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Nurses' organizational roles—Stakeholders' expectations

Abstract: In this study, we analysed stakeholders' organizational role expectations for nurses. We defined organizational role expectations as a set of informal expectations in behavioural patterns and formal expectations in work tasks related to a certain position in the organization. A qualitative study was conducted, and content analysis was applied to 150 articles published in a Finnish nursing trade journal. We identified five general organizational role expectations of patients and their relatives, physicians and other healthcare professionals, the work community, the nursing association, and legislators in our analysis: "the alongside stroller," "the patients' advocate," "the reliable colleague and team member," "the expert and skills developer," and "the organizational underdog." This study explores these nursing roles and links stakeholder perspective to the organizational role expectations in professional services.

Keywords: Organizational role, role expectations, profession, nurse, healthcare, stakeholders

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While perhaps not nearly as much as the physician profession, the nursing profession has received considerable attention in the extant research literature. To a large extent, the extant research deals with the nursing profession's content and changes (see Mason, 2011). In addition, some more specified research themes have gained considerable interest, including ethical perspectives, professional positioning, nurse education, the shortage of nurses, and nurses' intentions to leave the profession (see Flinkman, 2014; DeNisco & Barker, 2013; Kankaanranta & Rissanen, 2008; Tadd, 2003).

Traditional sociological research on professions has been related to professional power, autonomy, and self-regulation (Freidson, 1970). Abbott (1988) further suggested that professions are constantly changing systems rather than stable entities. In line with this, more recently, Muzio, Brock, and Suddaby (2013) encouraged scholars to study professions from the process perspective and thereby aim to understand the mechanisms that create, maintain, and change them. In this study, we perceive stakeholders' expectations as a mechanism that affects the nursing profession. Based on Muzio and associates' (2013) process perspective, we argue that stakeholders' expectations influence the nursing profession, nurses' professional identities, and the roles that nurses play in healthcare organizations.

In this study, organizational role expectations are defined as a set of informal expectations in behavioural patterns and formal expectations in work tasks related

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to a certain position in an organization.[1] In this sense, the work tasks originating, for instance, from legislation, as well as the associated rules, procedures, and job descriptions, constitute formal behavioural expectations (see Mintzberg, 1979). At the same time, many stakeholders of healthcare organizations, such as professional associations, patients, colleagues, and members of other professions, set somewhat more informal, yet similarly important, behavioural expectations (Robbins & Judge, 2010).

Besides the actual organizational roles, it is essential to recognize the stakeholders that set expectations. Although a lot of literature deals with stakeholders and their identification in healthcare organizations (see Blair & Fottler, 1990; Currie, Pouloudi, & Whitley, 2016), the literature does not address the stakeholders that set expectations for nurses' organizational roles. In this study, the purpose is to narrow this research gap by perceiving nurses' organizational roles and identifying the stakeholders that set their role expectations by analysing nurses' trade journal literature. The aim of this paper is to investigate, through a review of a nurses' trade journal, how nurses' organizational roles and related stakeholders' expectations are addressed in the published records. To be more specific, the research questions of our study are defined as follows:

1. What kind of organizational role expectations are set for nurses' within their own trade journal literature?
2. Which stakeholders, according to the trade journal literature, set organizational role expectations for nurses, and what are their locus and salience?

Our study applies the sociological process perspective and emphasizes the importance of expectations set by organizations (Olakivi & Niska, 2017; Postma Oldenhof, & Putters, 2015), as well as demonstrates how professions endeavour to adapt to these expectations (Noordegraaf, 2011). By examining stakeholder expectations, the study pursues to understand mechanisms that cause stability and change in the nursing profession and can help the profession to clarify nurses' identities, functions, and responsibilities. Nursing associations can apply the knowledge related to stakeholders' expectations while they evaluate whether these expectations should become part of professional repertoires (see Noordegraaf, 2011). In addition, nurse managers need to recognize these expectations when managing nurses' tasks and organization dynamics.

Background

Organizational role expectations

Whereas some of the extant studies have focused on the roles of nurses (see Jokiniemi, 2014; McGarvey, Chambers, & Boore, 2000; McKenna et al., 2008), the term "role" is seldom explicitly defined in this context. Often, this term seems to refer to different components or responsibility areas of nursing work (see Gibson & Bamford, 2001; McCarthy, Cornally, Moran, & Courtney, 2012), whereas in the organizational behaviour literature, a role refers to the behavioural patterns a person is expected to fulfil when occupying a certain position (see Robbins & Judge, 2010, p. 139).

