical approval for this research was granted by the Erasmus Medical Ethical Assessment Committee in Rotterdam (MEC-2019-0215). All participants were guaranteed confidentiality and we obtained their written approval.

Data collection

Data collection took place from February 2017 to December 2017 in the nursing home, and from July 2017 to January 2019 in the hospital. Data was collected through six qualitative, related research methods to obtain in-depth insight (Denzin & Lincoln 2000). First, we conducted observations of professionals (nurses and physicians) and nurse managers to gain insight into how nurses organize their work, the division of responsibilities in daily practice, and how nurses cooperated on or discussed the division of labor, both intra-, interprofessionally and with management. Secondly, we held informal conversations with participants, which enabled reflection on practices (Barley & Kunda 2001). Thirdly, we conducted semi-structured interviews to deepen insight into conduct, underlying choices, convictions and any intra- and interprofessional tensions between professionals in their own field and/or with professionals in another field, and between professionals and their managers. Interviews covered several themes, including tasks, responsibilities, the nurse's relationship and coordination with management, and the role and influence of external parties. Fourthly, the first and second author attended project team meetings, as well as interdepartmental and project group meetings. As participative observers the authors reflected on the development of nursing roles, sharing relevant findings on job differentiation and task reallocation. Fifth, we analyzed documents including policy documents, minutes and emails for background information that further deepened the insights. Finally, at the end of the fieldwork period, we held group interviews to deepen the research findings. For more details on the data collection see Table 1.

All interviews were tape-recorded and transcribed verbatim with permission. All observations and conversations were written up within 24 hours after collection in detailed thick descriptions to enhance data validity (Atkins et al. 2008; Polit & Beck 2008).

Data analysis

Data analysis involved analyzing the individual research projects and comparing and contrasting the findings from both (Creswell 2014; Polit & Beck 2015). We performed abductive analysis on each project, using both inductive and deductive analysis by combining the codes emerging from the data with the codes based on theory (Tavory & Timmermans 2014). This abductive strategy brought together insights from the data and theory on organizing professionalism, organizing work and hybridity. Letting the

data and theory ‘talk to each other’ (Stoopendaal & Bal 2013) provided situational- and theoretical-derived findings. Instead of limiting the process to a number of planned subsequent ‘phases’, the strategy of going back and forth through data and theoretical concepts allowed for a rich understanding of both theory and empirical phenomena (Dubois & Gadde, 2002). Codes included nurse, medical and management tasks; collaboration; independence/interdependency; power differences; interests; conflict; and legitimacy. Initial codes were grouped into subcategories revealing the microlevel processes. Subsequently these lead to three main themes on the development of nursing organizing roles and the dynamic relationship between nurses and managers (see additional file). During the coding process and analysis, all authors discussed the themes and categories until consensus was reached.

Table 1. Data collection methods for both cases, excluding document study

Cases	Participants	Observations	Conversations	Interviews	Meetings
Nursing home	NPs (n=6) ECPs (n=5) Top manager (n=1)	90 hours approx.	18 hours approx.	ECPs (n=5) NPs (n=6) Top manager (n=1) Nursing home manager (n=1) Total interviews n=13 45-60 minutes each	Dilemma discussion (problem setting) (n=1) Medical team meetings, including discussions on the collaboration model (n=6) NPs meetings on role development (n=5) Multidisciplinary patient care consultations (n=4) NP-ECP patient treatment reviews (n=5) Total meetings n=21
Hospital wards: * neurology * surgery * oncology * pulmonology	Ward nurses: VNs, BSNs, Senior nurses (n=120) Managers (n=4) Project group (n=7) Top manager (n=1)	65 hours approx.	15 hours approx.	Top manager (n=1), Nurse managers (n=4) VNs (n=6) BSNs (n=9) Paramedics (n=2) Total interviews n=22 60–90 minutes each Group interviews (n=4) 76–87 minutes long, 19 nurses in total (9 BSNs, 8 VNs, 2 senior nurses)	Kick-off meeting: nursing team, manager, project group members (n=2) Ward meetings: BSNs, VNs, senior nurses, manager (n=15) Interdepartmental meetings: 2 nurses per team, team managers, project group members (n=10) Project group meetings: nurse project leader, nurse project member, teachers/ coaches, HR staff, researchers (n=20) Total meetings n=47

RESULTS

The analysis identified three themes on developing professional organizing roles: 1) creating and constraining space to develop an organizing nursing role; 2) prescribing and negotiating nursing roles; and 3) balancing external requirements with internal demands. It appears that developing professional organizing roles is a tension-ridden, layered process of bringing together (perceived) organizational needs and (negotiating) desirable professional development. In presenting the results, we dwell on the microlevel processes of developing a new organizing nursing role that produce change as well as a continuation of vested work routines and power relationships. Envisioning the mundane actions underlying these actions and processes enables us to come to grips with the dynamics of crafting a new organizing role (see also Currie et al. 2012; Wallenburg et al. 2016).

Creating and constraining space to develop an organizing nursing role

At the outset, participants in both cases considered it crucial that nurses received the space and time to develop their own organizing role(s). Top managers of both organizations argued that nurses themselves were best suited to do this. The top manager of the nursing home argued: "I'm not the only one to determine where [things] should be heading, and I think it's important that they [NPs] use their own expertise." Similarly, the hospital top manager made nurses the primary change agent and introduced a local nurse leadership program to support the transition.

In both cases, nurses developed a (partial) new role. In the nursing home, NPs partly replaced ECPs, taking on a medical role in treating clients and organizing care. They also took organizing responsibility, positioning themselves as the (medical) point of contact for ward nurses, nurse assistants, clients, and family members. NPs took clinical responsibility for the residents (often in close contact with the physicians, see below), attended (multidisciplinary) consultations and referred clients to the hospital, and were involved in quality improvement projects.

In the hospital, BSNs took on a new organizing role, participating in the daily interdepartmental meeting on bed utilization, for instance. BSNs did the daily coordination on the wards. They led the daily shift evaluations with nurses, monitored the nursing workload, coordinated both the (re)allocation of patients among nurses and quality improvement activities done by their team. These tasks were partially new or used to be carried out by the team managers or senior nurses. However, both NPs and BSNs floundered in shaping a new organizing role without the involvement of team managers and felt they needed someone in authority to get things done, as they did not know how to influence and steer their teams or obtain an equal position compared to other disciplines (e.g. ECPs). In the hospital, the BSNs began keenly enough, but soon had problems finding the right approach. A nurse recalled:

> “We searched for a long time, how to get started. It put us back, not knowing how. There were plenty of ideas, we brainstormed with the whole team. […] Maybe, at the start, we’d have benefited from more [management] guidance. We had to figure it out by ourselves. The project group could have guided us more, but we could also have sounded the alarm sooner. We were very willing but didn’t know how.” (Group interview VNs and BSNs, neurology ward)

‘Thrown into the deep end’, nurses felt unable to adopt an organizing role as it was not clear what that would entail and they lacked the required knowledge and skills (e.g. for bed management and quality improvement). This also concerned the nursing leadership, as a nurse explained:

> “Our team manager gave the BSN the space [to develop a new role]. She encouraged us. At the beginning, she was not allowed to intervene. But when she saw that it wasn’t working, she stepped in and got involved. […] It really needs a manager, someone with a helicopter view, who can say: ‘Well, that’s the plan, let us go for it.’ After all, who am I to decide?” (Interview BSN1, traumatology ward)

Nurses’ initiatives in organizing and managing their work processes did not automatically find a way into daily practice. The nurses were bogged down by mundane obstacles, such as a lack of BSNs to shape the new role or having to prioritize direct patient care above organizational tasks due to a heavy workload. We noticed that embedding the new role demanded consultation and coordination between nursing and management. This was also apparent in the nursing home case. Here, too, NPs hesitated to take the lead:

> Reflecting on their limited input at team meetings, NPs said they found it hard to decide what to do, whereupon the top manager urged them to stand up and decide for themselves what their role should be. (Field notes nursing home, 29 September 2017)

Managers struggled to support the development of a nursing organizing role. They tried to give the nurses space, but sometimes fell back on traditional top-down decision making when frustrated by the nurses’ limited progress (see Van Wieringen et al. 2019 for similar observations). In the nursing home, the top manager took over the lead to resolve persistent disagreement on task division between NPs and ECPs (for more detail, see below). However, this steering role hindered the nurses from taking on the responsibility to give shape to their new role:

> NP1: "Today the wind blows east, tomorrow it'll blow west…"
>
> NP2: "Top management needs to give the green light. I wish they would organize a work group [delegation of ECPs and NPs] to make decisions so we can go on working in harmony." (Informal conversation, NPs nursing home, 3 November 2017)

In the nursing home, NPs felt overwhelmed when the manager interfered in their developmental process, constrained from taking over the lead and not getting enough time and space to figure out what their tasks, responsibilities and routines should be. They responded by taking a 'wait-and-see' approach, as opposed to the pro-active organizing role they were expected to adopt. This resulted in the top manager taking over even more. Management also took over in the hospital. Here, BSNs had discussed their new role without finetuning their plans with management, based on the agreement that nurses were in the lead and the assumption that managerial interference was not necessary to develop an organizing role. Yet, informed on nurses' actions afterwards, managers canceled plans that interfered with existing agreements:

> "Each nurse has an area of interest, like palliative care, insulin or needles. We [BSNs] thought, let's regroup that, cluster [the interests] under umbrella themes, coordinated by one BSN, who would look for what is evidence-based or patient-centered or value-based […] and be involved in that group. […] When she learned about this, our team manager informed us that she didn't want us to change the [division of] areas of interest, because so many people in the team had already agreed on them. I thought, here we go again." (Interview BSN2, traumatology ward)

This quote reveals how an organizing role for nurses can conflict with managerial responsibilities for previously agreed hospital policies, and how the absence of alignment between nurses and managers during the developmental process hindered the development of a nursing organizing role, causing frustration among the nurses.

After a while, nurses and managers found a balance between nurses taking up a new role and managers guiding them in this process. In the nursing home, the top manager found a balance in guiding the NPs by creating temporary, workable agreements (see below for further details). In the hospital, the manager found a balance by attending meetings where BSNs discussed their new role in detail and prepared and evaluated the pilots. If the discussion faltered or the manager wished to share an insight, she intervened:

> Near the end of the meeting, the manager brings in her finding: “I noticed in the schedule that [BSNs] mainly work the day shift. I wish you’d consider what that means for the evening and night shifts. What impact does it have on quality of care for example?” […] The BSNs discuss this and decide that it has a minimal effect on quality of care. They note other consequences for themselves: being unhappy with regular day shifts and missing out on the extra salary for working irregular hours. (Observation report, BSN oncology ward meeting, 6 September 2018)

The findings in this section have shown that nurses in both cases were given the space to develop a nursing organizing role, yet soon felt lost doing this as it required knowledge and skills about organizing care they did not own yet. Developing an organizing role also required coordination between nurses and managers to align corporate practicalities and responsibilities, as organizing remains part of the managerial role. Managerial interference, however, also evoked conflict as nurses felt it restricted their developing space. Our findings show that managers need to perform a balancing act in giving nurses space for role development (Van Wieringen et al. 2019). Managers balance between supporting nurse leadership in steering their own role development and steering nurses in a specific direction to align with organizational policy, thereby restricting their space. Our findings underscore this balancing act, yet also expand insight by showing the tensions, interests, and power differences this involves, often bringing both managers and nurses in complex, conflicting situations and negotiation processes. This is what we will turn to next.

Prescribing and negotiating nursing roles

In the hospital, developing the organizing nursing role began with a clear definition laid down in Dutch national job profiles. The VN job profile involved a fundamental change as VNs had to hand over responsibility for nursing complex patients to BSNs. The BSN profile prescribes specific nursing responsibility for complex patient care, an overarching role in care coordination and quality improvement, and coaching both VNs and (recently graduated) BSNs. One project team saw differentiating complexity of care as an opportunity to develop distinct nursing roles:

> “We thought we could achieve [differentiation in complexity of care] on this ward because we have so many BSNs. […] Here too, you must make a firm statement to draw the distinction because the BSNs, not the VNs, would be caring for complex patients. We believed in it, we were keen, and they wanted to experiment with this concept.” (Interview team manager, pulmonology)

However, the predefined role distinction in complexity of care soon led to heated discussions that evoked tension between VNs and BSNs. VNs felt downgraded and 'made inferior' by the role distinctions. BSNs wanted to enlarge their organizing role but felt increasingly uncomfortable with the downgrading of the VNs' professional expertise in caring for complex patients.

> "Complexity, they always make such a fuss about it. [...] At a given moment you're an expert in just one certain area; try then to stand out on your ward. [...] When I go to gastroenterology I think: how complex is the care here! [...] But it's also the other way round, when I'm the expert and know what to expect after an angioplasty, or a bypass, or a laparoscopic cholecystectomy. […] When I've mastered it, then I no longer think it's complex, because I know what to expect! So, it has to do with the patient, the patient's responses, what's involved, and with me as a person. With my competences and knowledge and skills." (Interview BN1, 19-07-2017)

Nurses had to deal with the organizational consequences of the distinction in complexity, such as bottlenecks in patient reallocation, rostering problems due to a shortage of BSNs and the limited knowledge and experience of recently graduated VNs. After several months of experimenting (and quarreling), nursing teams and management collectively decided to abandon the distinction in complexity of care. The focus shifted to a fully-fledged role in daily patient care for both VNs and BSNs, together with a focus on a care coordinating and quality improvement role for BSNs only. Using the competencies of both VNs and BSNs in daily practice kept new nursing role development on pace, yet in an altered direction, enhancing both VN and BSN roles instead of narrowing – particularly – the VN role.

In the nursing home, the top manager initially left role development to the professionals. Here, NPs and ECPs developed distinct roles 'on the way'. Due to differing intra- and interprofessional opinions on the NPs' role, both NPs and ECPs discussed each task separately. These discussions led to a great deal of fuss over practicalities, defining and redefining jurisdictional domains (Abbott 1988). This is illustrated below in a conversation between ECPs and NPs on the task of cleaning a pessary:

> NP1: "If you're competent, just do it".

> ECP1: "For years [NPs have had to] ask the elderly care physician to clean a pessary. It's simple, so easy to learn. It's annoying that I still have to do it."

> NP2: "The motive can't be: I don't like the job."

> NP3: "We [can] settle this matter between us. The task is simple and easy."
>
> ECP2: "If it gets complicated, we can work [on it] together."
>
> ECP3: "We don't have any real agreement on this. If someone doesn't dare, they can ask us. If someone wants to learn [how to do] it, they can. There's a huge variation in NPs." (Field notes, dilemma discussion, nursing home, 16 February 2017)

Establishing a clear working domain – and distributing related responsibilities – seemed to be a conflict-ridden, messy process (see also Currie et al. 2012). Developing roles 'on the way' led to longterm nonconformity, resulting in frustration and distrust. Besides, arbitrariness arose over what individual NPs could do, depending on what the ECP assigned and entrusted to them. The top manager, frustrated by the endless quarrels, took over and decided to formalize a previously designed collaboration model that had not been agreed:

> "I said: guys, it's really unacceptable that your tasks and responsibilities are still not clear. It creates external accountability issues. Let's take it from the bottom of the drawer, and just go ahead and implement it." (Interview, top manager nursing home)

And:

> "I said [to the NPs]: Do you actually want to get on? If you don't solve this, I have no choice but to install a traditional ECP group again [excluding the role of NPs]. That's not what I want, and it has nothing to do with my vision on [the further positioning of] NPs." (Interview, top manager nursing home)

Initially, the top manager's involvement did not solve the conflict. Conversely, she became part of the problem, as both parties tried to convince her to choose their side. The ECPs used their powerful position (i.e. certified ECPs are needed to maintain funding for rehabilitation programs) to narrow the NPs' role. The NPs appealed to the top manager's former strategy policy and personal commitment to give NPs a formal position with independent authority. The lack of mutual agreement on tasks and responsibilities not only forced the top manager to put a stop to the ongoing struggle, it also led to tension among NPs. Some NPs feared losing their job if they did not go along with the persistent complaints of the ECPs and the seemingly increasing support of the top manager for their claim to hand over more clinical responsibility to the ECPs. Other

NPs felt frustrated and humiliated and preferred to play it the hard way, proving their crucial and autonomous role to ECPs. This situation reveals the tensions caused by different perspectives and different power positions. It uncovers this manager's balancing act on a tightrope of tensions, needing to choose between what was considered best for the whole organization, and a personal vision on supporting nurse role development.

