

Pieterbas Lalleman

**on daily work and habitus
of nurse middle managers
in hospitals**

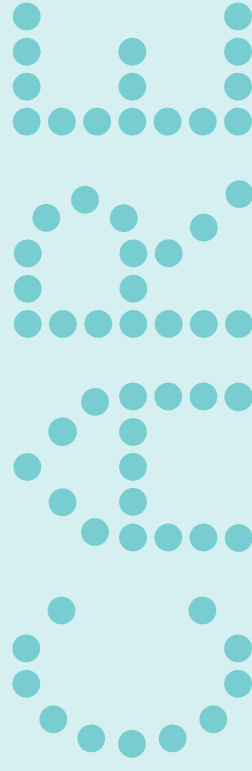
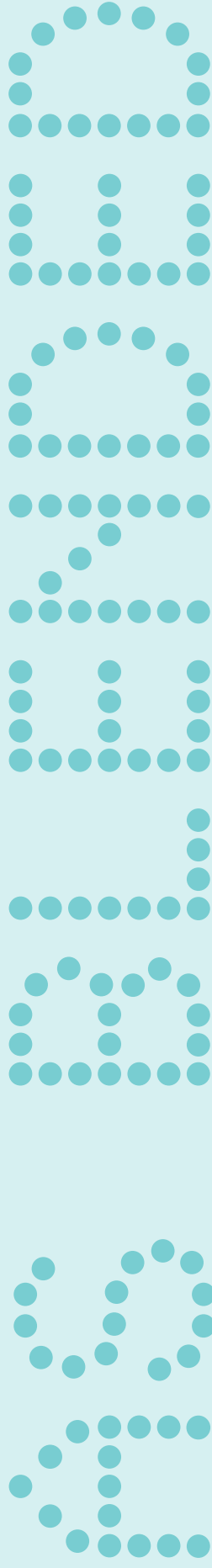
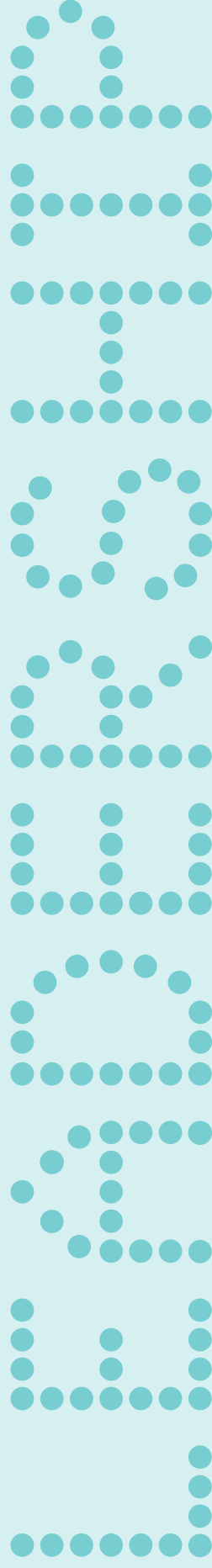
The cover of this thesis is made of Colback. A material produced by Low & Bonar. Colback is a non-woven material with a wide variety of technical characteristics. It is used in air filters of automobiles, as enhancement of carpeting, wallpaper, bituminous roofing materials or civil engineering.

Colback always plays a role at 'the back stage', the material is hardly ever seen at the 'front stage'. The designer of this thesis pulled Colback out of its shadow and illustrates the esthetical qualities in full bloom. She explored new utilization options for the material in a real crossfire of design, industry and creativity.

In analogy with the material, we see that nurses and nurse managers daily work is often at 'the back stage' of hospital organizations. As illustrated in Davina Allen's 2015 book: *The Invisible Work of Nurses: on Hospitals Organization and healthcare*, this crucial work at 'the back stage' is often not visible.

For clinical nurse leadership to succeed we have to make our work more visible. Nursing leadership as blended care has the potential to do so. By blending 'caring work' and 'organising work', the value that nurse leaders create for the patient and family, nurses and other professionals, and the organization hits the spotlight at the 'front stage' and becomes visible for everyone to see.

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Leadership as blended care: on daily work and habitus of nurse middle managers in hospitals

Leiderschap als 'blended care': over het dagelijks werk en habitus van verpleegkundig midden managers in ziekenhuizen

(met een samenvatting in het Nederlands)

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Pieter Cornelis Bastiaan Lalleman

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“The difficulty, in Sociology, is to manage to think in a completely astonished and disconcerted way about things you thought you had always understood.”

Pierre Bourdieu

Nursing leadership as blended care according to Florence Nightingale. From her book *To her nurses*. Letter from May 23rd 1873.

- 1. Have a real and personal interest for each one of your patients.**
- 2. Have a strong practical (intellectual if you will) interest in the case. This is what makes the true nurse. Otherwise the patients might as well be pieces of furniture, and we the housemaids.**
- 3. The pleasures of administration, which though a fine word, means only learning to manage a ward well.**

Chapter 1

General introduction

Introduction

From nursing to managing: a personal trajectory

In my early youth, I lived on the woody premises of an institute for persons with intellectual disabilities. Both my parents worked there as nurses. I remember playing in ‘snoezel rooms’ (for an explanation see: Lotan and Gold, 2009) that my mom and dad had developed and built themselves. My father, Gerrit Lalleman, was the unit manager of a day-care center of this institute. Later in his career, he worked in higher healthcare management. I still can remember standing in his office staring at the stacks of papers wondering, ‘what do managers do’? This is the same question management theorist Henry Mintzberg (1973) asked himself as a young boy glancing up at the desk of his father, a successful manufacturer.

General introduction

More than 15 years later I studied nursing myself and started working on a med-surg oncology ward in a hospital in Amsterdam. Here I learned the craft of nursing. Together with a team of nurses, we took care of our patients, from intake, diagnosis, and surgery to recovery and discharge. I can still remember the faces of many patients. The rhythm of the ward dictated my working life.

After one year working full time as a staff nurse on the ward, I started studying organizational sociology at the Free University of Amsterdam. During studies, I kept working as a part-time nurse with a fixed schedule, working shifts on Friday, Saturday and Sunday evenings. A hospital is a complex 24-hour organization but one way or the other there is a different vibe after 4 pm: lines are shorter, the organizational machinery is hibernating. After my graduation at age 28, I applied for a job as a nurse manager of a general – nephrology ward in a hospital outside Amsterdam. Now it was not only management that was new for me, the daily routine during the day shift was an eye-opener as well. Instead of ‘just’ taking care of the patients assigned to me for a shift, I was now faced with the challenge of supporting a team of approximately 30 staff nurses. Expecting me to know about their situations at home, their families, their career paths and ambitions, and, last but not least, to make their schedules. I had to attune with the clerks, and run a wide variety of projects. I worked closely with my nurse manager colleagues, quality improvement staff, HRM-managers, IT-support, facility management, OR and ER departments, radiology, and laboratory, infection prevention physicians, nurse specialists, physiotherapist, dieticians, and nurses aids. I had to deal with internal and external audits, visits from inspectors and accreditation program officers, and attend strategy meetings with higher management.

After a few weeks working as a nurse manager, I had a short introductory meeting with the board of directors. They asked me whether I liked working there and whether there was anything that surprised me. I told them that I was flabbergasted that the patients’ parameters (tension, pulse etc.) were not reported in the

patients’ nursing file but only in those of the physicians. This meant that after starting one’s shift as a nurse and reading report one had to walk to the physician’s room and go through all their patients’ files to actually know your patient’s condition. The members of the board answered that it was an interesting point but that that was the way things were done. End of story.

In the weeks and months that followed, I got pushed away further and further from the relative nitty-gritty, but essential nursing work, and got lured into what Allen (2016) calls, ‘the business of the system’. This complex organization was clearly not hibernating! Looking back at this period I find that the whole idea of patients, patient care, caring, nurse sensitive patient outcomes and clinical involvement had become completely eclipsed from my day-to-day practice. At the same time I worked so hard taking care of everything and everyone in the whole organization. After almost two years I resigned, disappointed and on the edge of burnout. Coincidentally, in that same period, Lee and Cummings (2008) published a systematic review in which they established that a high percentage of frontline nurse leaders suffers from burnout.

I have tried to comprehend what happens when nurses (such as myself) become managers. According to Mintzberg, nursing is managing, a notion that underlines the importance of the helping aspects of the craft of nursing and caring work. But my own experiences made me suspect that these aspects also have hindered my daily work as a nurse middle manager (NMM) in the hospital. I could not resist getting lured into the ‘business of the system’, taking me further away from those at the frontline of care (e.g., patients, nurses, physicians).

Nurses’ work

In 2015, Davina Allen published a new standard on nursing work in hospitals. In – *The Invisible work of Nurses. Hospital, organisation and healthcare* – she delivers a contemporary sociology of nurses’ work. Her book opens up the wonderful world of nursing care. According to Allen,

'nursing is typically understood, and understands itself, as a care-giving occupation. It is through its relationships with patients – whether these are absent, present, good, bad or indifferent – that modern day nursing is defined. Yet nursing work extends far beyond direct patient care activities. Across the spectrum of locales in which they are employed, nurses, in numerous ways, support and sustain the delivery and organization of health services. In recent history, however, this wider work has generally been regarded as at best an adjunct to the core nursing function, and at worse responsible for taking nursing away from their 'real work' with patients' (Allen, 2015 pp. XII).

Allen (2015) describes the difficulties in differentiating what she calls 'caring work' and 'organising work'. Furåker's (2009) claims that 'organising work' accounts for more than 70% of nursing activity and is often seen as 'the dirty work'. This emphasis on caring can be found as well in contemporary nursing schools: here as well 'organising work' is served as 'a side dish'. This results in (student) nurses who lack organisational intelligence which is necessary at the frontline of patient care in complex hospital organisations. Support from a nurse middle manager (NMM) to enhance this organisational intelligence in practice is therefore very important as a precondition for the delivery of safe and high quality patient care.

Nurse Middle Managers work

NMMs are the liaison between the frontline of patient care and, to put it simply, the rest of the organization and its direct surroundings. They play a crucial role in ensuring safe and high quality care, and in enhancing job satisfaction and overall organizational performance. In the literature, they are referred to as 'hybrid' middle managers (Burgess and Currie, 2013; Hewison, 2002; Oldenhof, 2015) who can, because of their professional background, mediate between professional and management expertise. Llewellyn (2001) has described this process of mediation with the metaphor of the 'two-way window'. Some say that managers could experience feelings of in-betweenness,

asking themselves whether they are nurses or managers (Hewison and Morrell, 2014). Others choose a different frame and state that nursing is managing (Mintzberg, 2013; Mintzberg, 1994)

In the daily work practices of NMMs, with a background in nursing, this challenge of balancing out 'the real work' of providing direct patient care and the so called 'wider work' of managing the system that helps providing this care, is under continuous inquiry. Questions are asked, for example, about NMMs' visibility on the ward and involvement in hands-on bedside patient care. Some question whether middle managers in healthcare need to have a clinical background at all. Some NMMs spend all day running around on the ward helping out the team, supporting them in the care of patients (i.e. 'the real work'). In a way, they lose themselves in one facet of their work which beautifully overlaps with their previous work providing nursing patient care, but creating a blind spot for some of the crucial 'wider work'. Others spend their time in their offices and meetings, doing computer work and fixing rosters (i.e. 'the wider work'). They lose themselves in 'organizing' and, turn away from 'the real work'. In the end, they run the risk of losing sight of exactly that for which they are lined-up, creating value for patients, employees, and the organization. The daily challenges of NMMs are described in literature as a no-win deal in which; 'middle managers feel themselves hemmed in by policies, procedures, and rules of someone else's making, and at the same time the urgency to innovate, communicate, and manage change. They feel pressure from the top and demands from the bottom' (Albrecht, 1990 p. 71). And what is most important, on a daily basis NMMs experience the challenges of playing the required role at the frontline of care. In this thesis, we hypothesize that NMMs' background of providing patient care is an important factor here: their professional backgrounds both helps and hinders them in playing the challenging role.

Aim and outline of this thesis

The general aim of this thesis is to examine the influence of the professional background of NMMs on their clinical leadership in daily work in hospitals in order to identify whether and when this helps or hinders their leadership practices.

This thesis will cover several topics:

- In chapter 1 we give a short introduction on the topic.
- In chapter 2 we decipher the dispositions of habitus of the NMMs (Lalleman et al., 2015) and illustrate the influence of these dispositions on NMMs' contributions to staff support (Lalleman et al., 2015)
- In chapter 3 we show how NMMs' habitus influences their clinical leadership and their contribution to patient safety practices (Lalleman et al., 2016);
- In chapter 4 we investigate what NMMs actually do in their daily work (Lalleman et al., 2017) and how what they do relates to patient-centeredness (Lalleman et al., 2017);
- In chapter 5 we investigate the possible role of the technique peer-to-peer shadowing to develop the required role at the frontline (Lalleman et al., 2017).
- In chapter 6 we conduct a general discussion on the overall results by presenting a typology of NMMs' daily work and a leadership practice, i.e., that of 'clinical leadership as blended care' (Lalleman et al., submitted).

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Chapter 2

Nurse middle managers' dispositions of habitus: a Bourdieusian analysis of supporting role behaviors in Dutch and American hospitals

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Abstract

A Magnet-related program has been recently adopted in the Netherlands. Support for staff nurses from nurse middle managers (NMMs) is a key component of such a program. A Bourdieusian ethnographic organizational case study in four hospitals in the Netherlands and the United States (Magnet, Magnet-related and non-Magnet) was conducted to explore NMMs' supporting role behavior. Bourdieu's concepts of habitus, dispositions, field and capital guided the analysis. Eight dispositions constitute NMMs habitus. A caring, clinical and scientific disposition enhance NMMs' capital in particular organizations-as-fields. Further research is necessary to link Magnet (related) program characteristics to various configurations of dispositions of NMMs habitus.

Keywords

Bourdieu, dispositions of habitus, hospital, international, Magnet, multi-sited nurse middle managers, organizational ethnography, supportive roles

Introduction

There is growing interest in the Magnet™ Recognition Program in the United States and related programs in other countries (de Brouwer et al., 2014; Flynn and McCarthy, 2008; Grant et al., 2010). This program was developed and is administered by the American Nurses Credentialing Center (ANCC). Its aim is to create a productive and healthy work environment for nurses in order to provide high-quality patient care (American Nurse Credentialing Center, 2008; Kramer and Schmalenberg, 2002). Support for staff nurses from nurse middle managers (NMMs) is identified as one of the key components (Kramer et al., 2007; Schmalenberg and Kramer, 2009). A Magnet-related program was recently adopted by the Dutch Nurses Association in the Netherlands under the name of Excellent Care (EC) (de Brouwer, 2014; Kieft et al., 2014). The purpose of this paper is to explore NMMs' supporting role by conducting a Bourdieusian ethnographic case study of NMMs' dispositions of habitus in four hospitals in the Netherlands and the United States with Magnet, Magnet-related and non-Magnet status.

A recent publication on the introduction of Excellent Care in Dutch hospitals confirms the importance of the supporting roles of NMMs in Magnet-related programs (Kieft et al., 2014). The paper stresses that, according to staff nurses, NMMs should, in order to create healthy working conditions, consider team spirit and unity, address conflicts, be visible and approachable (Kieft et al., 2014). A study by Kramer (2007) concludes that what staff nurses desire and consider important is a NMM who demonstrates 'caring' behavior by assisting them with their work. The literature mentions further supporting role behaviors, for example being accessible and safe or "walking the talk" (Kramer et al., 2007; Schmalenberg and Kramer, 2009).

For NMMs, actual behavior in daily practice does not always match with these desired supportive roles (Udod and Care, 2012). Staff nurses regularly experience challenges with NMMs in shaping care that meets patients' expectations, whereas NMMs are tied to a

system that emphasizes controlling costs (Kieft et al., 2014). Many NMMs also feel torn between their clinical and managerial roles (Orvik et al., 2013; Shirey, 2006; Shirey et al., 2008; Shirey et al., 2010; Sørensen et al., 2011; Taylor et al., 2014).

Boundary-spanning behavior (Allen, 2000; Meyer et al., 2011) could help NMMs to cope with these challenges because in their role as professional managers (Noordegraaf, 2007) they can relate to both clinical and managerial worlds and span the boundaries between them (Meyer et al., 2011). Llewellyn (2001) describes this as a hybrid role, using the metaphor of a "two-way window" that enables managers to mediate clinical and management expertise. Witman's (2011) ethnographic study, using Bourdieusian analysis, on the dispositions of habitus of healthcare professionals in leading positions in a Dutch University hospital, represents an example of this hybrid role. Witman demonstrates that applying Bourdieu's concepts of dispositions of habitus, field, and capital can improve our understanding of NMMs' supportive and boundary-spanning role behaviors.

Bourdieu's concepts: dispositions of habitus, field, and capital

Bourdieu states that habitus is "history turned into nature" (Bourdieu, 1977 p. 78), or an embodied history, internalized as a second nature (Bourdieu, 1977 p. 56). He further states that habitus is a system of dispositions (Bourdieu, 1977 p. 214). Dispositions are defined as durable, subconscious schemes of perception and appreciation that activate and guide practice (Bourdieu et al., 1989). According to Bourdieu (1977 p. 214), dispositions are the result of an organizing action, a way of being, a habitual state (especially of the body) and, in particular, a predisposition, tendency, propensity, or inclination. Dispositions of habitus generate a limited number of behavioral strategies. These strategies are manifested in certain visible patterns of behavior, manners, and beliefs: in practices (Bourdieu, 1990).

Bourdieu's concept of field refers to a social space with an internal logic (Bourdieu, 1989a). In a field, there

is always something at stake; there are struggles for positions and valuable resources or capital. Capital may be inherited through a position or acquired over time; it can be exchanged for other resources and has value within particular fields (Bourdieu, 1989b). As Bourdieu argues, 'capital does not exist and function except in relation to a field' (Bourdieu and Wacquant, 1992 p. 101). Building on Bourdieu, Vaughan (2008) explains that an organization-as-field perspective represents an organization as a field nested in a larger professional field. For example, a hospital can be regarded as a nested organization-as-field with an internal logic of its own within the larger professional field of NMM practices. NMMs may acquire capital by being supportive of, visible to and approachable by nurses (Kieft et al., 2014), but they may also acquire capital by controlling costs for higher management (Kieft et al., 2014). This example illustrates the challenges NMMs face in obtaining capital from both worlds and the importance of spanning boundaries between clinical and management worlds to create a healthy work environment (Meyer et al., 2011).

A few nursing studies have applied Bourdieu's concept of habitus (Angus et al., 2003; Rhynas, 2005; Rischel et al., 2008). A limited number of studies describe dispositions such as a caring disposition (Chan et al., 2009) or a critical thinking disposition (Profetto-McGrath, 2003). There is a vast literature on the roles of caring and critical thinking in nursing practice but none addressing these themes using Bourdieu's concepts. There is, to our knowledge, no literature on nurses' dispositions of habitus in management positions. We are aware of one study on dispositions of habitus and managerial work in hospitals by Witman (2011), but this is focused on physicians. We use the insights and knowledge from that study on healthcare professionals and managerial work to begin our research and address two central questions:

1. What are the main dispositions of NMMs' habitus as manifested in their daily practice?
2. To what extent do the dispositions of NMMs' habitus affect, through the attainment and

distribution of capital, a supporting role in Magnet, Magnet-related and non-Magnet hospitals?

Methods

Research design

A Bourdieusian (Bourdieu, 1977; Vaughan, 2008) exploratory, multi-sited ethnographic organizational case study approach was applied to gain insight into the dispositions of NMMs' habitus (Van Maanen, 1979; Ybema et al., 2009). Ethnography was used to describe the micro practices and complexity of NMMs' everyday work.

Selection of cases and ethical considerations

A total of sixteen NMMs from four different hospitals were recruited by purposeful sampling using the following criteria (table 1):

- NMMs: being a registered nurse, having a middle management position in an adult care unit of an acute care hospital and supervising a nursing unit of between 20 and 40 beds. We defined the middle management role as positioned between the work floor and higher management with first-line responsibilities regarding the supervision of care workers and the management of finances and quality of care (Hewison, 2006).
- Hospitals: nonprofit midsized general and teaching hospitals, two in the Netherlands and two in the U.S. Having Magnet, Magnet-related or non-Magnet status allowed us to show variation between NMMs' dispositions of habitus, supportive role behavior, and the attainment and distribution of capital in the various hospitals as organizations-as-fields. A brief introduction of the four hospitals can be found in the boxes in findings section.

Nurse middle managers' dispositions of habitus

Table 1 — Key characteristics of the participants and their organizational settings

	NMM	Gender	Ward Specialty	Spans of Control	Beds	Nursing Education Level [^]	Management training	Years of management experience
Site 1	Kim	F	Surgical	30	28	RN	In company	15
	Pat	F	Surgical	28	28	RN/BSN	none	2
	Toni	M	Medical	38	36	RN	In company	5
	Chris	M	Medical	28	26	RN	In company	10
Site 2	Dana	F	Surgical	30	32	RN/BSN	Post Bachelor's	1
	Eli	F	Surgical	26*	24	RN	In company	5
	Sal	F	Mother & Child	40*	38	RN/MSH	In company	2
	Sidney	F	Medical	26*	24	RN/BSN	Post Bachelor's	3
Site 3	Terry	F	Medical	30	26	RN	In company	15
	Tracy	F	Surgical	30	26	RN	In company	20
	Tyler	F	Step-down ICU	24	28	RN	In company	25
	Vic	F	Surgical		26	RN	In company	20
Site 4	Alex	F	Medical	34	24	RN/MSN	In company	5
	Jamie	F	Mother & Child	55	34	RN/BSN	In company	10
	Jordan	F	Medical / ICU	52	34	RN/BSN	In company	20
	Shawn	F	Surgical	35	24	RN/MSN	In company	5

*shared with co-manager

[^] RN = associate's degree or diploma, BSN= Bachelor of Science in Nursing,

MSN= Master of Science in Nursing, MSH= Master of Science in Health

Consent differed at the Dutch and U.S. hospitals because of national policies and the various means of accessing the sites. In the Netherlands, formal institutional review approval was not required for this type of research; the higher management of both hospitals approved the study. In the U.S., ethical approval was obtained from the institutional review boards of both participating hospitals and consent was obtained from each participating NMMs.

Arrangements were made with contact persons in higher management, the innovation and performance improvement departments, and shared governance councils. We asked the contact persons at each

organization to recruit the NMMs. NMMs who satisfied the inclusion criteria were eligible for participation and invited by e-mail to participate in the study. These potential participants received a letter of invitation including a description of the study and its purpose. An interview followed that discussed the aims, design and methodology of the study. Participation in the study was voluntary, and there was no disclosure of individual findings.

The participants were asked to inform their colleagues, staff nurses and other hospital employees of the study to avoid confusion regarding the presence of the researcher and to protect nonparticipants.

Chapter 2

The participants and nonparticipants in the units could ask the researcher to leave the room or area at any time. The researcher did not enter patient rooms, and no identifiable patient information was recorded.

Data collection

NMMs were shadowed (Czarniawska-Joerges, 2007; McDonald, 2005) for four days each, leading to a total of approximately 560 observation hours over a period of 19 months in 2010–2012 (**table 2**). The first author closely followed each of the 16 NMMs for an extended period of time (McDonald, 2005).

During shadowing, the researcher focused on behaviors that might indicate the NMMs' dispositions of habitus, i.e., subconscious schemes of perception and appreciation that activate and guide their practice (Bourdieu et al., 1989). Behaviors and manners of the NMMs were observed. Throughout the shadowing period, questions were asked of participants that

prompted a running commentary from the person being shadowed. Some of the questions were asked for clarification, such as what was being said on the other end of a phone call or what a departmental joke meant. Other questions were intended to reveal purpose, such as why a particular line of argument was pursued in a meeting or what the current operational priorities were (McDonald, 2005). Some questions led to semi-structured interviews concerning beliefs regarding NMMs' roles and challenges in the hospitals. For example, we asked questions regarding what a regular workday consisted of and how NMMs balanced the clinical, caring, and administrative aspects of their roles. In a semi-structured introduction interview, we learned about NMMs' previous careers and reasons for becoming nurse managers. A Livescribe™ Pulse™ Smartpen was used, which digitally stores handwritten field notes and audio fragments from both shadowing and interviews. The field notes and audio fragments were uploaded to a laptop computer with Nvivo 10 (Nvivo, 2012), a qualitative software analysis program

Table 2 — Design and data sources

	<div> <div>June 2010</div> <div></div> <div>May 2012</div> </div>			
Country	Phase 1: the Netherlands		Phase 2: the United States	
Hospital	Site 1	Site 2	Site 3	Site 4
Approx. hours shadowing	150	140	140	130
Shadowing days	Kim: 4 days*	Dana: 4 days	Terry: 4 days	Alex: 4 days
	Pat: 6 days*	Eli: 4 days	Tracy: 4 days	Jamie: 4 days
	Toni: 5 days*	Sal: 4 days	Tyler: 4 days	Jordan: 3 days^
	Chris: 4 days	Sidney: 4 days	Vic: 4 days	Shawn: 4 days
Field notes pages A5	700	670	640	480
Audio in hours	22	21	11	7

*pilot shadowing to come to an optimum of shadow days

^ which included one double shift from 7 A.M. until midnight

that helped manage the large amount of data.

A selection of the audio files was transcribed using this program. This approach provided the opportunity to refer back to the fragments after the fieldwork was completed.

Finally, two interactive discussion group meetings were organized with the participating NMMs. These meetings were used as member checks to strengthen the validity of our findings. Preliminary findings were discussed, which helped to assign meaning to the rich data (Balogun et al., 2003) and contribute to the triangulation of the observational data.

Data analysis

After completing the fieldwork, we conducted a data analysis based on inductive coding (Boeije, 2010). First, descriptive codes were developed: location codes, such as nursing station, office, or meeting outside the ward; interaction codes referring to actors with whom NMMs frequently spoke, such as nurses, colleagues, patients, or higher management, and codes on daily work and challenges. These codes helped us to navigate the data set.

Next, we used an inductive approach. After reading and rereading all field notes and transcriptions of audio files, we selected approximately 50 fragments from each hospital in which particular role behavior was manifested and could be geared toward dispositions of NMMs' habitus. We used the descriptions of dispositions previously identified by Witman (2011), but we bracketed these dispositions to ensure that our analysis of the NMMs' dispositions of habitus remained independent and focused on NMMs' work. The dispositions described by Witman(2011) sensitized our analysis but allowed sufficient room for tailoring and for NMMs' new, emerging dispositions. These fragments were entered into tables, and for each fragment in the table, we asked whether a disposition manifested itself and whether capital was gained or lost. We clustered the fragments, leading to a set of eight dispositions of NMMs' habitus.

Findings

In NMMs' daily work, various dispositions are simultaneously at play. Eight dispositions constitute NMMs' habitus. To answer the first research question, we constructed Table 3, which describes these eight dispositions and their schemes of perception, strategies and manifestations together with typical examples from the various sites.

In understanding the practice of NMMs, it is also important to address the dynamics between the various dispositions in action and the distribution of capital at the four hospitals employing an organization-as-field perspective. Therefore, in the next section, we demonstrate that various dispositions were valued differently at the four sites and that some dispositions created more capital than others. Furthermore, the dispositions affect one another; thus, particular combinations of dispositions in particular fields generated capital in unique ways. The analysis of relationships among the various configurations of dispositions provides insights into our second research question regarding the distribution of capital and NMMs supporting role behavior in Magnet, Magnet-related and non-Magnet hospitals.

We present the four sites in chronological order. First, various examples from hospital one (Magnet-related) are reported to demonstrate how both caring and clinical dispositions create capital in NMMs' daily work. Second, various examples from hospital two (non-Magnet) are provided, whereby we demonstrate how caring and collegial dispositions can become entangled and overshadow the clinical disposition. Third we introduce hospital three (non-Magnet) and illustrate how administrative and control dispositions can create friction with the professional and teaching dispositions. We conclude with examples from site four (Magnet) and demonstration how a scientific disposition can positively affect caring and other dispositions of NMMs' habitus.

Table 3 — NMMs dispositions of habitus

Descriptions of dispositions	Examples from field notes
Through a caring disposition , NMMs see patients as individuals who require care and attention. The corresponding strategies include answering the call for help of the other in the here and now; ad hoc, reactive reactions; and quick judgment. The caring disposition manifests itself by scanning the environment for calls for help. Excelling in the caring disposition provides capital that is based on taking care of and paying attention to patients.	This disposition is shown during patient rounds at the bedside with the physicians and nurses. During rounds, Pat stays in the background and scans the surroundings. She sees that the patient's hearing aid is not working properly. It was loudly beeping. Pat quickly helps the patient who was fiddling with his hearing aid. The physician keeps on talking. By the time Pat has the hearing aid in place, the physician turns around to walk to the next patient. Pat whispers a short summary of the physician's update in the patient's ear. Then, she quickly follows the small procession to the next patient. [Pat field notebook 2/ page 108].
Through a clinical disposition , NMMs see individuals as patients. The corresponding strategies include the search for the symptoms and causes for the conditions observed. The clinical disposition manifests itself by seeing patients, diagnosing their care needs and knowing their conditions. Excelling in this disposition provides capital that is based on having and using clinical expertise.	This disposition becomes evident while standing at the nursing station during a hectic morning shift. The typical position of Tracy: arms crossed, silently watching what goes on, and sometimes asking questions, mostly clinical questions, sometimes procedural. Tracy follows a nurse into a patient's room, looks at the patient and whispers to the nurse: "he seems to be more and more dependent, but we need to find out why his condition is getting worse". Tracy introduces herself to the patient: "My name is Tracy. I am one of the nurses...". She looks at the patient's feet and asks the clerk to come because she speaks Spanish, like the patient. [Tracy 11/124].
A collegial disposition refers to NMMs ensuring a positive team dynamic. The corresponding strategies include being friendly to team members and taking care of other colleagues. This disposition manifests itself by giving attention to members of the team, encouraging feedback and tacitly knowing other individuals' needs. Excelling in this disposition provides capital that is based on being collegial and preserving a friendly atmosphere.	We meet Toni at the beginning of his work day. Toni is also in charge of an 8-"bed" day care for oncology patients. Two of his nurses are assigned to day care: one is pregnant, and the other does not feel well. Toni: "We have to give those ladies some extra attention today." [Toni 3/66]. Giving attention to and taking care of colleagues are important, but they also create frictions and complications. Eli reflects on the dynamics of her team: "It is about taking care of each other, being nice without having to ask what is needed. This makes it extra complicated. Everybody "thinks" for the other, does not asks or gives feedback nor explicate what is needed." [Eli 7/138].
Through a teaching disposition , NMMs see themselves as tutor or mentor. The corresponding strategies include creating moments for coaching, instructing and learning. It manifests itself through teaching or instructing both patients and colleagues. Excelling in this disposition provides capital is based on sharing knowledge and teaching others.	As always, Pat starts at the nursing station, listening to the handover from the night to day shifts. Today, they are short of staff, so she will coach one of the senior-level nursing bachelor's students. Pat: "I will read a report with you. We are short of staff". Pat asks questions about the patients, their parameters and conditions. She asks the student to plan the care. First, they will give medication, then wash the patient and dress the wounds. After the student heads off, Pat checks the turnover on the whiteboard and walks to her office [Pat 2/ 26]. In the next fragment, Jamie emphasizes the importance of teaching in relation to patient care. Jamie talks with her nursing staff about the higher unexplained death rates of infants: "We are missing a lot of teaching. We have to remind ourselves how important assessments are. It takes an adult learner 7 times to have things sink in." [Jamie 14/137].

Nurse middle managers' dispositions of habitus

Descriptions of dispositions

Examples from field notes

Through a **professional disposition**, NMMs perceive themselves as both personally and collectively accountable for good patient care. The corresponding strategies include putting the interest of patients first and being accountable and taking responsibility. This disposition manifests itself by feelings of responsibility and sharing responsibilities. Excelling in this disposition provides capital that is based on being responsible and accountable both personally and collectively for patient care.

Jordan reflects on issues that concern sharing responsibly and accountability. Jordan: "I do not believe that I am in control. I am an educator and need to provide support in different phases, emotional, clinical, environmental, and patient safety. They want you to make the decision and blame you afterwards if it was incorrect. It is about accountability, of which we all have a piece." [Jordan 16/3].

A **scientific disposition** refers to NMMs work as a scientific and reflective practice. The corresponding strategies include referring to, gathering and using scientific evidence and asking reflective questions to enhance the quality of patient care. This disposition manifests itself through an investigative stance, postponing reactions, refraining from judging, focusing on research/EBP and reflection on action. Excelling in this disposition provides capital that is based on using scientific knowledge and asking reflective questions rather than ad-hoc action.

"It is not about feeling bad. Feeling bad gets us nowhere; we have to analyze the process" [Alex 14/52]. During observations, we frequently heard the phrase: "There is no literature for that". This reasoning provides some insight into the impact of the scientific disposition on NMMs. Another typical reaction of one of the nurse managers on acute events was: "I have to chew on that for a while". [Shawn 16/102].

Through an **administrative disposition**, NMMs view administrative work as legitimization of their activities. The corresponding strategies include the use of checklists, guidelines, benchmarks and reports. This disposition manifests itself through a focus on writing reports, filling out checklists, addressing administrative issues and performing clerical work. Excelling in this disposition provides capital that is based on the correct use of checklists and guidelines and handling administrative procedures.

Terry spends most of her days at the nursing administration office working on the schedule, floating staff, trying to cover each ward, filling out forms and checklists, and making phone calls begging nurses to do a double shift or come for an extra shift. After 30 minutes, she has everything well documented. Terry: "I think I covered everyone, thank the Lord!" [Terry 10/46]. In the next fragment, Eli explains that having clear guidelines are key. Eli: "It is all about money. We need some financial guidelines to work it out; otherwise, you start dreaming and they blow the whistle on you. We need a good and clear assignment from higher management." [Eli 6/77].

A **control disposition** views NMMs' work as a way to create order and serenity. The corresponding strategies include controlling daily situations by tidying up. This disposition manifests itself through a focus on controlling (complex) situations, creating order and clarity, cleaning up and clearing up. Excelling in this disposition provides capital that is based on being in control of situations.

Similar to most of the other nurse managers, Pat loves to create order, control and clean up her desk, agenda, office and ward. I see a lot of the nurse managers clearing up corridors, nursing stations or laundry rooms. They do it on the run, scanning the environment for clutter, it also cleaning up and clearing up. Making it orderly, neat and well-organized. Pat: "I really love to clean up this mess!" [Pat 2/69].

Site 1: Caring and clinical disposition as key for NMMs' daily work

Hospital 1 participates in the Excellent Care program of the Dutch Nurses Association. It is a vibrant city hospital near the center of town. The open, tolerant and outspoken city atmosphere is reflected in both the patient and employee populations. Each ward primarily has four-bed patient rooms, with some single patient rooms. The nurse managers' offices are on the ward, at the beginning or end of the corridor. NMMs refer to them as "my closet or hut". The nursing stations are open and at the center of the wards. NMMs frequently talk to physicians, nursing staff and patients. The hospital has an average ratio of nurses to patients. Two of the nurse managers had issues with high absenteeism; the others did not. All NMMs collaborated closely and floated personnel to guarantee an optimum nurse-patient ratio.

Three NMMs at site 1 gained capital by prioritizing the caring and clinical dispositions in their work, as demonstrated in the fragments below.

We start at the nursing station. It is 7:30 AM, and the nurses are reading their assignments and patients' files. Toni listens to a discussion between the night shift and a day nurse about giving extra insulin. Toni interrupts: "I would give the extra insulin if I were you." It is noisy at the nursing station. Toni frequently asks the nurses to lower their voices: "Sssshh, don't talk so loud." He does it with a smile, but the nurses know he is serious about it. [Toni 3/66].

The fragment clearly demonstrates caring and clinical dispositions. Toni directly responds to a call for assistance related to a clinical issue. He deliberately remains at the nursing station in the morning to be available and answer ad hoc questions. Thus, he can demonstrate his clinical expertise and involvement with patient care without actually seeing the patients. The nurses on the ward valued these interactions that focused on patient care in the here and now. The direct involvement and availability were especially appreciated. In the next fragment, we meet Kim, who

follows the same strategy of being clinically involved and heeding patients' calls for help.

Kim prepares for a round with the thoracic surgeons; she picks up the patient files on the ward. Kim: "This is my chance to see how the patients are doing. Aah, look at him sitting there; yesterday he was still lying in bed wearing his gown and now he is sitting up, completely dressed." [Kim 1/5].

For Kim, seeing patients is a key part of her work. Again, the emphasis is not on actually providing care but knowing the patients' conditions and seeing their faces. Both physicians and nurses value Kim's knowledge of the patients admitted to the ward. Being clinically involved and demonstrating one's skill in action provides capital, but there can be a trade-off between clinical and administrative work.

In the next fragment, we meet Chris, who seldom spends time on the ward or speaks with physicians or about performance improvement. He has conflicts with several physicians and does not make rounds with them or the nursing staff. Seeing patients is not his priority. In an exit interview, a disappointed nurse reports that she does not find Chris accessible, visible or to exhibit clinical interest.

Nurse: "I have to tell the medical residents that we give fraxiparine injections at 10 am, but it never changed [the residents kept prescribing at 6 pm]. No matter how many times I wrote a report or addressed it with you (Chris) or my colleagues, everyone just shrugs their shoulders. It is without obligation, informal. First thing I do when I start my shift is clean up the mess of the other colleagues, and if you address that, you are seen as having a big mouth. Many of my colleagues stopped saying anything; they felt unsafe. I never stopped addressing them, but now I am glad I am gone and do not have to do that anymore." [Chris 5/22].

The fragment illustrates the nurses' frustrations with Chris's behavior of shrugging his shoulders and not taking action. Not "doing" anything is an atypical

reaction for NMMs in this hospital and does not provide capital in relation to the caring disposition. Not seeing patients and not discussing patient care with nursing or medical staff reduces capital and erodes the supportive role.

Site 2: Gaining capital through the collegial disposition: employees as quasi-patients

Hospital 2 is situated in a relatively new building that was built in 2000 after a merger of three smaller local hospitals. It does not participate in the Excellent Care program of the Dutch Nurses Association. The building is light, with a calm atmosphere and long, wide corridors with natural stone on the floors. The NMMs have spacious modern offices situated off the wards, which they often share with another NMM with whom they jointly run the same ward. Most of our time was spent in the office; we saw few patients or physicians. The hospital has an average nurse-patient ratio; however, because of a relatively high absentee rate, they struggle to have enough nurses to work the shifts. For the previous two years, the hospital has been in what they call an "organic change" process toward a new organizational structure, which creates uncertainty and ambiguity for both managers and nursing staff.

At site 2, the collegial disposition generated more capital than the other dispositions. It was the most valued disposition for staff nurses, nurse managers and higher management. Capital from the caring and clinical dispositions decreased because the NMMs' main object of care was not the patients but the nursing staff. Employees who played quasi-patient roles provided a special connotation for a caring disposition among NMMs. This was first indicated by the prominent role of the company medical officer, who was the only physician with whom NMMs had regular contact. Instead of discussing patients or patient care, they discussed their sick personnel. In the next fragment, NMM Sidney meets with the company medical officer regarding her sick personnel and discusses a certain case. Company Medical Officer:

"It is not that she [a nurse on Sidney's team] does not like you, but you did not give her enough attention." This surprises Sidney; she did give that nurse a lot of attention lately but it never seemed enough. [Sidney 9/39].