Focusing on the organizational role to understanding certain work characteristics

[1] The nurse's role also includes aspects not explicitly related to organizational roles. For instance, nurses' involvement in discussions and decision-making in healthcare—both nationally and internationally—and their potential political activity (Arndt, 2003) are not explicitly connected to their organizational roles and therefore are outside the scope of this study.

is not a new approach. Particularly in the case of managerial work, there is a long tradition, originating from the seminal work of Henry Mintzberg (1973), of perceiving the different aspects of managerial work as roles. Sometimes these roles are perceived as more concrete activities (see Jokiniemi, 2014; Verschuren & Masselink, 1997) and sometimes more metaphorically (see Hatch, Kostera, & Kozminski, 2005).

As Verschuren and Masselink (1997) have noted, role expectations refer both to what should be done (tasks) and how it should be done (behaviour). While in some studies both tasks and behavioural expectations for nurses are combined, behavioural expectations are still more strongly linked to nurses' formal tasks (see Verschuren & Masselink, 1997) rather than their behavioural role expectations set by healthcare organizations' stakeholders.

Work tasks can originate, for instance, from legislation, such as the right to prescribe medicines or to dose them. Laws, moreover, define who has right to work as a nurse (Loversidge, 2013). In addition, nurses' own professional associations actively determine norms and regulations for nurses, such as ethical guidelines and codes (see Twomey, 2013). In addition to legislation procedures and job descriptions, such as the position of formal supervisor or the requirement of reporting adverse events in patient care, constitute formal expectations (see Mintzberg, 1979).

While nurses' work tasks obviously vary, for instance, across organizations, different specialty areas, hierarchical levels (McGarvey et al., 2000; Salmela, Eriksson, & Fagerström, 2011), positions, and country-specific legislation, some general nursing tasks can be identified (Evers, 2003). In Table 1, these common nursing work tasks are summarized according to Evers (2003), Gibson and Bamford (2001, p. 21−23), and Henderson (2011), and some specific examples related to each of them are provided.[2] As seen in Table 1, nursing work is wide-ranging, but nurses' main tasks are related to meeting patients' basic human needs (Durosaiye, Hadjri, Liyanage, & Bennett, 2018; Evers, 2003; Henderson, 2011).

Table 1
Common nursing work tasks areas with practical examples

Task area of nurses/role component	***Practical examples of the tasks***
Preventive tasks (clinical role component)	Monitoring symptoms and reactions (e.g., breathing) Detection of risks that can cause complications, diseases or disability
Educational tasks (education role component)	Providing instructions and information for patients on treatment, nursing care and patients' rights
Caring tasks (clinical role component)	Providing assistance in daily living, such as cleanliness, eating, clothing, sleep and rest Listening and providing emotional support for patients
Diagnostic and therapeutic	Carrying out therapeutic procedures and administering first aid

[2] Gibson and Bamford (2001) have identified research tasks as one of the role components of clinical nurse specialists. However, research tasks are not included in the general tasks of basic nursing work. Therefore, these are not included in Table 1.

tasks (clinical role component)	Collection of samples for diagnosis
Coordinative tasks (liaison and consultancy role component)	Consultation for colleagues and other healthcare professionals Delegation of nursing work and activities Coordinating patients' care
Reporting and administrative tasks (administration role component, consultancy role component)	Reporting observations and impressions about patient condition and treatment Participating in multidisciplinary team discussions about patients' care
Housekeeping tasks	Distributing meals Cleaning and maintenance of medical and nursing equipment

Organizational role expectations can also refer to stereotypes and cultural images of nurses (see Flinkman, 2014, p. 72). These, mostly informal, behavioural expectations refer to the way other actors and stakeholders, such as members of other healthcare professions, believe that a member of a certain profession should behave in a certain context (Robbins & Judge, 2010, p. 140). These are implicit social perceptions, such as attitudes and stereotypical expectations, as well as cultural images that set expectations for nurses' behaviour (Fagin & Diers, 2011; Flinkman, 2014, p. 72). Referring to the social perceptions associated with nursing, Fagin and Diers (2011) identified five metaphors—mothering, class struggle, equality, conscience, and intimacy—that create the milieu and setting for nursing work, for instance, in organizations. Fagin and Diers (2011) also note that the nurses themselves maintain the historical metaphor of Florence Nightingale. Table 2 summarizes the nursing metaphors according to Fagin and Diers (2011), Evers (2003), and Flinkman (2014) and illustrates some of their attributes.