In both cases managers found a way to balance professional interests with power differences in role development. In the nursing home, the top manager asked the NPs to agree with a proposal to formalize the ECPs' end responsibility, which actually meant restricting the NPs' autonomy. Simultaneously, she supported discussion of the NPs' role, opening new perspectives, especially for bridging the medical and caring domain:

> In a NPs' meeting on role development, the top manager asks NPs about their role and responsibilities. One NP says that they bridge the gap between cure and care by 'translating' medical knowledge to caring professionals, 'speaking the same language', and connecting medical treatment with caring and well-being. The top manager observes: "You're describing your coordinating, bridging role, but what does your [usual] day look like?" Another NP answers: "We go on our wards, ask the nursing assistants medical questions, what have you observed? We do an anamnesis, physical exam, diagnosis and start treatment. If necessary, we consult the ECP on specific medication, or symptoms we can't explain. We can do such a lot ourselves without ECP intervention." The top manager looks surprised [at the broad scope of the NP's role] and says that she needs this information as ammunition for her conversations with ECPs. (Field notes, nursing home, 29 September 2017)

Providing insight into the mundane activities carried out by the NPs appeared essential to give the manager insight into the NPs' growing role and position, to counterbalance the power differences between professional groups and move away from the narrow (and ongoing) discussion on clinical end responsibility between both disciplines.

Hence, crafting boundaries for a new organizing role of nurses encompasses ongoing discussions between the various actors involved, both within the nursing teams and with other disciplines and management. Change processes touch upon the extremely sensitive topics of professional jurisdiction, professional identity and (felt) responsibilities. Defining a new nursing role is an iterative process, going back and forth between predefined job descriptions, task division and daily practices. Tensions not only grew among professionals, but also influenced the role and position of managers. They struggled with contradictory interests, setting (temporary) boundaries and keeping the process of settling disputes going while also protecting organizational interests.

Balancing between external requirements and internal demands

In both cases, external opinions and requirements influenced nursing role development. The previous section has demonstrated the difficulty of implementing job profiles developed by a national advisory board, as these profiles did not fit the professional and organizational needs. At the same time, pending external factors – in this case, an announcement of an amendment to the law, requiring a distinction between different levels of training – provided both an infrastructure and incentive for managers to support nurses developing the new roles. However, our data show that external requirements also impeded progress. In elderly care, medical and nursing associations fundamentally disagreed on the NP's role in the organization of care. The medical association stressed the ECPs' professional end responsibility and thus their supervisory role over NPs. Following Dutch law, however, the nursing association laid a claim on the NPs' independent authority and role in both nursing and medical treatment organization, and their coordinating role in care processes. The ECPs and NPs in our study took over these conflicting points of view in their (heated) discussions on the NPs' role:

> ECP1: "I've been trained [to care for] the whole person [she points to a puppet inside a circle]. Now and then, a single part needs to be looked at by a specialist in hospital. I, however, have to solve the whole pie."
>
> NP1: "I think you're putting us down. You're calling our work a piece, a slice of a pie, but we're just as highly educated in cure and care. Master's level."
>
> ECP1: "Cure is our core business, but we can also care."
>
> ECP2: "I think we can't set our professions in opposition like this! I see NPs have competences in care that I don't have. And these competences are probably more important or more valuable: empathy, coping with family, assessing the body and mind, and dealing with both." (Field notes, dilemma discussion nursing home, 16 February 2017)

External views on the organizing role of nurses – within professional associations or advisory boards – enlarged the differences between professional groups internally, as professional groups adopted and defended these views within the organization. The ECPs' fear of malpractice and being held ultimately responsible for clinical affairs, and the opportunity to defend themselves in the Disciplinary Court were often mentioned especially as factors hindering agreement on the new organizing role of NPs. Even if "management says it's an organizational decision to give the NPs end responsibility." (Field notes, dilemma discussion nursing home, 16 February 2017).

This tension increased after the Healthcare Inspectorate visited the nursing home and requested clarity on the distribution of ECP and NP tasks and responsibilities. The top manager felt under pressure to meet the Inspectorate's requirements, to restore their trust and secure the continuity of the organization:

> "I told the medical team: It's very serious, I could get my head cut off. [...] I'm just saying that you must realize that your actions have major consequences for this organization. […] There's no time for complaining, if you don't get it together, and start becoming one group, then in the end, we might have to conclude that we'll go ahead with only ECPs. It's up to you now." (Interview, top manager nursing home)

The Inspectorate's demand for clarity and pressure of time halted the endless discussion of tasks and responsibilities. The ECPs tried to use these circumstances to their benefit. Some ECPs even threatened to quit their job if they had to share clinical responsibility with NPs, which deepened the urgency for the manager to act as this would endanger the continuity of the permit to offer rehabilitation care. This is how ECPs forced the manager to take their demands seriously. The ECPs' threat reflected the power inequalities between disciplines and impacted the organizing role development of NPs. However, the top manager did not want to let go of the NPs' new organizing role and began a negotiation process with both professional groups (as discussed above). This example illustrates how endless (ongoing) internal and external debates and conflicts guided the development of an organizing nursing role.

In sum, this section has shown how external parties impose their requirements on a healthcare organization, not only through (national) policy, or organizational demands at a managerial level, but also through the professionals themselves. Professional groups use these requirements (partially) to strengthen their internal position and protect their professional jurisdictions causing tension among all parties involved and thereby influencing the uptake of the organizational role of nurses. Managers play an important role in aligning the external requirements and internal needs to keep the development of the nursing role going.

DISCUSSION

Our study focused on the development of an organizing role for nurses and how this occurs in interaction with professional groups and managers. We show that developing a new nursing organizing role is a balancing act as it involves resolving various tensions concerning professional authority, task prioritization, alignment of both intra- and in-

terprofessional interests, and internal versus external requirements. Building on these findings, we take the debate on nursing as an organizing professionalism (Allen, 2014; Postma et al. 2015; Van Wieringen et al. 2017) a step further and show how nursing roles have been shaped in interaction with their own ambitions, organizational needs (i.e. shortage of physicians, the need for more nurse-driven care) and external stakeholders. The development of this organizing role goes beyond the traditional caring role in daily nursing practice (Carvalho, 2014) and the enabling work of managers (Van Wieringen et al., 2017), supporting the development of nursing as an organizing profession. The findings reveal that a nursing organizing role plays out at four levels: the individual patient level, the patient group level, the organizational level, and the policy level. At the *individual patient* level, nurses have an important role in organizing care and guiding the patient through the healthcare system. While Noordegraaf states that organizing professionalism is a new phenomenon, our findings resonate with Postma et al. (2015) and Allen (2014, 2018) that organizing patient care is inherent to the work of nurses. Yet, by discerning levels of organizing, we showed that the role at the departmental, organizational and policy levels is rather new for NPs and BSNs. At the *patient group* level, nurses have an organizing role in the distribution of patient groups according to the complexity of the care required (e.g., Allen 2014; 2019). We have shown that this form of organizing may suffer from many and varied tensions between professionals, as it encroaches on both intra- and interprofessional professional boundaries. On the *organizational* level, we show an enlarging nursing role, which considers not only quality improvement activities (Noordegraaf 2015), but includes all kinds of practicalities required to run patient care smoothly on the ward (i.e. multidisciplinary collaboration, bed management, quality improvement projects, as well as scheduling and allocating nursing staff) and which are shared by a larger group of nurses. Particularly the hospital case placed great emphasis on this level, as it offered opportunities to enhance the appeal of the BSNs' role and to position nurses to meet the challenges of dealing with growing complexity in healthcare. Yet this also has consequences for the organizational budget and logistics – revealing the impact of an emerging organizing professional role for healthcare organizations. Organizing at the policy level, finally, concerns professional role development, both internally and externally, leading for example to the adjustments made to national job profiles and touching upon traditional jurisdictional domains. This finding is in line with Alvehus et al. (2019) on teaching and Waring (2014) on medicine. Arranging the organizing role of nurses on these four levels creates a sharper distinction between different types of organizing within nursing, and shows how the nurse's focus on an organizing and meanwhile knowledge-extensive role becomes part of the further professionalization of nursing (see Carvalho 2014 for a similar observation) and a more profound role for nurses in the healthcare system in general. We have shown that nurses are able to blend organizing with caring tasks in a nurse professional role, and

that developing an organizing role entails a shift from a carer's to an expert's position for nurses. Further research should shed more light on the significance of an organizing role for nurse professionalization.

Our second theoretical contribution concerns the role of managers in organizing professionalism. Our empirical findings have revealed the close relationship between nurses and managers in developing a new organizing nursing role. We have shown that managers support nurses in taking up a new role, mediating between professional interests and power differences and simultaneously bringing in their own potentially conflicting interests. Finally, we have demonstrated that managers balance between internal and external requirements as nursing role development is heavily influenced by the external opinions and requirements of professional associations, controlling bodies (e.g., Healthcare Inspectorate, Medical Disciplinary Court), and public advisory bodies on nursing role development. These insights deepen and confirm Noordegraaf (2015) and Postma et al.'s (2015) assumption that managers play vital roles in empowering individual professionals and coordinating professional groups.

Our findings contrast with Currie et al. (2012) in that we reveal that nurses are reasonably successful at establishing an organizing role within the organization. However, we also showed that the nursing profession is limited in formalizing this organizing role on an official level beyond their direct working environment. Two phenomena could explain these findings. First, the close collaboration between nurses and managers on performing the organizing nursing role can be explained by their mutual albeit distinct responsibilities. We have shown that managers are involved in role development because they are responsible for the quality and continuity of care and appropriate nursing employment. Cohen et al. (2002) relate the relationship of professionals and managers to the organizational context of professional work as both parties belong to the healthcare system. Cohen et al (2002) regard dichotomized frameworks for understanding the relationship between professional work and management as unsuitable because managers and professionals have a more reciprocal relationship and professionals do not replace the managers' role. Second, although nursing role development is part of a broader organizational change (WHO, 2020), nurses seem hardly aware of this transition: they focus on their own hospital organization and professional content. Hence, an organizing nursing role does not replace the management hierarchy but adds to the complex constellation of diverse forms and practices of managing healthcare practices.

Noordegraaf (2015) argues that the nurse-manager relationship can be tense for both nurses and managers. We have shown how such tensions arise and play out in three microlevel processes. Tensions emerge simultaneously and require a balancing act to deal with negotiated needs and interests. First, there is vertical (hierarchical) tension concerning the creation of space for nurses as organizing professionals. Managers must balance between leaving nurses to it and steering their process. Nurses need space to

develop their new role and support in gaining new competences, including leadership, as their authority to perform an organizing role is still uncertain (Allen 2014). Secondly, our data reveals that managers tinker with and prioritize between intra- and interprofessional interests in (responsibility for) organizing care, as there is horizontal tension between nurses and professional peers in shaping a new organizing role (Postma et al. 2015), which also leads to intra- and interprofessional conflicts. Finally, tensions arise across organizational borders, for instance in interaction with regulatory authorities. This external focus is not incorporated in the nursing role (yet). Our findings have shown that managers seek to achieve a balance between (emerging) external and internal worlds. However, this balancing act can never resolve all tensions, as conflicts at the boundaries of professional and managerial domains are fluid and persistent. Moreover, managers cause tension themselves, due to their role as an actor in the healthcare system with their own interests and responsibilities. Although the nurse-managerial relationship is intrinsically not based on opposition (see also Oldenhof et al. 2013), the tensions provided by the medical professions' interest to protect their jurisdiction and the managerial interest to preserve the external trust in the quality of care provision hampers the authority of nursing and expansion of the nursing jurisdiction. These tensions complicate the relationship with management, causing conflict and distrust. This also resonates with Currie & Spyridonidis (2016) who have shown that financial pressures can threaten professional interest and that as hybrid professionals physicians may invoke their professional logic to protect existing institutional arrangements (e.g. in the case of remaining accountable in justifying professional and organizational issues in the Disciplinary Court and thus bearing final responsibility). Our study demonstrated that nurses lack the power and authority to fully resist medical or managerial dominance, and they struggle with related tensions and conflicts. More research is needed to investigate the historical social-cultural patterns of nurse subordination and their influence on nurse role development in more detail.

This study has limitations that also require further research. Our findings rely on two different management levels due to the different positions of nursing groups in the two cases. In the hospital case, we described the nurses' relationship with middle management. In the nursing home case, we dealt with top management, because they had no middle management level. Further research is needed to underpin or enrich our findings on the differences in managements' relationship with nurses, in terms of support, focus on professional roles, or action repertoire. Besides this, our study focused on growing organizing roles. Although the organizational logic that nurses and managers share can be counted on to maintain their close relationship, further research could shed light on a changing nurse-manager relationship when the organizing role for nurses is largely embedded or institutionalized in nursing practice. Second, by focusing on the nurse-manager and nurse-medical relationship, we largely left aside relationships with other

actors, both internal and external. Research on the nursing relationship with internal and external policy makers, for example, would be of great interest to gain more insight into the development of a nursing organizing role at the policy level. As Alvehus et al. (2019) suggest, further development of organizing professionalism on different organizing levels is related to the level of organizing in nursing. Studying this might generate new insights and tools for nurses to develop their own profession in a professional-organizational context.

CONCLUSION

Nurses and managers play an important role in developing a nursing organizing role, seeking to align (emerging) nurses' ambitions, organizational needs and external requirements. The development of the nursing organizing plays out at four levels of professional practice: (1) in the interaction with the individual patient and (2) with patient groups to streamline patient processes, (3) within the organization in managing the admission and throughput of patients and thereby (4) contributes to the professionalization of nurses at the policy level. Developing a new nursing organizing role is a balancing act involving a wide variety of tensions concerning professional authority, task prioritization, intra- and interprofessional interests, and internal and external requirements. Our study has shown that rather than affecting the management hierarchy, nurses engage with managers and managerial practices in crafting their organizing role. Dealing with emerging tensions and related uncertainties requires the support of higher and middle management to both help and equip nurses to position themselves as organizing professionals, and to balance the internal and external requirements of making space for role development. However, the organizational interest of managers – and the often strong (medical) professional interest – in the negotiation of professional jurisdictions hampers the nurses' authority over their own role development and restricts further nurse professionalization.

Studying role development at various levels within organizations, our study opens new research domains in organizing professionalism. It demonstrates the importance of taking a practice-based approach to understanding the development of professional organizing roles.

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5

Role of Dutch internal policy advisors in a hospital quality improvement programme and their influence on nurses' role development: a qualitative study

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ABSTRACT

Objective: Nurses are vital in providing and improving quality of care. To enhance the quality improvement (QI) competencies of nurses, hospitals in the Netherlands run developmental programs generally led by internal policy advisors (IPAs). In this study, we identify the roles IPAs play during these programs to enhance the development of nurses' QI competencies and studied how these roles influenced nurses and management.

Design: An exploratory ethnographic study comprising observations, informal conversations, semi-structured interviews, focus groups, and a strategy evaluation meeting.

Setting: A teaching hospital in an urban region in the Netherlands

Participants: Internal policy advisors (n=7) in collaboration with four teams of nurses (n=131), team managers (n=4), senior managers (n=4), and the hospital director (n=1).

Results: We identified five distinct advisory roles that IPAs perform in the hospital program: gatekeeper, connector, converter, reflector, and implementer. In describing these roles, we provide insights into how IPAs help nurses to develop QI competencies. The IPA's professional background was a driving force for nurses' QI role development. However, QI development was threatened if IPAs lost sight of different stakeholders' interests and consequently lost their credibility. QI role development among nurses was also threatened if the IPA took on all responsibility instead of delegating it timely to managers and nurses.

Conclusions: We have shown how IPAs' professional background and advisory knowledge connect organizational, managerial, and professional aims and interests to enhance professionalization of nurses.

Keywords: health policy, quality in healthcare, qualitative research, quality improvement, The Netherlands, internal policy advisor

Strengths and limitations

- An ethnographic design allowed the authors to analyze in detail the roles IPAs perform in a hospital program and their interaction with nurses and managers.
- The use of five different data collection methods strengthens the validity of the study.
- The results obtained during observations and informal conversations were verified in the interviews and focus groups.
- As always in ethnographic studies, there were chances of 'going native', and we tried to prevent this with ongoing reflection in the research team.

INTRODUCTION

Nurses are important for ensuring and enhancing the quality of patient care (Altman, Butler & Shern, 2016; WHO, 2020). The educational level and competencies of nurses affect patient satisfaction (Aiken, Sloane, Ball et al., 2021) and outcomes (Lehr, Vitoux, Zavotsky et al., 2019), including mortality (Audet, Bourgault & Rochefort, 2018; Griffiths, Ball, Murrells et al., 2016), hospital-acquired infections (Coelho, 2020), and length of hospital stay (Griffiths, Ball, Drennan et al., 2016). Nurses can improve patient care by blending evidence-based practices and quality improvement (QI) tools into daily practices (Hagle, Dwyer, Gettrust et al., 2020; Robert, Sarre, Maben et al., 2020). However, nurses sometimes lack the knowledge, skills, or opportunity to perform these tasks (Van Oostveen, Mathijssen & Vermeulen, 2015; Møller, Møller & Ledderer, 2020; Van Schothorst-van Roekel, Weggelaar-Jansen, Hilders et al., 2021).