The next fragment provides a second indication. Sidney meets with someone from quality improvement (QI). They discuss dynamics on the ward and the team's condition instead of discussing the next step in enhancing patient care:

QI: "How are things?" Sidney: "It is slowly getting better, but the quality keeps simmering; the nurses are in survival mode". QI: "Do you have concerns about the quality of care on the ward?" Sidney: "Last month, we had a lot of missing items from patients, complaints and issues with the attitude of nurses toward medication errors. They also stopped reporting errors. I think half of the errors are not reported; reporting takes too much time. My biggest worry is the fact that the nurses appear less alert. It is a vicious circle; we are monitoring it and try to spend as much time on the ward as possible; every hour we do rounds on the ward to determine how the nurses are feeling and to show our faces. QI: "How do they experience that?" Sidney: "OK, I think. They really need structure. They lost everything; they felt like victims of the situation, turned inward, complaining and feeling like they did not have the capacity to get the work done." [Sidney 9/90].

In these fragments, the NMM gives less priority to the clinical disposition. A clinical disposition facilitates a focus on clinical issues and quality improvement and supplements the caring disposition's focus on responding to calls for help from patients. However, these NMMs are preoccupied with caring for the staff instead of the patients, which could ultimately compromise quality of patient care. The nursing staff, NMMs, and higher management at this hospital had a strong focus on caring for one another in addition to the patients. Ultimately, by shadowing NMMs and examining the organization from their perspective,

we found that at this site, the patient perspective was frequently lost and the main issues in the NMMs' roles concerned employees as quasi-patients. This was what gave the NMMs the most capital.

Site 3: Hard play: the administrative and control dispositions vs. the professional disposition

Hospital 3 is a city hospital that serves an area of nearly one million people in one of the most ethnically and linguistically diverse communities in the U.S. It does not have a Magnet Recognition. It is a hectic place with a huge turnover in patients. Patients only come to the hospital if there is no other choice, and a majority of patients suffer from severe illness. The wards are clean, but they are worn out and overcrowded. The NMMs' offices are on the ward, do not have windows and are the size of a closet. During shadowing, we hardly spent any time in the offices; more time was spent at the nursing stations on the ward or in the nursing administration offices on the ground floor. There is a lot of noise from shouting patients and staff, alarms from beds, drip infusions, and telemetry. Although the patient-nurse ratio complies with the norm, the complexity of patients, the high absenteeism and the high turnover place a great deal of pressure on the patients, staff nurses and nurse managers.

At site 3, the administrative and control dispositions became visible in the NMMs' work. Both dispositions generated the capital necessary to address a general feeling of distrust between the NMMs and the employees. At this site there were ambiguities regarding responsibility and accountability which are part of a professional disposition. NMMs attempted to control these ambiguities via the creation of checklists and guidelines, which generated a substantive administrative burden. A teaching disposition was also manifested as an instrument of control rather than an instrument for learning, which affected and compromised a professional disposition. Instructing nurses on precisely how to use the checklists and guidelines was emphasized. The following fragment reveals an NMM's controlling and administrating

dispositions. It demonstrates that the nurses avoided taking responsibility and attempted to avoid trouble. In the next fragment we meet NMM Tyler who has to check a 2:1 (refers to a patient-staff ratio of 2 to 1 employed for wandering or at-risk patients).

Tyler walks into a room and finds a checklist filled out in advance; the nurses' aid (NA) "worked ahead" and checked the boxes for the hours to come. Tyler, in a loud voice: "Don't do that again." NA: "Ok Miss." Tyler: "You are documenting before it happened; I don't want that." Tyler grabs the checklist and shouts: "If I catch you again!" [Tyler 12/119].

This fragment emphasizes a preoccupation with monitoring, checking boxes and following correct administrative procedures. Both middle management and higher management manifested these behaviors in daily work at this site as is shown in the next fragment.

After a full day on the ward, we finally sit down in her little office. Tyler reflects on what she sees in the organization. She tells me that the lack of trust and double-checks are driving her crazy: "Everything has to be approved by higher management." [Tyler 12/46].

As the examples demonstrate, the roles of the NMMs at this site were influenced by dispositions to control and administer, which were promoted by the organizational field and the controlling approach of higher management. Surprisingly, this approach did not lead to reduced NMM visibility or involvement in clinical and patient-related issues. The NMMs needed the capital from the clinical disposition to teach and instruct: all NMMs were clinically very strong and could be regarded as the *primus inter pares* of the group. The teaching disposition became an instrument with which the NMMs attempted to control the employees and address the ambiguities of the professional disposition regarding responsibility and accountability.

Site 4: The scientific disposition as capital generator

Hospital 4 is a top-100 Magnet hospital that has won numerous awards and prizes for its care, treatment and services. In 2005, it moved to a completely new building. It is a calm and quiet place, with little noise, soft piano music in the corridors, and art on the walls. Green colors and plants suggest a healing environment. All wards have single-bed rooms, with many different pods for the nurses and large, well-lit break rooms for the personnel. The patient-nurse ratio is above the norm, and there are numerous support staff on each ward. The hospital increased nursing staff over the previous seven years despite a decrease in admissions. Performance improvement and patient safety are key issues. The nurse managers' offices are immediately off the wards. We spent more time in the office and in meetings, but this approach did not compromise the visibility of or contact or communication with the team and patients on the ward because the NMMs participated in rounds, multi-disciplinary meetings and frequently had short visits to the ward.

In this hospital, a scientific disposition was prominent. The two examples of the scientific disposition from Table 3 were both from this site and typical of the NMMs' manners and beliefs. This disposition was manifested in the form of NMMs who were analytic, strategic, in control, and less emotional and ad hoc in their decision making. Postponing reactions and de-escalation were second nature for the NMMs at this site. This led to a proactive rather than reactive stance which we observed at the other sites. For example, at the other sites a patient in need would generate a direct reaction, these NMMs would immediately respond to the call for help, thereby embracing the "calamity" and "doing something". At site 4, the NMMs curb this reflex, they postpone and analyze. The next fragment illustrates the analytical aspect of the scientific disposition.

After a medication error meeting I asked Alex about a discussion between her and several other NMMs on a mistake made by one of the nurses who apparently felt bad about her error.

Alex explained: "It is not about feeling bad; feeling bad gets us nowhere. We have to analyze the process." [Alex 14/52].

Alex demonstrates that in this field, the caring and collegial dispositions provide capital, but they are applied in a more analytical and investigative stance. The emergence of the scientific disposition affected the manifestations of the other seven dispositions. The caring disposition was less ad hoc and reactive, and clinical practice became more evidence based. Within the collegial disposition, greater feedback was provided, and reflective questions were asked; teaching became less about instructing and more about critical thinking. The professional disposition was characterized by taking responsibility for patient outcomes, and the administrative and control dispositions profited from this analytical stance by the availability of the data necessary to improve performance and the quality of care. In the next fragment, Shawn shares her analysis of a situation with an orthopedic surgeon.

Shawn: "We are at the high end of LOS (length of stay), —1.8 is best practice; we are at 3.2. We can improve if we focus on no nerve block during the operation, physiotherapy on the day of surgery, coaching, bowel regiment and pain regiment. We need to gain market." [Shawn 16/136].

The scientific disposition at this site positively affected NMMs' role behavior. The NMMs expressed no sense of role ambiguity or feelings of being torn between professional and managerial work, which resulted in a strong focus on nurse-sensitive patient outcomes and performance improvement.

Discussion

This paper depicts NMMs' habitus as a set of eight dispositions: caring, clinical, collegial, teaching, professional, scientific, administrative and control. Together, these dispositions give rise to a limited number of behavioral strategies. The findings demonstrate that, from an organization-as-field perspective, in particular hospitals, certain dispositions create more capital

than others, thereby enhancing or decreasing NMMs' supporting role behavior. The caring and clinical dispositions were crucial to nurse managers' support at site 1. At site 2 a collegial disposition generated capital but also compromised a focus on patient care when NMMs related to staff nurses as quasi-patients. A strong emphasis on control and administration at site 3 affected the professional disposition, leading to excessive monitoring and checking, which hindered the deployment of a supporting role. At site 4 the scientific disposition positively affected all the other seven dispositions of NMMs habitus leading to an increase of capital related to NMMs role behavior.

The findings contribute to the existing literature regarding the importance of supporting roles of NMMs (Brady and Cummings, 2010; Kieft et al., 2014; Kramer et al., 2007; Meyer et al., 2011). The manifestations of caring and clinical dispositions at site 1 are in line with studies that emphasize the importance of visibility, availability, and clinical involvement for nurse managers (Brady and Cummings, 2010; Kieft et al., 2014; Kramer et al., 2007; Meyer et al., 2011). The manifestations of the administrative and control dispositions at site 3 extend recent research emphasizing the challenges involving staff nurses and management in shaping care that meets patients' expectations and the impact on nursing management of a system dominated by controlling costs (Kieft et al., 2014).

Additionally, the Bourdieusian analysis led to four new insights that demand further discussion because they explain how the interactions among the various dispositions of habitus influenced the supporting role in Magnet, Magnet-related, and non-Magnet hospitals. We first discuss hybrid, boundary spanning roles of NMM's followed by an elaboration on the definition of the caring disposition from Table 3. Next we address the ambiguous role of the collegial disposition of NMMs at site 2 and reflect on the importance of the scientific disposition for supportive practices of NMMs at site 4.

First, the analysis contributes to the existing literature on hybrid management and boundary spanning

behavior (Allen, 2000; Llewellyn, 2001; Meyer et al., 2011; Noordegraaf, 2007) by demonstrating that habitus, as a dynamic system of dispositions in a nested organization-as-field, extends beyond the "two-way window" metaphor, which denotes the hybridity of "managerial professionals" (Noordegraaf, 2007). NMMs do not necessarily balance between "two windows" (i.e., management and clinical), but they do have to balance between a wide variety of dispositions: caring, clinical, collegial, teaching, professional, scientific, administrative and control. The findings also indicate that the daily challenges of NMMs are more varied and fine-grained than the challenges between "the managerial domain and the clinical domain" as studies of Sørensen (2011) and Orvik (2013) portray.

Second, in Table 3, we described the caring disposition as follows: "NMMs see patients as individuals who require care and attention. The corresponding strategies include answering the call for help of the other in the here and now; ad hoc, reactive reactions, and quick judgment. The caring disposition manifests itself by scanning the environment for calls for help". It is important to realize that caring is viewed as a central aspect in the field of nursing. In our study the caring disposition also plays an essential role. However, despite its fundamental place in clinical practice, researchers and scholars have failed to reach a common definition (Papastavrou et al., 2011; Sargent, 2012). Our description builds on Levinas' notion of care. He explained and justified why being there for the "Other" is an indisputable duty. This responsibility for the "Other" consists in 'not letting the Other alone', (Levinas and Cohen, 1985 p. 119) in other words, 's'occuper de l'autre' (Poirié, 1987 p. 92) (French for 'to take care of the other'). Analogous to Levinas' notion of care, a publication by the researcher Kim refers to 'an enthusiasm to respond to a patient's needs' (Kim, 2000 p. 38). At site 1, 2 and 3, the NMMs' unreflectively 'took care of the other' and responded immediately to needs. This disposition to care gave them capital and enhanced their supportive role; however, our findings also revealed the tradeoff of this disposition which is underexposed in contemporary nursing literature.

Third, at site 2, the tradeoff of the caring dispositions became visible. The NMMs at this site could not cope with the calls for help. This occasionally led to feeling drained and stressed, which is in line with other literature on NMMs role challenges (Orvik et al., 2013; Shirey, 2006; Shirey et al., 2008; Shirey et al., 2010; Sørensen et al., 2011; Taylor et al., 2014). Because NMMs did not interact directly with patients or physicians on a daily basis, neither caring nor clinical dispositions manifested themselves unequivocally, leading to a decrease of capital. However, these NMMs' tendency to take care of the "Other" remained and manifested itself in typical relationships with staff nurses. This, in turn, resulted in a collegial disposition infused with characteristics of the caring disposition. This interplay between two disposition led to a supportive and caring role of the NMMs regarding the hospital's employees but ultimately isolated them from direct patient care, which led to a loss of capital.

Finally, a very interesting finding of this study concerns the role of the scientific disposition at the fourth site. This disposition enhanced the capital-generating aspects of the other dispositions of NMMs' habitus and aligned most closely with the caring and clinical dispositions. It resembles the critical thinking disposition described by Profetto (2003). It was manifested by curbing or postponing ad hoc reactions and asking critical questions regarding both patient care and employee satisfaction. One could argue whether the label "scientific" fits the description, and perhaps a label of a "reflective" or "investigative" disposition would be more appropriate and aligned with NMM reflective practice literature (Matsuo, 2012). In defining this disposition, we follow Horton-Deutsch and Sherwood (Horton-Deutsch and Sherwood, 2008), who compare reflection to the scientific process. They concisely describe the particular value of profound, third-level reflection in the scientific process: 'Reflection is like the academic process of describing, analyzing, synthesizing and evaluating with the addition of self-awareness' (Horton-Deutsch and Sherwood, 2008 p. 949). Third-level reflection can therefore help to systematically examine experiences and situations from various perspectives to increase self-awareness and

promote learning from experience (Horton-Deutsch and Sherwood, 2008). The scientific disposition at site 4 facilitated third-level reflection, which helped the NMMs curb ad hoc reactions and the urgency of responding to the needs of the "Other" that can easily accompany the caring disposition. Moreover, the scientific disposition helped NMMs to avoid compromise in being attentive to patients and clinically involved.

One limitation of this paper is that the central focus on habitus and dispositions of NMMs in the empirical analysis may have inadvertently downplayed the role of organizational fields in our analysis. The shadowing method was crucial for the description of dispositions and 'in situ' behavior in managerial work, but appeared less suitable for capturing the organization-as-field perspective. This led to a less explicit analysis of organization-as-field characteristics related to Magnet, Magnet-related and non-Magnet hospitals. According to Vaughan the separation of Bourdieu's concepts and the difficulty of using them relationally is not limited to ethnographic organizational case studies. (Vaughan, 2008) Sallaz and Zavisca (2007) found that of all articles citing Bourdieu in four prominent American sociology journals between 1980 and 2004 only 9% (21 of 235) employed all of his main concepts relationally. We believe that the thorough description of habitus as system of dispositions could potentially help researchers to further explore the relationship between NMMs habitus and the field characteristics of the various sites in the near future. By doing so, a more relational analysis of Bourdieu's concepts of habitus, field and capital can be developed. Secondly, the effect that a researcher has on the situation he or she is researching, called the observer effect, is an obvious issue in shadowing. We cannot be certain whether the NMMs altered their behavior when the researcher was present. McDonald (2005) therefore argues that the observer effect can neither be ruled out nor measured. However, we noticed that the fast pace of NMMs' work allowed them to not take into account that they were being shadowed. McDonald (2005), moreover suggests that it is possible to directly discuss observer effects with those being observed. During shadowing, we discussed how 'normal' the NMM's day had been.

All managers responded that the shadowing either did not alter their behavior or, only had a small influence on their daily work.

Future study is on the scientific disposition is also warranted. The scientific disposition did not manifest itself as strongly in the Dutch Excellent Care hospital as in its U.S. counterpart. To further implement Excellent Care as potential new model of care, we recommend the development of an educational program for NMMs that emphasizes the use of reflective and investigative stances within a scientific disposition. Second, we recommend a more in-depth investigation of how NMMs' habitus influences the leadership practices of nurse managers and the impact of organizational context on nurse managers' work and challenges. These recommendations may contribute to the improved training and development of future nurse managers, who must cope with increasingly complex demands and work environments.

Conclusion

Both caring and clinical dispositions enhance NMMs capital and contribute to their supportive roles by fostering practices of being visible and discuss patient related issues. Solely being supportive toward employees and seeing them as quasi-patients, without emphasis on patient related caring and clinical issues, jeopardizes nurse managers' supportive role and ultimately decreases their capital. A scientific disposition however enhances NMMs' supportive role through practices of avoiding ad-hoc reactions and the tendency of unreflectively answering the call for help. Hence, asking reflective questions crucially enhances the capital of NMM's. With regards to the further introduction and development of Magnet (related) programs, it is important that caring, clinical and scientific dispositions are combined in order to facilitate the supportive role of NMMs. Especially investigative and reflective role behaviors are a central component for creating a productive and healthy work environment for nurses and high-quality patient care.

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Chapter 2

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Chapter 3

Curbing the urge to care: a Bourdieusian analysis of the effect of the caring disposition on nurse middle managers' clinical leadership in patient safety practices

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Abstract

Background: Nurse managers play an important role in implementing patient safety practices in hospitals. However, the influence of their professional background on their clinical leadership behaviour remains unclear. Research has demonstrated that concepts of Bourdieu (dispositions of habitus, capital and field) help to describe this influence. It revealed various configurations of dispositions of the habitus in which a caring disposition plays a crucial role.

Objectives: We explore how the caring disposition of nurse middle managers' habitus influences their clinical leadership behaviour in patient safety practices.

Design: Our paper reports the findings of a Bourdieusian, multi-site, ethnographic case study.

Settings: Two Dutch and two American acute care, mid-sized, non-profit hospitals.

Participants: A total of 16 nurse middle managers of adult care units.

Methods: Observations were made over 560 hours of shadowing nurse middle managers, semi-structured interviews and member check meetings with the participants.

Results: We observed three distinct nurse middle manager configurations of dispositions of the habitus which influenced their clinical leadership in patient safety practices; they all include a caring disposition: (1) a configuration with a dominant caring disposition that was helpful (via solving urgent matters)

and hindering (via ad hoc and reactive actions, leading to quick fixes and ‘compensatory modes’); (2) a configuration with an interaction of caring and collegial dispositions that led to an absence of clinical involvement and discouraged patient safety practices; and (3) a configuration with a dominant scientific disposition showing an investigative, non-judging, analytic stance, a focus on evidence-based practice that curbs the ad hoc repertoire of the caring disposition.

Conclusions: The dispositions of the nurse middle managers’ habitus influenced their clinical leadership in patient safety practices. A dominance of the caring disposition, which meant ‘always’ answering calls for help and reactive and ad hoc reactions, did not support the clinical leadership role of nurse middle managers. By perceiving the team of staff nurses as pseudo-patients, patient safety practice was jeopardized because of erosion of the clinical disposition. The nurse middle managers’ clinical leadership was enhanced by leadership behaviour based on the clinical and scientific dispositions that was manifested through an investigative, non-judging, analytic stance, a focus on evidence-based practice and a curbed caring disposition.

Keywords

capital, caring, clinical leadership, dispositions, field, habitus, hospitals, nurse middle managers, patient safety practices, shadowing

Introduction

Patient safety practices are crucial in hospital care in both Europe and the United States (Aiken et al., 2012). They can be defined as “interventions, strategies or approaches intended to prevent or mitigate unintended consequences of the delivery of healthcare and to improve the safety of healthcare for patients” (Dy et al., 2011). The Francis report of what went wrong at Mid Staffordshire demonstrated that often hospitals have difficulties in keeping focus on patient safety practices and that they easily become preoccupied with the business of the system (finance and targets) rather than the quality of patient care (Allen et al., 2013). Such difficulties particularly manifest themselves in the work of nurse middle managers who are positioned between the ward and higher management with first-line responsibilities regarding the supervision of care workers, the management of finances and the quality of care (Hewison, 2006).

Nurse middle managers are held accountable for initiating, guiding, promoting, facilitating, and sustaining patient safety practices (Birken et al., 2012). Their clinical leadership is considered as one of the factors that determine the success of patient safety practices (Agnew and Flin, 2014; Kaplan et al., 2010; Mannix et al., 2013; Ovretveit, 2011; Taylor et al., 2011). In a previous study we explored the presumption that having a background in clinical nursing practice – which is seen as a driver or condition for clinical leadership – can potentially help but may also hinder nurse middle managers in generating authority in daily work (Lalleman et al., 2015). This study was based on a Bourdieusian analysis of observations at four hospitals in the Netherlands and the United States. We derived eight distinct dispositions of the nurse middle managers’ habitus, which form various configurations. Some help and other hinder the supportive role behaviour towards the staff nurses (Lalleman et al., 2015). In this contribution, we investigate how the disposition to care, which is perceived by many as the core of the nursing profession, and is also central to nurse middle managers’ habitus, influences their clinical leadership in patient safety practices.

Background

Clinical leadership and patient safety practices

In a recent review, Daly et al. (2014) describe common aspects of clinical leadership in hospitals: “[...] the ability to influence peers to act and enable clinical performance; provide peers with support and motivation; play a role in enacting organizational strategic direction; challenge processes; and to possess the ability to drive and implement the vision of delivering safety in healthcare” (Garrubba et al., 2011). We further argue that for patient safety practices, the influence of effective clinical leadership must extend horizontally towards peers (i.e., to other nurse middle managers), upward (i.e., to higher management), and downward (i.e., to staff nurses). Moreover, nurse leaders must also influence other hospital professionals (e.g., physicians, quality improvement staff, and clinical nurse specialists). In order to influence in all these directions, nurse middle managers will need other resources than positional power alone (e.g., authority) (Martin and Waring, 2013; Oldenhof, 2015). Research has demonstrated that physicians in managerial positions derive authority from within their own professional group by exhibiting clinical involvement and interaction with patients (Witman et al., 2011). Inspired by this research, in order to fully comprehend how nurse middle managers generate authority in daily practice, we utilized the ‘practice equation’: $[\text{Habitus} \times \text{Capital}] + \text{Field} = \text{Practice}$ (Bourdieu, 1984).

Nurse middle managers’ dispositions of habitus

Bourdieu describes habitus as a system of dispositions (Bourdieu, 1977) p. 214). Habitus is an embodied history, internalized as a second nature (Bourdieu, 1977), p. 56). Dispositions are defined as durable, subconscious schemes of perception and appreciation that activate and guide practice (Bourdieu et al., 1989). Dispositions of habitus generate a limited number of behavioural strategies. These strategies are manifested in certain visible patterns of behaviour, manners, and

beliefs: in activities within practices (Bourdieu, 1990). Our previous study regarding the daily work of nurse middle managers revealed eight dispositions that shape the nurse middle managers' habitus (see table 4) (Lalleman et al., 2015).

These eight dispositions are simultaneously at play in the activities of nurse middle managers. Among the participating nurse middle managers, some dispositions were dominant, others were absent or interacted with each other, leading to various configurations that shaped nurse middle managers' practice. The genesis of these various configurations of dispositions of habitus depends on the distribution of capital and the nurse middle managers feel for the game in the field.

Game, capital and field

Bourdieu's concept of field refers to a social space with an internal logic (Bourdieu, 1989a). Field and habitus are locked in a circular relationship: involvement in a field shapes the habitus that, once activated, reproduces the field. On the other hand, habitus only operates in relation with the state of the field and on the basis of the possibilities of action granted by the capital associated with the position (Nicolini, 2013). In a field, there is always something at stake, i.e., there are struggles for capital such as positions and other valuable resources. Capital gives authority within the field (Bourdieu, 1986; Bourdieu, 1989b), and may be inherited through position or be based on knowledge or seniority (e.g., clinical credibility). Bourdieu's concept of field can be compared to a game with the aim of collecting valuable resources, or 'capital' (Bourdieu and Wacquant, 1992). Practices (such as patient safety practices) are conceived of as "clustered around social games played in different social fields, in which agents act with a feel for the game, a sense of placement in pursuing of interest" (Lau, 2004).

In a special issue of *Theory and Society* on 'Bourdieu and organizational analysis' Vaughan (2008) distinguishes between two specific fields. She explains that an organization-as-field perspective presents an organization (in our study, a hospital) as a field

nested in a larger professional field (in this study, nursing) (Vaughan, 2008). In our previous study we demonstrated that, in these two fields, certain behaviours are valued differently, and some underlying dispositions create more capital (i.e., authority) than others, thereby leading to the dominance of a disposition, the absence of a disposition, or a well-balanced configuration of dispositions (Lalleman et al., 2015). For example, in the professional field of nursing, caring "for the other" (i.e., for patients) is highly valued and generates capital, in the organization-as-field perspective, caring for patients is less valued, whereas having high patient turnover and/or low levels of sick leave of nursing staff may generate capital. In order to fully comprehend how nurse middle managers navigate between what Allen et al. (2013) refer to as "the business of the system (finance and targets)" (i.e., the organization-as-field) and "quality of patient care" (i.e., the professional field) a thorough understanding of the caring disposition is of importance.

The Caring disposition

In this paper, we focus on the caring disposition, a central disposition for the nursing profession. Nursing's claim to professional expertise has been expressed in terms of its caregiving function as a cornerstone of nursing practice (Allen, 2014b). However, this framing of caring as central to the nature of nursing, is under continuous debate and inquiry (Allen, 2014a; Allen, 2014b; Latimer, 2014; Rolfe, 2009; Scott, 2012). Allen(2014b), for example, puts forward the suggestion that this frame is ideological and hides the dominant work of nurses - i.e., their organizational work. Although we support this line of reasoning, in this paper we focus on the caring disposition because its importance in the practices of nurse middle managers.

In our previous study, we turned to Levinas to understand the notion of care. Levinas emphasizes the importance of being there for the "Other" and immediately responding to needs (Lalleman et al., 2015; Levinas and Cohen, 1985). Levinas' philosophy helped us to understand that being there for the "Other" implies an indisputable duty of "not letting the Other

Table 4 — eight dispositions of NMMs habitus

Disposition

Caring Disposition	<p>Through a caring disposition, NMMs see patients as individuals who require care and attention.</p> <ul style="list-style-type: none"> • The corresponding strategies include answering the call for help of the other in the here and now; ad hoc, reactive reactions; and quick judgment. • The caring disposition manifests itself by scanning the environment for calls for help. • Excelling in the caring disposition provides capital that is based on taking care of and paying attention to patients.
Clinical Disposition	<p>Through a clinical disposition, NMMs see individuals as patients.</p> <ul style="list-style-type: none"> • The corresponding strategies include the search for the symptoms and causes for the conditions observed. • The clinical disposition manifests itself by seeing patients, diagnosing their care needs and knowing their conditions. • Excelling in this disposition provides capital that is based on having and using clinical expertise.
Collegial Disposition	<p>A collegial disposition refers to NMMs ensuring a positive team dynamic.</p> <ul style="list-style-type: none"> • The corresponding strategies include being friendly to team members and taking care of other colleagues. This disposition manifests itself by giving attention to members of the team, encouraging feedback and tacitly knowing other individuals' needs. • Excelling in this disposition provides capital that is based on being collegial and preserving a friendly atmosphere.
Teaching Disposition	<p>Through a teaching disposition, NMMs see themselves as tutor or mentor.</p> <ul style="list-style-type: none"> • The corresponding strategies include creating moments for coaching, instructing and learning. • It manifests itself through teaching or instructing both patients and colleagues. • Excelling in this disposition provides capital is based on sharing knowledge and teaching others.

Disposition

Professional Disposition	<p>Through a professional disposition, NMMs perceive themselves as both personally and collectively accountable for good patient care.</p> <ul style="list-style-type: none">• The corresponding strategies include putting the interest of patients first and being accountable and taking responsibility.• This disposition manifests itself by feelings of responsibility and sharing responsibilities.• Excelling in this disposition provides capital that is based on being responsible and accountable both personally and collectively for patient care.
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Scientific Disposition	<p>A scientific disposition refers to NMMs work as a scientific and reflective practice.</p> <ul style="list-style-type: none">• The corresponding strategies include referring to, gathering and using scientific evidence and asking reflective questions to enhance the quality of patient care.• This disposition manifests itself through an investigative stance, postponing reactions, refraining from judging, focusing on research/EBP and reflection on action.• Excelling in this disposition provides capital that is based on using scientific knowledge and asking reflective questions rather than ad-hoc action.
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Administrative Disposition	<p>Through an administrative disposition, NMMs view administrative work as legitimization of their activities.</p> <ul style="list-style-type: none">• The corresponding strategies include the use of checklists, guidelines, benchmarks and reports.• This disposition manifests itself through a focus on writing reports, filling out checklists, addressing administrative issues and performing clerical work.• Excelling in this disposition provides capital that is based on the correct use of checklists and guidelines and handling administrative procedures.
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Control Disposition	<p>A control disposition views NMMs' work as a way to create order and serenity.</p> <ul style="list-style-type: none">• The corresponding strategies include controlling daily situations by tidying up.• This disposition manifests itself through a focus on controlling (complex) situations, creating order and clarity, cleaning up and clearing up.• Excelling in this disposition provides capital that is based on being in control of situations.
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alone” (Levinas and Cohen, 1985) (i.e., immediate responding to needs driven by a notion ‘to take care of the other’, in French, ‘s’occuper de l’autre’, p. 92). We used his philosophy as a “high level frame” to recognize behaviours that are, *prima vista*, not visible in nurse middle managers’ work. The principle of not letting the other alone and immediately responding to needs, is closely related to the caring disposition. It is present in various configurations of nurse middle managers habitus (Lalleman et al., 2015). Interestingly, in the case of the work of nurse middle managers, we have observed that “the Other” was not per se a patient but could also be a staff nurse, higher management, peers or numerous others working in the organization. In order to investigate the impact of the caring disposition on nurse middle managers’ work the following research question is formulated: how does the caring disposition in various configurations of dispositions within the habitus of nurse middle managers influence their clinical leadership in patient safety practices?

Methods

Design

A Bourdieusian (Bourdieu, 1977; Vaughan, 2008) multi-site ethnographic case study approach was applied (Van Maanen, 1979; Ybema et al., 2009), to gain insight into the role of the caring disposition in the various configurations of dispositions of the nurse middle manager habitus. Ethnography was used to assess and describe the practices and complexity of nurse middle manager clinical leadership in patient safety practices at a micro level. The design and execution of our study complied with the Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist (Tong et al., 2007).

Participants

Sixteen nurse middle managers of adult care units of acute care hospitals from four non-profit hospitals in the Netherlands and the United States (U.S.) participated in the study. The inclusion criteria were: being a registered nurse, supervising a nursing unit of between 20 and 40

beds, and being positioned between the work floor staff and higher management. The primary responsibilities of these nurse middle managers included supervision of direct care workers, management of budgets, and quality of care.

First, contact was made with higher management of each hospital. Further arrangements were made with contact persons in innovation and performance improvement departments and/or shared governance councils. We asked each contact person to recruit eligible nurse middle managers, by inviting them by e-mail to participate in the study. During this procedure the pattern at each site was the same; in the week after the first mailing, one or two managers responded. Then a second invitation was sent in order to motivate those who did not respond immediately. After three to four weeks the required number of four nurse middle managers had been reached. At none of the sites did more than four managers show interest. Prior to obtaining consent, the first author met with each potential participant to discuss the aims, design, and methodology of the study. One potential participant decided not to participate because a recently diagnosed illness which would not allow for the expected intensity of being shadowed. To find another participant we had to send a third invitation.

Ethical considerations

Consent differed at the Dutch and U.S. hospitals because of different national policies and the various means of accessing the sites. In the Netherlands, formal institutional review approval is not required for this type of research; the higher management of both Dutch hospitals approved the study. In the U.S., ethical approval was obtained from the institutional review boards (IRBs) of both participating hospitals and consent was obtained from each participating nurse middle manager.

The participants were asked to inform their colleagues, staff nurses, and other hospital employees of the study to avoid confusion regarding the presence of the researcher and to protect nonparticipants.

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Participants and nonparticipants in the units could ask the researcher to leave the room or area at any time. The researcher did not enter patient rooms, and no identifiable patient information was recorded. However, on several occasions during field work the researcher was invited into the patients' rooms by the nurse middle managers and asked to 'check' a wound or witness patients rounds. Standing in the door opening and keeping some distance was not always appreciated and could create some tension between researcher and nurse managers. These and other minor tensions (e.g. regarding conflicting audiences, unasked questions, revealing and concealing or concerns) are not uncommon when sociologists do field work in medical settings, see for example (Anspach and Mizrahi, 2006).

Role of the researchers

The first author (PL) can be considered as an 'insider' at site one and two. At site one, he worked as a student nurse between 1996 and 2000 and at site two, he

worked as a nurse manager between 2004 and 2005. Although an 'insider' at both organizations, PL had not worked with the eight nurse middle managers that participated in the study. PL did not have any prior knowledge about the organizations or the nurse middle managers at sites three and four in the U.S. The third (ML) and fourth (LS) authors supported PL by obtaining access to both hospitals, clarifying IRB procedures, and contributing understanding of local customs and cultures in the U.S.

Data collection

Each nurse middle manager was shadowed (Czarniawska-Joerges, 2007; McDonald, 2005) by the first author (PL) for 4-6 days. This resulted in a total of approximately 560 observation hours over a period of 19 months between 2010 and 2012 (Table 2). During shadowing, the researcher focused on behaviours that potentially indicated the habitual dispositions of the nurse middle managers. Examples of such instances are, among many others, frictions during

Table 5 — Design and data sources

	<div> <div>June 2010</div> <div></div> <div>May 2012</div> </div>			
Country	Phase 1: the Netherlands		Phase 2: the United States	
Hospital	Site 1	Site 2	Site 3	Site 4
Approx. hours shadowing	150	140	140	130
Shadowing days	Kim: 4 days*	Dana: 4 days	Terry: 4 days	Alex: 4 days
	Pat: 6 days*	Eli: 4 days	Tracy: 4 days	Jamie: 4 days
	Toni: 5 days*	Sal: 4 days	Tyler: 4 days	Jordan: 3 days^
	Chris: 4 days	Sidney: 4 days	Vic: 4 days	Shawn: 4 days
Field notes pages A5	700	670	640	480
Audio in hours	22	21	11	7

*pilot shadowing to come to an optimum of shadow days

^ which included one double shift from 7 A.M. until midnight

rounding, meetings with higher management or while supporting staff nurses double checking medication. The researcher occasionally asked questions that prompted comments from the participants. A few of them were asked for clarification, such as “what was being said on the other end of a phone call?” or “what was the meaning of this departmental joke?”. Other questions were intended to reveal the purpose of an action or communication, such as why a particular line of argument was pursued in a meeting or what the current operational priorities were (McDonald, 2005). Some questions led to short semi-structured interviews about beliefs regarding nurse middle manager roles and challenges in the hospitals. In semi-structured introductory interviews, we learned about the previous careers of the nurse middle managers and their reasons for becoming nurse managers.

A Livescribe™ Pulse™ Smartpen was used to digitally store handwritten field notes and audio fragments from shadowing and interviews. The field notes and audio fragments were uploaded and stored on a computer on which Nvivo 10 was installed. Nvivo 10 is a qualitative software analysis program that was used to manage the large amount of data. Selections from the audio files were transcribed. This approach provided access to recordings after the fieldwork was completed. Finally, two interactive discussion group meetings were organized with the participating nurse middle managers. Preliminary findings were discussed, and these discussions helped to assign meaning to the rich data (Balogun et al., 2003).

Data analysis

After reading and rereading all field notes and transcripts of audio files, descriptive codes emerged. Firstly, location codes, such as nursing stations, offices, or meetings outside the ward. Secondly, interaction codes, which refer to actors with whom nurse middle managers frequently spoke, such as nurses, colleagues, patients or higher management. Thirdly, codes regarding quality improvement, safety issues, medication errors and reports of concern. These codes helped navigate the data set.

The first (PL) and second (GS) authors selected characteristic sample fragments from each hospital that showed the presence of particular clinical leadership behaviour, as described by Garrubba et al. (2011), in relation to the patient safety practices defined by Dy et al. (2011). Levinas’s description of caring (Levinas and Cohen, 1985) and previous findings regarding the configurations of nurse middle manager habitus dispositions (Lalleman et al., 2015) were used as sensitizing concepts (Bowen, 2006) to guide our analysis. For each of the selected fragments, we examined the visible patterns of behaviour and read them as behavioural strategies (i.e., dispositions in action) of nurse middle managers (Bourdieu, 1990). We determined whether the disposition to care was dominant, absent, or well-balanced with other dispositions. Finally, we focused on the influences of these configurations on the clinical leadership of nurse middle managers in patient safety practice.

Findings

We observed three distinct configurations of dispositions with the care disposition in the centre of the habitus of nurse middle managers that influenced their clinical leadership in patient safety practices. Below, we first illustrate how a dominant caring disposition helps and hinders the patient safety practices of nurse middle managers. Second, we demonstrate how the interaction between the caring and collegial dispositions can lead to a minimal clinical involvement and discourage the patient safety practices of nurse middle managers. Third, we demonstrate how a dominant role of the scientific disposition can lead to a well-balanced configuration of the dispositions in the nurse middle managers’ habitus and positively contribute to their clinical leadership in patient safety practices.

Configuration 1: A dominant caring disposition

Caring, as being there for the other and immediately responding to needs, helps nurse middle managers solve urgent issues related to patient safety practice. Our field notes indicate that nurse middle managers’

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daily work is burdened with numerous issues (e.g., clinical, organizational, and procedural) that require on-the-spot attention. Addressing these issues immediately has advantages in terms of patient safety practices. We provide as an example a fragment with a situation in which nurse middle manager Kim seizes an opportunity to improve care when she runs into a few medical residents:

Kim: "Listen, this is what I hear: a patient was disconnected from telemetry, and a new patient directly took his or her place and was connected without doing a proper report. Like last Friday, we had a transfer from ICU connected to a telemetry assigned to a patient that only minutes before was discharged from our ward..."

Resident: "...and the name in the system was not yet changed."

Kim: "So, what do you get? The patient got an AV-block, we directly call, the cardiologist comes running to the ward and goes directly to the woman in room 7; but no, she is already discharged. Yes, what do you do then? Luckily, one of the nurses knew that she gave that telemetry device to the patient in room 19. This should not have ever happened; there will be casualties, and we will end up facing inspection or court. Therefore, as soon as you have a cancellation, make a report. OK?" [Kim, field notebook 1/page 41].

A root-cause analysis of the safety issue illustrated above was initiated and granted by Kim. This fragment illustrates Kim reacting on-the-spot in an ad hoc manner when she runs into the residents, questioning them and explaining the proper discharge procedure. Her knowledge and skills were appreciated by the medical residents; they listened to her and valued her judgment. This behaviour is valued (creates capital) in the hospital because it directly supports patient safety practice by immediately solving critical issues and can only be done if the nurse middle manager is knowledgeable about the procedures and clinical implications.

We also identified fragments in which the practices of nurse middle managers were solely focused on fixing immediate issues without involving others in the organization or without identifying the root cause of the issue. For example, in the next fragment, Toni reflects on the dominance of the caring disposition and its consequence in relation to physician involvement in improving patient safety:

During a performance improvement meeting with all nurse middle managers in the internal medicine units and the staff of the quality improvement department, several hospital-wide quality improvement projects and patient safety issues were discussed. A nurse middle manager vented her frustration about the lack of physician involvement in improving patient safety. Nurse middle manager: "We are not succeeding in getting the physicians involved, which is strange; it's their process, too." Toni: "It is not strange; we spoiled them by taking care of the process for them." [Toni 3/120].