To address this problem, national governments are developing educational programs to help nurses enhance QI (Meddings, Greene, Rats et al., 2020; Silvestre, Mannava, Corsino et al., 2018; Weggelaar-Jansen & van Wijngaarden, 2018; White, 2017). In addition, healthcare organizations are starting programs to help nurses develop QI roles (Evripidou, Merkouris, Charalambous et al., 2019; Figueroa, Feyman, Zhou et al., 2018; Plummer, Ruco, Smith et al., 2020; Speroni, McLaughlin & Friesen, 2020). In the Netherlands, these programs are created and run by internal policy advisors (IPAs). IPAs are employed in every Dutch healthcare organization and play an important role in supporting management and professionals in QI work. Most IPAs have a Masters in human resource management, healthcare management, healthcare economics, or health sciences. Like a business consultant, they provide formal and informal advice to management, and support and mentor all healthcare professionals in QI work. IPAs were mentioned for the first time in formal Dutch policy documents in the 1970s. Nowadays, IPAs do not have formal hierarchical 'power', but based on their expert role they play an important role in steering, supporting QI projects, and mentoring healthcare professionals in their QI work. However, it is not clear how IPAs contribute to nurses' role development. Nurses are currently in the spotlight as they ensure quality and safety of patient care in the fight against a global pandemic. More insight into the role of IPAs will help to enhance the support and professionalization of nurses to increase the quality and safety of healthcare.

The role of IPAs in healthcare and nurses' role development has not been properly defined. In the business and management literature, IPAs are described as internal consultants (Buono & Subbiah, 2014; Homemo, Powell & Ingvaldsen, 2018; Scott & Barnes, 2011), in-house consultants (Schumacher & Scherzinger, 2016), organizational development practitioners (Smendzuik-O'Brien, 2017), quality experts (Liff & Andersson, 2020), and "employees who apply broad-based knowledge and experience about a specific

area of the business to help develop and implement strategic improvement plans, identify performance gaps, and develop and support the implementation of a recommended plan of action to close the gaps and provide for long term sustainability of the initiative" (Thomas, 2020). Without the authority to decide on policy and implementation issues (Miller & Subbiah, 2012), they act as change agents (Speroni et al., 2020), boundary spanners (Korschun, 2015; Sturdy & Wright, 2011; Wright, 2009), intermediaries (Sin, 2008), legitimizers (Bouwmeester & van Werven, 2011), and/or influencers (Barnes & Scott, 2012). In these roles, IPAs have to find the balance between being an advocate and an advisor (Whittle, 2006) or between performance and relationships, keeping their program in pace with assimilation by stakeholders and giving individual stakeholders the support they need (Miller & Subbiah, 2012; Ejenas & Werr, 2011).

In our ethnographic study, we investigated the roles IPAs undertake in healthcare to support nurses in enhancing QI competencies. We asked how IPAs collaborate with nurses and nurse managers to foster QI competencies among nurses.

METHODS

We studied the roles of IPAs in a nurse professionalization program that focused on QI in a Dutch teaching hospital (481 beds and 2,600 employees including 800 nurses). We used exploratory ethnographic data collection methods to understand the roles of IPAs, including their patterns of action, meanings, accounts, and relationships with stakeholders (such as the hospital board, higher management, team management, and nurses) (Hackett & Hayre, 2021; Rendle, Abrahamson, Garrett et al., 2019).

Setting and participants

The hospital studied was chosen for convenience; this hospital allowed the researchers to follow the nursing professionalization program. At the time, most hospitals in the Netherlands were involved in experimenting with distinct nursing roles in QI (Van Kraaij, Lalleman, Walravens et al., 2022). Our hospital is a representative Dutch teaching hospital. From July 2017 to January 2019, we observed a project group (consisting of seven IPAs) as they developed and implemented a program to support nurses with QI work. We also investigated the project group's encounters with stakeholders (Table 1). All IPAs were employees of hospital advisory departments, held a staff position, advised the hospital board and management, and were responsible for implementing QI and other professional development programs. The project group and higher management selected four nurse teams (two from general wards and two from specialized wards) to take part in the program. The four teams included vocational trained nurses, Bachelor-trained nurses, nurse practitioners, specialized nurses, and nurse managers.

Table 1. Data collection methods

Hospital wards	Participants	Observations	Informal conversations	Interviews	Meetings
* Neurology * Surgery * Oncology * Pulmonology	Project group (n=7): 2 IPAs with a background in nursing and higher education in change management: 3 IPAs from Internal Training 1 IPA from HR 1 IPA from Quality & Safety Ward nurses: VNs, BSNs, senior nurses (n=131), team managers (n=4), senior management (n=4), board (n=1)	Approx. 65 hours	Approx. 15 hours	Top manager (n=1) Nurse managers (n=4) VNs (n=6) BSNs (n=9) Paramedics (n=2) 22 interviews, 60–90 minutes each.	Kick-off meetings: team manager, project group members (n=2). Team meetings: BSNs, VNs, senior nurses, manager (n=15). Bi-monthly interdepartmental meetings: 2 nurses per team, team managers, project group members (n=10). Project group meetings: nurse project leader, nurse project member, teachers/coaches, HR staff, researchers (n=20). Team focus groups (n=4; 19 nurses in total). Strategy evaluation meeting: board, higher management, IPAs incl. 1 from communications dept, and 1 researcher. *Reflection meetings: project leader (IPA1) and IPA2, Nurse Advisory dept, 2 researchers (n=9). Total meetings: 57

* The purpose of these meetings was to reflect on the program, progress, roles of stakeholders, and preliminary research findings.
IPAs: internal policy advisors, HR: Human Resources, VN: vocational trained nurses, BSNs: Bachelor-trained nurses.

The first author approached the participants by email or in person and informed them about the study aim and content, explaining that participation was voluntary and could be ended at will. All participants gave informed consent and the Ethical Review Board assessed the compliance with General Data Protection Regulation and gave ethical approval [MEC-2019-0215].

Data collection

We used five research methods over 19 months (Table 1). The first author led the data collection and the second author attended the project group and reflection meetings. Both authors maintained the observer-as-participant perspective (Baker, 2006). Observations and informal conversations during the development of QI competencies gave us in-depth insight into the opinions and beliefs of the respondents. Participating in

four different meetings showed us the roles of IPAs, the aims of IPAs, the results of the program, and interaction patterns. During observations, conversations, and meetings, we took brief notes that were shortly afterwards expanded to include full details to ensure data validity (Atkins, Lewin, Smith et al., 2008). These notes were complemented by formal minutes and material presented at meetings, such as organizational documents, IPA policy documents, activity plans, reports, and information letters (Leslie, Paradis, Gropper et al., 2014). We also conducted semi-structured interviews. The topic list, based on an analysis of the detailed notes and minutes, included the development of QI competencies, the way IPAs supported the development of QI competences, the influence of the program on the developmental process, the interaction of IPAs with stakeholders (e.g., nurses, managers, IPAs, director, external parties), distinctive roles the researchers observed, paradoxes based on the analysis, and balance between these paradoxes. Interviews were audio-recorded, transcribed verbatim, and anonymized, and helped us to deepen our findings. Finally, we held focus groups, a strategy meeting, and reflection meetings to share our findings (member checking) and to evaluate the program and the roles of everyone concerned. The focus groups were audio-recorded and transcribed verbatim.

The first and second author made reflective notes of their assumptions and feelings during fieldwork, which the research team discussed to prevent their 'going native' (Dwyer & Buckle, 2009).

Data analysis

We used a grounded theory approach to distinguish IPA roles (Rendle et al., 2019; Glaser & Strauss, 2017). After discussing the level of saturation, we began the analysis by reading the notes, organizational documents, detailed notes, and transcripts to understand the raw and unstructured data. Then, the first author identified the IPAs' actions, instruments, influence, intentions, and the impact on and reactions of the stakeholders. Next, the first author performed axial coding to compare single fragments, group codes, and/or re-coded fragments to distinguish patterns in actions and aims. After the research team had discussed and agreed on the axial codes, the first author coded selectively to reveal coherence between several group codes, iteratively comparing the findings with all data gathered to avoid forcing the data (Corbin & Strauss, 2014). This selective coding allowed the research team to formulate five distinct IPA roles, which were then compared with the roles described in the literature.

Patient and public involvement

No patients or members of the public were involved in this study.

RESULTS

In the program, we revealed five distinct roles for IPAs that aimed to develop the nurses' QI competencies. Here, we describe how the IPA statements reflect those roles and whether they help ward nurses become QI leaders.

The gatekeeper

IPAs designed the hospital program to steer the development of nurses' QI competencies. We noticed that IPAs decided which information (sources and people) was incorporated. We observed how IPAs acted as gatekeepers by limiting the flow of information to avoid overwhelming nurses and how they framed the core messages to suit different stakeholders:

> "In our hospital, the strategic focus is on professional leadership. The IPAs incorporated the national trend in enhancing the QI competencies of nurses in the 'Nurses' leadership' program. Subsequently, they present [the results] to the senior management team." (Nurses' leadership program 2017–2020)

This excerpt shows how the IPAs selected relevant themes (i.e., nurse leadership, expertise and autonomy, task reallocation on QI improvement tasks) to endorse the hospital's strategy and policy.

The IPAs also decided when and how to share information about the program and program results with the outside world. They mentioned that sharing experiences too early could undermine the organization's credibility, especially when things did not develop as anticipated. On the other hand, both internal and external public relations were important. As one IPA said: "Let's shine in this meeting [with regional partners] and show them all the good we are doing here" (fieldnotes1). We noticed that exchanging information with third parties influenced the ability of both the hospital and the sector to learn:

> "At the presentation of the new job profiles, representatives of the hospital's frontrunners group [the studied wards] jumped to the conclusion that differentiating jobs based on complexity of care would not work, and that they needed to focus on QI work. We [IPA1] said: Let's just try it, to understand why it won't work" (fieldnotes 2).

IPAs strategized the program development, so were part of strategic discussions to learn about the professional developments, policies, and challenges and to understand

the relevance of these for both nurses and managers. This allowed them to connect different practices for the uptake of a nurses' QI role.

The connector

IPAs connected hospital units/wards and different hierarchical levels of the organization to support shared decision-making and adoption of new policies or relevant themes. They served as a linchpin for different stakeholders and themes. Respondents considered the role of connector important to creating synergy and eliminating obstacles between different organizational processes and stakeholders to support nurses' QI professionalization.

> IPA1 reports that after senior management had approved the program, she was concerned about how to keep them involved and asked the director to discuss this with them: "She did a good job here, in her position." […] The project team was disbanded when the program was approved, but IPA1 said she would continue to hold informal meetings with team management, "to keep them from going every which way" (informal conversation 1).

and

> Team manager: "I once had a conversation with IPA6 (internal training) and indicated: "I really feel a bit sidetracked and I don't like that role." IPA6 said: "Well then we have to talk to each other. And we did. (…) And I don't feel the need to check the IPA, if the nurses have the feeling: we can get on with her, then I'm fine with it." (interview 1).

These examples show that by maintaining and investing in interpersonal relationships, the IPAs bonded with people from different organizational levels. In this way, they prevented collusion or nurses and managers turning against one another. Maintaining these extensive relationships gave IPAs access to privileged knowledge and confidential insight into the different needs, ambitions, and interests of people and committees.

We noticed that a professional background in nursing increased the IPAs understanding of the needs and interests of nurses. To be a connector, IPAs must speak the language of nurses. They must, knowing what to keep confidential, be politically sensitive and aware of stakeholder influences.

However, our data revealed a fragile balance between meeting different needs and keeping information confidential. Listening too closely to only one party threatens the IPA's role as an independent advisor and disrupts relationships and progress of the program. It leads to such questions as: "Who do you [they] belong to?". We observed

that when IPAs turned into ambassadors, advocating a particular theme or activity, it put them in a position of supporting or defending a certain group's interests and/or receiving criticism meant for others. This threatened the IPA's independence and their role as a connector.

> IPA1 and IPA3 discuss how nurses can use information on quality (nurse-sensitive outcomes or patient satisfaction measurements) to develop their QI role as well as the QI tasks they are already doing on the ward (theme discussions, bedside teaching, EBP discussions). IPA3 is keen to give the nurses this responsibility. Both IPAs weigh the pros and cons and discuss how to boost it, for example by setting up a steering group. IPA3 suggests first sharing this idea with other stakeholders because steering QI is the task of team managers. Disregarding them could cause a hassle, she supposes (fieldnotes 3).

This excerpt shows how IPAs bond together to support and steer the development of the nurses' QI role. Together, they find ways to balance openness and transparency with keeping things confidential to avoid damaging people's trust or becoming an advocate for one party only (in this case only for the nurses). This allows them to maintain their connector role.

The converter

IPAs had informal conversations with nurses and managers, attended meetings, taught staff, and wrote reports, activity plans and information letters to hold the interest of the various stakeholders. They modified information so different audiences could use and understand it. To engage effectively with their audiences, IPAs aligned their message on three levels: content, form, and voice.

> IPA1 shares a presentation she prepared for a higher management meeting, showing some slides with key objectives, to inform and get commitment for the chosen direction. On the content level, she stresses the strategic positioning of the organization, using managerial vocabulary and areas of interest, e.g., strategy, operation, patient safety, and quality, and restructuring work processes. When presenting the information to nurses, she chose to present a 'news bulletin', allowing nurses to take the floor, and blending the plans with stories from practice. The Nurse Affairs Department arranged the event (fieldnotes 4, PowerPoint presentation/news bulletin).

This excerpt shows that IPAs change their message, using different arguments, key words, and tone of voice and placing emphasis on specifics relevant to their audience to

get their message across. We observed them deliberately using 'the right language', to fit in better and gain support from nurses and managers for their program. The excerpt also shows that IPAs collaborate with others who can help spread the information, such as formal communications and training departments and informal leaders in the target groups, such as the nurses speaking in the news bulletin.

We observed that, in their converter role, IPAs are not always objective information distributers/disseminators. During interactions, they influenced people and (nursing) practices and sometimes translated a message for their own purpose. IPAs have power because of their formal position, network, and resources inside and outside the organization. This makes it easy to manipulate the flow of information, and influence different stakeholders. To act sincerely, they need to be aware of the paper-thin difference between adjusting information to make it easily understood and manipulating it in a specific direction. Ensuring sincerity calls for reflection, as we show in the next role.

The reflector

We observed that IPAs distanced themselves to observe, analyze, and interpret organizational processes and daily practices and discuss their reflections. To encourage reflection, the IPAs asked critical and thought-provoking questions, thus professionalizing nurses to take on a QI role.

> In discussing a QI role with nurses, IPA5 asks: "How is the patient put first? Is it 'providing direct patient care'? Yes, you say, that comes first. But in a QI role, you're still putting the patient first, perhaps very powerfully, taking care of that patient by doing research. And yes, that takes time, but otherwise nothing will change" (fieldnotes 5).

Reflection sessions on QI skills and the content of improvement projects were held with nurses and management to discuss the development of nurses as QI leaders. To perform this role, the IPAs relied on their knowledge of organizational change, learning strategies, feedback mechanisms, and mediation, as shown in a nurses' interdepartmental meeting:

> The nurses say that they will start with a coordinating role to improve the quality and coordination of care. The nurses have written a [role] profile and want to experiment with it in the coming evening shifts. IPA4 asks if and how they will evaluate this experiment. The nurses admit that they haven't figured that out yet. The IPAs wonder which criteria the coordinating role should meet. How do the nurses want to evaluate this role? They urge the nurses to think about this in advance (fieldnotes 6).

We observed that too much reflection from the IPAs irritated nurses and managers. They perceived this as undesired feedback and intrusion in the team's progress. IPAs need to balance when and how (tone of voice and content-wise) to intervene and when it is not appropriate to get involved and leave it to professionals themselves.

The implementer

IPAs designed and guided the implementation of QI initiatives in collaboration with stakeholders. IPAs prepared an action plan that covered various milestones and required resources such as infrastructure, finances, and training. We observed that IPAs often determine the unwritten rules, manners, and ethics of QI work, in addition to more formal aspects like planning and finances, which higher management expect IPAs to enforce. However, we observed that enforcement was difficult as IPAs cannot rely on a formal position from which to issue orders. We also noticed a lack of sanctioning power. IPAs' strength and personal power is based on their being regarded an expert in the field, their understanding of comparable organizational processes across the entire organization, and their close relationships with management.