This fragment demonstrates that although patient safety is a concern for both physicians and nurses, nurse middle managers address the issue on their own. Their practice of taking responsibility for immediate issues is an essential element of this configuration with the dominant care disposition. However, this practice can hinder clinical leadership because it prevents others from taking action and jeopardizes interdisciplinary quality improvement. Although appreciated by some physicians, this practice does not contribute toward patient safety because it undermines multi-disciplinary cooperation, which is an important aspect of improving patient safety.

As both fragments illustrate, a dominant caring disposition can both help and hinder the clinical leadership of nurse middle managers. We conclude with another example, in which nurse middle manager Kim, unreflectively yields to her caring disposition to provide help but hinders patient care:

Kim continuously monitors what goes on in her ward by, e.g. talking with patients, making sure that

there are clean bed linens, and checking patient admissions. This last task is assigned to the unit coordinator for the day. When we returned after the lunch break, Kim checked the admission board in the nursing station to determine whether an agreed transfer of patients between rooms had taken place. It had not. She rolled her eyes and sighed. Kim did not hesitate and began to assign various nurses to start moving patients as agreed during handover that morning. At that moment, the unit coordinator returned with an acute patient from the ER, who was announced during Kim's lunch break. The unit coordinator deliberately did not move the patients because she needed one of the single rooms for this acute and very ill patient. Kim apologized for the interference. When we walked back to her office, she said, "I got them out of the frying pan and into the fire" and laughed. The unit coordinator was not amused. [Kim 2/78].

Kim was clearly involved in the daily operations on the ward. However, this ad hoc reaction and quick judgment regarding the immediate situation, i.e., "Why hasn't that patient been moved? Let's take care of this right now," did not contribute to the safety of the patient in this particular situation.

A caring disposition manifests itself throughout the daily work of nurse middle managers. It is one of the fundamentals that drives their authority and leadership. However, the fragments above demonstrate that in the process of acquiring authority, a dominant caring disposition does not always result in the capital needed to guide patient safety practices and display clinical leadership behaviour.

Configuration 2: The interaction of caring and collegial dispositions

In the configuration in which the caring and collegial dispositions interact in such a manner that they become closely knit, nurse middle managers perceive and approach their nursing team as quasi-patients. This easily leads to minimal clinical involvement and a repressed nurse middle manager clinical disposition.

This configuration discourages patient safety practices. For example, in this configuration, the work routine of a nurse middle manager consists of monitoring sick leave, discussing the workload and work-life balance of staff nurses, recruiting nurses, and adjusting work schedules. This administrative work can still be framed as 'caring work', because it is completely focused on the satisfaction of the nursing staff, not on the patients. At one site, the continuous call for attention from the nursing team and the on-the-spot response of the nurse middle managers to this call, overshadowed their other work activities. When patient safety issues were discussed, the conversation had a negative connotation. For example, after a long day of administrative work in her office, Eli looked out of her window and sighed,

"Quality of care is a disaster here"
[Eli 6/105].

Eli was overtly frustrated about the third lost set of dentures of patients scheduled for surgery that month. The guidelines were clear: when patients are transferred to surgery, they are not allowed to wear their dentures and have to bring with them a small box with a name sticker such that they can have access to their dentures after surgery in the recovery room. Despite this relatively simple guideline, dentures were still regularly lost, leading to complaints and unsafe situations in which patients had difficulty properly communicating in the recovery unit. For Eli, this was a clear indication that patient safety was at risk.

"If this simple guideline is not followed, what else goes wrong?" she asked herself. [Eli 6/105].

The next fragment describes Sidney having a meeting with a representative from the quality department. This was a rare event: at this hospital site, this was the only meeting between the quality department and a nurse middle manager during the entire shadowing period.

QIS (Quality Improvement Staff): "How are things?"
Sidney: "It is slowly getting better, but the quality keeps simmering; the nurses are in survival mode."
QIS: "Do you have concerns about the quality of

care in the ward?" Sidney: "Last month, we had a lot of missing items from patients, complaints, and issues with the attitudes of nurses toward medication errors. They also stopped reporting errors. I think that half of the errors were not reported. My biggest worry is the fact that the nurses appear less alert. It is a vicious circle. We try to spend as much time on the ward as possible. Every hour we do rounds on the ward to determine how the nurses are feeling and to show our faces." [Sidney 9/90].

This last sentence of the fragment expresses that the nurse managers were often on the ward, focusing on how the nurses feel; however they did not discuss patient-related issues, only relational and personal issues within the team. This demonstrates the blending of caring and collegial dispositions, i.e., a repression of the clinical disposition and lack of focus on patient safety practices. When this configuration manifested itself in the daily work of nurse middle managers, hardly any fragments of patient safety practices were found in the field notes and audio transcriptions. This configuration leads to a *modus operandi* which hindered the patient safety practices of nurse middle managers.

This configuration was dominant at site 2 and resulted in nurse middle managers primarily focusing on their staff. The behaviour of these nurse middle managers was highly valued by higher management, who predominantly focused on maintaining low sick leave numbers and budgetary restraints. However, this configuration resulted in minimal clinical involvement among the nurse middle managers. Here, a practice in which clinical expertise and involvement did not generate capital for nurse middle managers had developed. Furthermore, we did not observe these nurse middle managers being involved in patient care or patient safety practices with physicians, other nurses or interdisciplinary teams.

Configuration 3: A dominant scientific disposition

A dominant scientific disposition curbs and postpones ad hoc reactions and leads towards a more critical,

investigative, and reflective stance towards patient care quality issues, employee satisfaction, and performance improvement in general. This scientific disposition manifests in formal and informal settings. In the following fragment, a nurse middle manager focuses on an important patient-related evidence-based performance improvement measure.

During an early morning 'check in' at the nursing station between Shawn and an orthopaedic surgeon before rounds. Shawn: "Hi boss, what is wrong?" Orthopaedic surgeon: "Nothing is wrong, everything is wrong." Shawn: "My worry is that you are going to knee surgery right away" (instead of doing rounds first). Orthopaedic surgeon: "Our responsibility is to fix the bone." Shawn: "That is the problem, you have more responsibilities. What do you got for me?" Orthopaedic surgeon: "Nothing... I did my total knee without a urinary catheter!" Shawn and the orthopaedic surgeon give each other a high five. [Shawn 16/146].

In this fragment, Shawn was not simply having a polite conversation with the surgeon. She was checking in on the orthopaedic surgeon and determining whether he was planning to walk rounds on the ward or leave early for the operating theatre. Shawn argued that the surgeon has more responsibilities than only fixing bones, such as doing rounds and helping out by preventing urinary tract infections by not putting in urinary catheters before surgery. Each morning, Shawn monitored urinary catheter use to decrease usage and thereby lower the prevalence of urinary tract infections. Shawn was able to convey this practice to the surgeon, as evidenced by the 'high five'. Moreover, he did not 'escape' to the operating theatre but did his patients rounds accordingly.

When this configuration manifested, we observed nurse middle managers consulting their peers (other nurse middle managers), staff nurses on their units, higher management, clinical nurse specialists, physicians, and many others to determine possible causes of undesirable clinical patient outcomes. This practice prevents nurse middle managers from looking for

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quick fixes and ad hoc solutions and stimulates them to strive for more sustainable and evidence-based interventions that require thorough analysis and inquiry. This behaviour was developed in a context in which dialogue between professions and hierarchical roles is common, and being inquisitive and conducting analyses are valued positive by all stakeholders (i.e., create capital). The focus on analysis and evidence-based practice was typically catalysed by the clinical nurse specialist at this hospital site. In the next brief fragment, Jamie speaks with a clinical nurse specialist assigned to her ward:

Jamie: "Should we go this way based on the evidence? Compile literature and research, ethics commission, state laws, intervention studies, what else have we got?" [Jamie 14/150].

The fragment demonstrates Jamie's focus on using research and benchmarking her patient outcomes to the literature. It, as well, shows a constative stance which fits the scientific disposition well. In addition to these larger studies, Jamie maintained an interest in single-patient cases that required further inquiry:

Jamie: "So you do not think we missed anything? I think it has to do with her blood alcohol content labs, definitely very interesting for an obstetrics case study." [Jamie 15/22].

As demonstrated by these examples, in this configuration, using research, being consultative, asking questions and doing analyses is nearly second nature. In the next fragment, Alex advocates an analytical approach and explicitly refrains from reacting emotionally to an event:

When we walked back to the ward after the medication error meeting, I asked Alex what she thought the theme of the meeting was. Alex: "For me, the theme was feeling sorry and regretting, which should not be the theme." (During the meeting, a fellow nurse middle manager told a story that made her staff feel bad about the error). Alex: "It is not about feeling bad; feeling bad gets us nowhere.

We have to analyse the process."
[Alex 14/52].

The nurse middle managers at the site where this configuration manifested itself were reflective and aware of their daily actions and behaviour. A dominance of the scientific disposition seemed to produce this behaviour. The clinical leadership behaviour that emerged with this configuration can be framed as consultative, with a clear focus on clinical outcomes. In the next fragment Jamie reflects on how she addressed errors and patient safety issues on her ward:

"Issues needs to be addressed; gentle is not the word. Respectful, not firmly, but kindly, don't cover it up." [Jamie 15/92].

Jamie tried to explain how to be caring without expressing emotions or resorting to an ad-hoc helping practice. She kept focus on the issue at hand, in her case, improving the care for a mother and child in her ward. In the next fragment Alex, who just had a discussion with one of her staff nurses about a patient how did not want to be taken care by that particular nurse anymore, puts it even stronger:

Alex toward staff nurse: "We are escalating and we should not." [Alex 14/97].

It does not matter what situation Alex is in, she always curbs emotions and de-escalates, trying to analyse and listen carefully. It is almost as if emotions do not play a role and if Alex does not care, but she does. In the next fragment we pass a patient, lying in bed, in the corridor of her ward. He is on his way for CT-brain; she looks at him, sighs, and says:

"that guy is not in good shape,
and he is going 43..." [Alex 14/42].

When Alex discusses processes or concerns with others in the organizations she stays calm and curbs her emotions but she is not made from ice, she cares about her patients.

Discussion

In this analysis, we investigated how three specific configurations of dispositions of habitus of nurse middle managers interact and influence their clinical leadership in patient safety practices. These configurations were: (1) a dominant caring disposition, which helped and hindered; (2) an interaction of caring and collegial dispositions that led to an erosion of clinical involvement; and (3) a dominant scientific disposition, which led to a well-balanced configuration of the clinical and caring dispositions.

Regarding the literature about patient safety practices and clinical leadership behaviour (Bohmer, 2013; Daly et al., 2014; Ham, 2003; Kaplan et al., 2010; Mannix et al., 2013; Ovretveit, 2010; Ovretveit, 2011; Parand et al., 2014; Taylor et al., 2011), our findings confirm that having technical knowledge of the micro practice of direct patient care, being clinically involved, and working in an interdisciplinary manner, increase the capital of nurse middle managers and enhance their clinical leadership. These practices are related to the clinical and caring dispositions in nurse middle managers' work. However, our findings also demonstrate that a caring disposition can complicate matters and potentially jeopardize the clinical leadership of nurse middle managers in patient safety practices. This is a new finding that requires careful evaluation and discussion.

Two distinct behaviours do not generate the authority required by nurse middle managers to enhance patient safety and portray clinical leadership behaviour. The first behaviour indicates a lack of clinical involvement as a result of the erosion of the clinical disposition and a caring directed mainly toward the nursing team. Much of the literature regarding nurse middle manager leadership supports the need for clinical knowledge and involvement in maintaining patient safety (Bohmer, 2013; Daly et al., 2014; Ham, 2003). What makes our findings unique is that we demonstrate that this lack of clinical involvement was a result of a caring disposition geared toward caring for the nursing staff instead of caring for the patients, as shown in configuration 2.

This configuration ultimately erodes the clinical disposition of the nurse middle manager habitus. Previous studies ascribe this lack of clinical involvement primarily to a dominant managerial field that emphasizes, for example, controlling costs (Kieft et al., 2014), leading to nurse middle managers feeling torn between their clinical and managerial duties (Orvik et al., 2013; Sorensen et al., 2008; Taylor et al., 2014). In addition to this external managerial influence, our findings suggest that the professional background of the nurse middle managers, especially their caring disposition, also contributes to the minimisation of clinical involvement. When the "being there for the other" behaviour is solely geared towards the nursing staff, nurse middle managers run the risk of losing sight of patients. This finding is a refinement on the vast literature from policy, management and leadership in nursing that promotes nurse managers being supportive of nursing staff wellbeing and job satisfaction (de Brouwer et al., 2014; Maben et al., 2012; Schmalenberg and Kramer, 2009; Upenieks, 2002). We, as well, underline the importance of staff wellbeing but stipulate there is a risk of eroding the clinical disposition, which can ultimately lead to leadership practice in which nurse managers avoid acting responsively, efficaciously, or decisively to improve patient safety (Jackson et al., 2013).

The second behaviour that does not generate authority and as a consequence does not portray clinical leadership, is a dominant urge to care, with as *modus operandi*, i.e., 'always' answering calls for help and focusing on quick fixes and ad hoc solutions. A recent article by van Oostveen regarding nurse staffing issues describes this type of behaviour as "*acting in an ad hoc and reactive fashion to processes over which they have little influence*" (van Oostveen et al., 2015). This behaviour links to what McNamara frames as a "compensatory mode". This mode unreflectively leads to constant compensations for deficiencies and gaps in service and care provision. According to McNamara, a "compensatory mode" is largely a by-product of a dysfunctional healthcare system (McNamara and Fealy, 2010). We take this argument further and argue that this compensatory mode is also unintendedly

internalized in the nursing profession and through that in the behavioural repertoire of nurse middle managers. The unintended erosion of clinical involvement leads to erosion of nurse middle managers' conscientious responsibility and liability for patient safety. This paradox is produced by the practices of the hospital organization itself and can be seen as an example in which field and habitus are locked in a circular relationship.

Hence, a caring disposition - solving ad hoc issues and being there for the other - is vital for the daily operations of contemporary, high-paced, and complex healthcare organizations such as hospitals. In short, nurse middle managers and their disposition to care, and through that, to compensate, keep the hospital running. However, our findings demonstrate that when this caring disposition is dominant in the work of nurse middle managers, they run the risk of producing short term quick fixes and non-sustainable solutions, which can jeopardize patient safety practices. This insight has consequences for those who advocate for professionals in leading positions. A recent review regarding the engagement of professionals in hospital management concludes that hospitals run by professionals perform better. However, the authors suggest that further research is required to determine the impact of specific professional backgrounds on hospital performance and patient safety (Lega et al., 2013). Here, we demonstrate how specific behaviours stemming from the professional background of managers might contribute to but also hinder patient safety unintentionally.

Our findings are consistent with the literature regarding clinical leadership and patient safety, which emphasizes the importance of evidence-based practice to address the root causes of patient safety issues (Fleiszer et al., 2015; Fleiszer et al., 2016). The reflective and inquisitive nature of the scientific disposition curbs – when dominant - the ad hoc reflexes of the caring disposition and gives way to the clinical disposition. Furthermore, a dominance of the scientific disposition enhances the positive impact of the caring disposition with respect to patient safety practices (i.e., a balance is created between narrow focus on quick fixes and

immediately answering the calls for help on the one hand, and analyses and evidence-based practice on the other hand). This finding is in agreement with Allen's re-conceptualization of the contemporary nursing mandate, which is "*with its exclusive focus on care-giving (...) no longer serving the profession or the public*" (Allen, 2014a). A broader repertoire that incorporates both caring and scientific dispositions will enhance the clinical leadership of nurse middle managers in patient safety practices. Furthermore, this repertoire counters the pervading "just do it" culture of many performance improvement programs such as the Nottingham University Hospitals Trust in the United Kingdom, which encourages members of staff to quickly champion and action good ideas. According to Weggelaar these kind of programs, lead to what she calls 'the projectification of quality improvement' in which a focus on 'low hanging fruit' with easy to achieve objectives overshadows thorough analyses and a focus of evidence-based practice (Weggelaar-Jansen, 2015).

This study has a few limitations that warrant consideration. First, this study was performed at only four hospitals in the Netherlands and the United States of America. Although the findings might be transferable to other Dutch and American hospitals, they cannot be generalized to all hospitals in these or hospitals in other countries. Secondly, the material in this study is much richer than we can present in this paper. It would have been interesting, for example, to differentiate between the various forms of capital (e.g., economic capital, cultural capital, social capital, symbolic capital) (Bourdieu, 1986). However, we do not believe it would contribute to a deeper understanding of the empirical material and might complicate analysis unnecessary. Further studies should elaborate on the various configurations of dispositions of habitus addressed herein and on other possible configurations in relation to clinical leadership and patient safety practices. The impact of other organizational contexts should also be studied in more detail. Finally, we recommend a thorough study of the possibilities to develop a well-balanced configuration of the various dispositions of nurse middle managers. Our experiences in the member

checking sessions indicate that shadowing is a very promising learning tool.

Conclusions

The dispositions of habitus of nurse middle managers influence their clinical leadership in patient safety practices. The caring disposition of nurse middle managers has an important role in maintaining daily operations in the hospital but can also hinder their clinical leadership, especially when the caring disposition is primarily focused on ad hoc actions. This potentially leads to short-term solutions and a “compensatory mode” of quick fixes. When a caring disposition becomes closely knit with a collegial disposition, the clinical disposition is suppressed and clinical involvement can even disappear from the habitus of nurse middle managers. In that case nurse middle managers do not exhibit clinical leadership or focus on patient safety practices. When a scientific disposition is dominant in a nurse middle manager’s habitus, the caring disposition becomes curbed or “restrained”, creating a balance between the caring, clinical, and scientific dispositions, leading to clinical leadership behaviour and focus on patient safety. This improves the quality of care through the use of a non-judgmental, inquisitive, analytic, and de-escalating approach based on evidence-based practice.

Relevance to clinical practice

This study addressed a critical and difficult topic. By understanding the impact of a caring disposition and its consequences for clinical practice and realizing the significant role that a scientific disposition plays in nurse middle managers’ habitus, the insights from this study contribute to improvement of practice in patient safety and quality of care. In order to realise this improvement, leadership and management development programs should incorporate the notion habitus, capital, field and game in their curricula and stimulate future nurse managers and leaders to reflect on their own professional habitus, feel for the game and field specific capital.

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Chapter 4

Nurse middle managers contributions to patient-centred care: A ‘Managerial Work’ Analysis

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Abstract

Nurse middle managers are in an ideal position to facilitate patient-centred care. However, their contribution is underexposed in literature due to difficulties to articulate this in practice. This paper explores how nurse middle managers contribute to patient-centred care in hospitals. A combination of time use analysis and ethnographic work was used to disclose their micro practices and contribution to patient-centred care. Sixteen nurse managers were shadowed for over 560 hours in four hospitals. Some nurse middle managers seldom contribute to patient-centred care, others are involved in direct patient care but this does not result in patient-centred practices. At one hospital the nurse middle managers did contribute to patient-centred care. Here balancing between 'organising work' and 'caring work' is seen as a precondition for their patient-centeredness. Other important themes are; feedback mechanisms; place matters; with whom to talk and how to frame the issues at stake and behavioural style. Both 'hands-on' and 'heads-on' caring work of nurse middle managers enhances their patient-centeredness. This study is the first of its kind to obtain the often difficult to articulate 'doings' of nurse middle managers with regards to patient-centred care through combining time use analysis with ethnographic work.

Keywords

patient-centred care, management, work organisation, ethnography

Introduction

There is a growing need to embrace patient-centred care (PCC) in hospital organisations (Epstein et al., 2010; Taylor and Groene, 2015). PCC is often mentioned in literature but lacks an accepted definition (Kitson et al., 2013; McCance et al., 2009). It is broadly described as an approach that positions the individual patient at the centre (McCance et al., 2009) and tailors care to each patient's needs (Clissett et al., 2013). PCC is acknowledged as effective and efficient, with beneficial outcomes at both the individual (i.e. patient) (Dwamena et al., 2012) and system (i.e. hospital) levels (Institute of Medicine, 2001; Luxford et al., 2011; The King's Fund, 2001).

Many studies about PCC have focused on the patient's perspective (Clissett et al., 2013; Dubbin et al., 2013; Köberich and Farin, 2015; Marshall et al., 2012; Olthuis et al., 2014; Tutton et al., 2008). Others have discussed the role of professionals such as physicians (Epstein et al., 2005; Mead and Bower, 2000) and nurses (Kelleher, 2006; McCance et al., 2009; McCarthy, 2006), or policy and strategy (Coulter and Ellins, 2007; Epstein et al., 2010; Herbert, 2005).

Surprisingly, the contributions of nurse middle managers (NMMs) to PCC are underreported in the literature. NMMs are 'positioned between the ward and higher management with first-line responsibilities regarding quality of patient care, the supervision of care workers and the management of finances' (Hewison, 2006 p. 1). Given this position and what is known in organization studies about the role of middle managers in implementing new practices, it is reasonable to expect that NMMs play a significant role in the creation of patient-centeredness in hospitals (Birken et al., 2012; Burgess and Currie, 2013). However, only a few articles have reported explicitly on NMMs and PCC. These emphasized their failure to implement PCC (Rankin, 2015; Rozenblum et al., 2013) or illustrate their perceptions of patient-centeredness (Gillespie et al., 2004; Taylor and Groene, 2015). Insight into the contributions of NMMs to PCC is lacking and asks for further exploration.

Background

Patient Centred Care and the work of middle managers

In a literature review, Kitson et al. (2013) have identified three core elements of PCC: 1. patient participation and involvement; 2. the relationship between patient and healthcare professional, and 3. the context of care delivery. Each element requires various actions in order to operationalize PCC in a hospital organization. NMMs are in a position to play a crucial role in initiating, guiding, promoting, facilitating, and sustaining patient-centred practices. They regulate budgets and time, and envision how these practices should be delivered. Therefore, we expect to see these core elements and categories for action in their daily work.

However, the literature regarding contributions of NMMs to PCC mainly has focussed on contextual factors and/or advocates managerial action. We did not find literature on how NMMs actually directly engage in patient participation and involvement (i.e. the first core element). With regards to the relationship between patient and healthcare professionals (i.e. the second core element), the literature mostly has focused on situations in which the NMMs indirectly contributed to PCC through optimizing nurse staffing levels (Aiken et al., 2014; van Oostveen et al., 2015) or nurse job satisfaction (Heinen et al., 2013), or through supporting role behaviours (Kramer et al., 2007; Lalleman et al., 2015). None of these authors incorporated PCC explicitly as a theme. Some articles have reported on the contribution of NMMs to the context for PCC (i.e., the third core element). Rozenblum et al. (2013) found that managers have difficulties implementing policy and strategy plans regarding PCC. They suggested that the majority of managers do not have a structured plan for promoting improvement of PCC. Taylor et al. (2015) reported on barriers that managers face in their efforts to enhance PCC, such as hospital organisational culture. Other sources have focused on desirable managerial action on several organizational attributes and processes that might enhance PCC such as; strong, committed senior leadership; clear communication of

strategic vision; sustained focus on staff satisfaction; active measurement and feedback reporting of patient experiences; staff capacity building, and a culture strongly supportive of change and learning (Luxford et al., 2011).

This literature resonates with a dichotomous view on professional organisations in which the professionals are the operating core and managers facilitate their daily work. Furthermore, the literature on being a NMM is full of normative accounts (see for recommendations about how to be efficient and successful: Kramer et al., 2009; Kramer et al., 2010; Upenieks, 2003). Both the dichotomy and the normativity hinder a further exploration and understanding of the contributions of NMMs. Theories should be based not only on what managers or others said about 'managerial work' or discursive analysis of these 'sayings', but also on observations of the 'doings', as work practices are heavily contextualized and are often difficult to articulate (Nicolini, 2013; Noordegraaf and Stewart, 2000). We need - in line with Arman et al. (2009) - more descriptive studies of work or 'doings' on the boundary of 'professional work'/'caring work' and 'managerial work' (see for examples: Allen, 2004; Allen, 2014a; Allen, 2014b; Everett and Jamal, 2004; Noordegraaf, 2015) related to PCC.

Managerial Work Studies and the practice turn

Traditional studies of managerial work have employed structured observation lists during the observation of activities and interaction patterns (the places they are, with whom they are interacting (participants), and who takes the initiative) as a basis for interpretation of the purpose of the activity, which is described in sub-categories such as administration, information, and decision making (see for examples: Arman et al., 2009; Hales, 1999; Mintzberg, 1973; Stewart, 1988). The recent 'practice turn' in managerial work studies (Korica et al., 2015) points to the contextualization of the unit of observation and adds a focus on the precise contributions of the various managerial activities to other actors and processes within the organization e.g.,

via processes of sense-making (Weick, 1995). This prompted us to conduct a study based on two research questions: 1). What do NMMs do in their daily work in hospitals? 2). How do they contribute to PCC?

Methods

Design

A combination of observation and analysis of time-use patterns (Arman et al., 2009; Hales, 1999; Mintzberg, 1973) with a structured list and ethnographic work (Van Maanen, 1979; Ybema et al., 2009) was used to describe the micro practices of NMMs and their contributions to PCC.

Setting and study sample

The study was conducted in non-profit midsized general and teaching hospitals, two in the Netherlands and two in the U.S.A.

The study sample consisted of 16 NMMs who were purposefully selected. These managers all had backgrounds in nursing, were Registered Nurses, and a middle management position in an adult care unit of an acute care hospital, and supervised a nursing unit of between 20 and 40 beds. We defined NMMs as positioned between the ward and higher management with first-line responsibilities regarding quality of patient care, supervision of care workers, and management of finances' (Hewison, 2006 p. 1).

After first contact with higher management of each hospital, further arrangements were made with contact persons in innovation and performance improvement departments and/or shared governance councils. We asked each contact person to recruit eligible NMMs, by inviting them by e-mail to participate in the study. No more than four NMMs showed interest in participating at any of the hospitals. Prior to obtaining consent, the first author met with each potential participant to discuss the aims, design, and methodology of the study. One potential participant decided not to participate due to a recently diagnosed illness. To find another participant

we had to send a new invitation. Consent was obtained from all participants. However, the procedure differed at the Dutch and U.S.A. hospitals because of different national policies and the various means of accessing the hospitals.

Data collection

Sixteen NMMs were shadowed (Czarniawska-Joerges 2007; McDonald 2005) for four to six days. This resulted in a total of approximately 560 observation hours over a period of 19 months between 2010 and 2012. In a semi-structured introductory interview, we learned about the previous careers of the NMMs and their reasons for becoming managers. During shadowing, a 15-minute time frame was used to make field notes of the NMMs' activities. Occasionally questions were asked that prompted comments from the participants. Some questions were asked for clarification. Other questions were intended to reveal the purpose of an action or communication (McDonald 2005). Some questions led to semi-structured interviews concerning beliefs regarding NMMs' roles and challenges in the hospitals. A Livescribe™ Pulse™ Smartpen was used to digitally store handwritten field notes and audio fragments from shadowing and interviews. These field notes and audio fragments were uploaded and stored with Nvivo 10 (a qualitative software analysis program). This was used to manage the data. Selections of the audio files were transcribed. This approach provided access to recordings after the fieldwork was completed. Finally, two interactive discussion group meetings were organized with the participating NMMs. Preliminary findings were discussed there, and this helped to assign meaning to the rich data (Balogun et al., 2003)

Data selection and analysis

After reading and rereading all field notes and transcripts of audio files, we analysed the activities of the NMMs using descriptive statistics. Due to the 15-minute time frame the activities should be seen as close estimates in that particular time slot. The categories we used for analysis stemmed from an

article by Arman et al. (2009), in which the authors adapted Mintzberg's (1973) original framework of categories to managers working in healthcare. Their categories were: (1) the place (e.g., sub-category: manager's office); (2) the participants who were with the manager (e.g., sub-category: higher management); (3) the type of activity (e.g., sub-category: scheduled meetings); and (4) the purpose of the activity (e.g., sub-category: administration) (Arman et al., 2009). We used two extra sub-categories in the category of purpose: set-up time and socializing (Stewart (1988); which also were used by Arman et al. (2009)).

During analysis, several new sub-categories emerged. Sub-categories "Nursing Administration Office" and "Breakroom" in the category place; sub-categories "Clinical Nurse Specialist" and "Quality Improvement Staff" in the category participants; and sub-categories "Scheduling", "Clinical Work", "Patient Rounds", and "Quality Improvement" in the category purpose. The results were put in one large table (see chapter 4, appendix 1) that reflects the NMMs' individual time use per (sub-) category. Then four histograms were created. Here we clustered the results of the managers per hospital per (sub-) category. In order to further explore the 'doings' on the boundary we used the insights of Allen (2014a; 2014b) and Noordegraaf (2015) to create a fifth histogram in which we synthesized the sub-categories of the purpose histogram. These five histograms reflecting what the NMMs in our study did, were the basis of an exploration of how the NMMs contributed to PCC.

Furthermore, we utilized the framework of Kitson et al. (2013) as a sensitizing concept (Bowen 2006) to select fragments from the field notes that referred to the contributions of these NMMs to PCC. These fragments were analysed using a thematic analysis approach, i.e. a flexible method for (collectively) identifying, analysing, and reporting patterns or themes within the data (Boeije, 2010 p. 96; Braun and Clarke, 2006). Five themes emerged that complemented the findings from the histograms. They illustrate the contextualized and often difficult to articulate 'doings' of NMMs.

Findings

First, we describe some demographics and key characteristics of the NMMs and the hospitals. The second section shows what NMMs did in their daily work in four histograms ('place', 'participants', 'type of activity', 'purpose'). In the third section a fifth histogram summarizes the sub-categories of purpose, and five emerging themes portray the contributions of NMMs to PCC in daily work.

Demographics and key characteristics of managers and hospitals

Fourteen of the NMMs were women and two were men. Their ages varied between 27 and 64 years, with a wide variety in experience as a manager. Table 6 provides a bird's eye view of the four hospitals and basic characteristics of the NMMs.

What do NMM do in their daily work?

We restricted our descriptive statistics to 14 nurse managers because in the field notes on the first two managers at hospital 1 the proposed 15-minute time frame design was not applied consistently. A total of approximately 490 hours of observations were analysed. The table in the appendix gives detailed insight into the individual time use of these 14 NMMs per subcategory. The next five histograms present the statistics (means) of the time use of the NMMs clustered per hospital. By doing so emerging patterns became visible.

Place

NMMs did not spend much time in patient rooms; but NMMs observed in hospital 3 spent more time there than the other NMMs. Time spent on the wards

Table 6 — Participants and hospital in birds eye view

	NMM	Gender	Ward Specialty	Spans of Control	Beds	Education Level^	Year as manager
Hospital 1	Kim	F	Surgical	30	28	RN	15
	Pat	F	Surgical	28	28	RN/BSN	2
	Toni	M	Medical	38	36	RN	5
	Chris	M	Medical	28	26	RN	10
Hospital 2	Dana	F	Surgical	30	32	RN/BSN	1
	Eli	F	Surgical	26*	24	RN	5
	Sal	F	Mother & Child	40*	38	RN/MSH	2
	Sidney	F	Medical	26*	24	RN/BSN	3
Hospital 3	Terry	F	Medical	30	26	RN	15
	Tracy	F	Surgical	30	26	RN	20
	Tyler	F	Step-down ICU	24	28	RN	25
	Vic	F	Surgical		26	RN	20
Hospital 4	Alex	F	Medical	34	24	RN/MSN	5
	Jamie	F	Mother & Child	55	34	RN/BSN	10
	Jordan	F	Medical / ICU	52	34	RN/BSN	20
	Shawn	F	Surgical	35	24	RN/MSN	5

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and at the nursing stations varied ; again in hospital 3, observed NMMs spent more time on wards and at nursing stations than the other NMMs. Time spent in conference rooms outside the ward varied greatly between hospitals. NMMs at all four sites spent the largest proportion of their time in their own offices. Hospital 3 seems an exception, but here 'office time' was divided between the NMMs' office on the ward and the larger nursing administration office at ground floor of the hospital; this, however, still resulted in less 'office time' compared to the other hospitals.

Participants

Figure II shows that observed NMMs spent little time with patients and families, with observed NMMs in hospital 3 again spending more time with patients and families than the other NMMs. With only moderate variation between sites, NMMs at each hospital spent

approximately one-fifth of their time with nursing staff. NMMs worked closely together with their senior nurses, unit coordinators, or head nurses. Again, with some variation between the hospitals, approximately another one fifth of their time was spent with these staff members.

Time spent with clerks did not vary much and accounted for only a small proportion of NMMs' time. More variation was shown in time spent with physicians, but in general this time only accounted for a fraction of NMMs' time. There was more variation found between the hospitals when we look at time spent with other NMMs and higher management, with hospitals 1 and 4 the least, and hospitals 2 and 3 the most. At hospital 4 the NMMs spent one-sixth of their time with the clinical nurse specialist and quality improvement staff while hardly any contact was reported at the other three sites. Finally, NMMs spent

Hospital

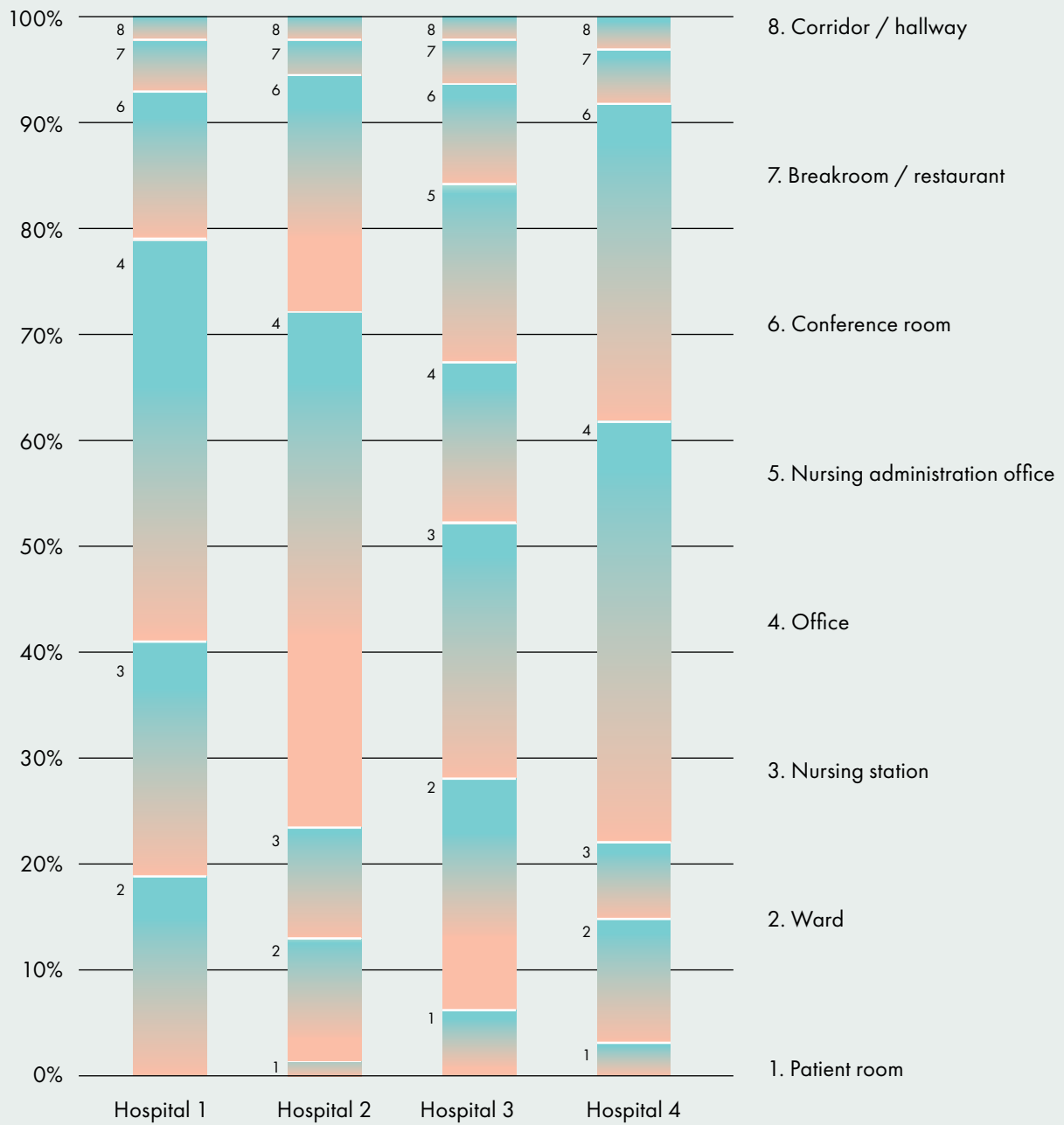
A vibrant Dutch big city hospital near the centre of town. The open, tolerant and outspoken urban atmosphere is reflected in both the patient and employee populations. Each ward primarily has four-bed patient rooms, with some single patient rooms. The nurse managers' offices are on the ward, at the beginning or end of the corridor. NMMs refer to them as "my closet or hut". The nursing stations are open and at the centre of the wards. NMMs frequently talk to physicians, nursing staff and patients. The hospital has an average ratio of nurses to patients. Two of the nurse managers had issues with high absenteeism; the others did not. All NMMs collaborated closely and floated personnel to guarantee an optimum nurse-patient ratio.

A relatively new Dutch hospital that was built in 2000 after a merger of three smaller local hospitals in a rural area. The building is light, with a calm atmosphere and long, wide corridors with natural stone on the floors. The NMMs have spacious modern offices situated off the wards, which they often share with another NMM with whom they jointly run the same ward. The hospital has an average nurse-patient ratio; however, because of a relatively high absentee rate, the NMMs struggle to have enough nurses to work the shifts. For the previous two years, the hospital has been in what they call an "organic change" process toward a new organizational structure, which creates uncertainty and ambiguity for both managers and nursing staff.

A big city East Coast U.S.A. hospital that serves an area of nearly one million people in one of the most ethnically and linguistically diverse communities in the U.S. It is a hectic place with a huge turnover in patients. Patients only come to the hospital if there is no other choice, and a majority of patients suffer from severe illness. The wards are clean, but they are worn out and overcrowded. The NMMs' offices are on the ward, do not have windows and are the size of a closet. There is a lot of noise from shouting patients and staff, alarms from beds, drip infusions, and telemetry. Although the patient-nurse ratio complies with the norm, the complexity of patients, the high absenteeism and the high turnover place a great deal of pressure on the patients, staff nurses and nurse managers.

A large Midwest U.S.A. hospital that has won numerous awards and prizes for its care, treatment and services. In 2005, it moved to a completely new building. It is a calm and quiet place, with little noise, soft piano music in the corridors, and art on the walls. Green colours and plants suggest a healing environment. All wards have single-bed rooms, with many different pods for the nurses and large, well-lit break rooms for the personnel. The patient-nurse ratio is above the norm, and there are numerous support staff on each ward. The hospital increased nursing staff over the previous seven years despite a decrease in admissions. Performance improvement and patient safety are key issues. The nurse managers' offices are immediately off the wards.