> IPA1: "We kept the nurses' QI role really open, and that's okay, it's a change process. But at a certain point you have to get results."
>
> Team manager 1: "But be realistic and look [what's happening on] our wards. Nurses have just started discussing which QI project to do first. It's going well, but it's creating a fuss [in the team]."
>
> IPA4: "I hear team managers saying, let it go, let them discover and learn for themselves." Team manager 2: "They have to carry it out themselves. I think that's vital" (fieldnotes 8).

And

> Director: "You need to have confidence in your officers who are in control in the process. Confidence that they will leave it up to the teams, that they have the experience and insight into the profession, estimating well what is needed, being ambitious, wanting to achieve something, and dialoguing with them. Here, the people who are familiar with the workplace, have to provide the framework and guide the process. (…) Management, advisors and professionals, they are synergetic" (interview 2)

The success of IPAs corresponded with the success of the program. This intermingling had three consequences. First, IPAs increased their control on the QI project to safeguard the success of the program, instead of keeping a distance to give nurses room to experiment with their roles and find their way in QI work. Second, focused on success, the IPA forced progress (including decision-making) instead of taking the time to get people on board with the program. When IPAs became advocates for the program, we observed they are no longer able to step back, to reflect with the group (see also the reflector role), to help nurses to develop, and to let go if interests change. They became overly involved and formed vested interests that confused the means and ends instead of directing the program.

> Guiding the implementation, the IPAs (1,2,5,6) look behind the scenes of the teams/managers at work. One IPA is critical of a team manager's performance. In her opinion, the team manager is not performing well, does not know what is required, is working without an improvement plan, and is choosing the 'wrong' people to take on a QI role. According to this IPA, the team manager is obstructing the development of a QI role for the nurses. The IPA puts pressure on the team managers and raises the topic in the project group and with the senior manager, who initially seems to agree with this opinion (fieldnotes 9).

As a result, the IPAs encroached on the managers' area of responsibility, which threatened their long-term relationship, and it became unclear whether the IPA was an ally. In our case, this confusion was discussed in an evaluation meeting between higher management and IPAs, reflecting on the importance of role integrity and clarity:

> IPA: "The Nurse Affairs Department is part of line management."
>
> Senior manager: "Is the Nurse Affairs Department a line manager?"
>
> IPA Q&S:" Are you staff, supporting…? [It's about] nurses who are developing…."
>
> Team manager: "The Nurse Affairs Department leads the way, hits the ground running, but the team managers aren't being heard. That's been expressed to the managers. It's a recurring pattern."
>
> IPA: "I don't have end responsibility. The line decides, I'm not in the lead. But I feel that I've just been abandoned. […] I'm wearing different hats. Not getting your support. And we're not on the same page."

> Senior manager: "I have to be kept informed, by line managers and staff. I only need some reflection from the IPAs to take on my responsibility. I don't need any judgment or stigma."
>
> Manager: "The Nurse Affairs Department represents the nurses' voice. What they suggest comes from the nurses. I suppose. Or is that not true? Now, it feels like your own opinion" (transcript of conversation 10).

Becoming an advocate for professional role development meant that IPAs – especially those with a professional background – lost their independence and credibility and overlooked the interests of others, especially when faced with opposing perspectives to their own on nurses' QI development. Moreover, as this excerpt shows, IPAs formed their own perspective, getting the critics from all parties together. Going too far threatened the whole trajectory as well as their own position; they put themselves on the line by claiming ownership of something that does not belong to them (at the time), but to managers or nurses themselves. To succeed in implementing a quality enhancer's role in nursing, we learned that IPAs balance between leading the implementation (process), facilitating the successful development of a nurses' QI role (content), and leaving responsibilities to managers and nurses when appropriate (ownership). They needed to maintain an advisor's position and prevent outright rejection of the program, even if it temporarily hampers the development of the QI role.

DISCUSSION

This study investigated IPAs' roles in leading a hospital program to improve the QI role of nurses, a topic seldom described in the current literature. We show that IPAs have five roles: gatekeeper, connector, converter, reflector, and implementer. These roles help nurses to develop QI competencies because they shape the program, frame information for different audiences, understand the needs and interests of nurses, and advocate for a QI role for nurses.

Our findings resemble those of general business and management studies on the roles of internal consultants (Batiste, 2007). We have defined the roles in which IPAs influence (Barnes & Scott, 2012), legitimize (Bouwmeester & van Werven, 2011), span boundaries (Korschun, 2015; Sturdy & Wright, 2011; Wright, 2009), and stir up change (Buono & Subbiah, 2014), to support QI role development in nurses. We have added to the literature by showing that, as gatekeepers, IPAs connect internal and external parties, protecting what comes in and goes out. As such, they act as boundary spanners (Korschun, 2015; Sturdy & Wright, 2011; Wright, 2009) and boundary setters to

protect the development of QI competencies in nurses. In the connector's role, IPAs are intermediaries (Sin, 2008) who partner with external (Korschun, 2015) and internal stakeholders to align objectives and values and gain knowledge on how to support nurses. As converters, IPAs bring relevant information to different audiences (Sin, 2008). This is not a neutral position. In contrast to others (Barnes & Scott, 2012), we have shown that IPAs develop the program and frame information to exert influence. Business and management studies have not investigated the effect of a professional background on the IPA's role; here, we show that a professional nursing background helps the IPA to develop a QI role for nurses. By blending their organizational/advisory skills with their nursing knowledge, IPAs can support and steer the development of a nurses' QI role. In contrast to a recent study on the quality experts' role (Liff & Andersson, 2020), we found that IPAs can fulfill a strategizing role. Their strategic position, nursing background and advocacy role (Scott & Barnes, 2011) help them to make an important contribution to the professionalization of nurses.

In contrast to previous studies (Schumacher & Scherzinger, 2016; Wright, 2009; Whittle, 2006), we showed that IPAs must balance between organizational/managerial and professional interests, to meet the interests of all stakeholders rather than being the only decision makers (Bouwmeester & van Werven, 2011). This presents several challenges. First, IPAs help nurses develop by advocating on their behalf and helping them reflect critically on their performance. Second, IPAs with a nursing background can lose their independence and credibility if they identify too strongly with nurses and lose their connection with other stakeholders' opinions and interests (Korschun, 2015). Third, balancing between managerialism and professionalism means that IPAs must realize what is achievable and what is desirable in terms of professionalization. Advocating too much for the program threatens the nurses' QI role development and the IPA's position (Scott & Barnes, 2011; Ejenas & Werr, 2011). Keeping ownership in the wrong spot puts pressure on the relationship between IPAs and management (Holmemo et al., 2018) and nurses.

Four wards of one Dutch teaching hospital were included in this study, which might limit the potential of generalizing our findings. A disadvantage of ethnographic studies is 'going native' (Kanuha, 2000; O'Reilly, 2009). However, we followed the suggestions of Maso & Smalling (1990) to prevent this: 1) every month, the researchers isolated themselves from daily hospital practice to reflect with the whole research team, 2) researchers avoided getting involved in hospital commitments and obligations beyond data collection, 3) researchers understood the issue of confidentiality of relationships and preserved sensitive information to avoid betraying trust. Another limitation of our study was the focus on the role IPAs play in a nurse development program. We paid less attention to collaborations with other professionals, management, and healthcare processes or outcomes. Further research in this direction is needed.

CONCLUSION

IPAs are vital to the development of QI competencies in nurses. IPAs fulfill five distinct advisory roles: gatekeeper (actively involved in the interchange of information on nurses' QI development between the internal and external environment); connector (connecting themes and wards horizontally and stakeholders hierarchically); converter (adapting content, form, and voice for different audiences); reflector (learning and reflecting with nurses about QI tasks and with management about developmental process and alignment with organizational goals); and implementer (designing and guiding implementation of QI initiatives in collaboration with stakeholders). In fulfilling these roles, IPAs use their knowledge of the organization and their professional background to promote the professionalization of nurses – especially in their QI. Simultaneously, IPAs must balance between organizational, managerial, and professional aims and interests to prevent obstructions or delays in QI role development. We showed that development of the QI role is hindered if IPAs give precedence to their own perspective on the profession and lose sight of the different interests and opinions of internal stakeholders.

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6

Discussion: professional role development in everyday practice

6.1 INTRODUCTION

This thesis explored how healthcare professionals perform and develop new professional roles in everyday healthcare practices. The topic is relevant because task flexibility and professional role development are considered highly desirable policy goals (RVS, 2019; 2020) in order to enhance patient-centred care, curb healthcare costs and provide a solution to a decreasing health workforce in the face of an ageing population (IOM, 2011, Allen, 2015a; NHS, 2016; WHO, 2016). However, as this dissertation shows, role development of new professions is a painstaking undertaking, not least due to resistance among settled or 'traditional' professional groups as well as vested institutionalized arrangements (Reay et al., 2006; Currie, Finn & Martin, 2009; Croft, Currie & Lockett, 2015; De Bont et al., 2016; Janssen, Wallenburg & De Bont, 2016). Currie et al. (2012) have shown medical doctors successfully resisting the introduction of new professions. Although our research partly confirms this observation, it has enabled us to gain a more precise understanding of how professionals shape and resist professional change.

This chapter answers the sub-questions of the main research question: How do healthcare professionals shape new professional roles in everyday healthcare practices? Drawing on three academic disciplines (sociology of professions, institutional theory, and practice theory), the chapter describes what we have learned about role development in daily practice and how both national policy and organizational rules and dynamics influences the process. In doing so, it adds to the literature on professional role development, task reallocation and the influence of the dynamic interplay between (national) policy, legitimacy among society and negotiation of jurisdictions in professional practices. The aim was to understand how professionals shape their roles in daily practices (6.2.1), how professionals interact both intra- and interprofessionally, to understand their relationship and influence with/on other actors in the organization (managers, board, internal policy advisors) (6.2.2), and how the institutional healthcare context impacts new professional role development (6.2.3). Moving into the world of doctors and nurses, we used a practice-based approach to analyse professional role development in everyday practices. In (6.2.4) we describe what we can learn from this approach, and what experimenting in the form of practice-based approach requires in terms of organizational support and policymaking, as well as the consequences for the further professionalization of new professions and new professional roles. Additionally, I will reflect on how scientists can study the development of new professional roles through job differentiation and task reallocation.

6.2 MAIN FINDINGS

6.2.1 How do professionals enact new roles in everyday healthcare practice?

Recent Dutch studies on professional role development and the relationship between nurses and physicians show the diversity in roles and tasks and the arbitrariness of agreements, which are often defined at the level of the individual professional partnership and generally based on (dis)trust, even though legal jurisdictions are determined (Kroezen, 2014; Stalpers 2016; Backhaus, 2017; Van der Biezen, 2017; Lovink, 2019; RvS, 2020). The literature shows that in professional role development, professional boundaries shift continuously, influenced by differing, conflicting intra- and interprofessional interests, societal expectations, and external requirements due to existing healthcare challenges (Abbott, 1988; Nancarrow & Borthwick, 2005; Currie, Koteyko & Nerlich, 2009). Professionals protect their domain in order to draw a distinction and lay claim to their domain. Most studies adopt a more functionalistic perspective which provides insights into the unrevealed variety in the division of labour (Bos-de Vos, Lieftink & Lauche, 2017; Kraaij et al., 2021; Langley et al., 2019), but this leaves aside the underlying sociological patterns in professional and managerial relationships. To gain more insight into the process of professional role development and going beyond notions of trust and resistance, we studied role development in daily practice. Our analysis shows that role distinctions are made – and hampered – by four elements: 1) negotiations and conflicts, 2) gaining and keeping control, 3) organizing support, and 4) relational work.

Negotiation and conflict

The first element concerns the process of experimenting with the development of new professional roles. Our research shows that the uptake of new tasks is an iterative process shared by those involved. Our case study on developing the role of bachelor-trained nurses (BNs) (Chapter 3) showed that a predefined distinction between roles based on complexity of care did not fit the professional knowledge and competencies, or organizational practicalities and so the distinction was abandoned. In this experimental process, vocationally trained nurses (VNs) and BNs figured out step by step which tasks in coordination and quality of care could be handed over. The reallocation of tasks means a shift in responsibilities (Abbott 2005; Dubois & Singh, 2009), which became especially clear in the learning process of gaining the knowledge and skills required in the new professional role (Nilsen et al., 2017). This is a process of continuously negotiating tasks and responsibilities in daily practice.

It requires both intra- and interprofessional negotiation as the handing over process is not linear given that the uptake of new tasks and responsibilities in one profession always influences other professions and work processes. Negotiations become even more

complex because handing over tasks is grounded in the shortages of one profession. We showed this in the case on long-term care for older persons (Chapter 4). In this case, the lack of physicians specialized in elderly care (ECPs) was the driving force to hand over some tasks to nurse practitioners (NPs). It took endless discussions between the two professions on what the required knowledge and skills would be, and what tasks could be carried out by whom, and who would take responsibility for what.

Negotiation takes place on both the shop floor (ward level) and among associations and policy makers as new professional role development implies the extension of a professional domain over another professional domain(s) or group(s). These findings resonate with Abbott (2005) as the constitution of new professional roles always leads to the negotiation of new openings for one profession and/or the degradation of adjacent professionals.

Our study uncovered the subtle micro-level processes of role development. Back and forth movement in negotiations is aligned with the distribution of tasks in everyday practice. This finding makes clear that the role and position of professionals cannot be fostered only by training or regulation (González Armengol, Oscar & Graham, 2013; Plunkett 2006), or by the delineation of roles in formal job descriptions or even laws, as is often argued (Jacob et al., 2015; Sermeus et al., 2011). It requires an intensive ongoing process of figuring out and negotiating tasks and skills in everyday practice.

Negotiation can create conflict between individuals both within and outside the profession and between professional groups. In the long-term care case (Chapter 4), NPs differed on how confident they felt in carrying out medical-oriented tasks. One group of NPs argued that they were trained to do these tasks and in their profession everyone should carry them out in complete autonomy, as they were legally allowed to do. Other NPs felt not competent enough and felt that it should be an individual choice not to carry out a medical task or to do so only under ECP supervision. The NPs' different opinions about tasks and responsibilities and their internal quarrels weakened their position and fuelled diversity in agreements. In contrast, our study shows that the profession that can have a united opinion and thus joins forces has a better power position and is more successful in the negotiation. This became apparent in the EP cases (Chapter 2), where the EPs were united in the tasks they aimed to perform and strengthened their professional role by joining the medical board. The literature on professions regards having a shared view on a professional role as a contributing factor to fulfilling and establishing a certain role (de Bont et al., 2016). Temporary agreements can be made in between these two outcomes, as Wierdsma & Swieringa (2017) explain. Temporary agreements perpetuate and limit new roles but leave room for ongoing development and negotiation.

In sum, role development is embedded in a negotiating process of handing over tasks and associated responsibilities that blends with a learning process to take on these new tasks. A united opinion (consensus) within a profession creates a better power position

and makes a profession more successful in the negotiation. In the negotiation process a gain for one profession is sometimes felt as a loss for the other. This is not just a power issue between professionals but can be seen as the emotional labour of role development in daily practice. More research is needed into this as it will give more insights into the emotional impact of interdependency in collaboration and the impact of fluid boundaries on professions (see also the next sections).

Professional jurisdiction and the protection of professional domains

The second element is about protecting professional jurisdiction. Our research shows the difficulty of shifting tasks and responsibilities as vested or traditional professionals seek to protect their professional domain. This is done both visibly and invisibly. For instance, in the emergency physicians (EPs) case (Chapter 2) the EPs were controlled by other medical specialists' groups (i.e. surgeons, medical specialists) as those groups protected their domain by controlling the crucial clinical situations and moments during the day, such as morning ward rounds and the review of patient treatment plans. Vested medical specialists kept in control by attending morning pounds, discussing cases and determining treatment, leaving little space for the EPs to create professional autonomy (Chapter 2). In the long-term care case (Chapter 4), ECPs protected their domain and kept control over the NPs by organizing multidisciplinary charts review meetings to review the patient plans the NPs had drawn up. The ECPs 'secretly' kept on checking the electronic patient records of all patients to evaluate the quality of care provided by the NPs. By continuing to do so, they secured their involvement in daily patient care and sought to minimize clinical risks. By hiding their controlling act from the NPs, they avoided arguments or endless negotiation on professional autonomy. However, this also led to new conflicts as sometimes the EPCs had to reveal their checking work, for instance, when they questioned the clinical decisions made by the NP. The BNs however also hid their activities from other groups (Chapter 3), in this case taking over bed management from middle managers to experiment with a new coordinating role. By going under the radar they sought to avoid a discussion in the nursing team about the reallocation of coordination tasks to BNs, and secured room for experimentation to craft the BN role and to enlarge their professional domain.