Figure I — Place — NMMS — per hospital



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Figure II — Participants — NMMS — per hospital

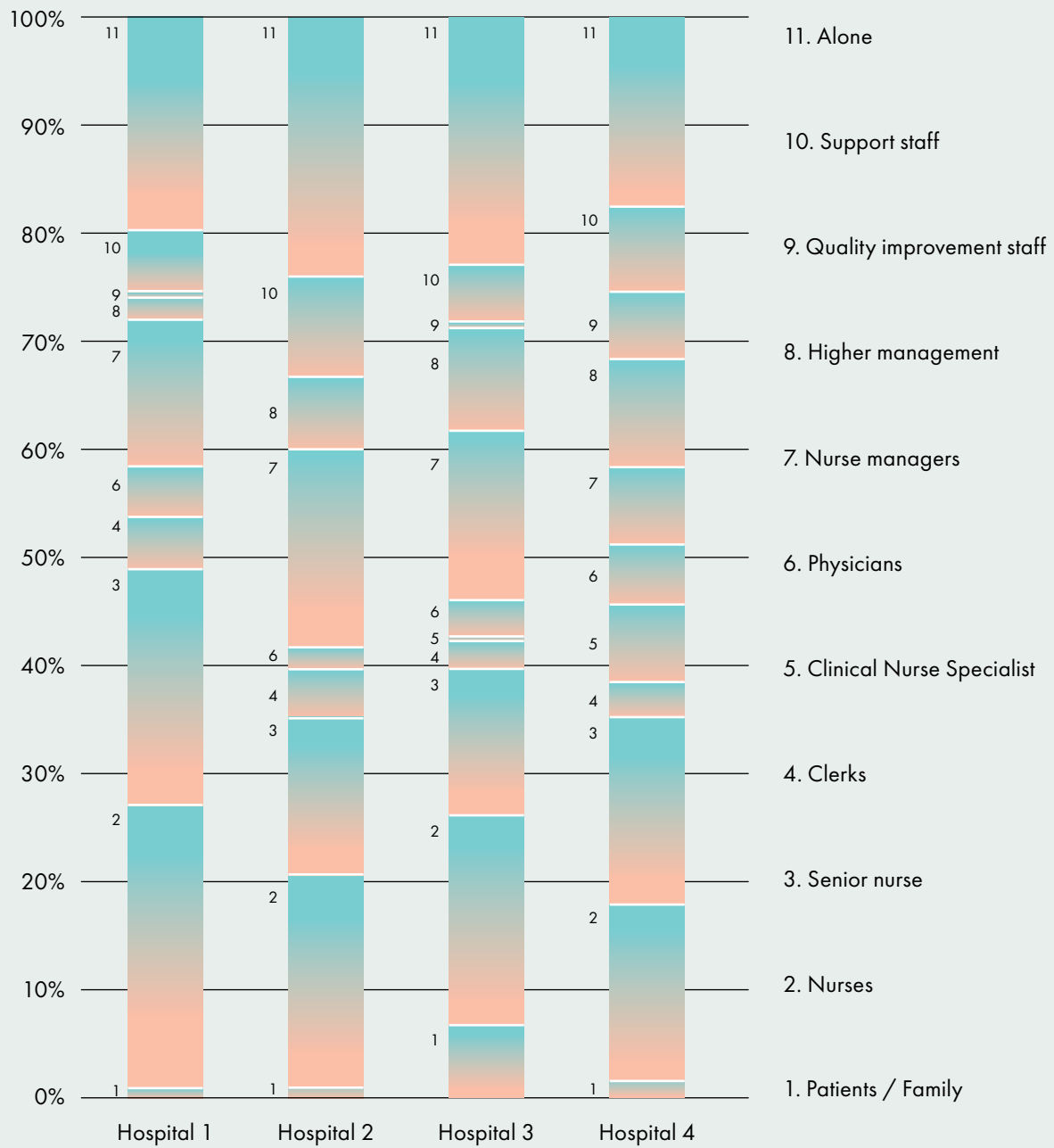
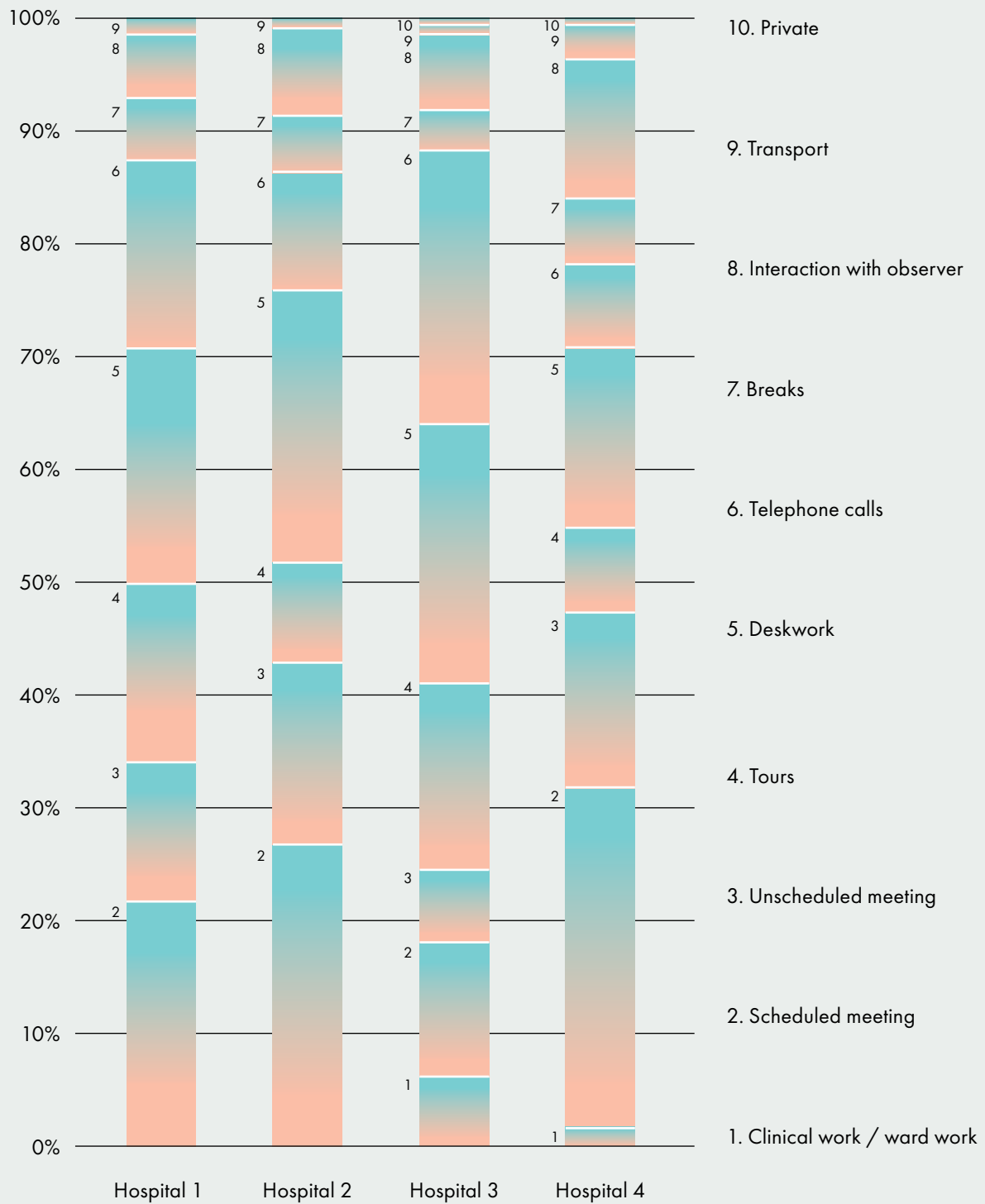
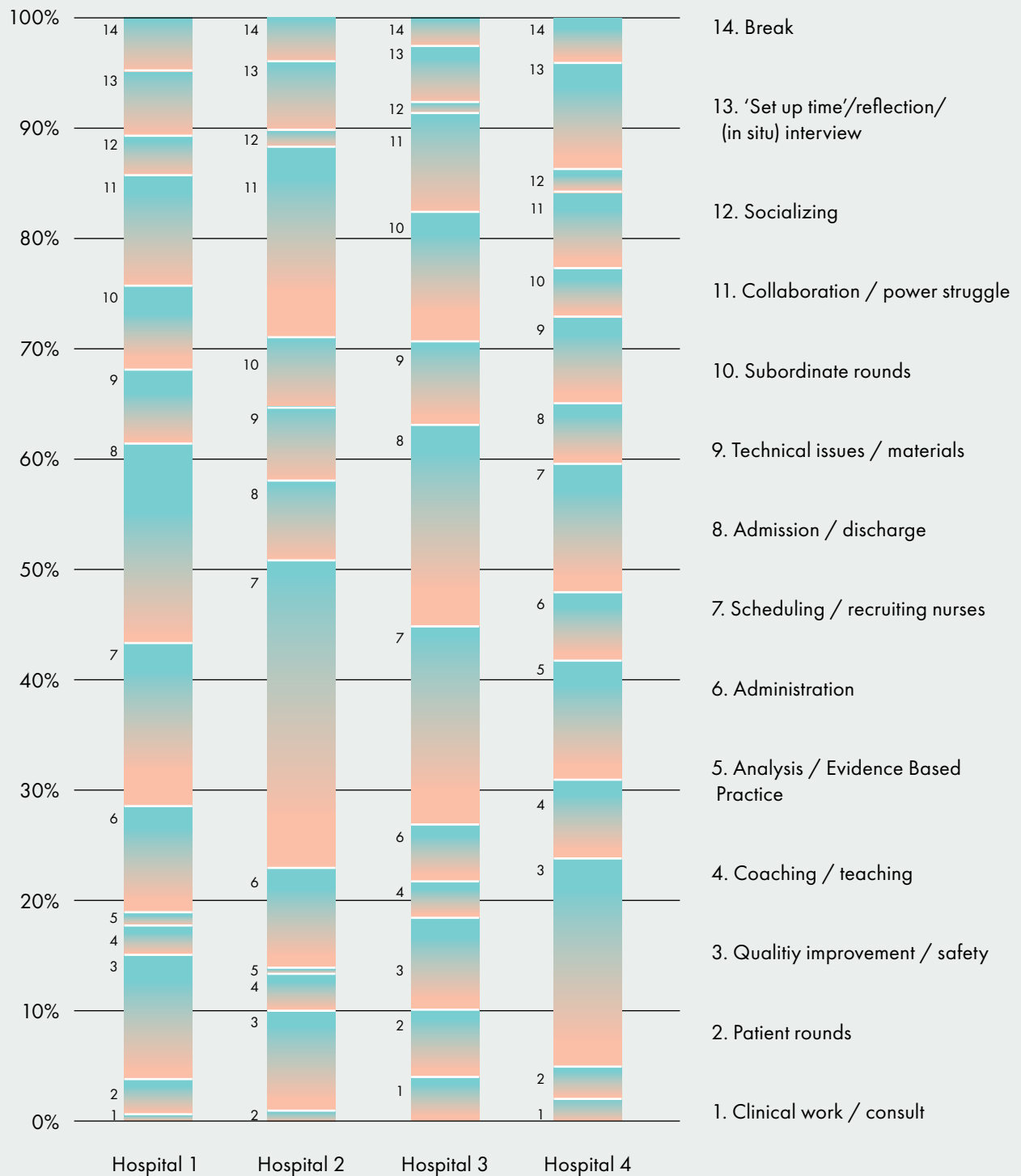


Figure III — Activity — NMMS — per hospital



Nurse middle managers contributions to patient-centred care

Figure VI — Purpose — NMMS — per hospital



one fifth of their time alone, with not much variation between the hospitals.

Activity

We also looked at the specific activities in which the NMMs were engaged. At hospitals 1 and 2 hardly any clinical or ward work was registered, while some was registered at hospital 4 and the most at hospital 3. NMMs spent a large proportion of their time in meetings (both scheduled and unscheduled), with quite some variation between the hospitals.

Both tours and desk work were part of the daily routine of nurse managers, with proportions ranging from one-fourth to one-third of their time. Some findings draw our attention. At site 3 the NMMs spent twice as much time on the telephone compared to the NMMS in the other hospitals. At hospital 4 one-fifth of their time was spent on interaction with the researcher (PL) and breaks, which is almost double the time compared spent on these activities in the other hospitals.

Purpose

Figure IV displays percentages of time spent, according to the purpose of the NMMs' work. We found that hardly any time was spent on clinical work or consulting (NMMs at hospital 3 most and at hospital 2 none). Time spent on patient rounds at hospital 3 was twice the amount NMMs spent in the other hospitals.

The difference between the NMMs in hospital 4 and the others is striking (more than one third versus 15% or less) when we look at; 1. coaching and teaching; 2. quality improvement and patient safety; and 3. Evidence-based practice and research. Time spent on administration varied moderately, with the most time, approximately one-tenth, in hospitals 1 and 2, slightly less at hospitals 3 and 4. A salient finding is that at hospital 2 over twice as much time was spent on scheduling and recruiting nurses than in the other three hospitals. It is interesting to see that at hospitals 1 and 3, the NMMs spent twice as much time on admission and discharge logistics when compared to hospitals 2 and 4. Subordinate rounds

took twice the amount of NMMs' time at hospital 3 in comparison to the other hospitals. At hospital 2 a lot of time was spent on collaboration and power struggles when compared to the NMMs in the other hospitals. Finally, NMMs in hospital 4 scored highest on setup time and reflection.

How do NMMs contribute to PCC?

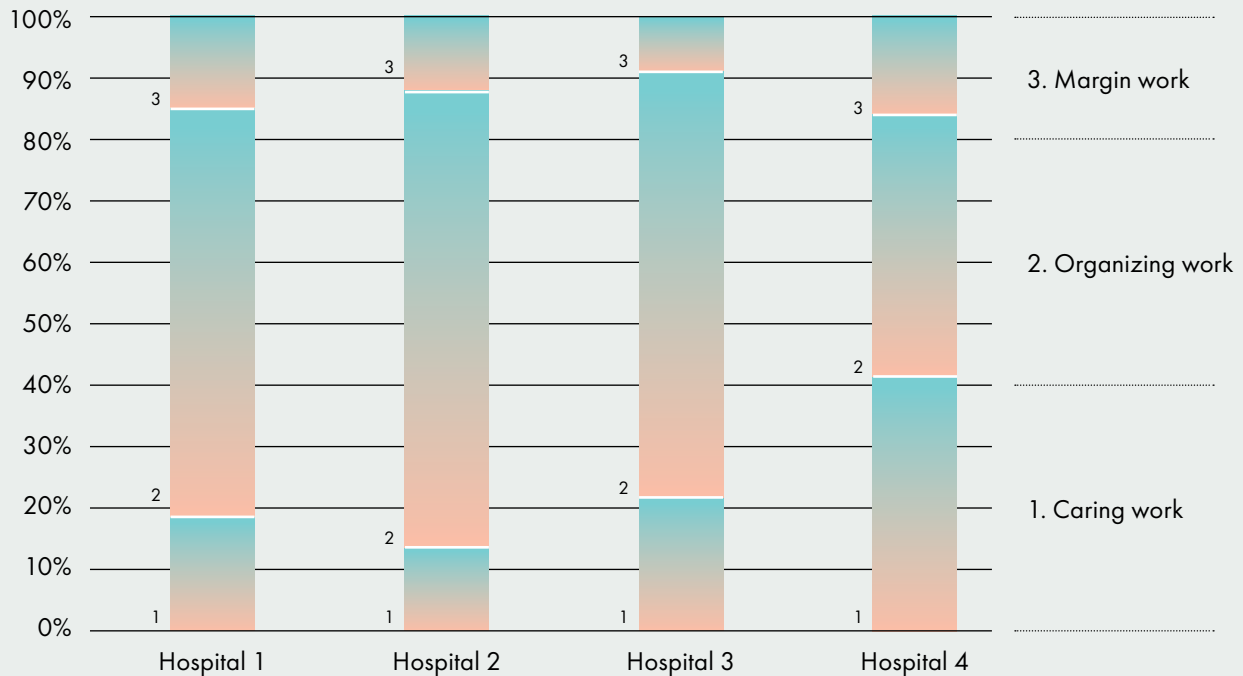
In order to explore how NMMs contributed to PCC, we focus at the category 'purpose'. The information in figure IV is quite fragmented. A summary of the sub-categories of 'purpose' resulted in a fifth figure with three distinct categories (see figure V).

The first category, 'caring work', contains all NMMs' sub-categories that involved patients or patient outcomes, such as clinical work, patient rounds, quality improvement, coaching or teaching, and evidence-based practice. The second category, 'organising work', covers the sub-categories that deal with work that did not per se involve direct patient care or focus on patient outcomes, such as administration, scheduling, admissions, subordinate rounds, and collaboration or power struggles. The third category, 'margin work', illustrates NMMs' flexibility and contains the sub-categories 'breaks', 'socializing', 'set-up-time', and 'reflection'.

Balancing as a precondition

Figure V demonstrates that in hospital 4 the amount of 'caring work' and 'organising work' of the NMMs was about equal. In the other three hospitals, however, the NMMs spent most of their time on 'organizing work'. A balance between 'organising work' and 'caring work', as found in hospital 4, can be seen as a precondition to NMMs' patient-centeredness. The NMMs here did not only address the schedules, admissions, and technical issues, but kept a focus on patient care, which resulted in closely coupling 'organising work' with 'caring work'. Furthermore, the NMMs took their time here preparing for meetings, reading reports, and writing memos. Here we always arrived 5-10 minutes before meetings started and stayed a bit longer with others after the

Figure V — ‘organising work’, ‘caring work’ and ‘margin work’ – NMMs – per hospital



meeting. These ‘margins’ in NMMs’ daily work allowed for socializing and reflection, but most of all, set-up or preparation time. In this hospital, we found several other cues that contributed to this focus. We will illustrate this in our discussion of the four other themes and contrast this with fragments of NMMs’ work in other hospitals.

This support system measured patient experiences and provides feed-back on macro, meso, and micro levels. In hospital 1 the department of performance improvement was trying to implement such a feedback mechanism, as illustrated by NMM Toni in the next fragment:

Feedback mechanisms

NMMs in Hospital 4 utilized a supportive system that measures patient experiences. In the next fragment, Alex received a phone call from the Director of Patient Experience:

After hanging up the phone Alex tells me that: “A patient reported to the patient experience office that a male nurse had not sanitized his hands”. The wards’ handwashing performance rate, which is benchmarked against other hospitals in the region, is approximately 90%. Alex has an idea of who the male nurse could be, she will talk with him later. [Alex 14/104].

Toni: “You have to deliver input and scores for their benchmarks but they do not administer them correctly and regularly lose data. They do not speak our language”. [Toni 3/89].

Both Alex and Toni dealt with benchmarks of patient outcomes in their daily work. Nevertheless, for them doing this was not the same. Alex saw the work of the director of patient experiences and the benchmark of hand sanitation as ‘caring work’ in order to enhance patient experience and outcomes. Toni experienced working with benchmarks as an administrative burden, as ‘organizing work’ that did not help him create better patient outcomes. As put forward by Toni, and elaborated upon later, the language used was key.

Place matters

Having an office off the ward (hospitals 2 and 4) decreased NMMs' time spent on both the ward and nursing station. NMMs who had their offices on the ward (hospitals 1 and 3), had to walk through their wards and pass their nursing stations to enter their offices. In addition, at hospital 2 the nursing station was a closed area instead of an open place in the centre of the ward. This did not support the NMMs spending much time on the wards. At hospital 4 there were several smaller nursing pods instead of one nursing station. The aims of this architectural choice were; 1. reduce the distance from the pods to the patients' rooms, which created a safer environment for patients and 2. reduce the extraneous sound at the nursing station. A team of 10 nurses makes more noise – due to handovers, chatting, beepers, phones, tele alarms etc. – than 2 to 3 nurses at a pod. Both examples illustrate the focus on PCC at hospital 4. The NMMs, however, had to put more effort into doing their rounds. Visiting several pods cost more time than visiting one station, which resulted in fewer rounds. Normally the NMMs at hospital 4 visited the pods twice a day, at the beginning of a shift and at the end. Visiting the ward and nursing station on a regular basis potentially facilitated the dialogue of the NMM with the staff nurses and physicians, and through that their patient centeredness. Seldom visiting the ward nor the nursing station during a shift (which occurred a few times at hospital 2) did not support patient centeredness.

We have to stress, however, that the purpose of visiting a place was important. The NMMs in hospital 3 spent, in comparison to the other hospitals, more time in patient rooms and less time in their offices. Here, this cannot be interpreted as an indication of more patient participation and involvement. These NMMs were preoccupied with checking nursing staff on errors and follow-up guidelines. In order to do this, they entered patient rooms regularly to monitor nurse performance, checking for example on bedsores, pain measurement, or whether the prescribed patient – nurse ratio of 2-1 to reduce fall risk was still valid. In the next fragment, Tyler conducted such a check:

Tyler enters a patient room checking the 2:1 patient-nurse ratio. She is not happy, there is no yellow sticker on the patient's bed (indicating a fall risk). Tyler: "what did I tell you, the bed exit alarm should be in the middle!" Tyler opens the blankets and shows the folly to the nurse. Tyler: "this is not the way we do this". [Tyler 12/44].

Although entering patient rooms and having patient contact, she did not demonstrate any behaviour that supported patient participation and involvement. On the contrary, she removed the blankets without asking the patient's permission in order to 'catch' the nurse doing something wrong. All the NMMs at hospital 3 were clinically strong and involved in direct patient care, as is shown with the category 'clinical/ward work' in figure III (NMMs' activity). At this hospital, the NMMs did clinical work in order to sustain control over the daily routine on the wards, not to enhance PCC.

Who to talk to and how to frame the issues at stake

NMMs talking about patients and patient care with the involved professionals was important for PCC. The inverse, when NMMs seldom talked about patients with involved professionals as in hospital 2, did not support PCC. But seeing patients is not per se a driver for involving patients in care, as we have seen in hospital 3. At hospital 4 the NMMs spent a large proportion of their time outside the ward, at their offices, or in conference rooms. However, during these meetings and in their offices they talked with other professionals such as nurses, physicians, unit coordinators, performance improvement staff, or Clinical Nurse Specialists about concerns related to patient care and nurse-sensitive patient outcomes. Moreover, in this hospital patient and family participation and involvement was incorporated and formalised in the daily work of nurse managers. It was quite common that the representative of the patient and family council attended the weekly medication error meeting. After the meeting was closed NMM Alex had a little chat with the one of the patient representatives and expressed her wish to expand the general patient and family councils into various disease-

specific groups in order to be able to better answer specific patient's needs.

If NMMs talked to physicians, this was mostly during patient rounds. This was an ideal setting to stimulate collaboration between nurses and physicians. In addition, in hospital 4, the NMMs talked with physicians on a regular basis during performance improvement or quality improvement meetings. Interestingly, both the Clinical Nurse Specialist (CNS) and quality improvement staff (who were referred to by the NMMs as 'the smart people') acted as liaisons between physicians and NMMs. As decentralised sparring partners of the NMM they helped keep the focus on clinical and patient-related issues and realised a more investigative and calm stance. In the next fragment Shawn discussed length of stay during an orthopaedics performance improvement meeting:

At the end of the meeting Shawn sums up the suggestions made so far: "Mobilize patients earlier, no follies [a Foley's catheter], discharge planning by case manager, discuss expectations of patient before admission, standardization of physician orders, start poop protocol". [Shawn 16/61].

The topic of length of stay discussed in the fragment could be seen as a pure organisational issue. Nevertheless, the way Shawn framed the topic, with a strong focus on nurse-sensitive patient outcomes, led to a patient-centred interpretation. At hospital 4 the importance of 'language', or framing' of issues, became most evident. The way these NMMs frame issues was a deliberate choice, which required reflection on habitual language.

Behavioural style

The final theme is the behavioural style of the NMMs themselves. We illustrate this via an event that occurred in a nearly identical way at both hospitals 3 and 4. In both hospitals a nurse entered the office of the NMM to report that a patient (with a drug misuse background) had 'discharged' himself and left the hospital with his vascular access device (VAD) still in.

At hospital 3 the NMM started yelling at the nurse, asking how this could have happened, telling the nurse that she directly needs to call the hospital police and write a report. At hospital 4 the reaction was completely different. The NMM looked calmly at the nurse and said:

■ "I have to chew on that for a while" [Shawn, 16/102].

This reaction was congruent and exemplary for the doings and sayings in hospital 4, with a balance between 'organising' and 'caring', with time to set-up, reflect and analyse, and engage in both 'hands-on' and 'heads-on' PCC. With this example we reiterate that NMMs' work was highly contextualised and that although the place (office NMM), participant (staff nurse), activity (unscheduled meeting) and purpose (safety – error report) were nearly identical, both context and behaviour of NMMs were not.

Discussion

The literature suggests that, although in an ideal position to do so, NMMs may not contribute to PCC to the fullest extent of their capacity. We thought that this could be because the underlying research is often based on 'sayings', which made it hard to uncover work practices that were heavily contextualized and difficult to articulate (Czarniawska-Joerges, 2007; Nicolini, 2013; Noordegraaf and Stewart, 2000). This paper contributes to the literature through descriptions of what NMMs were currently doing – in line with Arman et al. (2009) – and articulation of contributions to PCC at a micro level. We posed as research questions: What do NMMs do in their daily work in the hospital and how do they contribute to PCC? We provided insight in their doings through 4 figures that illustrate per hospital where they are, with whom they talk, their activities, and the purpose of these activities. A summary of the category 'purpose' led to a fifth figure with three categories: (1) organising work, (2) caring work, and (3) margin work. Five themes emerged: 1. Balancing as precondition; 2. Feedback mechanisms; 3. Place matters; 4. With whom to talk and how to frame the issues at stake; and 5. Behavioural style.

With regards to how NMMs contributed to PCC, our findings show several options. The first option is that NMMs, as shown in hospital 2, seldom contributed to PCC; the categories of place, participant, and purpose were strong indicators for lack of contributions to PCC. Not entering patient rooms, not seeing patients, and not focusing on patient-related issues when doing 'organising work' jeopardized NMMs' contributions to PCC. Neither 'hands-on' nor 'heads-on' foci on PCC were shown. Instead a preoccupation with the business of the system (finance and targets) (Allen et al., 2013) and a lack of a structured plan for promoting improvement of patient centred care (Rozenblum et al., 2013) characterised the daily work of NMMs at this particular hospital. In the second option, NMMs were 'hands-on' involved in direct patient care as found in hospital 3. 'Hands-on' practice might facilitate a contribution to PCC, but our findings demonstrate that the purpose of the 'hands-on' patient care here was to control and check the nurses, not to position the individual patient as an unique human being at the centre of care (McCance et al., 2009) nor to tailor care delivery to the patient's needs (Clissett et al., 2013). The third option is that NMMs did contribute to PCC as shown in hospital 4. One unexpected finding is that the work of NMMs at this hospital seemed to be less fast-paced, less fragmented, and less hectic than has been described in the literature on daily work of managers and NMMs (Arman et al., 2009; Mintzberg, 1994). Important here is the balance between 'organising work' as 'caring work' and creating 'margins' of time.

In her book, Allen (2014b) cites Furåker's (2009) who claimed that 'organising work' accounts for more than 70% of nursing activity. Our findings show a similar outcome for NMMs' activity at hospitals 1 to 3. However, the NMMs at hospital 4 showed a 40-40 balance. This cannot be explained through their closeness to care delivery or 'hands-on' caring work at the bedside. Key is the way the NMMs framed their 'organising work', or as we might call it 'heads-on' caring work. The NMMs of hospital 4 pulled 'organising work' across the boundary of the professional-organization dichotomy. When NMMs coupled 'caring work' to 'organising work' we see that

the purpose switched from the business of the system towards PCC. Here we find similarities with the literature on organised professionalism (see for examples: Evetts, 2009; Noordegraaf, 2011; Noordegraaf, 2015). As Noordegraaf (2011: p. 1358) argued, 'increasingly, organizing and managing must be seen as professional issues'. Hence, the NMMs at hospital 4, with their background in professional nursing, are an outstanding example of managers with strong foci on professional practice. Noordegraaf (2011, 2015) focused his research on the ability of professionals to manage and organise. Our empirical study demonstrates that the reverse is equally important (i.e. the ability of managers to demonstrate 'professional' / 'caring work'). When NMMs integrate both hands-on and heads-on 'caring work' into their 'organising work' it enhanced their contributions to PCC.

In addition, the five main themes in this study can be read on a scale from structure to agency. Structure (i.e. recurrent arrangements that enable and limit individual choice) and agency (i.e. individual autonomy) continuously interacted and through these interactions constituted each other (Giddens, 1979). For example, the investigative and calm behavioural style exhibited by the NMMs in hospital 4 only could be achieved or realised through a structure which included the support of Clinical Nurse Specialists, the 'smart people' from quality improvement, a unit coordinator as strong liaison between ward and NMMs, patient friendly architecture, and enough resources for staff. Hospital 4 acted in line with the recommendation of Luxford et al. (2011) to promote PCC in terms of strong, committed senior leadership, clear communication of a strategic vision, a sustained focus on staff satisfaction, active measurement and feedback reporting of patient experiences, staff capacity building, and a culture strongly supportive of change and learning. In hospital 3 this investigative style alone would not make the difference, as it was countered by an emphasis on command and control, a fast pace, high turnover, and a focus on checking and monitoring. Moreover, the low socioeconomic profile of the patients at hospital 3 put extra pressure on both the nursing staff and the NMMs daily work which did not enhance PCC. So, in order to allow NMMs

to integrate their professional caring work into their organising work, both behavioural style (agency) and organisational preconditions (structure), such as optimal skill-mix and nurse-patient ratios; supported staff on the wards; socioeconomic status of the patients and a patient and nurse-friendly built environment should be taken into account. The findings from hospital 4 suggest that investing in these factors supports NMMs in their patient-centeredness. These are important implications for further policy and practice developments.

This study has a few limitations that warrant consideration. First, by combining time-use analysis with an ethnographic approach, several analytical trade-offs were created. We had to cluster the individual time-use patterns of the NMMs per hospital to show emergent themes. This is in contrast with traditional managerial work studies that show the manager's individual time use (Arman et al., 2009; Hales, 1999; Mintzberg, 1973). Furthermore, this combination of approaches, in comparison to 'pure' ethnographic work, led to less space for thick descriptions and unravelling the cross cultural, socioeconomic and organizational/health system variations. Yet, our first aim with this study is to record patterns and explore the PCC role of the NMMs, not to elaborate on the differences between the hospital settings. Second, we did not use Mintzberg's (1973) structured observation list during shadowing but afterwards, as an analytical tool. Our 15-minute time frame to analyse NMMs' activity is not as precise as the analysis by Arman (2009), who used a 3-minute time frame; we traded off some precision to gain more contextual data. Thus, due to our focus on NMMs' practices, with time-use analysis in the background, we were able to portray what is contextualized and difficult to articulate. A third limitation of our study is the two missing cases (NMMs) for the descriptive part of this study from hospital 1 because in the field notes on the first two managers at hospital 1 the proposed 15-minute time frame design was not applied consistently. The observations and field notes that formed the basis for the way hospital 1 is portrayed in the figures does not completely capture the typical work of the NMMs observed at this site.

Finally, a strength of the study is that we were able to articulate NMMs' daily work, a result that is encouraging for future research and development of knowledge about NMMs' work. As argued by Allen (2016 p. 685), those at the frontline of care can "have an intuitive grasp of the salient features of a work setting even if they find these difficult to articulate". Literature suggests that collaboration between those at the frontline and social scientists could facilitate this articulation process (Dixon-Woods et al., 2011). Nevertheless, it is a challenging process to find common language between academic high grounds and "swampy lowlands" of practice (Allen, 2016; Schön, 1995). Practice-based approaches (see for example: Lalleman et al., 2016; Nicolini et al., 2011; Oldenhof et al., 2013; Postma et al., 2014) and especially those that are based on shadowing (Czarniawska-Joerges, 2007; McDonald, 2005) potentially facilitate this process of articulation and should be explored in more detail in future studies.

Conclusions

Managers who stay in their offices limit their contributions to PCC. Being with patients and providing 'hands-on' bedside nursing care could contribute to PCC, due to the closeness to care delivery. However, when the purpose of being in a patient's room is to check and monitor nursing staff, a NMM's proximity to the patient does not necessarily contribute to PCC. NMMs can practice what we call 'heads-on' PCC, which can occur whether one is with a patient or not, for example, during meetings. Then NMMs' 'organising work' becomes closely coupled to, or an integrated part of, 'caring work' through framing issues from a patient's perspective. Frequent contact with Clinical Nurse Specialists and quality improvement staff, good contact with the unit coordinator as liaison between ward and NMMs, and 'margin time' contribute to such a frame.

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Chapter 4

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Appendix 1: individual time use per sub-category

	Hospital 1			Hospital 2			Hospital 3			Hospital 4					
	Toni	Chris		Dana	Eli	Sal	Sidney	Terry	Tracy	Tyler	Vic	Alex	Jamie	Jordan	Shawn
Place % of time spend															
Nursing station	19%	26%		6%	6%	13%	18%	16%	37%	17%	29%	6%	5%	6%	12%
Ward	14%	21%		10%	6%	11%	1%	24%	25%	15%	26%	20%	8%	7%	14%
Office	37%	40%		53%	41%	52%	51%	8%	7%	27%	24%	37%	43%	49%	36%
Meeting outside ward	21%	8%		24%	41%	23%	5%	1%	11%	17%	11%	25%	35%	27%	31%
Nursing administration office	0%	0%		0%	0%	0%	0%	39%	11%	10%	0%	0%	0%	0%	0%
Breakroom/restaurant	7%	3%		2%	4%	1%	6%	2%	2%	7%	7%	5%	6%	6%	5%
Corridor/hallway/passageway	2%	1%		5%	1%	0%	0%	5%	0%	0%	2%	4%	1%	5%	2%
Patient room	0%	0%		0%	1%	0%	1%	6%	5%	7%	0%	3%	3%	0%	0%
Participants % of time spend with															
Alone	21%	18%		33%	17%	19%	25%	27%	0%	35%	29%	17%	19%	24%	12%
Nurse managers	15%	12%		14%	20%	24%	17%	16%	15%	19%	13%	6%	4%	10%	9%
Patients / family	1%	1%		0%	1%	1%	2%	4%	7%	8%	8%	4%	2%	0%	0%
Higher management	3%	1%		7%	4%	8%	6%	8%	10%	13%	9%	8%	12%	7%	12%
Nurses	28%	24%		17%	19%	17%	27%	18%	29%	14%	18%	14%	19%	20%	12%
Physicians	4%	5%		1%	2%	3%	0%	5%	6%	1%	1%	7%	1%	3%	9%
Support staff / HR / Education	8%	3%		8%	17%	7%	6%	4%	12%	0%	6%	13%	3%	5%	10%
Clinical nurse specialist	0%	0%		0%	0%	0%	0%	0%	0%	0%	0%	7%	6%	5%	10%
Quality improvement staff	0%	0%		0%	0%	0%	0%	1%	0%	0%	0%	9%	4%	5%	8%
Clerks	2%	9%		9%	1%	6%	2%	3%	6%	1%	2%	6%	6%	0%	0%
Senior nurse / unit coordinator / head nurse	18%	27%		12%	17%	15%	15%	15%	15%	9%	14%	9%	24%	20%	16%
Activity % of time															
Private	0%	0%		0%	0%	0%	0%	1%	0%	0%	1%	1%	0%	2%	0%
Transport	1%	2%		1%	1%	1%	1%	1%	0%	1%	1%	5%	1%	2%	4%
Scheduled meeting	27%	16%		21%	46%	35%	9%	6%	18%	16%	9%	25%	34%	31%	31%
Unscheduled meeting	13%	12%		25%	9%	11%	17%	5%	6%	8%	8%	12%	12%	16%	21%
Tours	15%	16%		9%	6%	6%	15%	12%	23%	14%	17%	10%	7%	2%	10%
Deskwork	19%	24%		30%	17%	20%	29%	31%	12%	24%	26%	19%	18%	9%	17%

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Telephone calls / beeper	9%	24%	2%	10%	11%	18%	30%	25%	16%	23%	9%	9%	4%	6%
Breaks	9%	3%	2%	3%	9%	7%	3%	2%	8%	3%	6%	5%	9%	4%
Interaction with observer	9%	3%	10%	8%	8%	5%	4%	8%	8%	8%	10%	11%	25%	5%
Clinical / ward work	0%	0%	0%	0%	0%	0%	8%	6%	6%	4%	3%	3%	0%	0%
Organizing work % of time	63%	71%	78%	71%	70%	76%	71%	68%	67%	71%	30%	45%	40%	50%
Administration	9%	9%	15%	4%	11%	6%	8%	3%	5%	5%	6%	8%	2%	7%
Scheduling / recruiting nurses / sick personnel	16%	15%	36%	23%	15%	35%	22%	15%	13%	22%	6%	15%	12%	12%
Admission / discharge, beds census, patient-nurse ratio	9%	29%	7%	8%	8%	7%	18%	19%	18%	18%	3%	2%	9%	8%
Technical issues / materials	9%	4%	1%	11%	8%	6%	5%	12%	8%	4%	4%	5%	11%	12%
Subordinate rounds / observational tours / check / monitor	11%	4%	5%	5%	4%	11%	12%	13%	10%	12%	5%	3%	5%	5%
Collaboration / power struggle / control issues / organization change	10%	10%	14%	20%	24%	13%	6%	7%	13%	10%	6%	12%	1%	6%
Caring work % of time	19%	19%	12%	19%	15%	10%	23%	25%	21%	17%	53%	43%	27%	41%
Clinical work / clinical consult	1%	0%	0%	0%	0%	0%	6%	4%	1%	5%	5%	2%	1%	0%
Patient rounds / observational tours / check / monitor	3%	3%	0%	1%	3%	0%	5%	9%	5%	4%	4%	4%	0%	3%
Quality improvement / safety / concerns / errors / risk management	11%	12%	9%	9%	12%	6%	11%	7%	10%	5%	24%	15%	16%	21%
Coaching / teaching / instructing	2%	4%	3%	3%	1%	4%	1%	5%	5%	2%	6%	12%	3%	6%
Evidence Based Practice / analysis / research / guidelines	2%	1%	0%	0%	0%	0%	0%	0%	0%	0%	14%	10%	6%	12%
Other % of time	18%	10%	10%	10%	14%	14%	5%	6%	11%	12%	17%	11%	31%	8%
Socializing	4%	3%	4%	4%	0%	2%	0%	1%	1%	3%	2%	1%	6%	1%
'Set up time' / reflection / clarification of work / interview	8%	3%	5%	5%	8%	6%	3%	4%	6%	7%	10%	7%	20%	4%
Break	6%	4%	1%	1%	6%	6%	2%	1%	4%	2%	4%	3%	5%	3%

Chapter 5

Peer-to-peer shadowing as a technique for the development of nurse middle managers clinical leadership: an explorative study

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Abstract

Purpose: The purpose of this study was to explore the experiences and impact of peer-to-peer shadowing as a technique to develop nurse middle managers' clinical leadership practices.

Design/methodology/approach: A generic qualitative study was conducted to gain insight into the experiences of nurse middle managers using semi-structured interviews. Data were analyzed into codes using constant comparison and similar codes were grouped under sub-themes and then into four broader themes.

Findings: Peer-to-peer shadowing facilitates collective reflection-in-action and enhances an 'investigate stance' while acting. Nurse middle managers' begin to curb the caring disposition that unreflectively urges them to act, to answer the call for help in the here and now, focus on ad hoc 'doings', and make quick judgments. Seeing a shadowee act produces, via a process of social comparison, a behavioral repertoire of postponing reactions and refraining from judging. Balancing the act of stepping in and doing something or just observing as well as giving or withholding feedback are important practices that are difficult to develop.

Originality/value: Peer-to-peer shadowing facilitates curbing the caring disposition, which is essential for clinical leadership development through unlocking a behavioral repertoire that is, not easy to reveal because it is, unreflectively, closely knit to the professional background of the nurse managers. Unlike most leadership development programs, which are quite introspective and detached from context and do not allow for collective learning while acting, peer-to-peer shadowing does have the potential to promote such an important process.

Keywords

shadowing; nurse middle managers, clinical leadership development

Introduction

Nurse middle managers' (NMMs) clinical leadership is of the utmost importance when delivering high-quality, safe, and cost effective care (Daly et al., 2014; Mannix et al., 2013; Sarto and Veronesi, 2016; Wong et al., 2013). In an international ethnographic study, we uncovered how NMMs' professional background influences their clinical leadership (Lalleman et al., 2015; Lalleman et al., 2017; Lalleman et al., 2016). By shadowing NMMs in their daily work we found that a combination of caring and scientific dispositions enhances clinical involvement and leadership. A scientific disposition curbs some manifestations of the disposition to care (e.g. solely focusing on answering the call for help and ad hoc quick fixes) and produces a de-escalating, non-judgmental, and inquisitive approach with an emphasis on evidence-based practice (Lalleman et al., 2015; Lalleman et al., 2017; Lalleman et al., 2016). The question was raised whether this technique of shadowing could be (in a modified form) useful in the development of clinical leadership of NMMs. In this paper, we report on our findings from an explorative study to address this question.

Nurse middle managers' clinical leadership

An abundance of literature reports the positive effects of nurse managers' (clinical) leadership practices on nurse job satisfaction (Cummings et al., 2010; Sellgren et al., 2007), on nurse sensitive patient outcomes (Wong et al., 2013), on patient safety practices (Christiana Stevens et al., 2014; Lalleman et al., 2016; Parand et al., 2014), and on patient centred care (Lalleman et al., 2017; Taylor and Groene, 2015). In our previous study, we defined clinical leadership based on Garubba's (2011) description. "Clinical leadership is the ability to influence all actors in and outside the healthcare organization to act and enable clinical performance; provide support and motivation; play a role in enacting organizational strategic direction; challenge processes; and to possess the ability to drive and implement the vision of delivering safety in healthcare" (Lalleman et al., 2016). Nevertheless,

there are strong indications that NMM's professional background (i.e. that of nursing) could as well, hinder their clinical leadership practices in daily managerial work (Lalleman et al., 2016).

Nurse middle managers' professional background

In our research we tried to decipher the influence of NMMs' professional background (in nursing) on their clinical leadership practices. We found that some drivers for nursing behaviour (e.g. scanning the environment and always answering the call for help in the here and now, and ad-hoc and quick judgment, i.e. - the caring disposition -) are still active in NMMs' practices, with both positive and hindering effects on their clinical leadership in daily work (Lalleman et al., 2016). These drivers are not easy to grasp via research techniques such as questionnaires or interviews because it is difficult for all practitioners to be aware of their own drivers in situ. The French sociologist Bourdieu refers to those drivers as dispositions. Bourdieu defines dispositions as durable, subconscious schemes of perception and appreciation that activate and guide practice (Bourdieu et al., 1989). A system of dispositions he calls habitus (Bourdieu, 1977). Some authors report that shadowing could reveal these dispositions in action (Jordan, 2010; Korica et al., 2015; Vásquez et al., 2012).

Shadowing

Shadowing is a research technique in which a researcher (shadower) closely follows a member of an organization (shadowee) over an extended period of time (Czarniawska-Joerges, 2007). This technique is the most in-depth type of direct observation of behaviours within a particular organizational or social setting (Bartkowiak-Theron and Robyn Sappey, 2012). During shadowing, one can capture the interruptive, fragmented, and hectic pace of work life (McDonald, 2005; Quinlan, 2008). McDonald (2005) distinguishes three forms of shadowing; 1. shadowing as a means of recording behavior; 2. shadowing as a means of understanding roles or perspectives; 3. shadowing

as experiential learning. In our previously mentioned study, as researchers, we shadowed 16 NMMs from both Netherlands and United States for approximately 560 hours employing McDonald's (2005) first two forms of shadowing (Lalleman et al., 2015; Lalleman et al., 2016). However, during the course of the study, the third form emerged, unexpectedly, as experiential learning for the *shadowee*. This is in contrast to McDonald (2005) who describes solely learning effects of shadowing on the *shadower*. In our study, the shadowees (NMMs) reported to gain from the experience of being shadowed by a researcher as well. At a member check with eight Dutch participants, one of them reflected: *"...after being shadowed I still felt some kind of virtual presence of the shadower, this made me more aware of my practices in action and thought what would happen if I would shadow one of the other colleagues..."*. This reflection prompted the participants to continue the shadowing experience and explore the possibility of shadowing each other (i.e. peer-to-peer shadowing) in order to further understand their own leadership in daily work.

Peer-to-peer shadowing: A development technique for clinical leadership?

Shadowing is used successfully in teaching nurses (Paskiewicz, 2002; Porter et al., 2009; Seldomridge, 2004) and medical students (Goldstein et al., 2014; Jain et al., 2012; Micallef and Straw, 2014; Spencer, 2003; Stalmeijer et al., 2009). Some authors name shadowing, among other methods, both as an instrument for training NMMs (Edmonstone, 2011a; Edmonstone, 2013; Skytt et al., 2011; Watkins et al., 2014) and as a technique for clinical leadership development (Crethar et al., 2011; Edmonstone, 2011b; Enterkin et al., 2013). Conventionally, shadowing is used as a learning tool in which a novice shadows a senior practitioner. The assumption here is that the junior learns from the problem solving actions of a more mature person who acts in the junior's zone of proximal development through interpersonal contact and subsequent internalization (Vygotsky, 1980 p. 86). In peer-to-peer shadowing this difference in maturity is absent. Shadowing here is a technique

for inquiry into current routines and norms of peers, which might enhance reflective practice *while acting* (Jordan, 2010), which is widely known for supporting professional development (Barnett, 1990; Mann et al., 2009). Moreover, Schön (1983) emphasizes that reflection-in-action is more than individual action, it is a social practice; in our case a practice in which both shadower and shadowee, as peers, frame their practices under investigation (Vásquez et al., 2012). What makes shadowing a promising technique for both shadower and shadowee is not the distance in maturity. Rather, we expect that the variation in clinical leadership and management practices, in reflection on roles, in problem solving strategies, and in dispositions in action will trigger learning processes that are supportive NMMs clinical leadership development.

Thus, the aim of this study is to explore the impact of peer-to-peer shadowing on the development of NMMs' clinical leadership practices. To investigate this impact, we formulated the following research question: What are the experiences of NMMs who shadow each other?

Method

Design

Qualitative description (Sandelowski, 2010) is a pragmatic approach (Neergaard et al., 2009) that fits well with our purpose for this study, which was to gain insight into the experiences of NMMs in peer-to-peer shadowing. Using this type of approach allows us to explore and gain deeper insights into the phenomenon under study through semi-structured interviews (Neergaard et al., 2009; Patton, 1990). These semi-structured interviews are part of a more action orientated research design (Brydon-Miller et al., 2003) in which the participants developed practical knowing through shadowing each other (Czarniawska-Joerges, 2007). Institutional review board approval was obtained from the university and participating healthcare agencies.

Table 7 — Key characteristics of participants and their organizational setting

	NMM	Ward Specialism	Span of Control	Beds	Education Level Nursing [^]	Management training	Years managerial experience	Shadowed
Site 1 City Teaching Hospital	Kim	Surgical	30	28	ASN	In company	15	Dana
	Pat	Surgical	28	28	BSN	none	2	Eli
	Toni	Medical	38	36	ASN	In company	5	Eli
	Chris	Medical	28	26	ASN	In company	10	Dana
Site 2 District General Hospital	Dana	Surgical	30	32	BSN	Post Bachelor	1	Kim
	Eli	Surgical	26 *	24	ASN	In company	5	Chris
	Sal	Mother & Child	40*	38	BSN	Msc Health Policy	2	Pat
	Sidney	Medical	26*	24	BSN	Post Bachelor	3	Kim

*shared with co-manager

[^] ASN=Associate of Science in Nursing, BSN= Bachelor of Science in Nursing

Sample and setting

NMMs were defined as: ‘positioned between the ward and higher management with first-line responsibilities regarding quality of patient care, the supervision of care workers and the management of finances’ (Hewison, 2006 p. 1). Eight participants (see table 7) from the two Dutch hospitals in the initial study (Lalleman et al., 2015; Lalleman et al., 2016) were approached by e-mail, which contained an invitation and information on this study. Participants were asked to shadow a colleague from the other hospital for one day. For feasibility reasons combined with the fact that the NMMs already had experience with being shadowed, the duration was set at one day.

Data collection

Data collection took place from February through May of 2012. For this study, shadower and shadowee were linked based on similar ward specialism or preference as mentioned in the introductory interview (table 7) for who shadowed

who) that was conducted approximately a week before shadowing. During this interview, participants filled out a demographic questionnaire (i.e. age, education, and professional experience). We also discussed the written instructions on shadowing that were provided to participants (see the instructions on shadowing in chapter 5, appendix 1). The second interview took place between one to two weeks after the shadowing day. Both interviews were semi-structured, held with each participant, and audio taped (see the interview topics in chapter 5, appendix 2) .

Data analysis

Audio recordings were transcribed verbatim by an independent transcriptionist and assessed for accuracy. Data were analysed into codes by the first and second author using constant comparison (Glaser and Strauss, 1967). Following Boeije’s (Boeije, 2010) analytical steps, similar codes were grouped under sub-themes and then into four broader themes. Rigor was improved by writing memos during analysis and using a systematic method of coding (Boeije, 2010). Audio-taping and transcription verbatim was meant

to ascertain credibility. Coding was done by the first and the second author independently to obtain intercoder agreement (Creswell, 2007). To improve trustworthiness, the findings were discussed with all participants (Holloway and Wheeler, 2013).

Findings

The research findings are presented in two parts. First, we explore the expectations of NMMs going to shadow a peer. Second, we present the reflections of NMMs' experiences with peer-to-peer shadowing activities, highlighting four themes: 1) enjoying 2) comparing what you see 3) learning to observe 4) asking, receiving and giving feedback.

Nurse Middle Managers expectations

Being shadowed by a researcher in the preceding study had an impact on the participants. Most of them were a bit nervous about it but in the end grew to enjoy the experience because they found it surprisingly enriching. All participants refer to particular moments of being shadowed by the researcher and getting feedback or questions that helped them mirror their own behaviour in action.

"It makes you aware of what you are doing and not doing. I can see myself running up and down the ward more than 10 times. Back in my office I felt the urge to jump up again to get something fixed but realized that I do not have to do it directly and [I'd] better stay in my office for a while"
[Chris 01 min; 56 sec - interview number 5].

Being shadowed by the researcher helped the NMMs to step aside or 'get dissociated' from work. His feedback or questions for clarification during the daily work enhanced this process.

NMMs experiences influenced their expectations of peer-to-peer shadowing. All of the participants looked forward to the shadowing. When asked what they expect to see or focus on while shadowing, they raised issues such as nurse staffing levels, sick leave

management, architecture, culture, and group dynamics. Some had pretty strong preconceived ideas and opinions about their peers' work and hospital culture. They expected that shadowing would confirm or refute these perceptions. Dana expected shadowing:

[akin to] being Sherlock Holmes doing an inquiry, observing, asking questions for clarification, while looking for, 'blindspots' and 'tunnelvision', in both her own behaviour and in the work of the NMMs she was going to shadow [Dana 07: 09-1].

In contrast, Pat expected that going in 'without an opinion' and 'looking open' would be the best strategy because:

"by just looking,... , it is a very direct way of learning, getting feedback without being judged and [letting] you uncover your subconscious routines" [Pat 04: 09-5].

These expectations reveal participants' positive attitude towards peer-to-peer shadowing as a clinical leadership development technique.

NMMs' experiences with peer-to-peer shadowing

Enjoying

All NMMs fully enjoyed the day with their colleague from the other hospital. All participants stated that it was inspiring but also tiring.

"It was, unexpectedly, a very enjoyable day. I had such a busy week, I was afraid I could not handle it but then thought, let's just do it. It's been a good learning experience and fun, I am happy I proceeded" [Dana 45: 07-6].

It is interesting to see that although some raised objections beforehand, such as having a too busy agenda, in the end all participants underline both the value and fun of the experience.

Comparing what you see

When NMMs shadow a peer they instantly start to compare what they observe with their own daily work (place) and emphasize similarities and differences. We organized these into the following subthemes: activities, behavioural style, culture, and organization.

First, regarding to the subtheme of *activities*, most NMMs agreed that the work in itself was almost the same, such as having to deal with ad hoc admissions, schedules and sick leave. Some of them even suggested that swapping places would not be an issue. The interview data reveal also that NMMs ventilate a wide range of differences in the activities, as Sal compares the work of her shadowee with her own,

“...they worked very close to the operational process on the ward, like a foreman, involved with nursing care and caring for the other” [Sal 04: 51-9].

Sal herself hardly did any clinical work and spent most of her days in her office or in meetings. The most striking difference was either the presence or absence of interaction among NMMs and staff nurses, physicians, or patients, which had a considerable impact on NMMs daily activities. Second, the NMMs underline that they all have a different *behavioural style*. While shadowing, NMMs see their counterpart react differently in situations, for example Kim reflects on being too soft or harsh:

“...just before I arrived Dana had to console a young unit coordinator who was in tears ...I am not so gentle anymore...I prefer to tackle the issue...stop whining...deal with it. But then again, when I saw Dana I thought of myself as a wicked witch. I can be empathic but we need to move on and don't get into a downward spiral” [Kim 16: 26-2].

On many occasions NMMs recognize a specific personal style element of their peers, compare it with their own style, and go on to describe something that they do not like or do not do anymore. This comparison helps them to make sense of their own 'doings'. In other

fragments, some NMMs illustrate a clear wish to be able to perform like their counterpart. For example, in the next fragment Sal expresses some envy on the relaxed style of Pat:

“...we had [a] meeting with other NMMs which was supposed to last one hour, but after that hour everybody just kept on discussing...I am pretty strict on time management...I think Pat felt it because after a while she said; 'our time management is lousy today'. I cannot overrun my schedule like that but I wish I could because it is much more relaxed and you can have that extra chat” [Sal 16:10-9].

Sal gives no indication that she would try to practice this more relaxed style in her work, as it seems an impossible goal to reach in her work setting. In contrast, Sidney sees the personal style of her peer as a reassurance,

“...she is firm...is self-confident and has character..., that is what I am going to be like in about 12 years from now,” [Sidney 16: 49-9].

Sidney shadowed a more senior NMM and gained a perspective on her career trajectory.

Third, each of the NMMs compared cultures between the two sites, as Pat shadowed Dana in a meeting about staffing.

“...Dana told me before we entered the room that it was going to be a heated discussion...I had been waiting for a full hour but nothing happened...it was a very pleasant and friendly meeting...our culture is so different.” [Pat 11:00-7].

After the meeting Pat asked Dana if she experienced the discussion as heated and Dana confirmed that it was. For Pat it was not heated at all, she realized that in her own hospital staff are much more direct and less reserved during meetings.

In the final subtheme, NMMs compared processes and structures within their *organizations*. This led mostly to

emphasizing differences instead of similarities, as Eli zooms in on such a difference:

“...what really surprised me was that she (Chris) did her own admissions, she even checked x-scan (i.e. computer program for admissions) to see who was planned for admission that day, we have a centrally organised admission department that takes care of that” [Eli 08: 46-6].

Having a centralized or de-centralized admission process in the hospital has a huge impact on NMMs daily work activities. When seeing Chris struggle with admission, Eli realised that at her hospital the admission process is organized in such a way that this does not interfere with her own daily work too much. Other differences that NMMs mentioned were: the possibility to float nursing staff between wards, centralized vs. de-centralized quality improvement staff, and a stable and strong organizational unit structure with clear responsibilities and authority vs. a simmering ‘organic’ organizational changes process leading to role and task ambiguity.

Learning to observe

For the NMMs, learning to observe, curb, and postpone their disposition to (inter) act and immediately express an opinion about what they see or hear, is a real challenge. In the next fragment, Kim cannot resist to act and starts helping.

“Eli had some kind of safety audit (...). She wanted to order new wastebaskets [as they were not hygienic] but could not work with the recently implemented ordering system yet. Luckily this was the same computer system we have, so I said, let me do it [and I ordered them].” [Kim 45: 52-8].

Kim was not the only NMMs who had difficulties with not acting. In the next fragment, Toni reflects on her struggles while shadowing.

“I really found it very hard to keep my mouth shut. In the end you are just a shadow, the only thing you do is observe. But then, everybody keeps on asking you all sorts of questions and wants your opinion.” [Toni 04:47-3].

Toni encounters that it is not only the shadowee that prompts her to respond while shadowing. In various instances, other people will ask what she is doing, why she is there, and what she thinks about the situation, or the shadowee, or the shadowee’s organization. Nevertheless, in the end, even when no questions are asked, Toni could not resist getting involved as illustrated in the next fragment. Here someone from facility management is explaining to shadowee Eli that, due to a new policy measure, from now on nutrition assistants will be doing nursing aids’ tasks.

“...it was incredible, this woman from facility management insinuated that a nutrition assistant can do the same work and has the same competencies as a nursing aid. My jaw dropped when she said that. I saw that Eli had the same thought. I looked at her and thought, are you not going to say anything? She did not. Then, I really could not restrain myself anymore, I sat like this (she shows how she has her mouth covered with both hands). So I say to this woman from facility management, washing a bare naked person from top to toe is very confronting and completely different from buttering a sandwich.” [Toni 12: 24-2].

Although Toni knew what was expected from her as a shadower – just observe – it was too hard not to interact on topics which she felt closely related to, in this particular case, standing up for professional and patient values.

As reflected upon by Pat in the next fragment this ‘balancing act’ of just observing versus getting involved and acting seems the most difficult practice to develop.

“I really have to try to just look and listen. I am not going to act as a sounding board. I realise I got lured in at particular moments, but I did not want to

adopt that role too much. I just wanted [to see] how she handles issues.” [Pat 37: 14-6].

Most of NMMs state that shadowing helps to put their own work in perspective and prevent them from getting emotionally caught up and personally involved in both their own work and that of their shadowee. Shadowing seemed to help regulate their emotions. Seeing other NMMs struggle with similar issues made them aware that they are not the only ones who are confronted with busy agendas and fast pace work as put forward by Sal in the next fragment.

“...being away from my own patch for a day showed me the relative importance of my own daily work, when I came back [to] the ward and saw my full agenda I thought, do I really have to do all of this today?”[Sal 29: 22-4].

Asking, receiving, and giving feedback

As illustrated above, shadowing prompts all kinds of situations in which both shadower and shadowee are confronted with the issue of whether one should stay silent, give feedback in private or in the open and intervene ad hoc. Giving feedback, in the sense of creating an opportunity to discuss and learn about what has been observed seems crucial as Pat put forward.

“I had a tough meeting and Sal asked me if she could give me feedback afterwards. I said yes, of course, normally you do not get this chance.” [Pat 49: 06-6].

Giving feedback is not easy, but peer-to-peer shadowing strengthened their conviction that, nevertheless, it should be done more often. Giving feedback in an open, constructive, and non-judgmental manner on observations enables both shadower and shadowee to derive meaning from what is seen. In the next fragment, Sal discussed whether to give feedback or not.

“Sometimes the shadowee does things of which you think, ouch this is not OK. Then it is really important

to balance out what is said, [which] is very tricky. You cannot discuss everything with a person you hardly know after just one day of shadowing.” [Sal 42: 21-4].

Choosing which feedback to give and when and how to give it is, again, a real balancing act for NMMs and is a prerequisite for meaningful learning experiences while shadowing.

Discussion

In this study we explored the experiences of NMMs who shadowed each other. Four themes emerged from the interviews: 1) enjoying; 2) comparing what you see; 3) learning to observe; 4) asking, receiving, and giving feedback. We will discuss the findings and reflect on the consequences for development of clinical leadership practices of NMMs.

Based on our findings, we can confirm conclusions from previous research, that shadowing is perceived as enjoyment (Barnett, 2001; Ferguson, 2016; Gill et al., 2014). This is a not to underestimate condition for shadowing to be a meaningful learning experience and leadership development tool. Others also found that shadowers’ struggle with giving feedback (Hall and Freeman, 2014; Roan and Rooney, 2006) and that shadowers’ reflective stance is enhanced through shadowing (Czarniawska-Joerges, 2007; Jordan, 2010).

However, we found the following aspects that are not elaborated upon in contemporary literature on shadowing. First, the reflective stance is mutual (i.e. for both shadower and shadowee). This is a novelty in our findings as this does not only relate to the shadower as pointed out by others like Jordan (2010) and Czarniawska (2007) but, as well, relates to the shadowee. In particular, our participants assumed both roles (i.e. shadower and shadowee), which enhanced this reflective stance. Our findings demonstrate that reflection-in-action is a social practice and should not be seen as an individual action. Theorists like Schön (1983), Sutcliffe (2006), Vázquez et al. (2012),

and Weick (1995) stress the importance of such collaborative reflection in action i.e. not only reflection on individual practice but also the relevance of collective inquiry into current routines and norms *while acting*. This is exactly what peer-to-peer shadowing offers.

Second, the theme of comparison does not occur in contemporary shadowing literature. It was interesting to uncover that NMMs in our study immediately started to compare what they observed with their own work. This process resembles that of social comparison. This is in contrast to researchers, who describe behaviour and try to understand roles or perspectives (Czarniawska-Joerges, 2007; Ekholm, 2012; Ellström, 2012; McDonald, 2005). Social comparison refers to the process of evaluating one's own characteristics by relating these to characteristics of other individuals (for a review see: Buunk and Gibbons, 2007). We saw examples of upward comparison (e.g. I wish a could do that), downward comparison (e.g. I am doing a better job at that), and lateral comparison (e.g. we are doing the same). Upward comparisons may serve as a form of problem-oriented coping, when those who "perform better" are used as a source of inspiration, learning, and self-improvement (Buunk and Gibbons, 2007). Downward comparisons (i.e. the information that another individual is doing worse) may make individuals feel better about themselves (Buunk and Gibbons, 2007). This practice of social comparison shows that managers should not per se learn from leading 'role models' (i.e. upward comparison) as often suggested (Kouzes and Posner, 2006) but can also learn from others in the organization, such as peers.

Third, none of the authors who name shadowing as an instrument for training NMMs (Edmonstone, 2011a; Edmonstone, 2013; Skytt et al., 2011; Watkins et al., 2014) or as a development tool for clinical leadership (Crethar et al., 2011; Edmonstone, 2011b; Enterkin et al., 2013) zoom in on the potential of shadowing in learning to deal with the dispositions that stem from the professional background of NMMs. According to Bourdieu (1989), these dispositions (i.e. subconscious schemes of perception and appreciation) are not easy

to uncover (Bourdieu, 1977; Bourdieu et al., 1989). This claim resonates in Wilson's (2004) research on the role of subconscious scripts that guide the formation of judgments, feelings, and motives. In order to change these scripts, Wilson (2004) advises to pay attention to what is actually done and what other people think about what is done. He suggest not to spend time solely on introspection regarding negative events (Wilson, 2004). Such introspection is often realized through techniques such as critical incident analysis, intervension (e.g. using Balint groups), or storytelling, which are frequently named as useful tools for leadership development (Gray, 2007; see for examples: Skytt et al., 2011). Yet, these tools still are quite introspective, isolated, and detached from context, unlike shadowing. Therefore, through shadowing, one has the potential to develop a scientific disposition that curbs some manifestations of the disposition to care, which is strongly represented in NMMs' behavioural repertoire (e.g. solely focusing on answering the call for help and utilizing ad hoc quick fixes). The scientific disposition manifests itself through an investigative stance, postponing reactions, refraining from judging, focusing on research utilization, and evidence-informed practice (Lalleman et al., 2016). Shadowing allows NMMs to fully experience and develop this disposition *while acting*. When shadowing, NMMs learn withhold action, curb, count to ten, and just observe (i.e. not get lured in), which we see as key aspects for clinical leadership development (Lalleman et al., 2016).

Fourth, for peer-to-peer shadowing to succeed it is of the utmost importance that both shadower and shadowee give feedback while shadowing, as indicated in our findings. Moreover, shadowing could be seen as an exercise to actually develop this crucial skill for clinical leadership practice, which enhances patient safety (Henriksen and Dayton, 2006), trust, and staff outcomes (Wong and Cummings, 2009). Choosing the right words, topics, and moments (i.e. framing the feedback message) for delivery to the shadowee is crucial. This is particularly challenging because, as described above, peer-to-peer shadowing is first and foremost an exercise in curbing the urge to act, answer the call for help, and judge. Mastering

curbing is a *conditio sine qua non* for the practice of giving feedback and clinical leadership development. Consequently, a thorough discussion on how and when the feedback should be delivered is of importance and should be addressed by both shadower and shadowee before starting the shadowing activity. Articulating individual learning goals and expectations is seen as key to peer-to-peer shadowing. Furthermore, our findings suggest that it is important not to shadow just one peer in another organization but various peers in various organizations. Since comparing is such a strong component of peer-to-peer shadowing, the shadower should ensure that more than one peer and/or organization is shadowed.

In this study, there were a few aspects that warrant consideration. First, a relatively small sample size of NMMs participated in this exploratory study. Based on the findings from this study, we think it is important to study the effects of shadowing for clinical leadership development (e.g. giving insight in leadership growth or capacity), in a variety of healthcare settings and with a larger sample size. Nevertheless, research on leadership development should not solely focus on personal leadership growth or capacity but as well on leadership as “the exertion of influence explained as a *joint accomplishment* and an *interpersonal process* between the *leader and followers*” (Larsson and Lundholm, 2010). Findings from this larger study should also result in a robust list of practical do’s and don’ts on peer-to-peer shadowing to inform future clinical leadership programs. Second, the NMMs from our study had some experience with being shadowed by a researcher, all volunteered to participate, and discussed shadowing during member checks prior to this study. Given the nature of this group of NMMs, our findings may be less generalizable to other groups of NMMs. Finally, this exploration can be seen as a spontaneous spin off from a larger study on NMMs’ daily work, which unintentionally led to a more action orientated research design (see for examples: Cardiff, 2014; Sharlow et al., 2009). To our opinion this is a strength, we demonstrate the close collaboration, curiosity, and flexibility of both research team and participants allowing to unveil aspects of peer-to-peer shadowing

as experiential learning and part of clinical leadership development, which were unknown, until now.

Conclusion

The aim of this study was to explore the impact of peer-to-peer shadowing as a technique to develop NMMs’ clinical leadership practices. We have learned that peer-to-peer shadowing has the potential to facilitate collective reflection-in-action and enhances the development of an ‘investigate stance’ while acting. This helps to curb NMMs’ caring disposition that unreflectively urges them to act, answer the call for help in the here and now, focus on ad hoc ‘doings’, and make quick judgments. Seeing a shadowee act at work leads to a process of social comparison by the shadower which allows the NMMs to learn to postpone reactions, refrain from judging, focus on reflection in action and asking, receiving and giving feedback. To further support our conclusion on peer-to-peer shadowing as a potential technique for clinical leadership development, we need to better understand the effects of the ‘comparison-mode’ through further research. Our exploration asks for a larger study so we can develop a practical guide on how to curb and postpone while shadowing, how to give feedback, how to deal with the shadower-shadowee relationship, and the continuous social comparison.

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Peer-to-peer shadowing as clinical leadership development technique

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Chapter 5

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Appendix 1

Practical guide for shadowing

In shadowing, it is about observing a colleague for a whole day, using the shadow technique. This means that you spend a whole day with your colleague, from the moment that this colleague begins the working day until he / she goes home. In addition to observing, ask questions. This involves questions for clarification, not for discussion, for example about what was said on the

other side of the phone or for finding the purpose of a meeting, for example. The intention is to understand what your colleague's activities are all about. You can also think of asking reflective questions, for example: "I see you doing this, I do not understand, can you explain it?" By explaining this, you let your colleague reflect on his / her own work.

Practical instructions:

- Do not go in cold. You know each other a little through the member checking meeting held on 6 July 2011. But make sure you get to know your colleague further, for example, by asking for the names of important people and the organizational environment, etc.
- Use a small notepad with a hard backside when you want to make notes.
- Do not judge and condemn your colleague, only observe.
- Make notes of your observations, especially when they are dealing with your own activities as a NMM. (Note: these notes are for you only.)
- Write a reflection on your own activities as a NMM after the shadow day. Take what you've been most surprised about, what hit you, made you happy or not and why. What does this say about you and what does it say about the person and organization you were a guest to. (In principle, this reflection is for yourself, but you can use it in the interview after the shadow day.)

Appendix 2

Interview topics

Subject	Topics introductory interview	Topics main interview
Concerning shadowing	Experience with shadowing Effect of shadowing Goal of shadow day	Experience shadow day Recognizable Surprise Most remarkable Insights Influence on own actions Look back on goals Usefulness
Added topic after 2 main interviews		Compare with other management training
Added topic after 6 main interviews		Could you take over the job of your colleague?
Practical issues	Plans how to shadow Any questions?	Sequence of day How did you go about? What went well? What would you change?

Chapter 6

Discussing nurse middle managers clinical leadership in daily hospital work: A re-conceptualisation of Mintzberg's 'managing as blended care'

Submitted as:

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Introduction

The management theorist Mintzberg suggested – more than 20 years ago – that nurse middle managers (managers with a professional background in nursing) are ideal frontline leaders in hospital care. He refers to nursing management as ‘blended care’. He considers the job of nurse middle managers (NMMs) as a blend of their earlier work of providing nursing care for patients and of managing a hospital ward (e.g. monitoring, liaison, disturbance handler), in such a way that NMMs behave towards nurses and others in the hospital in the way they previously behaved towards their patients. According to Mintzberg nurses move up easily into management roles because of their predisposition to caring. For Mintzberg, “nursing is managing” (Mintzberg, 1994; Mintzberg and van der Heyden, 1999, p. 94)

Mintzberg stresses the positive effects of having a background in nursing in management roles in hospitals. We contest this view. There is an abundance of research showing that NMMs have difficulties fulfilling a leading role at the frontline of care (Oldenhof, 2015; Orvik et al., 2013; Shirey et al., 2010; Sørensen et al., 2011; Taylor et al., 2014). We presume that some of these difficulties of NMMs at the frontline of care actually stem from their professional background as clinical nurses, which jeopardises their (clinical) leadership (Lalleman et al., 2017; Lalleman et al., 2016). Moreover, we presume that Mintzbergs 'blend' does not fit in contemporary high-tech and knowledge-intensive hospital organizations (for examples of such hospital see the literature on high reliability healthcare organisations Carroll and Rudolph, 2006; Pronovost et al., 2006; Sutcliffe, 2011). Furthermore, literature on contemporary healthcare models suggests that such high-tech and knowledge-intensive organizations, in the end, could strengthen the patients' ability to adapt and self-manage in the face of social, physical, and emotional challenges (Huber et al., 2011). All this demands far more of NMMs than (a blend of) caring alone.

In this paper we reflect on the studies that we have conducted over the last years to explore how NMMs' professional background (i.e. that of caring) influences their (clinical) leadership in daily work (Lalleman et al., 2015; Lalleman et al., 2017; Lalleman et al., 2016). First we explore the developments in the context of patient care and nurses' work in hospitals. We then explain why NMMs have difficulties fulfilling their role between higher management and the ward, resulting in risking a poor blend that does not support the work at the frontline of care. Subsequently, we briefly introduce tools to explore the professional background of these NMMs (i.e., Bourdieu's concepts of habitus, field, and capital). The method section provides an overview of the research project, introduces the instruments of inquiry, and gives insight in the secondary analysis of the papers and materials of our project. Then the synthesized results are portrayed through a typology of three types of NMMs' daily work practices. We also present a new model for leadership practice, that of

'(clinical) leadership as blended care'. In the discussion and conclusion we reflect on the question of how to further develop 'clinical leadership as blended care' in hospitals and its consequences for patients, employees, organizations, and society.

Background

Developments in the context of patient care and nurses work

Some authors see a slow and phased transformation in healthcare from cottage industry via an industrial mode towards high-tech knowledge-intensive institutions as part of a larger network (Maccoby, 2013; Smid, 2014). Moreover, in each of the three phases of the 'industry' various dependencies are articulated that correspond with a particular 'game type' (i.e., autonomy, control, cooperation) (Maccoby, 2013). Table 8, which is based on the work of both Maccoby (2013) and Keidel (2010) illustrates how these three 'game types' relate to characteristic business and leadership models, arrangements regarding quality and cost control, and values (table 8).

We suggest that all modes, with their game types, are simultaneously at play in the work of healthcare professionals in contemporary hospital organizations. All professionals have to switch frequently from, for example, control to autonomy to cooperation and back. In the contemporary work of nurses, all three 'game types' are articulated in daily practice. Often the craft mode is active. This can be illustrated through the traditional nursing mandate with an emphasis on caring, highlighting engagement with the 'Other' or the patient as a 'whole person' (see for examples: Armstrong, 1983; Lavoie et al., 2006; May, 1992; McCormack and McCance, 2006). Frequently the industrial mode dominates. Here a focus on classifications (Bowker and Star, 2000 p. 229) or tasks and competencies (Cowan et al., 2005) is dominant in nurses' work, as instruments for controlling clinical pathways, service, profitability, and outcomes (e.g. related to older patients: Dikken et al., 2016; or E-health: van Houwelingen et al., 2016). But nurses also work in the knowledge-intensive mode.

Table 8 — Transformation of healthcare and game type.
Based on Maccoby (2013) and Keidel (2010)

	Craft	Industrial	Knowledge
Organization	Cottage Industry	Stand-alone professional bureaucracy	High-tech collaborative learning organization
Game type	Autonomy	Control	Cooperation
Business model	Personal relationships Reputation	Price Scale Service	Community needs Prevention Health improvement
Leadership model	Master-apprentice Mentoring	Managerial	Visionary Dialogue Motivating
Quality and cost control	Peer review	Statistical process control Utilization management Outcome measures Clinical pathways	Continuous improvement Shared responsibility
Values	Caring Professional trust Expertise	Service Profitability	Teamwork Innovation

Here their work relies on close collaboration between healthcare professionals and other stakeholders in and outside the healthcare organization, with an emphasis on strengthening patients' ability to adapt and self-manage (Huber et al., 2011), and on realizing patient safety, continuous improvement, and shared responsibility (Batalden and Davidoff, 2007; Kaplan et al., 2010; Kaplan et al., 2012; Pronovost et al., 2006). Switching between these modes (and game types) is a challenge for any professional in healthcare and also for nurses. It is rather common that they are not conscious about the game they are in, as contextualized work practice is often difficult to uncover and articulate

(Czarniawska-Joerges, 2007; Gherardi, 2016; Nicolini, 2013). A particular role at the frontline potentially could support nurses in recognizing game types and switching between them in order to keep the focus on patients', professional, and organizational needs.

Hybrid nurse middle managers: the risk of a poor blend

NMMs might fulfil such a role at the front-line of healthcare institutions as they are 'positioned between the ward and higher management with first-line responsibilities regarding quality of patient care, the

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supervision of care workers and the management of finances' (Hewison, 2006 p. 1). Here they have to navigate between what Allen (2013) refers to as "the business of the system" (finance and targets) and "quality of patient care". Nevertheless, they can experience this navigating as problematic. They might feel torn between their clinical and managerial work (see for examples: Johansson et al., 2013; Orvik et al., 2013; Shirey et al., 2010; Sørensen et al., 2011; Taylor et al., 2014; Udod and Care, 2012).

Llewellyn (2001) describes such a role as 'hybrid', using the metaphor of a 'two-way window', which illustrates the mediation between clinical and management expertise (Llewellyn, 2001). This process of mediation can be challenging. Alternatively, more contemporary studies on middle managers in the healthcare sector reveal that middle management is less dichotomous (i.e. managerial vs. clinical) and more than just the middle between the work floor and higher management. According to Oldenhof (2015), 'rather than a singular middle, the middle is multiple and concerns conflicting values of good care, organisational boundaries, professional-managerial worlds, and different justifications'. This complicates matters and underlines the challenges NMMs face in a variety of 'game types' and a 'multiple middle' at the frontline of care.

Subsequently, such a challenging role requires (clinical) leadership practices that we describe as: influencing all actors in and outside the healthcare organization to act and enable clinical performance; provide support and motivation; play a role in enacting organizational strategic direction; challenge processes; and to drive and implement the vision of delivering safety in healthcare (Lalleman et al., 2016). Above all, we see (clinical) leadership practices as work-embedded influence (or authority) that 'emerges' from daily practice, and should be seen as a joint accomplishment and an interpersonal process between the leader and followers (Larsson and Lundholm, 2010; Smid and Lalleman, 2016). Furthermore, clinical leadership practices requires NMMs to initiate, guide, promote, facilitate, and

sustain: (1) patient safety and quality of care (Birken et al., 2012; Daly et al., 2014; Mannix et al., 2013); (2) patient-centred care (Rankin, 2015; Rozenblum et al., 2013); (3) support for staff nurses (Kramer et al., 2007; Schmalenberg and Kramer, 2009); (4) regulate finances and budgets (Douglas and Normand, 2005; McLarty and McCartney, 2009). Having a professional background in nursing care of patients could support such a clinical leadership practice as shown in recent studies (see for examples: Bohmer, 2013; Bohmer, 2010; Daly et al., 2014).

However, besides some crucial advantages, (e.g. knowledge of clinical micro practices) there may be risks of professional involvement in leading roles as well. More research is needed on whether and how this could lead to a poor blend at the frontline of care. For example, an individualist orientation with a focus on professional autonomy complicate the process of working towards shared goals (Bohmer, 2013). Recently some studies addressed the challenges and concerns of clinician engagement (nurses and physicians) in leading positions (Andersson, 2015; Loh et al., 2016; Spehar et al., 2015). However, to our knowledge, only Witman et al. (2011), in *Organization*, explicitly zooms in on the 'doings' of these frontline leaders to uncover the tensions and challenges 'in action'. Witman shows the dilemmas of physicians in leading positions due to their professional clinical background in more detail. In her ethnographic study, she first deciphers the dispositions that come with the professional background of these physicians, followed by an analysis of the influence of these dispositions on their daily leadership practices. For this analysis she applied Bourdieu's concepts of dispositions of habitus, field, and capital (Witman et al., 2011). Her analyses shows how the physicians' professional habitus sometimes helps and sometimes hinders their daily work as 'hybrid managers' through generating capital or authority. Her work is an important inspiration for us. In particular, her application of Bourdieu's concepts as tools for inquiry prompted us to design a study accordingly.

Bourdieu's tools: habitus, field and capital

Bourdieu describes habitus as a system of dispositions (Bourdieu, 1977 p. 214). Habitus is embodied history, internalized as second nature (Bourdieu, 1977 p. 56). Dispositions are defined as durable, subconscious schemes of perception and appreciation that activate and guide practice (Bourdieu et al., 1989). Dispositions of habitus generate a limited number of behavioural strategies. These strategies are manifested in certain visible patterns of behaviour, manners, and beliefs: in activities within practices (Bourdieu, 1990).