The space new professionals need to craft their role and clinical autonomy is determined by (1) individual relationships between a new and a vested professional; and (2) the collective action of a group of new professions to claim and defend their jurisdiction, keeping control over others. First, new professionals often work individually with a vested physician, for instance, running a nursing ward together. They settle on a local arrangement about the degree of autonomy in the performance of tasks and division of responsibilities. Trust between individuals, often based on mutual respect and recognition of each other's competencies and skills, plays a significant role in this. When mutual

recognition is lacking, it is most often the vested physician who decides on the task and responsibilities of the new professional. Also, when starting the new professional role, the professional has to build up trust again. Hence, it is about trust in individual professionals rather than in the professional role itself. Protecting professional domains and preserving dependence in professional relationships has been shown by several other studies in the field of the sociology of professions as well (e.g. Chua & Clegg, 1990; Currie et al., 2012; Hughes, 2017; Ayala, 2020). We found that allowing the redistribution of tasks but at the same time keeping control by holding on to traditional responsibilities causes dependency as well as feelings of being undervalued, frustration and distrust. This not only hinders day-to-day collaboration between professionals but also further development and leadership of new professional roles.

The third element is organizing support and protection from respected and highly placed professionals, including management, as recognition of competencies is crucial in professional role development. In the EPS case, a respected critical care specialist protected the EPs' role development from other specialists who defended their jurisdictions in acute care and used their authority to prevent EPs from taking over their clinical work. In doing so, the critical care specialist expanded the space EPs needed to carve out their position in the emergency department. We showed that EPs conducted institutional work not only by taking on individual patient care but also in organizing the ward (Currie, Koteyko & Nerlich, 2009; Currie et al., 2012; Lawrence & Suddaby, 2006; 2011; Suddaby & Viale, 2011).

While physicians more or less copied the strategies of their medical counterparts, nurses tried to find their own ways to establish new roles. One reason for this is the 'novelty' of the NP and BN roles. There are few peers in the nursing profession who can support their role enhancement. Therefore, nurses need other stakeholders for support, such as managers (see 6.2.2). In addition to internal role models and authorities, nurses sought support from their professional body and national networks, such as intervision groups (NPs) to support their ambitions in role development. Another reason for finding their own way was because nurses felt that this style of protecting and expanding their domain did not fit with their professional values on collaboration. Nurses struggled with the notions of strife and conflict over another profession, as Kim, Nicotera & McNulty (2015) also describe. Instead, they sought to establish a relational practice based on equality and collaboration, which I deal with in more detail below.

Developing nursing roles while preserving a relational practice

The fourth element concerns the development of nursing roles in relation to other professionals and management. Nursing is teamwork, on both the departmental level in relation to other professionals and the organizational level in relation to managers. Allen (2014) describes nurses as the 'glue in the system' with their ability to keep things

on track. Their necessity of being part of a team and crossing boundaries to keep things on track is essential for care quality. Allen (2018) describes this as the relational practice of nurses. Nurses often work together, handling tasks for each other, and aligning with other professions and management in order to streamline direct patient care as much as possible (Allen, 2018). This relational practice can be endangered in the development of new roles, as unwanted distinctions can undermine the collaboration needed to 'pass patients through the system' (a task described by Davina Allen, 2018). In contrast Abbott (1988) is of the opinion that divisions of labour are necessary to make clear distinctions at the policy level and in legislation. Our study shows that nursing roles are inherently blurred, not well demarcated, and task division is often unclear (Chapter 3). However, we saw nurses keeping on overlapping tasks, continuing being 'the glue in the system' and simultaneously making clear role distinctions in daily practice. For example, in organizing mundane ward processes and quality improvement, the nurses aimed to maintain mutual relationships by looking for a complementary division of tasks and responsibilities, instead of favouring one group over the other. In doing so, they preserved their cooperative relationship and supported interprofessional teamwork. By developing clear nurse role distinctions in practice, they had the opportunity to discuss role distinctions at the organizational level, including the hospitals' policy level. We also found that nurses can hinder the development of distinct nursing roles by aiming for equality, because of their sociological-cultural preference, resulting in less use of different competencies (as confirmed by Currie, Koteyko and Nerlich, 2009). This could hamper them in making larger distinctions and taking bigger steps in further job development and professionalization. Follow-up research is needed to gain more insights into the impact of social-cultural needs and patterns in professions (Hughes, 2017) on intraprofessional role development.

6.2.2 How do healthcare professionals interact with other organizational actors (i.e. managers, directors, internal advisors) in creating new professional roles?

To answer our central research question "How do healthcare professionals shape new professional roles in everyday healthcare practices?", we must pay attention to the intensive interplay between actors on different organizational levels in the development of new professional roles. This interplay is both horizontal (other departments and professions) and vertical (hierarchical) and can both support and hinder professional role development, often at the same time. External stakeholders (professional and supervisory bodies) can also influence and enlarge the complexity of professional role development. In this section we will explain the lessons learned about the internal and external influences on role development and how they impact professional role development. But first, we will discuss the current discourse on changing professional roles.

Changing professional roles: generalists, consultants and organizing professionals
Our research shows that in practice clear distinctions between roles can be made, even if several tasks overlap. We see this happening in the field: EPs versus vested medical specialists (assessing acute complaints), NPs versus ECPs (treating all residents in geriatric wards, giving practical advice) and VNs versus BNs (providing direct patient care to all, including complex patients). At the same time, all professionals seek distinctions in professional roles. This manifests itself in three ways: 1) from specialist to generalist, 2) from direct patient care to consultation, and 3) from caring to organizing.

First, in both medical and nursing professions there is a need for a more generic role. Healthcare is increasingly more complex, specialized, and fragmented due to the increase in knowledge and patient care demands (Allen, 2015a; NHS, 2016). The debate on professional role development has been dominated by such concepts as the division of labour, in tasks and skills (Abbott 1988; Dubois & Singh, 2009; Sermeus et al., 2011), leading to further specialization (Jones, 2005: Ranchal et al., 2015), advanced roles (Lowe et al., 2012; Fealy et al., 2018) and delegation of tasks to other professions. Our study shows that the discussion on role development also needs another perspective. Therefore I used the concept of organized professionalism, derived from the sociological literature on professions and organizations (Allen, 2014; Noordegraaf 2015, Postma, Oldenhof & Putters, 2015). Societal challenges, the complexity of care and the further specialization – and thus fragmentation – within professions, requires a generic professional role, having an overview and connecting different patient needs and professional tasks and roles. Together with the wish for further professionalization and professional development, professionals seek new opportunities and try to benefit from these trends. In our study, this led to the development of the EP role (generalist in acute care), the NP role (a general medical and organizing role in elderly care) and as BN (direct patient care, a quality enhancer's and organizing role).

Second, (super) specialists develop a consulting or supervising role removed from direct patient care. When other professionals take over tasks, the existing role of adjacent professions also shifts, in this case the role of physicians. In Chapters 2 and 4 we see the role of physicians in the hospital and in long-term care changes to a consulting or supervising role. They are consulted when cases are complex or other professionals experience a knowledge gap. As described above, physicians and upcoming professionals discussed whether new roles (e.g. EPs and NPs) had to be accompanied by independent (final) responsibility – described as substitution – or whether this professional had to work under supervision – described as task delegation. This determines whether a physician wants to be called for a consultation, is only responsible for the consultation, or whether a physician believes that they are or will remain a supervisor, and thus will be ultimately responsible for the entire diagnostic and treatment process. This discussion became particularly heated between EPs and physicians and NPs and ECPs after

numerous negotiation meetings led to conflict, both between individuals and on the organizational level. In addition, we see that (highly) specialized professionals chose to become a doctor to provide direct patient care, which means that they experience leaving the provision of direct care to others as a loss and thus it will not be simply released to others.

Third, nurses in particular are developing a more significant role in organizing care. Historically, nursing has a strong focus on caring (Dent, 2003; Davies, 2003). Allen (2015) describes that in a complex setting such as healthcare, professionals are needed who can connect the care needs of individual patients and 'translate' these to the healthcare organization and system (Allen, 2015b). Our study showed that organizational qualities, in both the coordination of care and quality improvement, became part of new nursing roles. As organizing professionals, nurses bridged the gap between professional and organizational logics (Evetts, 2009; Noordegraaf, 2011; 2015). Adding to the literature (Allen, 2014; Noordegraaf 2015, Postma, Oldenhof & Putters, 2015), we show that nurses fulfil an organizing role on several levels: the individual patient level, the patient group level, the organizational level and the policy level. In showing this, we refine and give meaning to Allen's idea (2014) that not all nurses need to have organizing skills at diverse levels of complex environments in today's healthcare setting. Simultaneously, we show that a contrived division between the duties in caring and organizing does not reflect the reality of nursing practices in which both elements are intertwined (ibid). Put the other way around, these insights into organizing can support nurses in discussing role development and role distinctions at certain organizing levels, for example, in the restratification of the nursing profession, a concept scarcely used in nursing. More research in this direction will shed light on the possibility of division in roles and responsibilities at certain levels, for the good of the whole profession. Further research could also show how the shift in discourse also impacts the nurse identity, and how this – as Carvalho (2014) describes – fosters their status.

Balancing collective interests

This research has revealed the importance of collective action from actors working at different organizational levels. We have demonstrated that the development of new professional roles is most successful when professionals and managers at different organizational levels align their efforts. For example, this is apparent in the EP's case (Chapter 2) where hospital executives, the middle manager and a group of vested physicians acted in close alignment to position the EP. Or in the hospital case, where management and BNs teamed up (Chapter 3) in handing over daily coordination of care to BNs. As described in detail in the previous section, physicians and nurses need the active support of their (medical and nursing) managers in taking up a new professional role to gain credibility and recognition for this new role.

In line with Carvalho (2014) and Van Wieringen (2017), our findings show the importance of a close relationship between nurses and management in developing nursing roles. Managers are key to facilitating the change process and mediating between professional and organizational interests and power differences (Chapter 3). Managers also play a vital role in formalizing decisions and embedding the new distinct professional roles in organizational structures (Chapters 3 and 4). We furthermore learned that this is a balancing act between conflicting interests which will not resolve all tensions, as conflicts at the boundaries of professional and managerial domains are fluid and persistent (Noordegraaf, 2015). Directors and boards supported the development of professional roles particularly in defining or supporting the direction – "the why" – of resource provision and in assigning policy advisors to the project. Doing so, they provided the teams with organizational support. Our findings also reveal that management can hinder professional role development because of decreasing support among organizational actors or competing organizational-managerial interests. This was revealed in the case on long-term care (Chapter 4). Here, the inspectorate intervened, which forced the director to adopt a different organizational strategy, which the NPs experienced as a devaluation of their work and affected their relationships of trust and recognition. Our data shows that managers seek to coordinate intra- and interprofessional interests in task division. This coordinating role can also be fulfilled by internal policy advisors (IPAs) who play a mediating role between the organization and the professional group. In Chapter 5, we showed how IPAs supported nursing role development, performing five roles: gatekeeper, connector, converter, reflector and implementer. These roles supported and sometimes protected the exchange of strategies and new policies between the internal and external environment, internally connecting the development of roles on different wards, informing these roles within the organization, converting the information to make it suitable for different audiences, and sometimes forcing decision-making. We hypothesize that these roles are essential for the process of role development and if IPAs are not part of an organization or do not fulfil these tasks, other professionals need to take on these roles. More research is needed in this direction.

Fulfilling an IPA's role also has several challenges that feed into this balancing act. First, IPAs play a key role in advocating for nursing role development and helping nurses develop their role by reflecting on their performance. Second, IPAs with a nursing background can lose their independence and credibility if they identify too strongly with nurses and lose their connection with other stakeholders' opinions and interests (Korschun, 2015). Third, balancing between managerialism and professionalism means that IPAs must realize what is achievable and what is desirable. Advocating too much for the one threatens the other and especially their position as a hospital advisor (Scott & Barnes, 2011; Ejenãs & Werr, 2011). In addition to Holmemo et al. (2018), we show that keeping ownership in the wrong spot puts pressure not only on the relationship

between IPAs and management, but also on their relationship with nurses. In contrast to former studies on internal advisor's roles (Schumacher & Scherzinger, 2016; Wright, 2009; Smendzuik-O'Brien, 2017), who describe the IPA's challenge to deal with organizational and managerial interests, we show that IPAs must balance between organizational/managerial interests, their own professional (departmental) development, fulfilling an advisory role to management and advocating for the nursing profession.

Influence of external stakeholders

External stakeholders, such as professional associations and regulatory bodies have a great mediating impact on new professional role development. In the long-term care case, for example, the Health Inspectorate asked the organization to draw up a list of tasks assigned to the NPs. This forced the organization to settle a long-lasting dispute about clinical responsibility. At the same time, the forced decision hampered the ongoing negotiation process in which the NPs slowly had gained ground – and now partly lost again. The example reveals the negotiation act nurses, physicians, and managers are engaged in, and how they must connect both internal and external interests and requirements. We show in addition to Noordegraaf (2015) and Postma et al. (2015) that in this process of negotiation diverse demands takes place on all levels of healthcare. In Chapter 4 we showed how professionals dealt with and used the external requirements to foster professional role development, experimentally adjusting practices in the hospital to the national requirements. Here we showed that professionals took the position of the professional association, regarding it as their most important external stakeholder and the leader of the internal discussion on role development. By defending the viewpoint of their professional association and the upcoming new legislation, which would enforce their legal rights, the professionals felt they had the power to discuss the current status quo that held them down in their current role. At the same time, the ECPs used the views of their professional body to defend their own position, protecting their domain and gaining legitimacy for the decisions that safeguarded their professional jurisdiction.

Although all stakeholders work on the development of a new professional role, in interaction with their own ambitions, their organizational needs, the broader organizational objective and external requirements, they could still be hampered by a lack of managerial interest and professional power differences. We assume that the nursing profession is limited in formalizing their role on a national level, yet they are capable of influencing their direct working environment. Consequently, new professional nursing roles remain a local achievement, and do not get institutionalized in the broader healthcare system. This causes fragmentation and lack of recognition as the new nursing roles remain largely invisible to others and have very limited impact on policy level.

In this section we first described how professionals seek to make new role distinctions in diverse ways, developing and shifting their roles 1) from specialist to generalist, 2) from direct patient care to consultation and 3) from caring to organizing. We then showed the collective, collaborative but also opposing actions of internal and external actors and how they are connected in the process of developing new professional roles. We argued that the development of new professional roles is most successful when professionals and managers at different organizational levels align their efforts, whereby managers play a vital role in both medical and nursing role development, not resolving all the tensions but also bringing in their own interests. Internal policy advisors also play a vital role in mediating between organizational and professional developments and interests. Our study showed the close connection between internal and external actors on role development, 'crossing organizational borders'. External parties, such as professional associations and the Healthcare Inspectorate, both influence the internal development by imposing their requirements on professionals and organizations and by being used by professionals to defend their own position and protect their domain and gain legitimacy for the decisions that safeguarded their professional jurisdiction. Further research can shed more light on the reverse movement of internal actors influencing external understandings of role development, thus influencing role development at a national policy level.

6.2.3 How does institutionalized healthcare impact professional role development?

New roles are shaped incrementally over lengthy periods of time as healthcare professionals and management figure out which tasks can be handed over and in what manner. This is how new professional roles become aligned with professional-institutional and organizational-institutional characteristics. A striking example is the case of NPs in which new roles had to be aligned with organizational characteristics, such as arranging medical care for specific wards or staff scheduling problems for night and weekend shifts due to the prevailing regulation and the need to comply with national changes in legislation (see Chapter 4). In this section we describe the situated-practice characteristics of professional role development to explain how organizational and institutional embedding can be supported.

Shaping new roles by organizational characteristics

Shaped differently in practice, professional roles are also based on the organizational characteristics that constitute the daily professional practices. Examples deriving from the case studies concern the way health services are organized, in such forms as patient streams, ward arrangements, staffing levels, and shift schedules (Chapters 2, 3 and 4). These characteristics influence role development in diverse ways.

On the one hand, organizational characteristics can support role development. In the long-term case, the NPs joined the medical team and thus became part of an existing organizational practice of medical care. Together with physicians they took care of patients and learned in daily practice how to perform new tasks, becoming 'naturally' responsible for their new role (Clegg et al., 2005). This example shows that professional role development practices involve strongly intertwined professional and organizational characteristics.