Bourdieu's concept of field refers to a social space with an internal logic (Bourdieu, 1989a). Field and habitus are locked in a circular relationship: involvement in a field shapes the habitus that, once activated, reproduces the field. On the other hand, habitus only operates in relation to the state of the field and on the basis of the possibilities of action granted by the capital associated with the position (Nicolini, 2013). In a field, there is always something at stake, i.e., there are struggles for positions and other valuable resources. Bourdieu's concept of field can be compared to a game with the aim of collecting valuable resources, or 'capital' (Bourdieu and Wacquant, 1992). Capital gives authority within the field (Bourdieu, 1986; Bourdieu, 1989b), and may be inherited through position or be based on knowledge or seniority (e.g., clinical credibility or leadership). Practices are conceived of as "clustered around social games played in different social fields, in which agents act with a feel for the game" (Lau, 2004).

To investigate this 'feel for the game', at the front-line and the influence of the professional background on these games, we formulated the following research questions:

1. What kinds of NMMs' clinical leadership practices is needed to successfully switch between the various game types in the frontline of hospital care?
2. What kinds of interventions are required to support the development of such practices?

Method

Design and data

A secondary analysis (Doolan and Froelicher, 2009; Hammersley, 2010), based on our previous projects within an international multi-sited ethnographic organizational case study at four hospitals was conducted, with the aim of synthesizing and discussing its findings, and enriching the literature.

These projects were reported in four papers. Three of them were based on a practice- oriented managerial work and behaviour approach (see for examples: Korica et al., 2015; Nicolini et al., 2003; Nicolini, 2013; Tengblad, 2012). Two of these also used Bourdieu's tools of dispositions of habitus, field and capital as sensitising concepts (Bowen, 2006). This open and grounded approach, with focus on the NMMs' work, answered Barley and Gunda's (2001) call to "bringing work back into organization studies".

For these three papers, eight NMMs at two Dutch hospitals and eight NMMs at two U.S. hospitals were shadowed by a researcher (PCBL) who is trained as a nurse and has worked as a nurse manager. Shadowing took place for approximately 560 hours in total and focused on their 'doings' in context (Czarniawska-Joerges, 2007; McDonald, 2005). Shadowing is a research technique in which a researcher (shadower) closely follows a member of an organization (shadowee) over an extended period of time (Czarniawska-Joerges, 2007). During shadowing, one can capture the interruptive, fragmented, and hectic pace of work life (McDonald, 2005; Quinlan, 2008) (see table 9).

Furthermore, we conducted numerous short reflective interviews and various member checking sessions. We organized a one week site visit of the Dutch participants to their U.S. counterparts. This catalyzed dialogues and helped to wrap up and discuss the preliminary findings of the research project. These member checking sessions led to a fourth paper for which we conducted a general qualitative interview study to investigate how NMMs experience peer-to-

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peer shadowing (i.e. shadowing each other) as a technique for experiential learning (Lalleman et al., 2017). We use the insights of this study in the discussion section of this paper on developing clinical leaders and leadership.

Materials

Through an extensive analysis of field notes, interviews transcripts, and audio fragments we:

- (1) Reconstructed what NMMs actually do in daily work (Lalleman et al., 2017) and how what they do relates to patient-centeredness (Lalleman et al., 2017).
- (2) Deciphered the dispositions of habitus of NMMs (Lalleman et al., 2015) and illustrated the influence of these dispositions on NMMs' contributions to staff support (Lalleman et al., 2015), and on both NMMs clinical leadership and contribution to patient safety practices (Lalleman et al., 2016).

We portrayed NMMs' professional background through eight dispositions of habitus (Lalleman et al., 2015; Lalleman et al., 2016) (see table 10). These dispositions were, in various configurations, simultaneously at play. The dispositions were valued differently at the four hospitals and affected one another. Thus, particular combinations of dispositions in particular fields (i.e. hospitals) generated capital in unique ways. We saw, for example, a configuration with a dominant caring disposition, leading to ad hoc, reactive practices, quick judgment, and answering the call for help in the here and now. In another configuration, caring and collegial dispositions resonated most, leading to NMMs' practice mostly geared toward caring for the team as a pseudo-patient and consequently eroding the clinical disposition. Only in one particular configuration was a scientific disposition visible in NMMs' work practices. This led to an investigate stance which affected, among others,

Table 9 — Design and data sources

	<div> <div>June 2010</div> <div></div> <div>May 2012</div> </div>			
Country	Phase 1: the Netherlands		Phase 2: the United States	
Hospital	Site 1	Site 2	Site 3	Site 4
Approx. hours shadowing	150	140	140	130
Shadowing days	Kim: 4 days*	Dana: 4 days	Terry: 4 days	Alex: 4 days
	Pat: 6 days*	Eli: 4 days	Tracy: 4 days	Jamie: 4 days
	Toni: 5 days*	Sal: 4 days	Tyler: 4 days	Jordan: 3 days^
	Chris: 4 days	Sidney: 4 days	Vic: 4 days	Shawn: 4 days
Field notes pages A5	700	670	640	480
Audio in hours	22	21	11	7
Additional study: NMMs site 1 & 2 shadow each other (exploring clinical leadership development). Design: interview based generic qualitative study.				

*pilot shadowing to come to an optimum of shadow days

^ which included one double shift from 7 A.M. until midnight

Table 10 — eight dispositions of NMMs habitus

Disposition

Caring Disposition	<p>Through a caring disposition, NMMs see patients as individuals who require care and attention.</p> <ul style="list-style-type: none"> • The corresponding strategies include answering the call for help of the other in the here and now; ad hoc, reactive reactions; and quick judgment. • The caring disposition manifests itself by scanning the environment for calls for help. • Excelling in the caring disposition provides capital that is based on taking care of and paying attention to patients.
Clinical Disposition	<p>Through a clinical disposition, NMMs see individuals as patients.</p> <ul style="list-style-type: none"> • The corresponding strategies include the search for the symptoms and causes for the conditions observed. • The clinical disposition manifests itself by seeing patients, diagnosing their care needs and knowing their conditions. • Excelling in this disposition provides capital that is based on having and using clinical expertise.
Collegial Disposition	<p>A collegial disposition refers to NMMs ensuring a positive team dynamic.</p> <ul style="list-style-type: none"> • The corresponding strategies include being friendly to team members and taking care of other colleagues. This disposition manifests itself by giving attention to members of the team, encouraging feedback and tacitly knowing other individuals' needs. • Excelling in this disposition provides capital that is based on being collegial and preserving a friendly atmosphere.
Teaching Disposition	<p>Through a teaching disposition, NMMs see themselves as tutor or mentor.</p> <ul style="list-style-type: none"> • The corresponding strategies include creating moments for coaching, instructing and learning. • It manifests itself through teaching or instructing both patients and colleagues. • Excelling in this disposition provides capital is based on sharing knowledge and teaching others.

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Disposition

Professional Disposition	<p>Through a professional disposition, NMMs perceive themselves as both personally and collectively accountable for good patient care.</p> <ul style="list-style-type: none">• The corresponding strategies include putting the interest of patients first and being accountable and taking responsibility.• This disposition manifests itself by feelings of responsibility and sharing responsibilities.• Excelling in this disposition provides capital that is based on being responsible and accountable both personally and collectively for patient care.
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Scientific Disposition	<p>A scientific disposition refers to NMMs work as a scientific and reflective practice.</p> <ul style="list-style-type: none">• The corresponding strategies include referring to, gathering and using scientific evidence and asking reflective questions to enhance the quality of patient care.• This disposition manifests itself through an investigative stance, postponing reactions, refraining from judging, focusing on research/EBP and reflection on action.• Excelling in this disposition provides capital that is based on using scientific knowledge and asking reflective questions rather than ad-hoc action.
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Administrative Disposition	<p>Through an administrative disposition, NMMs view administrative work as legitimization of their activities.</p> <ul style="list-style-type: none">• The corresponding strategies include the use of checklists, guidelines, benchmarks and reports.• This disposition manifests itself through a focus on writing reports, filling out checklists, addressing administrative issues and performing clerical work.• Excelling in this disposition provides capital that is based on the correct use of checklists and guidelines and handling administrative procedures.
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Control Disposition	<p>A control disposition views NMMs' work as a way to create order and serenity.</p> <ul style="list-style-type: none">• The corresponding strategies include controlling daily situations by tidying up.• This disposition manifests itself through a focus on controlling (complex) situations, creating order and clarity, cleaning up and clearing up.• Excelling in this disposition provides capital that is based on being in control of situations.
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the caring disposition of the configuration positively (Lalleman et al., 2015).

For this paper, these insights on the various configurations of dispositions of NMMs' habitus from two papers (Lalleman et al., 2015; Lalleman et al., 2016) were combined and synthesized with data concerning the place where the NMMs were, the people with whom the NMMs talked, their activities, and whether the purpose of these activities helped or hindered their clinical leadership (Lalleman et al., 2017b). Finally we enriched these insights with current literature on clinical leadership practices and NMMs' work in hospitals.

Secondary analysis

Secondary data analysis enabled us to pose new questions of our extant results (Corti, 2007; Du Plessis and Human, 2009; Parry and Mauthner, 2005). While secondary analysis of quantitative data is well-represented in the literature, there is very limited discourse detailing accepted processes and methods that can be used to re-explore existing qualitative data (Doolan and Froelicher, 2009; Hammersley, 2010; Thompson, 2000). Re-analysing data can yield new insights that may not be revealed unless a different question is asked of the data and a fresh lens is applied. For this paper we applied both Mintzberg's idea of management as blended care and Maccoby's insights on changing healthcare contexts as lenses to create a typology of NMMs' (clinical) leadership practices. With the use of these lenses we integrated the findings of our various papers on this topic. Furthermore, we expect that this typology supports theory building, prompts reflection, and captures the imagination of readers through on spot descriptions and providing a broader view than a focus on complex processes and organizational activities (see for critical review and example on typologies: Doty and Glick, 1994; Sturdy et al., 2016). Furthermore, we expect that this typology helps in designing future leader and leadership development programs.

Current findings

From a wide variety of configurations to a typology

Our re-analysis led to a typology of three distinct types of managerial work practices in the hospital, and a new clinical leadership practice (i.e. that of leadership as blended care). First we introduce and elaborate on the typology of NMMs' work, followed by an exploration of the clinical leadership as blended care practice. We elaborate on the type we have labelled "the craft" in the form of a narrative, next we present the narrative of "the manager" and finally that of "the clinical leader".

Type 1: The Craft – Hands-on

Monday morning, 11 AM. I meet nurse middle manager Amy, standing at the nursing station, scanning the ward. She wears scrubs. It's been a busy morning but it went well. She answered some call lights, rushed to the lab for packed cells and partly joined patient rounding with the surgeons. She is on to it, reacting to the calls for help in the here and now. In a few minutes she retracts herself to update some national hospital-based outcome indicators at her office on the ward. She keeps her door open so she can see patients pass by and receive nursing staff, physicians and others for a chat at her desk. Every now and then she leaves her office and walks fast paced to the nursing station for a short question, a telephone call or to double check on the nurse-patient assignment board. At 12 AM she still has not updated the indicators. She doesn't mind. To her they are not that important. It's higher management and external audits who are asking for transparency and evidence based practice. She knows what is best for the patients, others don't. After all she has worked 34 years in the same hospital where she earned her diploma degree in nursing. She glances at her agenda, sees 'another accreditation process meeting', she sighs. If it was up to her she would stay on the ward to join the handover and try to get the TV fixed at the patients' and family room. Caring is all that counts for her.

She has the reputation, expertise and hands-on mentality to keep her ward running. She longs for those days when she was really fully in charge of the patients and her influence extended beyond the ward premises.

This narrative demonstrates a typical 'hands-on' practice. NMMs spending time with staff, patients, and families at the ward, the nursing station or in patient rooms (Lalleman et al., 2017). With this narrative we illustrate that a caring and clinical disposition are key for NMMs' daily work. We see these NMMs working close to the frontline of care, interacting with patients, families and most of all with staff nurses, senior unit coordinators and physicians. The work of these NMMs is fragmented, ad hoc and reactive. NMMs respond to the call for any help in the here and now regardless the direction of this call (e.g., from staff nurses, HRM, physicians, higher management, patients or colleague NMMs). For these NMMs 'doing' and solving ad hoc problems 'in the frontline' creates capital or authority (Lalleman et al., 2015).

However, such a dominant urge to care, with as modus operandi, 'always' answering calls for help and focusing on quick fixes and ad hoc solutions, could as well hinder NMMs' work. It leads to a "compensatory mode" which unreflectively prompts NMMs to constant compensations for deficiencies and gaps in service (McNamara and Fealy, 2010). We argue that this compensatory mode also has a source in the nursing profession itself (Lalleman et al., 2016). It is unintendedly internalized in the work of nurses and through that in the behavioural repertoire of NMMs. Hence, a caring disposition - solving ad hoc issues and being there for the other - is vital for the daily operations of contemporary, high-paced, and complex healthcare organizations such as hospitals. Moreover, NMMs' disposition to care keeps the hospital running. However, our findings demonstrate that when this caring disposition is dominant in the work of nurse middle managers, they run the risk of producing short term quick fixes and non-sustainable solutions, which does not facilitate collaborative inquiry and can jeopardize patient safety practices and quality of care (Lalleman et al., 2016).

Type 2: The manager – Hands-off

Monday morning, 11 AM. I meet nurse middle manager Joanne at her office located off the ward. She is wearing her favourite red blouse. The door is closed, not a sound. She is staring at two wide screen monitors figuring out how to control the nursing shortage for the coming week. She has not visited the ward yet, too busy with putting out fires, recruiting and floating nursing staff. Hopefully nobody calls in sick, because then she has to make some extra calls. Then, for the fourth time in a row she can't make it to the medication risk inventory meeting in the afternoon. She calls her colleague NMM to ask if she is planning to attend the mysterious emergency meeting initiated by higher management on the 'organic change process' and planned cut backs, that popped-up in her agenda this morning. Joanne earned her Bachelor in Nursing twelve years ago and recently followed a management development course on budget regulation, service and process improvement. She is thinking about implementing a self-scheduling project. Her unit coordinator drops in, the ward is in chaos, a patient fell out of bed and the physicians will file a complaint because two patients were late at OR. The unit coordinator prompts her to arrange extra staff for the evening shift and pay a quick visit to the breakroom because some of the staff nurses are crying and want Joanne to experience how busy the ward is. Joanne stares at her computer. She will drop by later she says, but first, she has a meeting with HR to discuss how to 'rehabilitate' her team aka 'the pseudo-patient'.

This narrative shows NMMs who do not visit the ward, do not see patients, and do not focus on patient-related issues when doing 'organising work' (see for explanation organising work: Allen, 2015 p. 8; and further discussion: Lalleman et al., 2017). These NMMs focus mostly on administration and scheduling staff nurses, and see their nursing staff as quasi-patients. Not much time is spent in the frontline of patient care while these NMMs are pre-occupied with 'being there for their staff' and the organization. This is mostly done

in their offices, discussing sick leave and life-work balance, recruiting nurses to step in on an ad hoc basis, and bed flow management in order to regulate nurse-patient ratios. For these NMMs, taking care for staff nurses and monitoring rosters and bed flow creates authority. Seeing or being involved with patients' care and outcomes, or focusing on patient safety and quality of care, does not. In the end, this results in a lack of clinical involvement and losing sight of patients as a result of a caring disposition geared toward caring for nursing staff instead of caring for patients.

This finding is a refinement on the vast literature on policy, management, and leadership in nursing that promotes NMMs being supportive of nursing staff wellbeing and job satisfaction (de Brouwer et al., 2014; Maben et al., 2012; Schmalenberg and Kramer, 2009; Upenieks, 2002). We, as well, underline the importance of staff wellbeing but emphasise that with type 2 leadership in NMMs' work practice, there is a risk of eroding the clinical disposition, which can ultimately lead to leadership practice in which NMMs avoid acting responsively, efficaciously, or decisively to improve patient safety (Jackson et al., 2013).

Type 3: The clinical leader - Heads-on

Monday morning, 11 AM. I meet nurse middle manager Mary at an orthopaedic patients' performance improvement meeting. She listens to the geriatrician presenting a patient case in which the importance of decreasing sleep medication to prevent falls is discussed with a multidisciplinary team of nurses, physicians, patient experience staff, researchers, and policy makers. Last week Mary read an interesting mixed-method article on the topic. Mary starts the day at her office, quickly going through her agenda and doing some preparation reading. She then grabs her white lab coat and goes off to the nursing station, saying hello to the nursing staff and attending patient rounding. When staff nurses and orthopaedic surgeons discuss a complex patient with a hip fracture she wants to intervene, but in the end she curbs this urge. They will manage without her. The next six

hours are filled with meetings outside the ward. After the performance improvement meeting she consults her clinical nurse specialist on decreasing hospital readmission, analyses the results of a joint regional research project on urinary tract infections, and chairs a dialogue session with a patients' representative on the development of a healing environment that affects nurse-sensitive patients outcomes. Mary recently finished her Master of Advanced Nursing Practice and uses her knowledge about evidence-informed practice and innovation to continuously improve the context of care. At the end of the day she does a round on the ward asking staff about their day and chats with the family of the complex patient with a hip fracture.

In this narrative the scientific disposition can be seen as 'capital generator' in NMMs' daily work. We see NMMs who react more reflectively, and are more analytic, strategic, and in control, and less emotional and ad hoc during their daily work activities. Postponing reactions and de-escalation were second nature for these NMMs. This leads to a proactive rather than reactive stance. The disposition to care is curbed. Nevertheless, this type shows NMMs that position the individual patient as an unique human being at the centre of care (McCance et al., 2009) and tailor care delivery to the patient's needs. The work of these NMMs seems to be less fast-paced, less fragmented, and less hectic than has been described in the literature on daily work of NMMs and managers in general (Arman et al., 2009; Mintzberg, 2013; Mintzberg, 1994).

Type 3 NMMs practice what we call 'heads-on' patient-centred care, which can occur whether the NMM is with a patient or not, for example, during meetings. They frame contextual issues from a patient's perspective. This 'heads-on' patient-centred care is facilitated through several contextual factors, such as frequent collaborative work with clinical nurse specialists and quality improvement staff, good contact with the unit coordinator as liaison between ward and NMMs, doing analysis, and being consultative.

General discussion

Above all, we wish to underline that the 'heads-on' patient-centeredness and investigative stance of type 3 clinical leaders allows them to incorporate the importance of the specific context into what Glasziou (2005) calls an evidence-informed practice. This is in line with a recent report of the Dutch Council for Public Health and Society (RVS) which advocates for context-based practice instead of evidence-based practice (RVS, 2017). In their report, *No evidence without context*, they refer to Greenhalgh et al. (2014) who asked themselves whether the evidence-based practice movement is in crisis. The report gives insights in a wide variety of critiques on evidence-based practice. For example, it focusses too much on epidemiological knowledge and generic evidence, advocates a univocal hierarchy of evidence with the Randomised Clinical Trial as its flagship, and has a reductionist view on evidence that ignores the patient-centred context in which it is used. It is important to note, however, that the report was mainly focused on the medical domain and not per se geared towards the field of nursing. Nevertheless, in the field of nursing there is some recognition of this critique. Thorne (2016) for example, states that 'evidence out of context is a dangerous tool' and 'oversimplification creates the conditions for harm'. This being said, we see a trend in the field of nursing, which works hard on incorporating context into EBP. For example, the usage of the Medical Research Council (MRC) framework for researching complex interventions (Richards and Borglin, 2011). This leads to a mix-methods approach that allows for what Richards (2015) refers to as 'the amalgamation of marginal gains' (i.e. combining insight from both qualitative as quantitative studies in essential nursing care research). See for practical examples the studies of Bleijenberg and Ettema (2016a; 2016b; 2014). Above all, a type 3 clinical leader with an investigative stance could work towards such a context-based clinical leadership practice at the frontline of care.

Clinical leadership as blended care

Our third type of NMMs' work practice is compelling because it has the potential to fulfill a vacant role at the frontline of care. It shows a resemblance to Daly's et

al. (2014) description of clinical leadership practices in the hospital setting. In their review they present a wide variety of clinical leadership practices – which they frame as characteristics –, as well as corresponding leader foci and leader attributes. Table 11 sums up their work.

Their article and table are especially helpful for us because they provide an overview of clinical leadership practices. Above all, they demonstrate clearly that one crucial issue is not yet touched upon in the rapidly expanding field of literature on clinical leadership – the impact of professional background. Our study on NMMs' professional backgrounds allows us to complement the original table with a new clinical leadership practice – based on our type three clinical leader; that of '*leadership as blended care*'. This time the blend is made between a caring and investigative stance, which contributes to emerging clinical leadership practices of NMMs that facilitate 'a feel for the game' at the frontline of care.

Through a leadership as blended care practise, NMMs focus on; (1) reflection regarding their own behavioral repertoire (habitus) and that of others; (2) influencing through asking questions and; (3) using a context based practice. Important leader attributes are curbing the urge to care, being inquisitive, analytical and consultative, and finally learning collaboratively in context (see table 11). Our findings show that '*leadership as blended care*' allows for switching between the various industry types described by Maccoby (2010), for the following three reasons:

- a. A leadership as blended care practice preserves the key characteristics and values of the caring disposition, which helps solve ad hoc issues at the frontline of care and articulates the core of nursing practice, that of being there for the other. These are important aspects in a cottage industry or craft mode with an emphasis on autonomy, personal relationships, reputation, personal trust, expertise, and craft.

Table 11 — Clinical leadership practices, leader foci and attributes

Leadership practices	Leader foci	Leader attributes
Leadership as situational	Context specific Diagnose microsystem issues	Directly involved in care Custodian of care processes & micro systems Reflexivity
Leadership as skill driven	Challenge the process and affect change Innovative problem solving	Clinical passion & credibility Expert knowledge Courage
Leadership as value driven	Faith and respect Heightened sense of responsibility	Professional identity Positive attitudes toward own profession
Leadership as vision driven	Translate broader vision into point-of-care delivery Interpret managerial agenda for clinicians Provide challenging goals	Strategic view Drive Sees important opportunities Understands improvement techniques
Leadership as collective	Complementarity Constellation of co-leaders	Enabling others to act Advocacy skills Approachable Works well in team
Leadership as co-produced	All staff have responsibility to lead Independent In interaction with others Networked	Effective communicator Able to influence others to act Inter-personal skills Ability to lead a team
Leadership as exchange relationships	Modeling the way Inspiring a shared vision	Capacity to enlist colleagues Role model Provides support Motivator Empowers others Supports others
Leadership as boundary spanning	Spans collegial, bureaucratic, interdisciplinary boundaries Links across point-of-care microsystems	Ability to work across teams Systems knowledge
Leadership as 'blended care'	Behavioral repertoire (habitus) of leader and others Influences through asking questions Context based practice	Curbing the urge to care Inquisitive, analytical & consultative 'heads-on' patient-centeredness Collaborative learning in context

Notes: table based on (Daly et al., 2014) who distilled the first 8 practices from; (Clark, 2012; Dierckx de Casterlé et al., 2008; Edmonstone, 2009; McKeon et al., 2009; Stanley, 2012; Patrick et al., 2011; McKee et al., 2013), complemented with a 9th practice from: (Lalleman et al., 2016; Lalleman et al., 2017a; Lalleman et al., 2015; Lalleman et al., 2017b).

- b. A leadership as blended care practice, focusses on clinical outcome measures of clinical pathways, blending price, scale, and service. These are important aspect of a stand-alone professional bureaucracy or industrial mode, with an emphasis on control and administration.
- c. A leadership as blended care practice helps curb the urge to care and invites NMMs to be more inquisitive and analytic, and to ask questions, which leads to a context-based clinical practice. These are important aspects of a high-tech collaborative learning organizations or knowledge mode with an emphasis on cooperation, prevention, health improvement, dialog, continuous improvement, innovation, and shared responsibly.

Discussion

In this paper we explored what type of clinical leadership practice is needed for NMMs to successfully facilitate the switching between the game types in the frontline of hospital care. We synthesized the various configurations of dispositions of NMMs' habitus into three types. This led to a re-conceptualization of Mintzberg's idea of 'managing as blended care' (blending caring and managerial practices) into 'clinical leadership as blended care' (blending a caring and investigative stance in the practices of NMMs).

From 'pure' managers to clinician engagement: the elephant in the room

Before we elaborate on the re-conceptualization of managing as blended care, we have to address an elephant in the room: do middle managers in health care need to have a clinical background at all? Aren't hospitals better off with so called 'pure' general managers (i.e. those with just an MBA or financial background) instead of these 'hybrid' or even 'multiple middle' NMMs? Clearly, in the work of these 'pure' general managers the professional (i.e. clinical)

background does not hinder their managerial work or leadership practices. On the other hand, they miss the (clinical) authority (Witman et al., 2011) and the understanding of the micro practices (Bohmer, 2013). Above all, as concluded by Sarto and Veronesi (2016) in a recent review on clinical leadership and hospital performance, managers with a clinical professional background 'have a positive impact on financial resources, the quality of care offered and the social performance of service providers'. Their review underlines the prevalent move across health systems toward increasing the presence of clinicians in leadership positions in healthcare organizations (Sarto and Veronesi, 2016). Thus, when hiring new middle managers or restructuring the hospital organization, choose for clinician engagement (i.e. in our case, a manager with a background in clinical nursing).

Nurse middle managers clinical leadership as 'blended care'

As demonstrated, successful clinician engagement is not easily realized. Much can go wrong. Mintzberg's (2013; 1994) sympathetic statement that 'in a sense, nursing is managing' is too simple. Mintzberg's blend resembles both our type 1's (the craft) and 2's (the manager) description of busy NMMs with a (pre) disposition to care, through scanning the environment, taking care of the team (as pseudo-patient), with ad hoc and fragmented work, plenty of administrative work, and many meetings. We have shown that some of these features facilitate NMMs' work in particular situations. But, because controlling or curbing these is difficult (and not conscious, as is the case in type 3 clinical leadership) they might as well hinder their work. That is why we re-conceptualized Mintzberg's 'managing as blended care' into 'leadership as blended care'. The new blend, with a prominent role for the scientific disposition, leads to NMM practices that are characterized by an investigative stance.

As demonstrated, this investigative stance, as part of a clinical leadership as blended care practice, enables NMMs to switch between all three of Maccoby's (2010) industry modes and game types. Mintzberg's

(1994) 'managing as blended care' as a more traditional concept of caring utilizes only two industry modes, that of craft combined with an industrial mode of managerial control. We believe that none of Daly's et al. (2014) clinical leadership practices facilitate switching between all three game types in such a way that the newly added leadership as blended care practice does.

Recognizing habitus, the first step of conversion into leadership as blended care

Being able to switch between game types asks for a 'conversion' of habitus (i.e. a re-configuration of the dispositions). In the literature on habitus only a few authors have touched on the subject of alterations of habitus by using the concept of conversion. This concept refers to a change in the basic structure of the scheme of dispositions of habitus (Eacott, 2013; Smid, 2001; based on Windolf, 1981). Such a change is not done easily, because the sub-conscious second nature of habitus makes it difficult to recognize. Above all, it is the scheme or configuration that changes, not the elements (dispositions) of habitus itself. The scheme is rebuilt to provide responses to new situations (e.g. a more prominent – capital generating – role of the scientific dispositions can be seen as a response to NMMs' work in a more knowledge-intensive hospital organization). Bourdieu (1977) himself states that the dispositions of habitus (as embodied history and internalized as a second nature) are durable (Bourdieu et al., 1989). This durability is partly constituted by the circular relationship of field and habitus: involvement in a field shapes the habitus that, once activated, reproduces the field (Nicolini, 2013). In sum, to set a conversion in motion, the first crucial and most challenging step in clinical leader development is to recognize one's own habitus and that of others.

From conversion of habitus towards a transition of field (and vice versa)

One could see conversion of habitus as a metaphor for some of the transitions in working life (Smid,

2001). It is a transition of work (doings in context) and intrapersonal features. For example, the NMMs of the fourth hospital of our multiple case study (here we observed managers who practice type 3 clinical leadership) went through such a transition. This transition of their field is characterised by a merger of locations into a complete new building based on; a healing environment for patients; the principles of Magnet® that include a supportive work structure and culture for nurses, and a strong encouragement of the organization towards lifelong learning (e.g., NMMs earning a Master of Advanced Nursing Practice (MANP) degree) (see description site four in: Lalleman et al., 2015). Here, habitus and field are interlocked and reinforce each other. The MANP program facilitates the conversion of the habitus (e.g. through emphasising research, the investigative stance, analysis, and EBP), and the new building and Magnet® recognition program enhanced this conversion. So, in order to develop clinical leadership as blended care, transition towards a supportive work environment and emphasis on training leaders are crucial.

Leadership as blended care as catalyst of a new definition of health

The conversion of the basic structure of habitus, which leads to curbing the urge to care and focuses on de-escalating, pro-active and preventive care as well, supports the dissemination of the new suggested definition of health, which focusses on the ability to adapt and self-manage in the face of social, physical, and emotional challenges (Huber et al., 2011). According to Huber et al. (2011), 'redefining health is an ambitious and complex goal; many aspects need to be considered, many stakeholders consulted, and many cultures reflected, and it must also take into account future scientific and technological advances'. Leadership as blended care supports such a complex process because it touches the core element of nursing practice, that of caring. It allows nurses and NMMs to tailor the care provided (e.g. through curbing the urge to care and focus on context based practice), enhance patient centred care (Kitson et al., 2013; Köberich

and Farin, 2015), and underline that with regards to self-management of patients, 'one size does not fit all' (Trappenburg et al., 2013). Again, a conversion of both the professional habitus of NMMs and nurses and that of the field of healthcare is warranted in order to move from the present static formulation of health towards a more dynamic one based on resilience or capacity to cope and maintain and restore the patients' integrity, equilibrium, and sense of wellbeing (Huber, 2010).

Developing clinical leaders and leadership practices as blended care

Despite recognition of the importance of effective clinical leadership to patient outcomes (Daly et al., 2014; Sarto and Veronesi, 2016), there are considerable barriers to participation in clinical leadership practices. These include (1) poor preparation for leadership roles, (2) curriculum deficiencies at undergraduate level, (3) experience as participants in poorly constructed clinical leadership programs, (4) poor leadership and lack of vision and commitment at the higher management levels, (5) the perception of leadership as 'other' and not core to a clinical practice role and (6) poor interdisciplinary relationships (Daly et al., 2014).

Before we elaborate on how to overcome some of these barriers through training and development, it is important to note that according to Day et al., (2014) the distinction between developing *leaders* and developing *leadership* is an important one. Leader development focuses on developing individual leaders whereas leadership development focuses on a process of development that inherently involves multiple individuals (e.g., leaders and followers, or among peers in a self-managed work team). Thus, for clinical leadership as blended care to be successful we need to develop both the individual leader (i.e. an *intrapersonal* process) and the emerging collective practice of leadership (i.e. an *interpersonal* process) focused on enhancing leadership capacity and resulting in joint accomplishments (Day et al., 2014). Taking all this in account, we recommend the following to further develop the participation of clinical leaders in collective leadership practices.

Developing leaders

First, we propose that NMMs should at least have a graduate-level (masters) degree. Ideally they have followed a combined or dual degree, with clinical and organizational / managerial content, that includes emphasis on context based practices, organization theory and behavior, strategy and leadership, (mixed-methods) research methodology, and focus on nurse sensitive patient outcomes. In a similar vein, Knol (2016) suggests introducing what she calls 'hospital studies' that combine clinical as organizational issues as be part of the initial and ongoing training of nurses and managers. The American Nurses Association (ANA) (2009) and the American Organization of Nurse Executives (AONE) (2010) have advocated for such curricula as a baseline for a nurse middle management position.

This 'upgrade' of NMMs should be synchronous with the further development of nursing staff's educational levels; otherwise a gap between the two could jeopardize future collaboration. Moreover, such an upgrade resulting in a skill-mix with increasing numbers of undergraduate or Baccalaureate level nurses in hospitals will, according to research by Aiken et al, (2014), lead to a decrease of patient mortality and morbidity. Finding such an optimal skill-mix and staffing level that fits the patients' care intensity and complexity is a daily challenge for NMMs (see for example: Oostveen, 2015).

Furthermore, this overall upgrade of NMMs and nurses educational level will catalyze their organizational intelligence necessary to articulate their often 'invisible work' at the frontline of care. This is in line with literature on organized professionalism, which emphasizes the negotiated and reciprocal relationship between organizational and professional logics. Dual degree programs that focus on logics and foster an investigative stance for undergraduate and graduate levels will support nurses and NMMs to increasingly engage in new organizational issues and incorporate them into their daily nursing work (Allen, 2014; Allen and May, 2017; see for example: Noordegraaf, 2011; Noordegraaf, 2015; Postma et al., 2014; Wallenburg et al., 2016).

Developing collective leadership practices

Second, we advocate for a practice-based approach to collective leadership learning (contrary to an competency-based leader development approach) (Carroll et al., 2008; Edmonstone, 2014). This approach can be realized through a blend of situated (i.e. shadowing) and online learning (see for examples: Garrison and Kanuka, 2004; Lalleman and Verdonk, 2015). In order to promote the social interaction necessary for developing the relational, interpersonal, and collective aspects of developing leadership practices, it is advisable to work with multi-disciplinary small private online courses (SPOCs) instead of massive open online courses (MOOCs) (Uijl et al., 2017).

Literature suggests utilizing a R2D2 model (read, reflect, display, and do) of learning, which is a constructivist model for designing and delivering blended education (Bonk and Zhang, 2006; Willis and Wright, 2000). The R2D2 model allows for carefully rebuilding the scheme of NMMs' *habitus* and developing collective clinical leadership as blended care practice through: (1) *reading* and (2) *reflecting* on a wide variety of healthcare, organizational, and clinical leadership literature, (3) making short videos, blogs and mind maps that *display* personal daily leadership practices and finally (4) *shadowing* one or more 'clinical leaders' *in situ* (i.e. *do*). The model supports changing the question from 'what is it that clinical leaders [really] do?' to 'how can the clinical leader facilitate self-meaning, positioning and value' (Carroll and Levy, 2008), and contributes to a joint accomplishment and an interpersonal process between the leader and followers with a focus on delivering safe and high quality care.

With a collective leadership as blended care practice, we are re-framing the image of a more heroic and hierarchical leader at the frontstage and advocating for a more distributed leadership practice (Oldenhof, 2015 p. 141) at the backstage. This concept has a strong collaborative focus that can be located at designated positions in the organization (e.g., middle management, shared governance nursing councils,

higher management, executive boards) and at non-designated positions in the organization (e.g., nursing staff on the ward, nurse(s)(scientist) working on quality and performance improvement departments or clinical nurse specialists) (see for example: The King's Fund, 2011; Šliwa et al., 2013).

Finally, a collective leadership as blended care practice will, through the investigative stance and consultative contribution of the NMM, support the further development of collaborative problem solving skills (CPS) (Hesse et al., 2015) and 'teaming' (Edmondson, 2012), which are crucial for building safe and high quality learning organizations. The RVS Report (2017) as well recommends to stimulating collaboration between multi-disciplinary players in order to better comprehend the context of patient care. Collaborative problem solving means approaching a complex problem responsively by working together and exchanging ideas. This is not yet a common routine in all hospitals (see for example: West and Lyubovnikova, 2013). In an intriguing study on collaborative problem solving and learning from failure in healthcare Edmondson (2004) describes how nurses took the quick fix route (often workarounds) in 93% of the failures observed. Her article shows that these responses allowed patient care to continue; however, neither the hospital nor the other employees or departments who may have contributed to the problem were able to learn from these process failures. This so called 'first order problem solving' of the nurses kept communication of problems isolated so that they did not appear as collective learning opportunities. Moreover, although most of the problems observed were small, requiring only a few minutes to resolve, the cumulative impact of these solutions, often workarounds, can be substantial and lead to poor use of well-paid professionals' time. Besides poor use of time, these constant struggles and annoying problems – or compensatory mode (McNamara and Fealy, 2010) – takes a toll and leads to frustration and burnout (Edmondson, 2004).

In contrast, 'second order problem solving' can have positive consequences for the worker as well as for the organization (Edmondson, 2004). Here a worker takes

action to address underlying causes, which invariably requires collaborative problem solving and 'teaming' with others in the organization (in addition to a quick fix enabling the immediate task to be completed). Whereas in the type 1 and 2 practices NMMs may easily get lured into the first order quick fix, in the third type one is more likely to – due to the investigative stance - focus on collaborative problem solving and teaming as interventions to foster second order learning. According to Edmonson, teaming is: 'flexible team-work, a way to gather experts from far-flung divisions and disciplines into temporary groups to tackle unexpected problems and identify emerging opportunities'. The ground rules of teaming are in line with our call for frequent switching between games. It is not about being in the lead of a 'stable team' per se, but the ability of the NMMs to engage in 'teaming', thus bridging between players and switching between game types at the frontline of care. In a similar vein, West et al., (2013) describe the difficulties of team work in health care and stipulate the importance of (team) leadership (see for example: Harvey and Edmondson, 2016) and (team) reflexivity (see for example: Schippers et al., 2014), which supports the development of collaborative aspects of a leadership as blended care practices.

Reflections on methodology, process and role of the researcher

Although this research project has made a number of notable contributions to the field of NMMs' work and leadership studies, the project had to deal with a number of challenges. These challenges relate to using Bourdieu's work as -analytical- tools, shadowing in four hospitals, and the role of the researcher.

First, a commonly mentioned limitation with regards to Bourdieu's 'practical theory' is that in an attempt to overcome dualities, it is nuanced and is overtly complex (King, 2000). A special issue on Bourdieu and organizational analysis in *Theory and Society* zooms in on these complexities (Dobbin, 2008; Emirbayer and Johnson, 2008; Swartz, 2008; Vaughan, 2008) and echoes the critique that Bourdieu inconsequently uses his own concepts (Witman et al., 2011). We employed

a relatively small range of these 'tools' (i.e., dispositions of habitus, field and capital). We could have chosen specific types of capital (i.e. economic capital, cultural capital, social capital) or introduced typical Bourdieusian concepts such as 'doxa' and 'illusio' to further understand NMMs' daily work (see for such a comprehensive and more theoretical example: Noordegraaf and Schinkel, 2011). For us, however, Bourdieu's work should support the articulation of both the 'invisible work' and the 'organizational intelligence' at the frontline of care in a practical sense, in situ and preferably while doing research (i.e. through shadowing). Hence, literature suggests that collaboration between those at the frontline and social scientists could facilitate such an articulation process (Dixon-Woods et al., 2011) through creating a common language between the academic high grounds and 'swampy lowlands' of practice (Allen et al., 2016; Schön, 1995). Following Witman (2001), and keeping Bourdieu 'simple', supported this articulation process. Second, shadowing sixteen NMMs for more than 560 hours in four hospitals in both the Netherlands and the United States is rewarding, but also creates a large amount of data on behavior or 'doings' (McDonald, 2005). Our strategy of going in 'open' and focusing first and foremost on the NMMs' job, and not on the organization (field) itself, helped us decipher NMMs' habitus, describe daily work, and foster leadership practices. However, when asked about, for example, the differences between the four organizations or between the two countries, shadowing does not allow for very detailed comparative analysis. Looking back, the variations between the four hospitals are not exposed to their full extent. Although the overall tasks of the NMMs' job itself is more or less the same, the dynamics on the ward, in the hospital organization, region and nation, had a impact on NMMs' daily work. We tried to depict these dynamics in the various papers of this project but, despite the rich ethnographic character, the end result shows a phenomenon that in photography is called a 'bokeh' effect. Bokeh comes from the Japanese word boke (ボケ), which means "blur" or "haze". The use of a bokeh lens results in a soft out-of-focus background. Our research technique of shadowing and a clear focus on the NMMs' job led to a 'bokeh' view of the organizations in the background, with rich colours and

contrasts in a haze. For studies like ours, Nicolini's (2009) advises to both zoom in (i.e. closely look at the micro practices of the NMMs) and zoom out (i.e. see practices in the context of work) systematically. We, however, mostly zoomed in and closely looked at the NMMs' work and behaviour. After all, in this study, NMMs' professional clinical background (i.e. habitus) was at the front-stage and the context of their work (i.e. field) at the back-stage. Nevertheless, the managerial work and behaviour analyses (Lalleman et al., 2017) did provide us with crucial context information of the various fields and support our further analyse of NMMs' habitus.

Third, regarding the role of the researcher. I am a male nurse. I have worked in nursing management. I know the two Dutch hospitals from inside because I have worked in both for several years. This had some advantages. I know the micro practices and life on the wards. From a Bourdieusian perspective this could hinder as well. Hence, how do I observe 'second nature' or habitus if these dispositions are also anchored in myself? I believe that this research project, as part of a PhD trajectory, actually helped to convert my own professional nursing habitus. I refined my scientific disposition and learned to curb the urge to care better than before. In the end, after four years of collecting data, conducting analysis and writing papers, I caught myself of becoming more researcher than clinical nurse. From that moment on I started working as a per diem district nurse next to my job as a researcher and lecturer at the university in order to practice what I preach: clinical leadership as blended care.

Conclusion

NMMs can play a crucial and not-to-be underestimated role at the frontline of care. They can ensure safe, high quality and patient-centered care, and support for nurses, organizational continuity and performance. In order to realize this, NMMs have to have a feel for the game in various industry modes and game types. Above all, it is key that they can switch between these modes - from a cottage industry mode via a bureaucratic approach to a knowledge intensive

mode and vice versa - and support others to do so. This requires a specific leadership practice: that of clinical leadership as blended care. This emerging leadership practice is characterized by curbing the urge to care, an investigative stance, 'heads-on' patient-centeredness, context-based practice, teaming, and collaborative organizational learning. The challenge is now to create an overall upgrade of NMMs' and clinical nurses' educational levels through a dual track curriculum that focusses on both clinical and organizational aspects of daily hospital work, with shadowing as a potential strong experimental learning tool in the development of clinical leadership practices. Future research should focus on mixed-methods and practice-based studies to decipher in more detail the working elements of leader and leadership development programs and their impact on patient care and hospital performance.

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Summary

This thesis describes the daily work of nurse middle managers at the frontline of patient care in general hospitals. With this description we explore which dispositions¹, originate from their clinical nursing profession, help or hinder them in their daily activities and contribute (or not) to their clinical leadership, in areas such as, support of the nursing team, realizing patient safety or patient centeredness. The final goal of this thesis is to develop tools and techniques that help the development of the nurse middle manager, enforcing the advantages of having a background in clinical nursing and curbing the disadvantages. We argue that this requires a work practice in which the nurse middle manager combines both ‘organising work’ and ‘caring work’ that has a close fit with the context in which it takes place. We call this combination *‘leadership as blended care’*.

1. According to Collins Cobuild’s advanced dictionary of English, someone’s disposition is the way he or she tends to behave or feel. In this study we use Bourdieu’s description, which we explain later.

Summary

This study explores the clinical leadership of nurse middle managers with a background in clinical nursing, as an example of *professionals in the lead*. To enhance readability we use the term nurse manager. This clinical leadership is of the utmost importance in hospitals. It contributes to continuous quality improvement, patient safety practices, patient centeredness, support of nursing staff and the continuity of the organization. In short, it contributes to patient, employee, and organisation value. Literature on '*professionals in the lead*', shows that healthcare managers with a clinical background are in advantageous positions in comparison with those managers with no clinical background. They understand the complexity of the biological and healthcare systems. Moreover, they have influence on their own professional group and control over the micro practices at the frontline of patient care.

Being a '*professional in the lead*' has some disadvantages as well. The dissertation of Yolande Witman gave a description of the advantages and disadvantages of *physicians* who work as department heads in academic hospitals. The thesis at hand can be seen as a continuation of that study. We explore the advantages and disadvantages of having a clinical *nursing* background in a management position in a general hospital. The following research questions were key:

1. What do nurse managers do in their daily work? (chapter 4)
2. What is their contribution to safe and patient-centred care? (chapter 3 and 4)
3. How do nurse managers create value for employee and organisation? (chapter 2 and 4)
4. What dispositions help? (chapter 2 and 3)
5. What dispositions and work environment hinder? (chapter 2, 3 and 4)
6. What could support nurse managers in further developing and optimizing their contributions to create patient, employee, and organisation value? (chapter 5)

Ethnography is used to describe nurse managers' daily work. We shadowed nurse managers during their

work activities in the hospital. This helped us create an insightful picture of what their practice entails. It became clear when their clinical nursing backgrounds helped and hindered. In total, sixteen nurse managers were shadowed. They worked in four different hospitals, of which two were situated in the Netherlands and two in the United States. In each hospital four nurse managers were shadowed for four days per person. This led to 560 hours of observation, 2490 pages of field notes and 61 hours of audio fragments. Additionally, we conducted document analysis, member checks and semi structured interviews. During data analysis we used a variety of 'sensitizing concepts' from literature to give further meaning to our observations, such as 'habitus', 'disposition', 'field', 'capital', as well as, 'patient centeredness', patient safety and 'social comparison theory'. The data analysis has been both inductively developed, and theoretically based.

The research design is to a large extent based on Mintzberg's managerial work and behaviour approach, with his structured observation method as cornerstone (see his classical book, *The nature of Managerial Work* from 1973). His shadowing method and his fascination with the work of managers in hospitals are sources of inspiration; it was Mintzberg who argued in the mid 1990's in the *Journal of Nursing Administration* that 'nursing is managing'. For a full comprehension of the influence of professional clinical backgrounds on the leadership of nurse managers, the work of Bourdieu, especially his concepts of dispositions, habitus, field and capital, plays an important role.

The result of this research project is a bundle of five papers. They offer an ethnography of the daily work of nurse managers in hospitals. First we present the dispositions we found, followed by an analysis of the contributions of nurse managers in supporting their teams, realising patient safety and realising patient-centred work. The papers show that, depending on the work context, different dispositions are helping or hindering in the emerging clinical leadership practices of these nurse managers at the frontline of patient care. Next, we give some suggestions on how to support nurse managers in their clinical leadership development in daily work.

Summary

Chapter two is the foundation for the other papers. It explains the concepts of Bourdieu, which helps us articulate and visualize the dispositions of nurse managers. It describes the four hospitals in which the observed nurse managers work. Eight different dispositions are presented that emerged from our analysis. Our results show how the different dispositions in various configurations contribute to the supportive role behaviour of the nurse managers towards their teams of nurses.

The four concepts – Bourdieu calls them ‘tools’ – help us to articulate the impact of professional clinical backgrounds on nurse managers’ clinical leadership. First habitus, which, according to Bourdieu, is a system of dispositions, or durable, subconscious schemes of perception and appreciation that activate and guide practice. These subconscious schemes are like a forgotten history. The second concept of Bourdieu is dispositions. Dispositions are basic underlying assumptions, and an important source of values and practices. The dispositions that together form the habitus play an important role in how a human being perceives, values, thinks and acts. This happens in what Bourdieu calls a field, his third concept.

A field refers to a social space with an internal logic of its own. This can be a professional field, such as that of nurses or an institutional field, such as that of a hospital as part of a larger system of healthcare in a particular region. Bourdieu closely couples this concept of field to his fourth concept, that of capital. In a field, there is always something at stake, i.e., there are struggles for forms of capital such as positions and other valuable resources. Capital gives authority within the field, and may be inherited through position or be based on knowledge or seniority. Bourdieu’s concept of field can be compared to a game with the aim of collecting valuable resources, or ‘capital’. Some literature compares capital with authority. In the institutional field of a hospital a nurse manager can acquire capital through being supportive and visible for the team of staff nurses but also through controlling costs for higher management. It depends on what is most valued in that particular field. This determines which

dispositions of habitus subconsciously come into to play.

The second chapter demonstrates how eight dispositions are simultaneously ‘in play’ during nurse middle managers’ daily work.

Through a **caring disposition**, nurse managers see patients as individuals who require care and attention.

- The corresponding strategies include answering the call for help of the other in the here and now; ad hoc, reactive reactions; and quick judgment.
- The caring disposition manifests itself by scanning the environment for calls for help.
- Excelling in the caring disposition provides capital that is based on taking care of and paying attention to patients.

Through a **clinical disposition**, nurse managers see individuals as patients.

- The corresponding strategies include the search for the symptoms and causes for the conditions observed.
- The clinical disposition manifests itself by seeing patients, diagnosing their care needs and knowing their conditions.
- Excelling in this disposition provides capital that is based on having and using clinical expertise.

A **collegial disposition** refers to nurse managers ensuring a positive team dynamic.

- The corresponding strategies include being friendly to team members and taking care of other colleagues. This disposition manifests itself by giving attention to members of the team, encouraging feedback and tacitly knowing other individuals’ needs.
- Excelling in this disposition provides capital that is based on being collegial and preserving a friendly atmosphere.

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Through a **teaching disposition**, nurse managers see themselves as tutors or mentors.

- The corresponding strategies include creating moments for coaching, instructing and learning.
- It manifests itself through teaching or instructing patients and colleagues.
- Excelling in this disposition provides capital based on sharing knowledge and teaching.

A **scientific disposition** refers to nurse managers' work as a scientific and reflective practice.

- The corresponding strategies include referring to, gathering and using scientific evidence and asking reflective questions to enhance the quality of patient care.
- This disposition manifests itself through an investigative stance, postponing reactions, refraining from judging, focusing on research/EBP and reflecting on actions.
- Excelling in this disposition provides capital that is based on using scientific knowledge and asking reflective questions rather than ad-hoc action.

Through a **professional disposition**, nurse managers perceive themselves as both personally and collectively accountable for good patient care.

- The corresponding strategies include putting the interests of patients first, and being accountable and taking responsibility.
- This disposition manifests itself by feelings of responsibility and sharing responsibilities.
- Excelling in this disposition provides capital that is based on being responsible and accountable both personally and collectively for patient care.

Through an **administrative disposition**, nurse managers view administrative work as legitimization of their activities.

- The corresponding strategies include the use of checklists, guidelines, benchmarks and reports.
- This disposition manifests itself through a focus on writing reports, filling out checklists, addressing

administrative issues and performing clerical work.

- Excelling in this disposition provides capital that is based on the correct use of checklists and guidelines, and handling administrative procedures.

A **control disposition** views nurse managers' work as a way to create order and serenity.

- The corresponding strategies include controlling daily situations by tidying up.
- This disposition manifests itself through a focus on controlling (complex) situations, creating order and clarity, cleaning up and clearing up.
- Excelling in this disposition provides capital that is based on being in control of situations.

These eight dispositions emerge in various configurations depending on the field in which they are active.

In understanding the practice of nurse managers, it is also important to address the dynamics between the various dispositions in action and the distribution of capital at the four hospitals (institutional field).

Subsequently, we show in this chapter two how the dynamics in the four hospitals result in different configurations, which result in varying supportive role behaviours of nurse managers towards their staff nurses.

The analysis shows how a configuration in which the care disposition and the clinical disposition dominate and generates capital (authority). This configuration results in nurse middle managers showing supportive role behaviours through being visible and being involved in direct clinical patient care. This configuration generates authority with the physicians as well, hence, in this relation the clinical disposition plays a more prominent role because value that disposition most.

We also saw a configuration combining a dominant caring disposition (always being there for the other, ad hoc and reactive reactions and quick judgment) and a collegial disposition (being friendly and keeping a good atmosphere). This configuration focusses on role behaviours that support the team. This generates capital because taking care of the team is valued by the team

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(attention and recognition) and higher management (matching schedules and low sick leave).

In short: the team becomes a pseudo-patient for the nurse manager. In the end, however, this leads to less supportive role behaviours because the nurse manager loses clinical authority (capital). This sounds contradictory but when nurse managers only focus on the schedules, sick leave and moods of their personnel, their clinical authority erodes over time. The nurse managers do not address patient related issues, do not discuss patient cases and are not involved with the core of nursing work: the patient (care) and his or her family. This diminishes their supportive role behaviour.

Yet another configuration shows dominant control and administrative dispositions. At this site there were ambiguities regarding responsibility and accountability which are part of a professional disposition. Nurse managers attempted to control these ambiguities via the creation of checklists and guidelines, which generated a substantive administrative burden. A teaching disposition was also manifested as an instrument of control rather than an instrument for learning, which affected and compromised a professional disposition. Instructing nurses on precisely how to use the checklists and guidelines was emphasized. The focus of the nurse managers is mainly on monitoring the nurses, compliance to rules, and filling out checklists and guidelines. There is minimal attention to and recognition for the professional nursing work itself. This results in an abundance of administrative work and pressure for the nursing staff and nurse managers. This configuration does not generate value or capital from the staff nurses; they do not experience supportive role behaviour of the nurse managers.

We round up chapter 2 with showing that a dominant scientific disposition can play an important role in further development of a healthy work environment via supportive role behaviours of nurse managers. This cannot be addressed, however, without underlining the key role of the caring disposition. This disposition already proved its value, but becomes even more valuable – generates more capital – with the scientific disposition in play. In this particular configuration the

scientific disposition shows a nurse manager who has a more investigative stance and reacts less ad hoc.

This creates a quiet and calmer atmosphere.

The reactions on daily reoccurring issues is not that prominent, the nurse managers try to think a few steps ahead, and be more analytic and systemic in their search for durable solutions based on evidence instead of temporary quick fixes.

In **chapter three** we describe and define clinical leadership of nurse managers and relate this to their patient safety practices. Literature shows that healthcare professionals in a leading role have a significant impact on patient safety. We explore how three particular configurations of dispositions of habitus influence patient safety practices of nurse managers. We zoom in on those configuration in which the care dispositions plays an important role. After all, as shown in chapter two, this disposition plays an important role in the configuration of habitus of nurse managers but could, as well, hinder their work and ability to generate capital.

In this chapter we show that the care disposition of nurse managers positively influences their clinical leadership and patient safety practices. Still, nurse managers find it difficult to keep their foci on patient safety practices during mundane work activities. They get easily lured into being busy with the schedule, budgets, finance or benchmarks. We argue that even the care disposition could contribute to this and hinder nurse managers' clinical leadership. This happens in two distinct ways. Firstly, when the care disposition of the nurse manager is only geared towards the nursing team (in a configuration with the collegial disposition), and the team becomes a quasi-patient. The nurse manager indeed is doing 'caring work' but it has nothing to do with patient care, and results in deterioration of the patients' safety. Secondly, we see nurse managers who do focus on patients but where the caring disposition results in ad-hoc and reactive behaviours. This leads to short-term solutions in which a nurse manager realize a quick fix but does not inquire into the root cause of the issue. This is provoked by a caring disposition that subconsciously urges the nurse managers to jump to conclusions and answer the call for help.

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This behaviour has its advantages; after all, all the small system failures are fixed in the here and now without any big disturbances. Some call this the 'compensatory mode'. However, when nurse managers learn to curb the care disposition (and through that the compensatory practices), and thus do not react ad-hoc and answer all the calls for help, they are more likely to be more investigative first, ask questions and take their time for analyses. The result is more room for continuous patient safety practices.

This analysis underlines the importance for nurse managers of knowing their own dispositions (or said in a different way: their preferred behavioural repertoire). This means, knowing when their care disposition generates capital or authority and when they need to curb this disposition and be more reflective and investigate as seen at the scientific disposition. This, however, is not easy. Only when nurse managers fully comprehend the strengths and pitfalls of the caring disposition, will they be able to adjust their behavioural repertoires and focus on patient safety practices. Developing a 'feel for the game' is crucial. Both the behavioural repertoire and the work environment – Bourdieu would say field – play an important role in this game.

In **chapter four** we use the managerial work and behaviour approach to explore nurse managers' contributions to patient-centeredness. Nurse managers are in an ideal position to facilitate patient-centeredness. However, not much is written about their contributions in literature. The studies that report on this topic are mainly interview studies in which nurse managers talk about the way they facilitate patient-centeredness. In this chapter we show how they contribute to patient-centred work on a daily basis on the ward. We focus on their 'doings' and less on their 'sayings'. According to the literature patient-centeredness has three core elements: 1. patient participation and involvement; 2. the relationship between patient and healthcare professional, and 3. the context of care delivery. In this chapter we do not use Bourdieu's tools as 'sensitizing concepts' but Mintzberg's managerial work and behaviour approach.

In four histograms we show for each of the hospitals how nurse managers use their time.

- Histogram 1 shows the place the nurse manager is at (e.g. office, nursing station or meeting room),
- Histogram 2 shows with whom the nurse manager is having contact (e.g. nursing staff, physicians or higher management),
- Histogram 3 shows their activities (e.g. deskwork, meetings or clinical work), and finally,
- Histogram 4 shows what the purpose is of all these activities (e.g. making a schedule, admission and discharge of patients, quality improvement or patient care).

We then synthesize these data into a concluding histogram, which is mainly based on the fourth histogram. This histogram shows per hospital that the ratio between 'caring work' (e.g. doing patient rounds, talking to family and patients, initiating quality improvement or evidence based practice), 'organizing work' (e.g. making schedules, admission and discharge or organizational change) and, 'margin work' (e.g. set up time, breaks, reflections or chit chat) could differ significantly. At three of the four hospitals the ratios are in line with the literature. Here the nurse manager spends 70% of the time on 'organising work', 20% on 'caring work' and 10% on 'margin work'. However, at one hospital the ratio between 'caring work' and 'organising work' was equal, namely both 40%. The managers at this hospital had 20% 'margin time'. This ratio strongly contributes to nurse managers patient-centeredness.

Managers who stay in their offices limit their contributions to patient-centred care. Being with patients and providing 'hands-on' bedside nursing care could contribute to patient-centred care, due to the proximity to care delivery. However, when the purpose of being in a patient's room is to check and monitor nursing staff, a nurse manager's proximity to the patient does not necessarily contribute to patient-centred care. Moreover, we saw examples of nurse managers whose proximity to patients was limited – minimal 'hands-on' – but still, to a large

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extent contribute to patient centeredness. These nurse managers facilitate patient-centred practices of their nursing staff through, regardless of context, emphasis on the importance of patient participation and patient-professional relationships. Nurse managers can practice what we call 'heads-on' patient-centred care, which can occur when one is near a patient, or for example, during meetings. Curbing the caring disposition, as described in chapter 2 and 3, could contribute to this 'heads-on' patient centred practice. The nurse managers reacts less ad hoc and is more investigative, with a focus on evidence-based practice and nurse-sensitive patient outcomes (e.g. infection prevention, wound recovery, patient falls). What we see is that during meetings of the nurse managers when the theme is on the agenda, this could be classified as an 'organising work' (e.g. administration, budgets, guidelines) frame from a patient's perspective. Here nurse managers' 'organising work' becomes closely coupled to, or an integrated part of, 'caring work' through framing issues from a patient's perspective. Coupling 'organising work' to 'caring work' asks for a work environment that allows this to happen, with factors such as optimal nurse-patient ratios, staff mixes, and built environments present.

Nurse managers who had frequent contact with a clinical nurse specialist portrayed 'heads-on' patient-centred care more easily. After all they are continuously challenged, in spite of time pressures, to reflect on complex patient cases and dilemmas. Hence, the clinical nurse specialists' focus is on patient outcomes and evidence-based practice that has relevance for the wards' patient population. The clinical nurse specialist is the manager's catalyst for a continuous dialogue about patients and their most relevant health outcomes. In the hospital with the 40-40-20 ratio the clinical nurse specialist played a crucial role as a sparring partner of the nurse manager. Other characteristic of this hospital that support 'heads-on' patient-centred care were frequent contact with the unit coordinator as liaison between ward and nurse managers, good contact with physicians, patient councils and other professionals, and favourable patient-nurse ratio's. There were centrally-located quality and performance improvement

staff (referred to as 'the smart people' without any irony) and a decentralised quality and improvement staff that teamed up with the nurse managers and her clinical nurse specialist). Moreover, the relatively new building (5 years old) was built with the professionals in mind and had a 'healing environment' design. All factors that could generate stress and thus delay recovery were kept in mind, such as optimal light conditions, colours and sound. Lastly, the nurse managers were stimulated to get their master in nursing science (MSN) degree.

Chapter five provides tools to further develop nurse managers' clinical leadership. At one of the member checks the participants suggested that shadowing as a research technique could as well be used as a technique for leadership development. We confirmed this idea with a review of the literature. The nurse managers that participated in our study reported that after the shadower (researcher) left they still felt his virtual presence in particular situations, as if he was watching over their shoulders. This made them more aware of their behaviour in situ and prompted them to suggest shadowing each other and becoming researchers of their own work practices.

Eight nurse managers shadowed each other. A researcher interviewed them before and after shadowing and asked them about their experiences. The study shows that peer-to-peer shadowing has the potential to facilitate collective reflection-in-action and enhances the development of an 'investigate stance' while acting. This helps to curb nurse managers' caring disposition that unreflectively urges them to act, answer the call for help in the here and now, focus on ad hoc 'doings' and make quick judgments. Seeing a shadowee in action at work leads to a process of social comparison by the shadower, which allows the nurse managers to learn to postpone reactions, refrain from judging, focus on reflection in action and asking, receiving and giving feedback. To further support our conclusion on peer-to-peer shadowing as a potential technique for clinical leadership development, we need to better understand the effects of the 'comparison-mode'. Our exploration asks for a larger study so we can develop a practical guide on how to curb and

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postpone while shadowing, how to give feedback, how to deal with the shadower-shadowee relationships and continuous social comparison.

Chapter six provides the conclusions and discussion.

In this chapter we reflect on the influence of nurse managers' habitus on their clinical leadership.

The starting point is a claim of one of the founding fathers of the managerial work and behaviour approach, Henry Mintzberg. He claims that 'managing is nursing'. Subsequently he concludes that what is needed for successfully managing a hospital is a *blend of care*. Mintzberg considers the job of nurse middle managers (nurse managers) as a blend of their earlier clinical work with patients and of managing a hospital ward (e.g. monitoring, liaison, disturbance handler). Nurse managers behave towards nurses and others in the hospital in the way they previously behaved towards their patients. Then we discuss the work of Maccoby, who differentiates three modes of healthcare systems. The first is a craft mode with a cottage industry feel in which professionals work isolated. The second mode is that of a professional bureaucracy and in the third mode the hospital has changed into a knowledge intensive, high tech collaborative learning organization. Maccoby sees these three modes as linear and chronologically stepped phases. We suggest, however, that all modes are simultaneously at play in the work of healthcare professionals in contemporary general hospital organizations. Keeping a focus on the patients puts high demands on the professional at the frontline of care. The nurse manager is supposed to support the nurses at the frontline in this focusing. That is why it is important that nurse managers recognize these three modes and can support each other in switching between them. This is a difficult task and asks for the further development of nurse managers. In order to provide insights into this development issue and make it simpler, we constructed a typology of the nurse managers' work practices.

A secondary analysis of our own data, together with insights from literature, helped us step from a wide variety of configurations towards a typology of the work practices of nurse managers. This typology supports theory building, prompts reflection and

captures the imagination of readers through on spot descriptions and glossing over the complex processes and organizational activities. These types are more recognizable than the various configurations and show a repertoire with which we can answer the research questions from chapter one. We introduce three types.

The first type is *the craft – hands-on*. We see nurse managers working 'hands-on', on the ward with a lot of contacts with others such as nurses, physicians, patients and families in the cottage-like 'workshop'. The modus operandi is 'doing'. We especially see the care disposition in action: frequently answering the calls for help in the here and now. Little or no attention is given to quality indicators, EBP, guidelines, benchmarks or long meetings about the strategic direction and vision of the hospital. This authority of the nurse manager is based on her long track record as a nurse and her knowledge of the micro practices on the ward.

The second practice is different. We call this type *the manager – hands-off*. The manager spends her days in her office, doing administrative work, checking bed census, scheduling and addressing sick leave. There is not much contact with other disciplines. She sees her team as a pseudo-patient. The basis of her authority lies with higher management, not her own team.

The third type is *the clinical leader – heads-on*. This manager is on the ward, where she talks to the team, patient and family, at numerous meetings about concerns such as quality improvement, strategy, medication safety and multidisciplinary research. What is most striking is that although this type of manager spends a considerable amount of her time in meetings, the patient perspective is not overshadowed. This nurse manager is investigative, postpones or suspends her judgment and knows when to functionally curb the caring disposition because it is hindering her in daily practice. During all contacts with various others – we see her switch all the time – she manages to keep focus on the patient perspective. This provides her with authority among all players in the hospital. This practice enables the nurse manager to recognize the various modes. At this site there were ambiguities

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regarding responsibility and accountability which are part of a professional disposition. NMMs attempted to control these ambiguities via the creation of checklists and guidelines, which generated a substantive administrative burden. A teaching disposition was also manifested as an instrument of control rather than an instrument for learning, which affected and compromised a professional disposition. Instructing nurses on precisely how to use the checklists and guidelines was emphasized fulfil her role at the frontline in support others to switch between the modes and keep the focus on the patients.

In order to address this type concisely we introduce a new leadership practice, that of '*leadership as blended care*'. We use the word 'blend' to indicate that it is a matter of mixing various ingredients, in this particular case the dispositions of nurse managers' habitus. In a leadership as blended care practice we see nurse managers who combine the strengths of the caring disposition and the clinical disposition with those of the scientific disposition. This enables the nurse manager to switch between modes (craft-professional bureaucracy-knowledge intensive) at the frontline of care and support others to do so as well.

Next we suggest that Mintzberg's initial idea of 'managing as blended care' is an interesting first step. It matches more closely with the craft mode and/or that of the professional bureaucracy than with the requirements of the knowledge intensive organization mode that becomes more frequent in contemporary hospitals. *Leadership as blended care* seems to have a much better fit with the last mode because of its dominant and regulating scientific disposition.

Subsequently we reflect on how to develop nurse managers who practice leadership as blended care. What is needed are nurse managers who understand their own repertoire and thus dispositions of habitus. Only then a nurse manager knows which dispositions are dominant, opening the door for a conversion about the habitus. According to Bourdieu a conversion of habitus is difficult but not undoable. What helps is if the field – context – changes as well. In order to create

more playing room for the scientific disposition it is wise to invest in lifelong learning programs for nurses and nurse managers. We strongly advise an overall upgrade of the educational level of staff nurses and nurse managers. In line with other studies we advocate for developing nurse managers' 'investigative stance' at the frontline of care. In order to make this successful we recommend hiring and educating more baccalaureate trained nurses in hospitals and encourage positioning of masters and PhD trained nurses on key positions, such as nurse managers and clinical nurse specialists, in the hospitals near the frontline of patient care to enhance 'heads-on' patient centred care This upgrade should contribute as well to making the 'invisible work' more invisible. The idea of 'invisible work' comes from Allen's book *The invisible work of nurses* from 2015. The nurses and nurse managers have a key role in all the 'organising work' in the hospital. That is, all the work that does not directly touch patient care and is therefore not visible for the outside world. In contrast, the 'caring work' is much more visible. Think of terminologies as 'bedside nursing' which emphasize where the nursing care should take place, at the bedside. However, if nurses and nurse managers are capable of making their invisible 'organising work' visible for the public and moreover, frame it as 'heads-on' patient-centred work done by investigative and organising professionals, leadership as blended care will be able to contribute significantly to enhancing safety and quality of patient care. This 'organising work' is not – as frequently claimed in literature – the 'dirty work' but a substantive and crucial part of the daily work activities of clinical nurses and nurse managers.

We conclude that nurse managers can play a crucial and not-to-be underestimated role at the frontline of care. They can enhance safe, high quality and patient-centred care, support for nurses, and organizational continuity and performance. In order to realize this, nurse managers have to have a feel for the game in various industry modes and game types. Above all, it is important that they can switch between these modes and provide support to others to do so. This requires a specific leadership practice: that of clinical leadership as blended care. This emerging leadership practice

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is characterized by curbing the urge to care, an investigative stance, 'heads-on' patient-centeredness, context-based practice, teaming, and collaborative organizational learning. The challenge now is to create an overall upgrade of nurse managers' and clinical nurses' educational levels through a dual track curriculum that focusses on both clinical and organizational aspects of daily hospital work, with shadowing as a potential strong experimental learning tool in the development of clinical leadership practices. Future research should focus on mixed-methods and practice-based studies to decipher in more detail the working elements of leader and leadership development programs and their impact on patient care and hospital performance.

Samenvatting

Dit proefschrift geeft een beschrijving van het dagelijkse werk van verpleegkundig managers in de frontlinie van de zorg in algemene ziekenhuizen. We willen op basis daarvan achterhalen welke neigingen of disposities, die voortkomen uit hun verpleegkundige achtergrond, hen helpen of juist in de weg zitten bij hun leiderschap in de klinische praktijk (klinisch leiderschap). Hierbij valt te denken aan het ondersteunen van een verpleegkundig team, het realiseren van patiëntveiligheid en van patiëntgericht werken. Het uiteindelijke doel van het proefschrift is het ontwikkelen van handvatten waarmee verpleegkundig managers zich zo kunnen ontwikkelen dat het voordeel van de verpleegkundige achtergrond voor het klinisch leiderschap versterkt wordt en de nadelen daarvan beteugeld. We zullen betogen dat dit vraagt om een werkpraktijk, waarin de verpleegkundig managers in het dagelijkse werk ‘organiseer-werk’ combineren met ‘zorg-werk’, in nauwe aansluiting op de context waarin zij acteren. We zullen deze combinatie *leadership as blended care* noemen.

1. Volgens Van Dale is een neiging een lichte drang om iets bepaalds te doen. Synoniemen zijn, aandrang, aandrift, inclinatie. Betekenisontlening van het Duitse woord *Neigung*; voorkeur, genegenheid. In deze studie gebruiken we de term *disposities*, waarbij we Bourdieu volgen.

Samenvatting

Deze studie gaat over klinisch leiderschap van middenmanagers met een verpleegkundige achtergrond. Voor de leesbaarheid hanteren we de term verpleegkundig manager. Dit leiderschap is van groot belang in ziekenhuizen. Het draagt bij aan het duurzaam verbeteren van de kwaliteit en veiligheid van patiëntenzorg, aan patiëntgericht werken, aan het goed functioneren van verpleegkundig personeel én aan de continuïteit van de organisatie, kortweg gezegd: het draagt bij aan patiënt-, medewerker- en organisatiewaarde. De literatuur over professionals in the lead, laat duidelijk zien dat managers in de zorg voordeel hebben van een professionele achtergrond bij hun leiderschap. Ze begrijpen de complexe fysiologie, anatomie en pathologie van het menselijk lichaam én de organisatie als systeem. Daarnaast hebben ze controle over de prestaties op de werkvloer, dichtbij de patiënt. Bovendien hebben zij invloed op hun eigen professionele groep.

Naast voordelen zijn er ook nadelen aan *professionals in the lead*. Het proefschrift van Yolande Witman beschreef beide voor artsen die als afdelingshoofd in een academisch ziekenhuis werken. De nu voorliggende studie kan gezien worden als een vervolg daarop. Wij verkennen de voordelen én nadelen van het hebben van een verpleegkundige achtergrond in een managementpositie in algemene ziekenhuizen. Hierbij staan de volgende vragen centraal:

1. Wat doen verpleegkundig managers precies? (hoofdstuk 4)
2. Wat is hun bijdrage aan veilige en patiëntgerichte zorg? (hoofdstukken 3 en 4)
3. Op welke wijze creëren zij waarde voor medewerker en organisatie? (hoofdstukken 2 en 4)
4. Wat in hun disposities helpt hen daarbij? (hoofdstukken 2 en 3)
5. Wat in hun disposities en werkomgeving zit in de weg? (hoofdstukken 2, 3 en 4)
6. Wat zou hen helpen om zich zo te ontwikkelen dat zij hun bijdrage aan patiënt-, medewerker- en organisatiewaarde kunnen optimaliseren? (hoofdstuk 5)

Om het dagelijkse werk van verpleegkundig managers in kaart te brengen hebben we etnografische onderzoeksmethoden benut. We hebben verpleegkundig managers geschaduwd tijdens hun werkzaamheden in een ziekenhuis. Daarmee kregen we een omvattend beeld van hun werk. Ook werd duidelijk wanneer de verpleegkundige achtergrond helpt of in de weg zit. In totaal zijn zestien verpleegkundig managers geschaduwd. Zij werkten in vier verschillende ziekenhuizen, waarvan twee in Nederland en twee in de Verenigde Staten. In elk ziekenhuis zijn vier verpleegkundig managers geschaduwd gedurende vier dagen per persoon. Dit leidde tot 560 uur observaties, 2490 pagina's met veldnotities en 61 uur aan audio fragmenten. Ter aanvulling van deze gegevens zijn documentanalyses, member checks en semigestructureerde interviews uitgevoerd. Gedurende de data-analyse zijn verschillende 'sensitizing concepts' uit de literatuur gebruikt om verder betekenis te geven aan de observaties zoals 'habitus', 'dispositie', 'veld', 'kapitaal', maar ook 'patiëntgerichtheid', 'patiëntveiligheid' en de 'sociale vergelijkingstheorie'. De data-analyse is zowel inductief ontwikkeld als gefundeerd vanuit theorie.

De onderzoeksaanpak is in hoge mate gebaseerd op Mintzbergs *managerial work and behaviour approach* en het achterliggende gedachtegoed van zijn gestructureerde observatiemethode, uit zijn klassieke boek – *The Nature of Managerial Work* uit 1973. De schaduwmethodiek die Mintzberg inzette en zijn fascinatie voor het werk van managers in ziekenhuizen zijn belangrijke inspiratiebronnen. Het was Mintzberg die in het midden van de jaren negentig in het *Journal of Nursing Administration* suggereerde dat 'verpleegkunde is managen'. Bij het grip krijgen op de gevolgen van de professionele achtergrond voor het leiderschap speelt het werk van Bourdieu, met name zijn begrippen disposities, habitus, veld en kapitaal, een centrale rol.

Het resultaat van deze onderzoeksaanpak ligt nu voor u in de vorm van een bundel van vijf artikelen. Zij bieden een etnografie van het dagelijks werk van verpleegkundig managers in ziekenhuizen. Na het presenteren van de gevonden neigingen, gaan we

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achtereenvolgens in op de bijdrage van verpleegkundig managers bij het ondersteunen van een verpleegkundig team, bij het realiseren van patiëntveiligheid en van patiëntgericht werken. De artikelen laten zien dat al naargelang de werkcontext, verschillende disposities helpen en/of in de weg zitten bij het ontstaan van een klinische leiderschapspraktijk in de frontlinie van de zorg. Tevens doen we enkele suggesties hoe we verpleegkundig managers kunnen ondersteunen bij het ontwikkelen van klinisch leiderschap in het dagelijks werk.

Hoofdstuk twee legt de basis voor de andere hoofdstukken. Het doet het begrippenkader van Bourdieu uit de doeken waarmee we taal kunnen geven aan de neigingen van verpleegkundig managers. De vier ziekenhuizen worden kort beschreven waarin de verpleegkundig managers werkzaam zijn. Vervolgens worden acht verschillende disposities van verpleegkundig managers gepresenteerd. Het laat zien hoe de disposities in verschillende samenstellingen (configuraties) bijdragen aan het ondersteunen van een verpleegkundig team door de verpleegkundig manager.

Vier begrippen – Bourdieu noemt ze ‘tools’ of ‘werktuigen’ – helpen ons bij het verwoorden van het werk van de verpleegkundig managers. Ten eerste heeft Bourdieu het over habitus. Habitus is volgens hem een systeem van verschillende disposities (neigingen): duurzame, onderbewuste schema’s van waarneming en waardering die aanzetten tot praktisch handelen en daar richting aan geven. Het ‘onderbewuste’ beschouwt hij als een vergeten geschiedenis. Het tweede begrip van Bourdieu is dispositie. Disposities zijn basale, onderliggende vooronderstellingen en een belangrijke bron van waarden en handelen. De disposities die samen de habitus vormen, spelen een belangrijke rol bij hoe een mens waarneemt, waardeert, denkt en handelt. Dit gebeurt in een veld, het derde begrip van Bourdieu.

Een veld refereert naar een sociale plek met een eigen interne logica. Dat kan een beroepenveld zijn, zoals dat van verpleegkundigen, maar ook een institutioneel veld, zoals dat van een ziekenhuis als onderdeel van

een stelsel van gezondheidszorg in een bepaalde regio. Bourdieu verbindt zijn begrip veld nauw met zijn vierde begrip, namelijk kapitaal. In een veld staat er altijd iets op het spel en is het van belang dat mensen bereid zijn het spel te spelen. Bepaalde posities staan onder druk en om waardevolle bronnen (hij noemt dat: kapitaal) wordt gestreden. Kapitaal kan verbonden zijn aan de positie die iemand heeft binnen zijn professionele groep of in een organisatie, of kan gedurende een lange periode langs informele weg zijn verworven. In de literatuur wordt kapitaal ook wel vergeleken met gezag. In het institutionele veld van het ziekenhuis kan een verpleegkundig manager bijvoorbeeld kapitaal verwerven door ondersteunend en zichtbaar te zijn naar het personeel maar ook door de kosten te beheersen voor het hoger management. Het hangt af van wat er in het veld het meest gewaardeerd wordt, dus waarmee kapitaal gegenereerd kan worden. Dit is bepalend voor welke disposities van de habitus onbewust in het spel worden gebracht.

Het tweede hoofdstuk laat zien dat er acht verschillende disposities tegelijkertijd in het spel zijn bij het dagelijks werk van verpleegkundig managers.

Door de **zorg dispositie** zien de verpleegkundig managers patiënten als individuen die zorg en aandacht nodig hebben.

- Strategieën die verpleegkundig managers hanteren zijn: altijd de hulpvraag beantwoorden in het hier en nu, ad hoc en reactief reageren en direct oordelen.
- Deze dispositie manifesteert zichzelf door scannen van de omgeving en het op zoek zijn naar een hulp vraag.
- Excelleren in deze dispositie genereert kapitaal dat gebaseerd is op zorgen en aandacht hebben voor patiënten.

Door de **klinische dispositie** zien de verpleegkundig managers individuen als patiënten.

- Strategieën die verpleegkundig managers hanteren zijn het zoeken naar symptomen en oorzaken van de geobserveerde condities.

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- Deze dispositie manifesteert zichzelf door het zien van patiënten, een inschatting maken van hun zorgbehoefte en weten hoe hun conditie is.
- Excelleren in deze dispositie genereert kapitaal dat gebaseerd is op het hebben en inzetten van de klinische expertise.