On the other hand, organizational characteristics can hamper a specific developmental path. As we showed in the previous section, essential characteristics could be invisible beforehand. For instance, in the hospital case, the nurses preferred a specific BN-VN ratio to take care of complex patients. However, existing staffing levels and the complexity levels of patients proved an inadequate measure to produce an appropriate staff mix (Chapter 4). This example shows organizational limitations demanding renewed discussion on the preferred and feasible role distinctions. It also shows the added value of a practice-based approach, revealing the interplay of organizational features and day-to-day professional interactions that shape the role and positions of professionals in healthcare. Following on from the trial-and-error process, it seemed very hard to determine beforehand whether a particular division of labour fits the professional and organizational characteristics and hence this influenced role distinctions. On the profession level, this led to the need to discuss the extent to which professionals will allow for and support a certain division of tasks and responsibilities. Similarly, on the organizational level it led to the need to discuss the extent to which existing operations can be changed and how much room there is for adjusting routines.

In the experimental practice-based approach these aspects are continuously negotiated and weighted, "not as separated from agents, or as constructed by agents, but as brought into being by everyday activity" (Feldman & Orlikowski, 2011:1241). Our findings show that role development-as-a-practice is an ongoing process. Clegg et al. (2005) describe this as an ongoing "journey" without clear routes as role development is a fragile situational process requiring ongoing work to keep actors involved and keep role development going.

Reshaping routines as a basis of institutional change

New professional roles develop step by step, reshaping routines to fit professional knowledge and interests, and organizational appropriateness. Although legislation, job descriptions and profiles serve as a framework, there remains a gap between what is put down on paper and what is achieved in daily practice (Ten Cate & Scheele, 2007; Van der Lee et al., 2013; Matthias, 2017). Our study shows how this gap was filled by experimenting with small adjustments to tasks and responsibilities in the institutionalized context of healthcare practice. In the case of the EPs, for example, in one hospital EPs took over

night and weekend shifts for the medical specialities that did not have medical residents. In another hospital, EPs supervised interns and subsequently began supervising all medical residents too. This allowed them to enhance their medical knowledge of the discipline while developing their skills in supervising and prepared them for their own EP education. Our findings show how these experiments in role development, act as series of small changes, based on action and appraisal (Bohmer, 2016; Clegg et al., 2005; Ellström, 2001; Lyman et al., 2018), in a process of trial and error (Levitt & March, 1988), to develop and create sustainable new professional roles. In doing so, they changed their role step by step in the existing institutions.

The literature on organizational routines helps us to understand how the step-by-step change of institutions in role development works. Feldman et al. (2016) argues that organizational routines are stable features of institutions and hard to change, but also an important source of action in the continuous production and reproduction of practices (Feldman, 2000; Nicolini, 2012; Feldman et al., 2016; Kuiper, 2018). In line with Feldman (2000), we show that role development is an intensive, necessary process of reshaping existing roles by developing new routines. Zooming in (Nicolini, 2009), we saw how the small adjustments professionals made were embedded in existing routines and how professionals conducted tough work to either reshape or develop new routines to fit professional knowledge and interests, and organizational appropriateness. BNs, for example, tried out many different forms of partnership and collaboration between VNs and BNs, including reallocating patients, coordinating daily care, multidisciplinary consultations and supervising nursing students (Chapter 3). These tasks, which in the first instance were experimental, required adjustments in, for example, schedules, staff mix, bed management, and daily nursing programmes, requiring moments of alignment in daily work processes. Doing this, the nurses developed new routines laid down in organizational structures. We noticed how tough and intensive changing of routines was because of the necessity of learning new skills and developing new work patterns. Adding to the literature (Feldman, 2016), we argue that experimenting in daily practice leads, albeit partly, to the embeddedness of new professional roles, as the accumulation of minor changes included embedding new routines in organizational structures. In the hospital case (Chapter 3), the successful uptake of a coordinating BNs' role in ward evaluation and bed management became part of the BNs' daily routines. Even if this began as an experiment, this case makes visible how the successful uptake of new tasks can become ingrained in daily practice through the reshaping of (new) routines.

Constituting professional roles in the constitution of practices

New roles are constituted by existing professional practices, but practices in turn are shaped by new professional roles. The two are strongly connected. Changing the practices of one means simultaneously changing the embedded practices of the other, and

vice versa. This continuous interplay comes about because professions 'inhabit' their practices (Nicolini, 2012). Chapter 2 described how EPs expanded their professional domain when they took over the night shift to provide 24/7 acute care. For starters, EPs could do this because they had sufficient staffing. By taking on the night shift, they increased their level of expertise in patient assessment above that of other physicians and this allowed them to expand their domain, thereby reshaping the organization of acute care. To conclude, role development and practices are strongly intertwined: practice constitutes role development and role development constitutes practice.

Developing new roles in relation to an existing practice means a degree of path dependence that results in a local interpretation of the new role. In the long-term case (Chapter 4) the shortage of ECPs boosted the development of a strong medical profile for NPs. In the EPs case as well (Chapter 3), their new role was strongly influenced by supportive parties, leading to the development of a specifically 'surgical' profile in one hospital versus a broader profile in the other hospital. Looking from an institutional perspective or in terms of healthcare system arrangements, it can be questioned if such variety in role development is desirable. Role variety can also be questioned from a professional perspective, as it will lead to unclear job distinctions and can hinder further professionalization.

Thus new professional roles evolve step by step, reshaping routines to fit professional knowledge and interests, and organizational appropriateness. Over time, new routines appear in a practice-based approach, albeit partly embedded in everyday professional practice. However, there is no fixed route or end point to the journey. Every step on the way invites appraisal and further development, when actions do not fit, when goals are not reached entirely or, as in professional role development, (as Feldman, 2000 also describes), when new possibilities or obstacles arise.

6.2.4 What does a practice-based approach offer when studying new professional role development?

In the organization and change literature, the way of thinking about change processes is strongly influenced by an engineering mindset of designing and implementing new ways of working (Vermaak, 2013). Such a linear approach is described as a planned, straightforward process of designing 'blueprints', separating the object and subject, developed by a few –experts in the field – and implementation is rolled out over others (Marshak, 1993). From the perspective of linear change, knowledge is often isolated and simplified (Nicolini et al., 2003). Knowledge and tasks are set down in job descriptions and profiles that subsequently get implemented or placed back into practice. However, this approach is problematic for new professional roles. Predefined role descriptions, top-down, rolled-out implementation of new tasks and a training programme to teach everyone the new tasks will not support sustainable change. The literature shows that

even when professional nursing roles are described, for example, there are no proper guidelines on how these roles should be differentiated and integrated into everyday practice (Duffield et al., 2019). In medical role development as well, scholars show that the vague description of competencies as in the CanMEDS roles supports for educational settings but translating competencies into distinct tasks in daily practices is a struggle (Ten Cate & Scheele, 2007; Chou et al., 2008; Van der Lee et al., 2013).

In our study, we applied a practice-based approach to studying new and distinct practices and routines, producing and reproducing new ways of working and collaboration, thereby influencing professional and organizational characteristics. This is in line with current debates in Australia, Singapore and the United States of America on the difficulty of designing and subsequently implementing distinct nursing roles. Gardner et al. (2016), for instance, revealed that RNs roles are not well-defined and that job profiles focus too much on patient care and too little on the ward organization. Predefined job profiles are problematic as the description of job competencies is based on the existing situation (Reeves et al., 2009). Most of the time new profiles are a reproduction of existing thinking, patterns, values, and relationships (Mills, 2000). Additionally, Reeves et al. (2009) showed that once a model is adopted and implemented, it leaves little room for modification driven by new ideas or innovations.

Based on our findings, we argue that professional role development is not the optimization or continuation of an existing situation but an iterative process of figuring out new ways of working that reconfigures the professional and organizational characteristics. Those involved in the role development (re)configure object and subject while considering visible and invisible knowledge, professional and managerial routines, powers and interests, organizational structures, and external demands/requirements. In this section we will explain the building blocks of this iterative process.

Reconfiguring professional roles and practices

A practice-based approach is characterized by putting the development of professional roles in a context or 'practice' of learning by doing (Nicolini, 2003) and what Clegg (2005) calls 'becoming by organizing'. Role development and implementation are not separate stages but connected and intertwined in the practice-based approach (Hacking, 1992; Gherardi, 2012). It involves several layers, which complicates the steering of the process. For example, which knowledge is relevant, which experiences and routines are invisible and must be considered? What influence do professional power and interests have? What are the underlying or related conflicts and which organizational structures are supportive or not?

Role development is thus a process of reconfiguration in practice, not of knowledge that can be detached from the context. A practice-based approach policy is supportive, guiding the way in which roles can develop. A strong example is the development of

VN and BN roles in the hospital case (Chapters 3 and 4). Beforehand, a distinction in job profiles was based on national policy and expected legislation and was grounded in the complexity of care. However, the distinction proved to be untenable. Experiments in practice demonstrated that the distinction did not lead in a sustainable direction (Chapter 3). Through experiments, the BNs and VNs learned how to use the competencies of each nursing level. Experimenting, we learned, means reflecting on doing, lingering back and forth and figuring out the desired shift in day-to-day professional tasks, while negotiating professional boundaries and jurisdictions. Agreements on jurisdictions are not a one-off exercise but an ongoing process of negotiation and contesting (6.2.1) accompanied by continuous proof of expertise which thereby gains legitimacy for the new role. In these negotiations, professionals look for legitimacy for specific tasks and jurisdictions in knowledge and experience, in (improving and guaranteeing) the quality of care (Eps and BNs), in policy proposals and legislation (BNs), in the necessity of absorbing shortages in other professions (NPs) and better organization of care (all cases).

In line with other studies (Bohmer, 2016; Ellström, 2001; Lyman et al., 2019), we showed that a practice-based approach leaves room for an iterative process of slight changes in tasks based on the professional's thorough knowledge of their practice (Reay et al., 2006). By leading their change process (Mannix et al., 2015; Nelson-Brantley, 2017; Boamah, 2019) healthcare professionals become empowered. Hence, we argue that a practice-based approach can positively influence the further professionalization of the involved stakeholders. Also adding to the literature (Reay et al., 2006) we revealed that not only stakeholders – especially healthcare professionals – should be in the lead, but practices should be kept central in the development of professional roles, as organizational and professional characteristics and routines influence this as well. A constellation of actors and factors influencing the development of professional roles is key.

Microprocesses within and outside the profession

Professional role development is shaped and supported from both within and outside the professions. Within professions, there is the need to play a role to improve the quality of care and fuel further professionalization (IOM, 2011; NHS, 2016; Berwick et al., 2020; Bourgault, 2020). In the EP case (Chapter 2), recently graduated medical residents worked in the emergency departments under the supervision of physicians. This model suffered increasing criticism, because junior residents were left to their fate in acute, critical situations and a high turnover of residents created discontinuity in the emergency room. This fuelled the development of an EP role. A practice-based approach would shed light on the subtle microprocesses of role development and the negotiations on work that takes place in everyday healthcare practice (Reay et al., 2006; Nicolini, 2012; Vermaak, 2013; Smets, Greenwood & Lounsbury, 2015).

From outside the profession, institutional work takes place at various organization levels and is conducted by a wide variety of stakeholders, such as managers, internal policy advisors and healthcare executives. Governing bodies outside the organization, such as professional associations and supervisory authorities also have an impact. In Chapter 3, we showed how nursing roles pre-designed by governing bodies did not align with professional practice. Chapters 3 and 4 show that governing bodies expected new professional roles simply to 'appear' and that professionals would automatically be able to put legislation into effect. Our case studies revealed that in the development of new professional roles, actors became mired in institutional confusion. Professionals struggled with negotiation as it put under pressure their relations as well as the incorporation of new tasks in daily practice. This becomes apparent in a practice-based approach so that managers and professionals can consider the need to balance between conflicting internal and external interests and how external bodies interfere to protect or enlarge professional domains.

Three stages of developing professional roles in practices

A practice-based approach provides the opportunity to study the work actors do in the field as leadership-as-practice (Raelin et al., 2018) illuminating the agency, the collective actions and interplay between actors and between actors and organization, producing and reproducing all these interactions and routines (Smets, Greenwood, Lounsbury, 2015). Most practice theorists would subscribe to the view that "agency and structure are mutually constituted and constituting" (Raelin et al., 2018:10). Using a practice-based approach, we shed light on three steps or processes in this complex, unsettling process of professional role development: 1) experimenting with tasks, 2) negotiating jurisdictions and 3) strategic role positioning.

First, in a practice-based approach, role development starts with experimenting with day-to-day tasks. Over time, a continuous process of experimenting with tasks to achieve a coherent set of tasks results in a new role. As described in section 6.2.3, this is a messy process of trying step by step to reallocate or enlarge professional tasks. It is hard to determine beforehand which tasks will fit with a professional role, both professionally (appropriate to competencies, knowledge and experience), and organizationally (appropriate to organizational characteristics and routines). On the one hand, the consequences for professionals are unknown in this uncertain process; for instance, what they will lose by making new role distinctions (see Chapters 3 and 4)? Uncertainty about the outcome can mean that the ongoing negotiation is accompanied by quarrels and even strife. On the other hand, professionals gain new knowledge and expertise in professional subjects and experience in taking on leadership for the further professionalization and improvement of care and the organization. Our study shows that a practice-based approach gives professionals the space to fill the gap between what they

have already learned in former education (Skela-Savič et al., 2017; Furåker et al., 2008) and what they do in daily practice, and this supports the integration of learning, appraising and doing (Ellström, 2001; Clegg et al., 2005).

Second, establishing jurisdiction is a difficult, complicated, and lengthy process. Formal jurisdiction is of immense importance because it determines the professional's formal power and influence (Abbott, 1988). However, our study shows that reallocation of tasks is generally not combined with the reallocation of jurisdiction. Rather, jurisdiction maintains a hold over new professions, preserving dependency between stakeholder groups and thus hampering professional development and leadership. Jurisdiction can also result in disproportionate, untenable responsibility, holding for vested professionals accountable for (medical) incidents or shortages in a complex system of multidisciplinary healthcare delivery. Therefore, continuous negotiation on jurisdiction not only hampers the shift in tasks and thereby professional roles, but also the necessary transitions in the healthcare system, for example, in countering shortages in the 24/7 availability of ECPs in elderly care (see Chapter 4) or the entrance of a new profession in acute care (Chapter 2). Our findings resonate with Currie and Spyridonidis (2016) who describe how financial pressures threaten professional interests and that as hybrid professionals, how physicians protect existing institutional arrangements.

The negotiation of jurisdiction between professions takes place not only in the organization but is also a continuous movement between the internal and external environment. In our three case studies, national debates on professional boundaries were replicated in organizations (RVS, 2020). We noticed professionals used the external negotiation on jurisdictions to legitimize their position and resolve the internal discussion. Furthermore, although professional jurisdictions are laid down in legislation, professionals continue to challenge the recognition of (shifting) jurisdictions by questioning the suitability of the policy or legislative formulation for their own context (Chapters 3 and 4). For example, in the hospital case study (ibid) the challenge to the Individual Health Care Professions Act II, fuelled by a group of concerned nurses, evolved into a national and political – top-down again – discussion that ended up with the abandonment of this long-prepared amendment. This led to national and organization confusion, with professions and professionals struggling with related tensions and conflicts, not knowing how to proceed. In contrast, the practice-based approach to developing distinct nursing roles in everyday practice – hence allowing for other outcomes rather than pre-designed job descriptions – led to healthcare professionals and management broadly supporting new role distinctions that fit the relevant organizational characteristics and routines of healthcare delivery.

Third, in a practice-based approach, role development is characterized by the strategic positioning of a new role. Strategic positioning takes place both vertically and horizontally and between the internal and external environment. It takes place verti-

cally by giving role development a place in the strategic policy. This can be initiated by professionals, (higher) management, policy advisors and the board of directors. In an early phase of role development, establishing strategic positioning can be no more than expressing an intention, making resources available and outlining a framework or motivation. For example, motives include more nurse-driven care in the long-term care (Chapter 4), improving the quality of acute care (Chapter 2), and assigning IPAs to support a programme (Chapter 5). During this process, role development remains a topic on the strategic agenda. The moment new roles become clear and organization-wide decisions must be made, a more detailed role description can be made to direct the required choices or organization-wide decisions on tasks and jurisdictions. Our study shows that at this level, mutual tensions arise between professionals and between professionals and management. It requires a balancing act to deal with negotiated needs and interests (Chapter 4). Our data also reveal the vulnerability of individual arrangements among professionals. The stronger the united perspective of a profession on their role, the stronger their position in the negotiation of tasks and jurisdictions (Chapter 4). This shared perspective on a professional role is strengthened by horizontal strategic positioning, unifying role development right through the organization. In the hospital case (Chapter 5), continuous coordination and pushing along the internal and external environment facilitated an unambiguous vision of the IPA role across the organization. Finally, strategic positioning takes place between the inside and the outside world on two levels. On the first level, the context of direct patient care, it enables external parties to act on the new role interpretation, for example in referral patterns (Chapter 2 and 4). On the second level, in the context of national role development, it aligns fellow organizations, professional associations, ministries and supervisory authorities, to strengthen unambiguous role interpretation across the country (Chapter 5). However, organizations cannot be the only ones to initiate strategic positioning of role development at the national level. Although professional associations do play a vital role, the hospital and long-term care cases reveal the gap in connecting internal role development with the national negotiation on role development. At this national level policy advancement or adjustment barely plays a role.