Een **collegiale dispositie** verwijst naar verpleegkundig managers die een positief teamklimaat realiseren

- Strategieën die verpleegkundig managers hanteren, zijn vriendelijk zijn voor het team en zorgdragen voor collega's.
- Deze dispositie manifesteert zichzelf door het aandacht geven aan het team, aanmoedigen om feedback te geven én stilzwijgend weten wat de individuele behoeften zijn in het team.
- Excelleren in deze dispositie genereert kapitaal dat gebaseerd is op collegiaal zijn en het 'gezellig houden'.

Door de **onderwijzende dispositie** zie verpleegkundig managers zichzelf als docent of mentor.

- Strategieën die verpleegkundig managers hanteren zijn het creëren van momenten voor coaching, instrueren en leren.
- Deze dispositie manifesteert zichzelf door het doceren en instrueren van zowel patiënten als collega's.
- Excelleren in deze dispositie genereert kapitaal dat gebaseerd is op het delen van kennis en onderwijzen.

Door de **professionele dispositie** zien verpleegkundig managers zichzelf zowel persoonlijk als collectief verantwoordelijk voor goede patiëntenzorg.

- Strategieën die verpleegkundig managers hanteren zijn het belang van de patiënt vooropstellen en zich daar verantwoordelijk voor achten.
- Deze dispositie manifesteert zichzelf door een gevoel van verantwoordelijkheid en het delen van deze verantwoordelijkheden.

- Excelleren in deze dispositie genereert kapitaal dat is gebaseerd op zich zowel persoonlijk als collectief verantwoordelijk voelen voor de zorg voor de patiënt.

Een **wetenschappelijke dispositie** verwijst naar het werk van verpleegkundig managers waarbij wetenschap en reflectie centraal staan.

- Strategieën die verpleegkundig managers hanteren zijn het verwijzen naar en verzamelen van evidence based practice bronnen en het stellen van reflectieve vragen om op die wijze de kwaliteit van zorg te vergroten.
- Deze dispositie manifesteert zichzelf door een onderzoekende houding, opschorten van reacties, niet oordelen en een focus op onderzoek, evidence based practice en reflectie op actie.
- Excelleren in deze dispositie genereert kapitaal dat is gebaseerd op het gebruik van wetenschappelijke kennis en het stellen van reflectieve vragen in plaats van ad-hoc reageren.

Door een **administratieve dispositie** zien verpleegkundig managers het doen van administratie als een legitimatie van hun activiteiten.

- Strategieën die verpleegkundig manager hanteren zijn, gebruik maken van checklists, richtlijnen, benchmarks en rapportages.
- Deze dispositie manifesteert zich door een focus op het schrijven van verslagen, invullen van lijsten, druk zijn met administratieve zaken en het doen van secretariael werk.
- Excelleren in deze dispositie genereert kapitaal door het op correcte wijze gebruiken van de checklists, richtlijnen en administratieve procedures.

Door een **controle dispositie** zien verpleegkundig managers de mogelijkheid om rust, reinheid en regelmaat in hun werk te creëren.

- Strategieën die verpleegkundig managers hanteren zijn orde houden over het dagelijks werk door op te ruimen.

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- Deze dispositie manifesteert zichzelf door te focussen op orde houden of grip zien te krijgen op (complexe) situaties, duidelijkheid creëren en opruimen.
- Excelleren in deze dispositie genereert kapitaal door controle te hebben over bepaalde situaties.

Deze acht disposities zien we terug in verschillende configuraties (combinaties) al naargelang het veld waarin ze actief zijn. Het is belangrijk om de dynamiek tussen de disposities te benadrukken, die is niet te zien in de gegeven opsomming. Verschillende configuraties leiden in ieder geïnstitutionaliseerd veld tot een andere verdeling van kapitaal.

In dit tweede hoofdstuk laten we vervolgens zien hoe de dynamiek binnen de ziekenhuizen leidt tot vier verschillende configuraties met als resultante variatie in het ondersteunend gedrag richting het team van verpleegkundigen.

In het onderzoek hebben we gezien hoe een configuratie waar de zorgdispositie en de klinische dispositie domineren kapitaal (gezag) genereert. Als effect van deze configuratie gedragen de verpleegkundig managers zich ondersteunend naar hun verpleegkundig team door zichtbaar en betrokken te zijn bij de directe patiëntenzorg op de afdeling. Ze kennen de patiënten en bespreken complexe cases met het team. Deze configuratie leidt ook tot kapitaal (gezag) in de relatie tot de artsen, hierbij speelt de klinische dispositie wel een prominentere rol dan de zorg dispositie.

We zagen, in het werk van verpleegkundig managers, echter ook een configuratie met een dominantie van de zorg dispositie (er zijn voor de ander, aanslaan op de hulpvraag, ad-hoc reacties en snel oordeel) en de collegiale dispositie (aardig zijn en het gezellig houden). Hier richt de zorg dispositie zich volledig op het ondersteunen van het team. Dit genereert kapitaal, immers goed zorgen voor het team wordt gewaardeerd door zowel het team zelf (aandacht, erkenning) als het hoger management (de dienstroosters kloppen, het ziekteverzuim is laag). Dus: hier is het team tot een soort

pseudo-patiënt gemaakt. Uiteindelijk leidt dit tot een vermindering van de ondersteuning die de manager aan het team kan geven rondom klinische cases en tot vermindering van kapitaal (gezag). Dit klinkt tegenstrijdig, echter als een verpleegkundig manager alleen maar bezig is met hoe de verpleegkundigen zich voelen, de roosters en het ziekteverzuim erodeert de klinische bijdrage. De verpleegkundig manager verliest klinisch gezag en praat en denkt niet meer mee over wat de kern is van het eigenlijke verpleegkundig werk: de patiënt(enzorg) en diens familie. Juist hierdoor kan de manager het team niet meer goed ondersteunen.

In een andere configuratie zijn de controle dispositie en de administratieve dispositie dominant. Deze dispositie kregen waarde door het algemene gevoel want onderling wantrouwen tussen verpleegkundig manager en verpleegkundig team, tevens waren er onduidelijkheden over verantwoordheden en bevoegdheden van verpleegkundigen. Mede hierdoor was er veel aandacht voor de regels, afvinklijstjes en richtlijnen en is er weinig ruimte voor aandacht voor de verpleegkundigen. De verpleegkundig manager was hier met name bezig met het controleren van het personeel. Ook de onderwijzende dispositie werd in gezet als middel tot controle in plaats van leren. Hierdoor was de professionele dispositie ook amper manifest. Er werd geen verantwoordelijkheid genomen. Dit leidt tot een enorme administratieve druk bij zowel het verpleegkundig personeel als de managers aangezien alles volgens regels, checklist en controle georganiseerd moet worden. Deze configuratie genereert geen waarde of kapitaal bij de verpleegkundigen en resulteert in het niet ervaren van ondersteuning door de verpleegkundig manager door het verpleegkundig team.

In hoofdstuk twee maken we tot slot aannemelijk dat een goed ontwikkelde wetenschappelijke dispositie een belangrijke rol kan spelen bij het verder ontwikkelen van een gezonde werkomgeving via het ondersteunen van het verpleegkundig team. Hierbij kan niet voorbijgegaan worden aan de sleutelrol van de zorg dispositie. Deze is zeer waardevol, echter door de wetenschappelijke dispositie neemt haar kapitaal

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(waarde) alleen maar toe. De configuratie waarin de wetenschappelijke dispositie zich sterk manifesteert zorgt ervoor dat de verpleegkundig manager zich meer onderzoekend opstelt en minder ad-hoc reageert. Dit creëert rust in het team, bij dagelijkse terugkerende problemen wordt niet onmiddellijk gereageerd, men denkt meer vooruit, maakt analyse, baseert zich op evidence based practice, en zoekt naar meer duurzame oplossingen dan naar een tijdelijke reparatie.

In **hoofdstuk drie** definiëren we het klinisch leiderschap van verpleegkundig managers in relatie tot patiëntveiligheid. De literatuur laat zien dat zorgprofessionals in een leidende rol in het ziekenhuis een belangrijke bijdrage kunnen leveren aan patiëntveiligheid. We onderzoeken op welke wijze drie verschillende configuraties van de disposities van habitus van invloed zijn op het patiëntveiligheidswerk van verpleegkundig managers. We zoomen in op configuraties waarin de zorg dispositie een belangrijke rol speelt. Immers, in hoofdstuk twee werd al duidelijk dat de zorg dispositie een sleutelpositie heeft in de habitus van verpleegkundig managers maar soms ook aardig in de weg kan zitten

In dit hoofdstuk wordt aangetoond dat de zorgdispositie van verpleegkundig managers hun klinisch leiderschap en werk op het gebied van patiëntveiligheid positief beïnvloedt. Echter, verpleegkundig managers vinden het lastig om in het dagelijks werk focus te houden op patiëntveiligheid en kwaliteit van zorg. Zonder moeite zijn hun dagen gevuld met roosters, budgetten, financiën en benchmarks. De zorg dispositie kan in de weg zitten. En wel op twee manieren. Ten eerste, als bij de verpleegkundig managers de zorg dispositie alleen fungeert om het team als quasi-patiënt te bedienen. De managers doen weliswaar aan 'zorg-werk' maar dit heeft weinig tot niets te maken met patiënten, waardoor de veiligheid van patiënten uit beeld raakt. Ten tweede zien we verpleegkundig managers die zich nog wel op de patiënten richten maar waar de zorg dispositie zich alleen maar richt op ad-hoc gebeurtenissen. Dit leidt tot korte termijn oplossingen waarin de verpleegkundig manager snel iets 'repareert' wat niet goed gaat, maar niet goed onderzoekt wat daadwerkelijk de oorzaak

is van het probleem. Dit wordt uitgelokt door een zorg dispositie die maakt dat men snel een oordeel vormt en men snel aanslaat op de hulpvraag. Dit heeft voordelen, namelijk het 'systeem' wordt draaiende gehouden, in dat verband spreekt men wel van 'compensatie'. Daar waar verpleegkundig managers leren hun zorg dispositie op gezette tijden in te houden, dus niet aan te slaan op een zorgvraag, niet iets te vinden maar een vraag te stellen, en rustig de tijd te nemen voor analyse, ontstaat ruimte voor aandacht voor meer duurzame patiëntveiligheid.

Deze analyse maakt duidelijk hoe belangrijk het is dat verpleegkundig managers hun disposities (of anders gezegd: voorkeursrepertoire) kennen. Dus, weten wanneer hun zorg dispositie van waarde is en kapitaal genereert, en wanneer zij deze moeten intomen en de meer reflectieve en wetenschappelijke dispositie de boventoon moeten laten voeren. Dit is echter niet eenvoudig. Alleen als verpleegkundig managers zowel de sterke kanten als de valkuilen van de zorgdispositie én de kracht van de wetenschappelijke dispositie goed begrijpen, zullen ze in staat zijn hun repertoire aan te passen en aandacht te hebben voor de veiligheid van patiënten. Het ontwikkelen van een 'gevoel voor het te spelen spel' is hierbij cruciaal, waarbij naast het eigen repertoire en de werkomgeving, Bourdieu zou zeggen veld, een niet te onderschatten rol speelt.

In **hoofdstuk vier** verkennen we, door middel van de *managerial work and behaviour approach*, op welke wijze verpleegkundig managers bijdragen aan patiëntgericht werken. Verpleegkundig managers zijn in de ideale positie om patiëntgericht werken te faciliteren. Echter, over hun bijdrage is weinig gepubliceerd. Als er al over is geschreven zijn dit op interviews gebaseerde studies waarin de verpleegkundig managers vertellen over de wijze waarop zij patiënt gericht werken faciliteren. In dit hoofdstuk laten we zien hoe zij dagelijks op de werkvloer daadwerkelijk bijdragen aan patiëntgerichtheid. Het accent ligt dus op wat ze 'doen', niet op wat ze 'zeggen' dat ze doen. Volgens de literatuur is er sprake van patiëntgericht werken wanneer drie kernelementen goed tot ontwikkeling

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komen. Ten eerste de patiënten participatie en betrokkenheid, ten tweede de relatie tussen patiënt en zorgprofessional en ten derde de context of werkomgeving waarin de zorg geleverd wordt. In dit hoofdstuk gebruiken we niet Bourdieu's tools als *sensitizing concepts* maar de *managerial work and behaviour approach* van Mintzberg. In vier staafdiagrammen laten we per ziekenhuis zien hoe de verpleegkundig managers hun tijd besteden.

- Diagram 1 beeldt uit op welke plaats zij zich bevinden (bijvoorbeeld het kantoor, de verpleegpost of een vergadering),
- diagram 2 laat zien met welke mensen zij contact hebben (bijvoorbeeld met de verpleegkundigen, de artsen of hoger management),
- diagram 3 laat zien welk type activiteit zij ondernemen (bijvoorbeeld bureauwerk, vergaderen, klinisch werk) en tot slot verbeeldt
- diagram 4 wat het doel is van deze activiteiten (bijvoorbeeld rooster maken, patiënten opnemen of ontslaan, kwaliteit van zorg verbeteren, patiënten verzorgen).

We synthetiseren de gegevens in een concluderend overzichtsdiaagram dat met name gebaseerd op het vierde staafdiagram. Dit diagram laat zien dat per ziekenhuis de verhouding tussen 'zorg-werk' (bijvoorbeeld: visite lopen, familie en patiënt spreken, bezig zijn met kwaliteitsverbetering en evidence based practice), 'organiseer-werk' (bijvoorbeeld: roosters maken, opname en ontslag regelen en organisatie verandering) en het hebben van 'marges tijd' (pauze nemen, reflectie en bijkletsen) aanzienlijk kan verschillen. Bij drie van de vier ziekenhuizen komt deze verhouding redelijk overeen met wat de literatuur beschreven is: verpleegkundig managers besteden het gros van hun tijd, ongeveer 70%, aan 'organiseer-werk', 20% aan 'zorg-werk' en beschikken over 10% marge op een dag. Echter bij één ziekenhuis is de verhouding tussen 'zorg-werk' en 'organiseer-werk' gelijk, namelijk beide zijn 40%. De manager heeft hier 20% marge-tijd. Bij deze verhouding is te zien dat de verpleegkundig manager sterk bijdraagt aan het patiëntgericht kunnen werken.

Uit de analyse blijkt dat verpleegkundig managers die zich niet op de werkvloer laten zien en alleen in hun kantoor zitten, niet bijdragen aan patiëntgericht werken. Wanneer zij zich wel op de werkvloer laten zien en 'hands-on' meewerken in de patiëntenzorg, kan dit bijdragen aan de patiëntgerichtheid. Maar als het doel daarvan is om het werk van het team te controleren, dan draagt dit niet bij aan patiëntgericht werken. Immers, de verpleegkundig manager richt zich op het team, de afvinklijsten en richtlijnen, niet op de patiënt zelf. Nabijheid van de verpleegkundig manager bij de patiënt is kortom geen garantie dat de manager een bijdrage levert aan patiëntgerichtheid. Omgekeerd zien we voorbeelden waar verpleegkundig managers minimaal nabij zijn – dus minimaal 'hands-on' werken – maar toch een grote bijdrage leveren aan patiënt gericht werken. Zij faciliteren het patiënt gericht werken van hun mensen door in de context zodanig te acteren dat daar aandacht is voor patiëntparticipatie en de relatie tussen patiënt en professionals. Dit typeren we als 'heads-on' patiënt gerichtheid. Het in hoofdstuk 2 en 3 beschreven opschorten van de zorg dispositie kan een bijdrage leveren aan dit 'heads-on' patiënt gericht werken. Hierdoor reageert de verpleegkundig manager minder ad-hoc en gaat meer onderzoekend en bevragend te werk met expliciete aandacht voor evidence based practice en focus op patiëntenuitkomsten die door verpleegkundigen te beïnvloeden zijn. We zien dan bijvoorbeeld hoe verpleegkundig managers tijdens vergaderingen waarbij het 'organiseer-werk' – dus administratie, budgetten, richtlijnen – op de agenda staat, deze verschillende thema's toch vanuit een patiëntenperspectief weten te framen. Ze koppelen als het ware het 'organiseer-werk' aan het 'zorg-werk'. Het koppelen van 'organiseer-werk' aan 'zorg-werk', lukt hen met name goed als de organisatiecontext zo is ingericht dat zij ook de ruimte hebben en kunnen creëren om dit te doen. Het gaat daarbij bijvoorbeeld om personeelssamenstelling, opleidingsniveau, manier waarop coördinatie is georganiseerd, patient-verleegkundigeratio en gebouwde omgeving.

Verpleegkundig managers die op de afdelingen een *clinical nurse specialist* als sparring partner hebben,

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zijn eerder geneigd om 'heads-on' patiëntgericht te werken. Zij worden continu uitgedaagd om ondanks grote drukte stil te staan bij klinische vraagstukken en dilemma's. De verpleegkundig specialist richt zich immers meer dan de verpleegkundig manager op relevante patiënten uitkomsten voor de afdeling en gebruikt *evidence based practice* om in de context van het dagelijks werk maatwerk voor patiënten te realiseren. De verpleegkundig specialist jaagt continu het gesprek over de patiënt en diens relevante verpleeg sensitieve uitkomstmaten aan. In het ziekenhuis met de 40-40-20 verhouding had de verpleegkundig specialist een belangrijke rol. Daarnaast waren andere aspecten van belang. Zo was er frequent contact tussen de verpleegkundig manager, artsen, patiëntenraden en andere professionals rondom de patiënt, een afdelingscoördinator die als liaison fungeerde tussen afdeling en manager, gunstige patiënt-verpleegkundige ratio's. Tevens was het ziekenhuis vijf jaar daarvoor gebouwd met zowel de patiënt als de zorgprofessional als belangrijkste eindgebruiker in het vizier. Er is in dit ziekenhuis sprake van een *healing environment*. Verpleegkundig managers werden hier aangespoord een master in de verpleegkunde te halen en door een afdeling kwaliteit zowel centraal als decentraal ondersteund.

Hoofdstuk vijf bevat handvatten voor het verder ontwikkelen van het klinisch leiderschap van verpleegkundig managers. Tijdens het onderzoekswerk, met name tijdens een member check, ontstond het vermoeden dat schaduwen als onderzoeksmethodiek ook goed te gebruiken is als methodiek voor leiderschapsontwikkeling. Dit vermoeden werd bevestigd via literatuurstudie. De verpleegkundig managers uit de studie gaven aan dat zij, ook nadat zij geschaduwd waren, het idee hadden dat de onderzoeker nog 'virtueel over hun schouder meekijk'. Zij werden zich meer bewust van hun handelen in situ. Tevens gaven zij aan graag elkaar te schaduwen en op die wijze zelf onderzoeker te worden naar hun eigen werkpraktijken.

In totaal hebben acht verpleegkundig managers elkaar geschaduwd. Zij zijn voor het na het schaduwen

geïnterviewd waarin ervaringen werden opgevraagd. De studie laat zien dat schaduwen van een collega, die weliswaar hetzelfde werk doet maar in een andere organisatie, een gezamenlijke reflectie-in-actie faciliteert en een onderzoekende houding stimuleert terwijl men aan het werk is. Het ondersteunt het leren opschorten van de zorg dispositie op het moment dat deze het meest actief is, namelijk in de context van het dagelijks werk zelf. Het observeren van een collega, zonder zelf echt iets te mogen 'doen' resulteert, via een proces van sociale vergelijking, in een gedragsrepertoire waarbij het opschorten van reacties en uitstellen van het oordeel centraal staan. De betrokkenen oefenen in de context van het dagelijks werk met een van de meest cruciale maar lastig te ontwikkelen leerpunten voor klinisch leiderschap van verpleegkundig managers: 1. Balanceren tussen 'iets doen' of juist alleen observeren. 2. Wel of niet feedback geven op wat je ziet gebeuren. Het onderzoekswerk waar dit artikel verslag van doet is te zien als een eerste studie. Nodig is een groter onderzoek waarin we preciezer kunnen uitzoeken hoe de 'sociale vergelijkmodus' werkt. Tevens kan dan een praktische toolbox ontwikkeld worden voor schaduwen in de praktijk als een ontwikkeltechniek voor klinisch leiderschap.

Hoofdstuk zes bevat de conclusies en discussie. In dit hoofdstuk geven we een reflectie op het werk van verpleegkundig managers en de invloed van hun habitus op hun klinisch leiderschap. Het vertrekpunt is een uitspraak van een van de grondleggers van de *managerial work and behaviour approach*: Mintzberg. Hij zegt: 'verpleegkunde is managen'. Hij concludeert dat het bij managen in ziekenhuizen gaat om een blend van zorg – hij ziet het werk van een verpleegkundig manager als een mengeling (blend) van hun eerdere baan waarin werd gezorgd voor patiënten én de zorg voor het draaiende houden van de afdeling. Tevens bespreken we het werk van Maccoby die differentiatie in drie verschillende gezondheidssystemen laat zien. Hij spreekt over drie typen praktijken of op zijn Engels, *modes*. Wij gebruiken het Nederlandse woord *modus* waarbij het bij de eerste modus gaat om het ambacht waarin er kleine werkplaatsen zijn waar professionals

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geïsoleerd hun werk doen, vervolgende de modus van de professionele-bureaucratie en ten slotte de modus van het technologische kennisinstituut waarbij het draait om organiseren en netwerken. Maccoby ziet deze verschillende modi als elkaar opeenvolgende fasen. Wij schatten echter in dat verpleegkundigen en verpleegkundig managers in grote algemene ziekenhuizen op één en dezelfde dag meerdere malen met elk van die modi geconfronteerd worden in één en hetzelfde ziekenhuis. Dit vraagt veel van de professionals op de werkvloer. De verpleegkundig manager wordt geacht deze professionals aan de frontlinie te ondersteunen. Belangrijk is dat de managers deze drie verschillende praktijken en hun werkwijzen herkennen, én anderen kunnen helpen bij het switchen. Dit is geen eenvoudige taak en vraagt om het verder ontwikkelen van verpleegkundig managers. Om deze ontwikkelvraag eenvoudiger en inzichtelijker te maken hebben we een typologie van de werkpraktijk van verpleegkundig managers geconstrueerd.

Aan de hand van een secundaire analyse van onze eigen data, aangevuld met inzichten uit de literatuur gaan we van een brede variëteit aan configuraties naar een typologie van de praktijk van de verpleegkundig manager. De typen zijn beter herkenbaar en hanteerbaar in de praktijk dan verscheidene configuraties en gedragingen. Ze laten een repertoire zien waarmee we onze onderzoeksvragen uit hoofdstuk 1 kunnen beantwoorden. We introduceren drie typen.

Het eerste type is het *ambacht – hands-on*. Hier werkt de verpleegkundig manager 'hands-on'. Dus, is veel op de afdeling en heeft veelvuldig contact met de anderen op de 'werkplaats' (lees de afdeling) zoals het team, de artsen, patiënten en familie. De modus operandi is 'doen'. We zien hier vooral de klassieke zorg dispositie in actie: frequent aanslaan op de hulpvraag en handelen in het hier en nu. Kwaliteitsindicatoren, *evidence based practice*, richtlijnen, benchmarks of lange vergaderingen over de strategische richting en visie van het ziekenhuis zijn aan deze manager niet besteed. Gezag wordt ontleend aan jaren lange ervaring als verpleegkundige en het kunnen runnen van de afdeling.

Het tweede type praktijk is geheel anders. Dit type noemen we de *manager – hands-off*. De manager is veel in het kantoor, druk met administratie, de nieuwe organisatie structuur, beddenbezetting, het rooster en ziekteverzuim. Er is weinig contact met het team of andere disciplines. De manager ziet het team als het ware als pseudo-patiënt. De gezagsbasis ligt eerder bij het hoger management dan de werkvloer.

Het laatste type is de *klinische leider – heads-on*. Hier is de manager zowel op de afdeling, waar gepraat wordt met het team, de patiënt en familie, als bij talloze vergaderingen, over onder andere kwaliteitsverbeteringen, strategie, medicatieveiligheid en multidisciplinair klinisch onderzoek. Wat hierbij opvalt dat het patiëntenperspectief niet naar de coulissen verschuift. Deze manager is onderzoekend, schort oordeel op en weet de zorg dispositie waar deze niet functioneel is te beteugelen. Dergelijke verpleegkundig managers zorgen er voor dat inde gesprekken het patiënten perspectief voortdurend domineert. Dit geeft de manager gezag bij alle partijen in het ziekenhuis. Deze praktijk maakt dat de verpleegkundig manager de verschillende modi kan herkennen en de rol kan vervullen om ondersteuning te bieden bij het switchen tussen de verschillende modi.

Om dit kernachtig te kunnen agenderen introduceren we vervolgens naam voor een nieuwe leiderschapspraktijk, die van "leiderschap als blend van zorg" of in het Engels: *leadership as blended care*. Het woord blend gebruiken we om aan te geven dat er sprake is van een samenstelling van disposities van de habitus van verpleegkundig managers. Bij een leiderschapspraktijk als blend van zorg zien we dat de manager de kracht van de zorgdispositie én de klinische disposities combineert en tevens de wetenschappelijke dispositie heeft ontwikkeld. Hierdoor is de verpleegkundig manager in staat om te switchen tussen de verschillende modi (dat zijn: ambacht; professionele-bureaucratie; kennisintensief) aan de frontlinie van de zorg, en anderen daarbij te ondersteunen.

Vervolgens stellen we in de discussie dat Mintzberg's initiële idee van *managing as blended care* een mooie

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eerste stap is. Echter, deze lijkt beter te passen bij de ambachtsmodus of de modus van de professionele-bureaucratie, maar niet bij het spelen van rollen bij het kennisintensieve werk dat in de hedendaagse ziekenhuizen vaak van verpleegkundig managers wordt gevraagd. Leiderschap als blend van zorg kan dat, mede door de goed ontwikkelde wetenschappelijke dispositie wel.

We staan vervolgens stil hoe we verpleegkundig managers zo kunnen ontwikkelen dat zij leiderschap als blend van zorg praktiseren. Het eerste wat daar voor nodig is, is het herkennen van de eigen habitus en disposities. Pas als een verpleegkundig manager deze herkent en weet welke disposities bij hem of haar dominant zijn, kan er begonnen worden aan een conversie van de habitus. Volgens Bourdieu is een conversie van de habitus niet eenvoudig maar zeker niet ondoenlijk. Wat helpt is als het veld, de context, mee verandert. Om de wetenschappelijke dispositie meer 'in het spel' te krijgen en op die wijze te komen tot *leadership as blended care*, argumenteren we dat investeren in een leven lang leren voor verpleegkundigen en verpleegkundig managers belangrijk is. Hiervoor adviseren wij een upgrade van het opleidingsniveau over de hele lijn van het verpleegkundig vakgebied. We pleiten in lijn met andere studies voor het creëren van meer 'onderzoekend vermogen' aan de frontlinie van het ziekenhuis. Dat kan worden gerealiseerd door het aannemen en opleiden van meer bachelor opgeleide verpleegkundigen én het stimuleren van meer master en PhD opgeleide verpleegkundigen op sleutelposities dicht en rondom de patiënt (zoals de verpleegkundig managers en de verpleegkundig specialist). Deze upgrade moet ook bijdragen aan het meer zichtbaar maken van het vaak 'onzichtbare werk' van verpleegkundigen. De term 'onzichtbaar werk' komt uit het boek *The Invisible Work of Nurses* van Allen uit 2015. Zowel verpleegkundigen als verpleegkundig managers hebben een belangrijke bijdrage in 'organiseer-werk'. Dat is al het werk om de patiënt heen, dat niet direct zichtbaar is voor de buitenwacht. Dit in tegenstelling tot 'zorg-werk' dat wel zichtbaar is. Als zowel verpleegkundigen als

verpleegkundig managers hun vaak onzichtbare 'organiseer-werk' zichtbaar weten te maken door het 'heads-on' te framen als patiëntgericht en als onderzoekende en organiserende professionals te acteren kan *leadership as blended care* bijdragen aan de kwaliteit en veiligheid van zorg voor patiënten. Dit proefschrift bepleit kortom een herwaardering van het 'organiseer-werk' van verpleegkundig managers én verpleegkundigen. Het is niet – zoals het vaak wordt gezien 'het vuile werk' – maar het is een substantieel en cruciaal onderdeel van de zorgpraktijk.

Ten slotte concluderen we dat verpleegkundig managers een niet te onderschatten rol spelen in de frontlinie van de zorg. Zij zijn het die kunnen bijdragen aan veilige zorg, van hoge kwaliteit die patiëntgericht is, ondersteuning biedt aan verpleegkundigen en de continuïteit van de organisatie garandeert. Om dit te realiseren moeten ze kunnen acteren in de drie verschillende modi (ambacht; professionele-bureaucratie; kennisintensief). Sterker nog, ze moeten frequent tussen de drie modi kunnen schakelen. Dit vraagt om een bepaald type leiderschapspraktijk: dat van klinisch leiderschap als blend van zorg. Deze leiderschapspraktijk wordt gekarakteriseerd door het kunnen opschorten van de zorgneiging en het oordeel, een onderzoekende houding en 'heads-on' patiëntgerichtheid. De uitdaging voor de komende jaren is om een investering te doen over de hele breedte van het opleidingscontinuüm van zowel verpleegkundigen als verpleegkundig managers waarbij zij in een duale track worden opgeleid waarin zowel aandacht is voor klinische als organisatorische aspecten van het werk. Hierbij is naar verwachting schaduwen een sterk instrument voor de ontwikkeling van klinisch leiderschap voor deze verpleegkundig managers.

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‘No Good with faces and I’m bad with names’
Jack Johnson. Album: To the sea.

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Auteurs van het boek Verpleegkundig Leiderschap,

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Curriculum Vitae

Name: Pieterbas Lalleman-Bout
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HU University of Applied Sciences
Utrecht
Promotor: Prof. dr. M.J. Schuurmans
Prof. dr. G.A.C. Smid



Personal Statement

For several years my program of research has focused on front-line leadership of nurses, especially nurse managers in complex healthcare organizations such as hospitals. Insights from this research track are incorporated in undergraduate and graduate programs such as the online course Leadership in Healthcare from Elevate, UMCU. It is my ambition to amalgamate the knowledge and insights of our research on healthcare leadership and put it into practice, together with a strong network of excellent professionals in the field, researchers, entrepreneurs and educators, in the coming five year.

"The difficulty, in Sociology, is to manage to think in a completely astonished and disconcerted way about things you thought you had always understood."

Pierre Bourdieu

Curriculum Vitae

Education / training / courses

2014	Online course: developing an online course at Elevate, Utrecht
2014	Shadowing workshop, Warwick University, Birmingham
2013	Course: Writing in English for Publication at Babel, Utrecht
2011 – 2012	Course: Craft of Ethnography at the NYU Institute of Public Knowledge and Columbia University New York (with Richard Sennett & Diane Vaughan)
2010 – 2011	Online course on Health Insurance Portability and Accountability Act (HIPPA) for Institutional Review Board (IRB) of Mt. Sinai New York and Bronson Methodist Hospital Kalamazoo
2009 – 2016	Participation in a learning community of scholarly consultants at Sioo, Utrecht
2007 – 2008	Course: Didactics, Pedagogics and Learning for University of Applied Sciences lecturers at HU University of Applied Sciences Utrecht
2005 – 2006	In-company Management Development training at Ziekenhuis Gelderse Vallei, Ede
2001 – 2004	Master Policy, Communication and Organization at VU University, Faculty of Social Sciences, Amsterdam
1995 – 2000	Bachelor of Nursing (dual-track) University of Applied Sciences InHolland, Diemen / Onze Lieve Vrouwe Gasthuis, Amsterdam
1988 – 1995	VWO Lorentz College Arnhem

Positions and Employment

2016 – present	Part time district nurse at Buurtzorg
2014 – present	Course director Elevate and Utrecht Summerschool international course Leadership in Healthcare
2009 – present	Researcher at Center for Innovations in Health Care HU University of Applied Sciences Utrecht/UMCU Utrecht
2006 – present	Lecturer at Institute of Nursing Studies HU University of Applied sciences Utrecht
2011 – 2012	Visiting Research Scholar at Pace University New York and Western Michigan University Kalamazoo
2011 – 2012	Research Associate at Elmhurst Hospital Center in New York and Bronson Methodist Hospital in Kalamazoo
2006 – 2011	Senior Policy Officer International Affairs of Faculty of Healthcare at HU University of Applied Sciences Utrecht
2008 – 2014	Trainer at Sioo / Boer & Croon course Successful Governance of Hospitals
2004 – 2006	Nurse Manager at Hospital Gelderse Vallei in Ede
2000 – 2004	Registered Nurse at Onze Lieve Vrouwe Gasthuis, Amsterdam
1995 – 2000	Student Nurse at Slingeland Ziekenhuis, Doetinchem, Onze Lieve Vrouwe Gasthuis, Amsterdam and Whangarei Area Hospital, Whangarei, New Zealand

Honors and awards

2017	Awarded € 29.000 for launching website www.verpleegkundigleiderschap.nu from ZonMw.
2010 – 2011	Sia RAAK International research subsidy “Excellent Nursing Care: Magnet in the Lowlands” awarded € 260.344,-

Boards

2014 – present	Board Member Florence Nightingale Institute (Institute for History on Nursing Profession, Education and Research)
2013	Sigma Theta Tau International Rho Chi – appointed as counselor for Institute of Nursing Studies, HU University of Applied Sciences Utrecht
2008	Sigma Theta Tau International Rho Chi – Inducted as Member
2000 – 2002	Board Member Johannes Wier Foundation for Human Rights in Healthcare

Selection oral presentations (out of 90 on chronological order)

- New Strategic Clinical Nurse Leaders: on habitus and leadership. **Erasmus Centrum voor Zorgbestuur**, course New Nursing Leadership, Rotterdam (invitational) | January 2017
- Post-doc nursing leadership development: towards a sociology of nursing work. **'Leadership Mentoring in Nursing Research' (LMNR)** ZonMw. Zeist. (invitational). | December 2016
- Development of a nationwide blended nursing leadership course: **European Nursing Congress**, pre conference on nursing leadership (chair). Rotterdam | October 2016
- District nursing: on power, influence and clinical leadership. **Ambassadors of District Nursing** (ZonMw), Utrecht | September 2014, 2015, 2016, 2017.
- The Chief Nursing/Medical/Executive Officer as Anthropologist: understanding the nursing logic. **Sioo and Boer & Croon**, Amersfoort (invitational) | March 2015
- Professionals in the Lead: on nurse middle managers leadership and habitus. Symposium at **Antonie van Leeuwenhoek Institute**, Amsterdam (invitational) | February 2015
- Nurse Leaders; hindering and helping factors. **Medilex symposium on Nurse Leadership Development**, Amersfoort (invitational) | May 2014
- Nursing and the influence on daily work. **Nurses Day symposium Radboud UMC**, Nijmegen | May 2014
- Shadowing Nurse Managers: from research method to management development. **Symposium Shadowing as Practice at Warwick Business School** Warwick United Kingdom | March 2014
- Nursing Specialist as boundary spanner between Management-Research-Operations. **National Congress Dutch Nurses Association Nursing Specialist**, Papendal Arnhem (invitational) | October 2013
- Magnet and Excellent care: facilitators for nursing Leadership? **National Symposium from dreaming to acting**, Rotterdam (invitational) | September 2013
- Nurse Manager Leadership: an exploration. **Symposium on Nurse Managers Daily Work: Pace University**, New York, United States | May 2012
- Nurse Managers Daily work: a collaborative search for successful repertoires. **Good Work Conference: the Ethics of Craftsmanship at University of Humanistic Studies**, Utrecht | October 2012
- On shadowing and nursing leadership: an exploration. **Annual Performance Improvement Symposium at Elmhurst Hospital Center** New York, United States (invitational) | November 2011
- Nurses and Nurse Managers: different tribes? **Sioo and Boer & Croon Executive Training**, Amersfoort (invitational) | October 2010

Publications, interviews and abstracts

- Het is hoog tijd dat we ons weer laten zien. Interview samen met Hester Vermeulen over het boek én lancering van de website over Verpleegkundig Leiderschap. Nursing, oktober 2017
- Onder de loop: Verpleegkundig Leiderschap. Interview in *V&VN magazine*. Jaargang 12, nr. 1 februari 2017
- Lalleman P.C.B., Smid GAC, Lagerwey M, Oldenhof L, Schuurmans MJ. Nurse Middle Managers' Dispositions of Habitus: A Bourdieusian Analysis of Supporting Role Behaviors in Dutch and American Hospitals. *Advances in Nursing Science* 2015;38(3):E1-E16.
- Lalleman P.C.B., Smid GAC, Lagerwey MD, Shortridge-Baggett LM, Schuurmans MJ. Curbing the urge to care: A Bourdieusian analysis of the effect of the caring disposition on nurse middle managers' clinical leadership in patient safety practices. *Int J Nurs Stud* 2016; 63
- Lalleman P.C.B., Smid GAC, Dikken J, Lagerwey MD, Schuurmans MJ. Nurse Middle Managers contributions to patient-centred care: A 'Managerial Work' Analysis. *Nursing inquiry*, 2017.
- Lalleman P.C.B., Smid GAC, Bouma J, Rasiah J, Schuurmans MJ. Peer-to-peer shadowing as a technique for the development of nurse middle managers clinical leadership: an explorative study. *Leadership in Health Services* (2017). doi:10.1108/LHS-12-2016-0065
- Lalleman P.C.B., Vermeulen, H. Inleiding in Verpleegkundig Leiderschap . In Vermeulen H., (eds.) *Verpleegkundig leiderschap*, BSL, Houten (2017)
- Lalleman P.C.B., Ista, E., Groeneweg, P., Verpleegkundige leiderschap: Macht en invloed. In Vermeulen H., (eds.) *Verpleegkundig leiderschap*, BSL, Houten (2017)
- Lalleman P.C.B., Smid G.A.C. Dispositions of habitus: on the moderating effect of the Scientific deposition of Nursing habitus on Nurse Managers Leadership in action. Paper presented at International Sociological Association 'professional group' conference in Milan Italy March 2015. Sub-theme: Profession, Bounds and Boundaries: Engaging Doctors and Health Professionals: What Is It? Does It Matter?
- Lalleman P.C.B., J. Dikken. Invloed van de VAR op zorgbeleid: een landelijke inventarisatie . *TvZ*
- Interview: Onderzoek naar VAR's in Nederland: weinig VVT-instellingen met VAR. *V&VN Magazine* , mei 2014 p.4-5
- Lalleman P.C.B., Smid G.A.C., Lagerwey M. & Schuurmans M.J. Discovering nursing habitus in the work of nurse managers: an international ethnographic organizational case study in four hospitals. Paper presented at the 29th European Group of Organization Studies (EGOS) Colloquium Montreal Canada 2013. Pre-colloquium development workshop: New Ways of Writing Organizational Ethnography
- Interview: Jij maakt het verschil: over wonen en werken als verpleegkundig onderzoeker in de Verenigde Staten, *V&VN Magazine*, maart 2013 p.13-14
- Lagerwey M., Lalleman P.C.B. Field, habitus, and nurse managers' use of capital: A socio-historic analysis in four hospitals. 2012;11(5):843-843. Abstract presented at University of Alberta Quality Improvement Conference
- Rosendaal B, Lalleman, P.C.B. Trust, Heed and Knowledge diffusion on the work floor: Looking for antecedents of knowledge sharing in a large hospital. Paper presented at the 21th European Group of Organization Studies (EGOS) Colloquium Berlin Germany 2005. Sub-Theme 19: Practice-Based Study of Knowledge, Work and Technology

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