In a practice-based approach, adjustments and negotiations take place continuously. However, this approach has a limitation when role development and negotiations on tasks and jurisdictions are merely situational and waged internally, keeping the professionalization and positioning of new professional groups fragile. At the same time, jurisdictions proposed in policy are not fully utilized in practice (e.g. NPs participating in 24/7 shifts, prescription policy for NPs in the long-term care case; see Chapter 4). Further action research is needed on the process of blending organizational changes and national policy to facilitate further professionalization and foster healthcare transitions.

Role development in practice requires intense and thorough work; it evolves slowly and stagnates easily. Another limitation of the practice-based approach is that it misses a clear developmental path. What has been learned is hard to translate or roll out over other practices because shaping roles in daily practice – combining learning, doing, appraising and embedding – requires every organization (or ward or even professional) to follow the development journey. However, it does lead to the development and partial embeddedness of distinct professional roles.

As a research method, the practice-based approach is labour-intensive, evoking classic methodological questions about the generalizability and replicability of the findings and the degree of involvement and influence of the researcher on the cases (see 6.2.5 below). Further research is needed to develop evidence about usefulness of a practice-based approach in the development of professions and organizations. A specific question to address is how the unique situational development and institutionalization can go beyond the organizational borders in an iterative process, to anchor not only what has been learned in practice but also national policy levels.

6.2.5 Reflections on methodology

Ethnography is a well-known and broadly accepted research method in healthcare to investigate in-depth practices, meanings and beliefs of the actors involved, placed in their specific professional and organizational context (Atkinson & Hammersley, 2007; Leslie et al. 2014; Draper, 2015). Ethnography is also often used in the research on role development and quality improvement (Huizenga et al., 2016; Janssen et al., 2016; Lavander et al., 2017; Kraaij et al., 2021; Cupit et al., 2018; Leslie et al., 2013). Several studies are based on (focus group) interviews, but as outlined above, role development is generally a messy process and can only be investigated close to practice, to understand the microprocesses of change in professional roles and practices (Smets et al., 2015). We conducted a multiple-case study, using a variety of qualitative research methods, which allowed us to gather in-depth data within a case and also analyse data across cases. Investigating different cases in professional role development in time, place and profession would protect us from making simple generalizations on the findings and deepen our understanding of the phenomenon of professional role development (Gustafsson, 2017). Therefore, we gathered ethnographic data in three cases, doing 54 interviews, approximately 300 hours of observations, 33 hours of conversations, and being involved in 47 diverse types of meetings. We wrote thick descriptions within 24 hours after observations and meetings. However, our chosen method and the role we played in these cases questions whether we conducted ethnographic or action-oriented research.

Action-oriented research is a process-oriented methodology intended to accomplish collective knowledge creation about complex issues in social systems, by means of shared change objectives and learning goals for the actors involved, in a practice of

reflection-in-action and involvement of scientific knowledge (Argyris, 1995; Greenwood & Levin, 2007; Bradbury-Huang, 2010; Bradbury et al., 2019; Jansen et al., 2021). This approach is useful in situations where the available (academic) knowledge is not sufficient to solve a problem, which was the case in professional role development. In contrast to ethnographic research, participants are involved in action research; they are not just a subject of study (Reason and Bradbury, 2008). Research is done with practitioners instead of over them (Bate, 2000). Schön (1983) argues that this is relevant as practitioners exhibit a kind of knowing that is both tacit and implicit and as practitioners generally know more than they say, there is a distinction between theory in use (what people actually do) and espoused theory (what people think they do). Tacit knowledge is generally separated from the scientific body of knowledge (Levin, 2012). In our case studies we aimed to develop new knowledge on organizational change fostered in an iterative back and forth movement between professionals, management and organizational characteristics, structures and routines. As individual agents and their setting, personal experience, experiment and reflections, emotions and intentions are all relevant to the study, action-oriented research is appropriate (Bradbury et al. 2019:7). To study professionals "frequently embroiled in conflicts of values, goals, purposes and interests" (Schön, 1983:17) we needed in-depth insights into how professionals dealt with tensions, conflicts and interests and interacted in several attempts to reach their goals and create the desired change in their professional and organizational field.

In contrast to what is described in the rational, evidence-based approach of action-oriented research in which experiments are conducted following well-defined scientific interventions that follow a clear loop – to plan, do, check, reflect and act on chosen interventions – our study revealed that experimenting is methodologically messy and iterative. Often begun without a well-defined intervention, the experimental process is guided by the implicit, intuitive and thorough knowledge of professionals (Reay et al. 2006) and managers (Currie and Spyridonidis, 2016). This messiness does not mean that the research is done poorly, even if action-oriented methodology is often criticized, especially for the degree of bias. Although all qualitative and quantitative methods can be used in both ethnographic and action-oriented research, we generally applied abductive analysis to reveal and understand new phenomena emerging from the data, combining our findings 'back and forth' with what is already known in theory (Stoopendaal & Bal, 2013; Tavory & Timmermans, 2014). Consistent with Dubois & Gadde (2002), we found alternative explanations for the complex issue of professional role development using this abductive approach. The close interaction with our respondents, which is key to action-oriented research, subsequently enabled us to check our findings and obtain a thorough understanding of professional role development in healthcare practice.

As researchers we were involved in several cases for more than three months, working on the basis of a relationship and gaining the trust needed to obtain insight into the

feelings, meanings and beliefs of the study participants (McCormack & McCance, 2010; Vindrola-Padros et al. 2019). This relationship was complicated at times. As a researcher you know that your academic background gets used, for example, to legitimate the further development of certain roles, or as spokespersons for a certain group. This happened in the hospital case, for example, where our academic background legitimized the development of the BN role, emphasizing that the choices made in the distinction between the BN and VN roles were scientifically based. In the NP case as well, as researchers we had to balance our engagement between "it is useful in the process of co-creation and developing new configurations" versus "it is necessary to pull back to support the development of personal and professional leadership for a certain group". Indeed, "as an action researcher you are engaged and vulnerable, you commit yourself to the issue and the people involved" (Jansen et al., 2021:75). However, this becomes vulnerable as diverse groups and hence (conflicting) issues are at stake.

To secure trustworthy, rigorous research, Levin (2012) describes four factors to assess the quality of action-oriented research to its specific objective of solving problems and producing new knowledge. First, the researcher should assess "the epistemological and ontological foundation of action-based research" rather than through "the lens of the positivist paradigm" (Casey, O'Leary and Coghlan 2018). The high relevance of action-oriented research can be combined with high rigour through research partnering, controlling biases, using standardized methods and alternative explanations. In our research, partnering took place by discussing and reflecting on the research process and findings in our research team (not all were involved in data gathering) as well as in the project teams of our studies. Both ethnography and action-oriented research consider the influence of the researcher's meanings and beliefs, seeing the researcher at one end of the scale as a 'fly on the wall' with no influence on the research setting, to, at the other end of the scale, always influencing people or situations under observation (Glaser & Strauss, 2017). As a highly respected action-oriented researcher said in a personal meeting: "We are insiders everywhere. Insider knowledge is very rich. We need to hear the insider's story. It's only a problem for people whose research paradigm is grounded in a particular, positivistic way. You won't lose your critical reflection, asking critical questions. We often work on untested inferences. We try to move from reflection afterwards to reflection inside or during the process. When things go wrong, we want to go back to the doings, instead of going back to the inferences." (David Coughlan, 2017). Combining our thick descriptions with reflection on the data made our perceptions explicit in descriptions of where and how we co-designed, co-implemented and co-evaluated. For example, in the discussion with a hospital manager about appointing some team members to the specific role of her trusties, I suggested she organized this with a small group of BNs and thus brought the development of the BNs' role a step further.

7

Concluding remarks

The development of new nursing and medical roles in the healthcare organization is central to this dissertation. Our findings show that developing new professional roles is a layered process that takes place on several levels: the work floor, within organizations and at the levels of professional associations and policy making. Development is a 'back and forth' process, whereby new professionals are meant to fulfil organizational needs (shortage of ECPs, unavailability of expertise in emergency rooms, staff turnover), while simultaneously having to maintain the domains of traditional professions. This leads to ongoing conflict in which new professional groups find it hard to establish their new professional role. However, by zooming in in this ethnographic study, we discerned more precisely what takes place within healthcare organizations. Then we also see success stories, often facilitated by the support of managers and internal policy advisors. These parties constantly act to tie together the internal and external interests, moving between vested and new professions, whereby especially the new professions have to handle disappointments. This leads to 1) ongoing uncertainty and the urge to prove, which may negatively affect not only resilience, but also quality of care; 2) problematic discussions on (medical) final responsibility, which hinders the development of other professions and causes control, protection of domains and a lack of recognition and distrust; 3) fragmentation: new roles take shape slightly differently in different contexts; 4) which leads to weak reflection and representation on the overarching and even national level. New professional roles appear to be mainly organization driven, a new form of organized professionalism, with an emphasis on the organization. This causes a high degree of dependence. It can be questioned how sustainable professional role development is and whether the grand expectations of new professions can be realized.

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SUMMARY

Dutch healthcare has to deal with significant challenges in healthcare delivery and financial sustainability due to the growing ageing population, mounting social and healthcare needs and the increasing complexity of care, combined with rising shortages in nursing and medicine. This has led to a national focus on the possibilities of reorganizing healthcare practices, including deploying professionals differently, reallocating professional tasks and differentiating professional roles. Meanwhile, healthcare professionals feel the need to further develop their profession, distinguishing their knowledge and expertise from others to protect and enhance their domain. However, professional role development is often initiated top-down at a national policy level, designed by expert committees and rolled out over the professions. Several studies show that this approach is problematic. Role distinctions are heavily debated, are complex to define or once defined, lack guidelines on how to implement and differentiate the roles in daily professional practice. Although the value of differentiation is widely recognized, it is not clear how it should be done within professions and be embedded in daily organizational practice. We need to investigate the microprocesses of professional role development in healthcare organizations to deepen insight into the process and actors who influence it.

The aim of this thesis is to investigate how nursing and medical professionals develop their roles in everyday healthcare practice, both intra- and interprofessionally, shaping their roles in close collaboration with managers, directors and internal advisors. We show how external parties influence the internal process of professional role development and how managers must find a balance between internal needs and external requirements. Using a sociological, institutional and practice-based perspective, the analysis sheds light on the iterative process and complex constellation of (f) actors in professional role development.

We studied professional role development with an ethnographic multiple-case study. Ethnography provides in-depth insights into people's actions and accounts in everyday contexts and using an array of data resources but generally focusing on a few cases. Working with multiple cases provides the opportunity for a cross-case analysis. Over the course of six years we investigated role development in the medical profession, in the nursing profession, and role development and nursing-medical role development in mutual relationship. We selected three convenient samples. First, we investigated the development of an emergency physicians' (EP) role in three top clinical teaching hospitals. Second, we investigated role development by nurse practitioners (NPs) in a nursing home organization who, as members of the medical team, partly replaced elderly care physicians (ECPs). Third, we participated in a case study on nursing role development in a teaching hospital, following nurses in four wards in the development of distinct VN and BN roles. Together the results provide an answer to the main research question:

"How do healthcare professionals shape new professional roles in everyday healthcare practices?"

Chapter 2 investigates from an institutional perspective how EPs develop their role in this new, fast-growing specialism. Currently, what EPs do and the responsibilities they bear differs considerably between hospitals. This article addresses the question of how the role of EPs is shaped and institutionalized in the everyday context of acute care in hospitals. To answer this, we conducted a cross-case ethnographic study, comprising observations, document analysis and in-depth interviews in three emergency departments of Dutch hospitals. Drawing on the theoretical concept of institutional work, we show that managers, already established medical specialties and EPs all conduct institutional work to enhance private interests, which both restricts and enlarges the EPs' work domain. These actions are strategic, both intentional and unintentional and part of EPs' daily work in acute care delivery. Tasks and responsibilities are redistributed and the role of the EP is shaped in this very process. These findings question arguments in the current literature, that the role and status of EPs would be enhanced by strengthening regulation and improving training programmes. This article shows that attention should also be paid to the more subtle everyday processes of role development.

Chapter 3 investigates the experimental process of developing distinct nursing roles in daily hospital practice through job differentiation. Policy attempts to implement new competency frameworks and job profiles often fails by not serving existing nursing practices. This study aimed to understand how licensed vocational nurses (VNs) and nurses with a Bachelor of Science degree (BNs) shape distinct nursing roles in daily practice. We conducted a qualitative study in four wards (neurology, oncology, pneumatology and surgery) of a Dutch teaching hospital. Various ethnographic methods were used: shadowing, observations and participation in relevant meetings, informal conversations, semi-structured interviews and member-checking with four focus groups. We show how hospital nurses develop new role distinctions in a series of small-change experiments, based on action and appraisal. Through thematic analysis, our findings show that: (1) this developmental approach incorporated the nurses' invisible work; (2) nurses' roles evolved through the accumulation of slight changes that included embedding the new routines in organizational structures; (3) the experimental approach supported the professionalization of nurses, enabling them to translate national legislation into hospital policies and supporting the nurses' (bottom-up) evolution of practices. The new roles required the special knowledge and skills of bachelor-trained nurses to support healthcare quality improvement and connect the patients' needs to organizational capacity. We conclude that conducting small-change experiments, anchored by action and appraisal rather than by design, clarifies distinctions between vocational and bachelor-trained nurses. The process stimulates personal leadership and boosts the responsibility nurses feel for their own development and the nursing profession in

general. This study indicates that experimental role development provides opportunities for professionalization and gives nurses, managers and policymakers a 'two-way window' on nursing roles, aligning policy initiatives with daily nursing practices.

Chapter 4 examines how nurses shape a more organizing role in healthcare practices. Scholars have described the concept of organizing professionalism as 'the intertwinement of professional and organizational logics in one professional role'. Organizing professionalism bridges the gap between the often-described conflicting relationship between professionals and managers. However, the ways in which professionals shape this organizing role in daily practice, and how it impacts on their relationship with managers has gained little attention. Based on an ethnographic study, this chapter reveals how nurses shape and differentiate themselves in organizing roles. We explore two empirical cases on nurse role development: 1) NPs in elderly care, who partly replaced elderly care physicians in nursing homes; and 2) nurses with a bachelor's degree in a general hospital gaining a larger role in organizing and providing hospital care. Our findings reveal that developing a new nurse organizing role is a balancing act as it involves resolving tensions in professional authority, task prioritization, alignment of intra- and interprofessional interests, and internal versus external requirements. We discuss how managers play an important yet ambiguous role in this development process as they both cooperate with nurses in aligning organizational and nursing professional aims, but at times hamper the development of an independent organizing nursing role due to conflicting concerns.

Chapter 5 investigates the role of internal policy advisors (IPAs) to enhance the quality improvement (QI) competencies of nurses in a developmental programme in an urban Dutch teaching hospital. We conducted an exploratory ethnographical study comprising observations, informal conversations, semi-structured interviews, focus groups and a strategy evaluation meeting to identify the roles IPAs play in these programmes and to study how these roles influence nurses and management. We identify five distinct advisory roles for IPAs in the hospital programme: gatekeeper, connector, converter, reflector and implementer. In describing these roles, we provide insights into how IPAs help nurses to develop QI competencies. The IPA's professional background is a driving force for nurses' QI role development. However, QI development is threatened if IPAs lose sight of the various stakeholders' interests and consequently lose credibility. We also show that QI role development in nurses is threatened if the IPA takes on all responsibility instead of delegating it to managers and nurses. We conclude that the IPAs' professional background and advisory knowledge connects the organizational, managerial and professional aims and interests to enhance professionalization of nurses.

Chapters 6 contains the discussion and answers the main research question of how nursing and medical professionals shape their professional roles in daily healthcare

practices. We discuss the methodological approach and theoretical perspectives we used in this thesis. We argue that role development is not a straightforward, simple implementation of a pre-designed distinction in tasks and roles. It involves a reconfiguration of professional roles and practices and arises in a complex intra- and interprofessional interplay between professionals themselves and with managers, directors and internal advisors. Influenced by external parties, professional role development is shaped and reshaped, back and forth, in practices and routines and thus we argue that role development has to be considered as a practice. The discussion points to three important findings. First, experimenting with the development of professional roles in daily healthcare practice incorporates invisible work as implicit and tacit knowledge, and the invisible organizational practicalities also steer professional role development. Second, the experimental practice-based approach facilitates shaping and reshaping professional and organizational routines, supporting the embeddedness of new tasks and roles and thus the reconfiguration of roles in daily practice. Third, our multiple-case study on nursing and medical role development, studied separately and in mutual relationship, sheds new light on nursing action patterns in change processes, revealing that personal and professional leadership is involved in developing new professional practices.

Chapter 7 ends the dissertation with concluding remarks on the development of new professional roles. This layered process occurs on several organizational and professional levels. In line with the sociology of professions, our study shows that role development often leads to conflict. However, from an institutional work and practice theory perspective, and zooming in on the microprocesses of practices, we reveal how professionals incrementally shape new roles with the support of managers and internal policy advisors. Despite these successes, there is still uncertainty about the viability of developing professions due to such setbacks as unresolved discussions on final responsibility, fragmentation of new roles in different contexts and weak representation at an overarching level. Factors such as these raise the question whether the grand expectations of upcoming professions can be realized.

SAMENVATTING

De Nederlandse gezondheidszorg heeft te maken met grote uitdagingen op het gebied van zorgverlening en financiële houdbaarheid als gevolg van de toenemende vergrijzing van de bevolking, de toenemende sociaal-maatschappelijke behoefte en zorgvraag en de toenemende complexiteit van de zorg, in combinatie met toenemende tekorten in verpleging en medische hulpverlening. Dit heeft geleid tot landelijke aandacht voor de mogelijkheden om zorgpraktijken te reorganiseren, zoals het anders inzetten van professionals, het toepassen van taakherschikking en functiedifferentiatie. Tegelijkertijd voelen zorgprofessionals de behoefte om hun vak verder te ontwikkelen, hun kennis en expertise te onderscheiden van anderen om hun domein te beschermen en te versterken. Professionele rolontwikkeling wordt echter vaak top-down op nationaal beleidsniveau geïnitieerd, ontworpen door commissies van deskundigen en uitgerold over de beroepsgroepen. Verschillende studies tonen aan dat deze aanpak problematisch is. Onderscheiden professionele rollen zijn hevig bediscussieerd en moeilijk te definiëren of, eenmaal gedefinieerd, ontbreken richtlijnen voor het implementeren en differentiëren van de rollen in de dagelijkse beroepspraktijk. Hoewel de waarde van differentiatie algemeen wordt erkend, is het niet duidelijk hoe dit binnen beroepen moet worden gedaan en in de dagelijkse praktijk van zorgorganisaties moet worden ingebed. Het is belangrijk om op microniveau het proces van professionele rolontwikkeling te onderzoeken om inzicht te krijgen in het proces en de (rol van) actoren die dat proces beïnvloeden.

Het doel van dit proefschrift is om te onderzoeken hoe verpleegkundigen en artsen hun professionele rol in de dagelijkse zorgpraktijk ontwikkelen, zowel intra- als interprofessioneel, en hoe zij hun rol vormgeven in nauwe samenwerking met managers, bestuurders en interne adviseurs. We laten zien hoe externe partijen het interne proces van professionele rolontwikkeling beïnvloeden en hoe managers een balans moeten vinden tussen interne behoeften en externe vereisten. Vanuit een sociologisch, institutioneel en praktijkgericht perspectief werpt de analyse licht op het iteratieve proces en de complexe constellatie van (f)actoren in professionele rolontwikkeling.

We hebben professionele rolontwikkeling bestudeerd door het uitvoeren van een etnografische meervoudige casestudy. Etnografie biedt diepgaande inzichten in de acties en gedragingen van mensen in alledaagse contexten, daarbij gebruik makend van een scala aan gegevensbronnen, maar richt zich over het algemeen op een beperkt aantal cases. Het werken met meerdere cases biedt de mogelijkheid voor een cross-case analyse. Over een periode van zes jaar onderzochten we rolontwikkeling in de medische professie, in de verpleegkundige professie, en rolontwikkeling en verpleegkundig-medische rolontwikkeling in onderlinge samenhang. We selecteerden drie geschikte voorbeelden op basis van het netwerk van de onderzoekers. Ten eerste onderzochten

we de ontwikkeling van de rol van SEH-artsen in drie topklinische ziekenhuizen. Ten tweede onderzochten we de rolontwikkeling van verpleegkundig specialisten in een ouderenzorgorganisatie die, als leden van het medisch team, specialisten ouderengeneeskunde (SO's) in de ouderenzorg gedeeltelijk vervingen. Ten derde namen we deel aan een casestudy over de ontwikkeling van verpleegkundige rollen in een topklinisch ziekenhuis, waarbij we verpleegkundigen op vier afdelingen volgden bij de ontwikkeling van de rollen van verpleegkundige en regieverpleegkundige. Samen geven de resultaten een antwoord op de centrale onderzoeksvraag: “Hoe geven zorgprofessionals vorm aan nieuwe professionele rollen in de dagelijkse zorgpraktijk?”

Hoofdstuk 2 onderzoekt vanuit institutioneel perspectief hoe SEH-artsen hun rol in dit nieuwe, snelgroeiende specialisme ontwikkelen. Wat SEH-artsen doen en welke verantwoordelijkheden ze dragen, verschilt aanzienlijk tussen ziekenhuizen. Dit artikel gaat in op de vraag hoe de rol van SEH-artsen wordt gevormd en geïnstitutionaliseerd in de dagelijkse context van acute zorg in ziekenhuizen. Om dit te beantwoorden hebben we een cross-case etnografisch onderzoek uitgevoerd, bestaande uit observaties, documentanalyse en diepte-interviews op drie spoedeisende hulpafdelingen van Nederlandse ziekenhuizen. Op basis van het theoretische concept van institutioneel werk, laten we zien dat zowel managers, gevestigde medische specialismen als SEH-artsen institutioneel werk verrichten om persoonlijke belangen te vergroten, wat het werkdomein van de SEH-artsen zowel beperkt als vergroot. Deze acties zijn strategisch, zowel doelbewust als onopzettelijk, en maken deel uit van het dagelijkse werk van SEH-artsen op het gebied van acute zorg. Taken en verantwoordelijkheden worden herverdeeld en de rol van de SEH-arts krijgt in dit proces vorm. Deze bevindingen stellen de argumenten in de huidige literatuur ter discussie dat de rol en status van SEH-artsen zou worden verbeterd door regelgeving en trainingsprogramma's te verbeteren. Dit artikel laat zien dat er ook aandacht moet zijn voor de meer subtiele alledaagse processen van rolontwikkeling.

Hoofdstuk 3 onderzoekt het experimentele proces van het ontwikkelen van verschillende verpleegkundige rollen door middel van functiedifferentiatie in de dagelijkse ziekenhuispraktijk. Beleidspogingen om nieuwe competentiekaders en functieprofielen te implementeren mislukken vaak, omdat ze niet ondersteunend zijn aan de verpleegkundige praktijk. Het doel van dit onderzoek was inzicht te krijgen in hoe Mbo-, in-service opgeleide en Hbo-opgeleide verpleegkundigen verschillende verpleegkundige rollen vormgeven in de dagelijkse praktijk. We voerden een kwalitatief onderzoek uit op vier afdelingen (neurologie, oncologie, longgeneeskunde en chirurgie) in een Nederlands topklinisch ziekenhuis. Er zijn verschillende etnografische methoden gebruikt: schaduwen, observaties en deelname aan relevante bijeenkomsten, informele gesprekken, semigestructureerde interviews en membercheck met vier focusgroepen. We laten zien hoe verpleegkundigen in het ziekenhuis onderscheiden rollen ontwikkelen

in een reeks kleinschalige experimenten, gebaseerd op actie en evaluatie. Door middel van thematische analyse laten onze bevindingen zien dat: (1) deze ontwikkelingsbenadering het onzichtbare werk van de verpleegkundigen incorporeert; (2) de rollen van verpleegkundigen door ontwikkelen door de opeenstapeling van kleine veranderingen, waarbij nieuwe routines ingebed raken in bestaande organisatiestructuren; (3) de experimentele benadering de professionalisering van verpleegkundigen ondersteunde, zowel in het vertalen van nationale wetgeving in ziekenhuisbeleid, als het (bottom-up) ontwikkeling van verpleegkundige praktijken. De nieuwe rollen vereisten de specifieke kennis en vaardigheden van Hbo-opgeleide verpleegkundigen ter bevordering van kwaliteitsverbetering in de gezondheidszorg en om de behoeften van patiënten te verbinden met de organisatorische capaciteit. We concluderen dat het uitvoeren van experimenten waarin de opeenvolging van kleine veranderingen, op basis van actie en evaluatie centraal staat, leidt tot een helder onderscheid tussen Mbo- en Hbo-opgeleide verpleegkundigen. Het proces van experimenteren stimuleert persoonlijk leiderschap en vergroot de verantwoordelijkheid die verpleegkundigen voelen voor hun eigen ontwikkeling en het verpleegkundig beroep in het algemeen. Dit onderzoek geeft aan dat experimentele rolontwikkeling kansen biedt voor professionalisering, en verpleegkundigen, managers en beleidsmakers een 'tweerichtingsvenster' geeft op verpleegkundige rollen, waardoor beleidsinitiatieven worden afgestemd op de dagelijkse verpleegkundige praktijk.

Hoofdstuk 4 onderzoekt hoe verpleegkundigen vorm geven aan een meer organiserende rol in zorgpraktijken. Wetenschappers hebben het concept van 'organizing professionalism' beschreven als 'de verwevenheid van professionele en organisatie logica in één professionele rol'. 'Organizing professionalism' overbrugt de kloof tussen de vaak beschreven conflicterende relatie van professionals en managers. De manier waarop professionals deze organiserende rol in de dagelijkse praktijk vormgeven en hoe dit van invloed is op hun relatie met managers heeft in onderzoek echter weinig aandacht gekregen. Op basis van een etnografisch onderzoek laat dit hoofdstuk zien hoe verpleegkundigen een organiserende rol vormgeven en zich hiermee onderscheiden. We onderzoeken twee empirische cases over de ontwikkeling van de rol van verpleegkundige: 1) verpleegkundig specialisten in de ouderenzorg, die de SO's in verpleeghuizen gedeeltelijk vervingen; en 2) Hbo-opgeleide verpleegkundigen in een topklinisch ziekenhuis, die een grotere rol krijgen bij het organiseren en verlenen van ziekenhuiszorg. Onze bevindingen laten zien dat het ontwikkelen van een nieuwe organiserende rol voor verpleegkundigen balanceerkunst is, aangezien het gaat om het oplossen van spanningen in professionele autoriteit, taakprioritering, afstemming van intra- en interprofessionele belangen, en interne versus externe vereisten. We bespreken hoe managers een belangrijke maar ambigue rol spelen in dit ontwikkelingsproces, aangezien ze zowel samenwerken met verpleegkundigen om organisatorische en verpleegkundig-professionele doelen op el-

kaar af te stemmen, en op sommige momenten de ontwikkeling van een onafhankelijke organiserende verpleegkundige rol belemmeren vanwege tegenstrijdige belangen.

Hoofdstuk 5 onderzoekt de rol van interne beleidsadviseurs bij het ontwikkelen van kwaliteit bevorderende (QI) competenties van verpleegkundigen in een ontwikkelingsprogramma in een stedelijk topklinisch ziekenhuis. We hebben een verkennend etnografisch onderzoek uitgevoerd met observaties, informele gesprekken, semigestructureerde interviews, focusgroepen en een strategie-evaluatiebijeenkomst om de rollen die interne beleidsadviseurs spelen in deze programma's te bepalen en om te onderzoeken hoe de rollen van interne beleidsadviseurs de verpleegkundigen en het management beïnvloeden. We onderscheiden vijf verschillende adviesrollen voor intern beleidsadviseurs in het ziekenhuisprogramma: poortwachter, verbinder, omvormer, reflector en implementatie-ondersteuner. Door deze rollen te beschrijven, geven we inzicht in hoe interne beleidsadviseurs verpleegkundigen helpen om QI-competenties te ontwikkelen. De professionele achtergrond van de interne beleidsadviseur is een drijvende kracht achter de ontwikkeling van de QI-rol van verpleegkundigen. De ontwikkeling van QI komt echter in gevaar als interne beleidsadviseurs de belangen van de verschillende stakeholders uit het oog verliezen en daardoor aan geloofwaardigheid verliezen. We laten ook zien dat de ontwikkeling van QI-rollen bij verpleegkundigen wordt bedreigd als de interne beleidsadviseur alle verantwoordelijkheid op zich neemt in plaats van deze te delegeren aan managers en verpleegkundigen. We concluderen dat de professionele achtergrond en advieskennis van de interne beleidsadviseur de organisatorische, bestuurlijke en professionele doelen en belangen verbindt om de professionalisering van verpleegkundigen te bevorderen.

Hoofdstuk 6 bevat de discussie en beantwoordt de centrale onderzoeksvraag hoe verpleegkundigen en artsen hun professionele rol in de dagelijkse zorgpraktijk vormgeven. We bespreken de methodologische benadering en theoretische perspectieven die we in dit proefschrift hebben gebruikt. We stellen dat rolontwikkeling geen rechttoe rechtaan, eenvoudige implementatie is van een vooraf ontworpen onderscheid in taken en rollen. Het gaat om een re-configuratie van professionele rollen en praktijken, die ontstaat in een complex intra- en interprofessioneel samenspel tussen professionals onderling en met managers, bestuurders en interne adviseurs. Beïnvloed door externe partijen wordt professionele rolontwikkeling gevormd en hervormd, heen en weer bewegend, in praktijken en routines en daarom stellen wij dat rolontwikkeling als een praktijk moet worden beschouwd. De discussie wijst op drie belangrijke bevindingen. Ten eerste omvat het experimenteren met de ontwikkeling van professionele rollen in dagelijkse zorgpraktijken onzichtbaar werk als impliciete en stilzwijgende kennis, en de onzichtbare organisatorische praktische aspecten sturen ook de ontwikkeling van professionele rollen. Ten tweede vergemakkelijkt de experimentele praktijkgerichte benadering het vormgeven en hervormen van professionele en organisatorische routines, waardoor de

inbedding van nieuwe taken en rollen en daarmee de re-configuratie van rollen in de dagelijkse praktijk wordt ondersteund. Ten derde werpt onze meervoudige casestudy over verpleegkundige en medische rolontwikkeling, afzonderlijk en in onderlinge relatie bestudeerd, nieuw licht op verpleegkundige actiepatronen in veranderingsprocessen, waarbij zichtbaar wordt gemaakt dat persoonlijk en professioneel leiderschap betrokken is bij het ontwikkelen van nieuwe professionele praktijken.

Hoofdstuk 7 sluit het proefschrift af met een slotopmerking over de ontwikkeling van nieuwe professionele rollen. Dit gelaagde proces speelt zich af op verschillende organisatorische en professionele niveaus. In lijn met de sociologie van professies laat ons onderzoek zien dat rolontwikkeling vaak tot conflicten leidt. Echter, vanuit een institutioneel werk- en praktijktheorieperspectief, en inzoomend op de microprocessen van praktijken, maken we inzichtelijk hoe professionals stapsgewijs nieuwe rollen vormgeven met de steun van managers en interne beleidsadviseurs. Ondanks deze successen is er nog steeds onzekerheid over de levensvatbaarheid en duurzaam voortbestaan van zich ontwikkelende beroepen door tegenslagen als onopgeloste discussies over eindverantwoordelijkheid, versnippering van nieuwe rollen in verschillende contexten en zwakke vertegenwoordiging op overkoepelend niveau. Factoren als deze roepen de vraag op of de grote verwachtingen van opkomende beroepen kunnen worden gerealiseerd.

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PHD PORTFOLIO

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Courses

How to manage your PhD project	2017
Great thinkers of the 20th century	2018
Searching, finding and managing your literature	2018
Basiscursus Didactiek	2018
English academic writing	2019

Additional activities

Action oriented Research in-company	2017
PhD meetings	2018-2020

Conferences and presentations

NIG conference, article presentation	2013
Organizational Behaviour in Healthcare Conference	2018
Verpleegkundig Leiderschap, posterpresentatie	2019
Congres Taakherschikking	2018
Nursing Delta, posterpresentatie	2019

Teaching activities

Kritische studies van Management en organisaties (Pre-Master)	2019
Kritische studies van Management en organisaties (Pre-Master)	2020
Critical Studies of Management and Innovation (Bachelor)	2020
Quality & Safety (Master)	2019-2020
Advanced Research Methods (Master)	2020
Supervising bachelor graduation projects	2020-2021