Table 2
Nursing metaphors

Nursing metaphor	***Expectations towards and perception of the nurse role***
Mothering	Maternal types of behaviour: caring, nurturing, comforting Womanhood: warm, nice, and cordial Professional mother
Class struggle	Underdog: struggling to be recognized and approved Semi-profession Physicians' handmaid and assistant
Equality	Small social distance
Conscience	For physicians, nurses represent the feature of conscience, responsible for spotting any neglect or failure regarding patient care
Intimacy	Trusted peers: facing patients' vulnerability, hearing secrets
Florence Nightingale	Nurses' own expectations for their role: tough, canny, powerful, autonomous, heroic

Stakeholder perspectives of organizational roles

Since the seminal work of Freeman (1984), the stakeholder theory has gained considerable interest in various fields of the social sciences. The stakeholder theory has been increasingly applied also in analyses related to healthcare (see Currie et al., 2016). From the stakeholder theory perspective, a healthcare organization can be understood as a complex nexus in which nurses are the largest internal stakeholder group (see Currie et al., 2016; Marquis & Huston, 2006). However, adopting the perspective of nurses—instead of that of the organization—offers a somewhat different angle to this organizational role thematic. Although there are numerous definitions of stakeholders, in this study, stakeholders are understood according to Bryson's (2004, p. 48) classification, which defines stakeholders as an "extremely broad range of actors" such as individuals, groups, organizations, or institutions.

Stakeholder analysis is interested in who or what really counts and in what way (see Mitchell, Agle, & Wood, 1997). In this study, we focus on the locus (Blair & Fottler, 1990) and the salience (Mitchell et al., 1997) of stakeholders, as these two aspects are useful in grouping actors that have expectations regarding the organizational role of nurses and understanding the nature of their stake.

According to Blair and Fottler (1990), stakeholders can be classified into the following three groups according to their locus: internal, external, and interface. Internal stakeholders are those who operate within the borders of (healthcare) organizations, like management and other professional groups, and external stakeholders are those who operate within the broader organizational environment, like legislators and competitors. Interface stakeholders either operate simultaneously inside and outside the borders of the organization, such as members of the hospital board or operate mainly outside those borders but nonetheless influence the internal practices of the organization, such as professional associations.

In addition to the locus of stakeholders, it is essential to understand the nature of their stake—also known as stakeholder salience (Mitchell et al., 1997). Mitchell et al. (1997) determine the salience of stakeholders by analysing three stakeholder attributes: power, legitimation, and urgency. They define definitive stakeholders as those who possess both power (i.e., are able to bring about the outcomes they desire) and legitimacy (i.e., are considered to have the right to do so) and whose claims are urgent (i.e., their claims demand immediate attention). Dependent stakeholders are those who possess legitimacy and urgency but lack power. According to Mitchell et al. (1997), dominant stakeholders have power and legitimacy but not urgency, while those who have urgency and power but not legitimacy are dangerous stakeholders.

Data and method

The data of the study consisted of articles published in the *Sairaanhoitaja* journal. The journal is published in Finnish, and its title can be translated as *Nurse*. It is stated that the journal's aim is to focus on topical and central issues concerning nursing work and the nursing profession in general. As the purpose of the journal is to deal specifically with the themes associated with nurses and nursing on a practical level, as well as related issues from different perspectives, the journal highlights different dimensions of nurses' roles and thus was considered highly useful for the purposes of this study.

Nurse has been published by the Finnish Nurses' Association since 1927, and it is issued approximately eight to ten times per year. The journal's distribution in 2015 was around 40,000, and the measured readership in 2014 was over 77,000 (Sairaanhoitajat, 2016a), which is considered a relatively high number in a small country such as Finland. The journal is sent to all members of the Finnish Nurses' Association and can be considered the association's main tribune. Consequently, the journal has an agenda to promote nurses' matters and the nursing profession's development and visibility in society (see Sairaanhoitajat, 2016a; Sairaanhoitajat,

2016b.) Therefore, the articles do not merely report the perspectives of nurses but also reflect the agendas of the journalists, the editor, and the Nurses' Association. As a consequence for our empirical data, the stakeholders and their expectations are interpreted through a nursing lens, and data from other trade journals, such as physicians' trade journals, might have produced somewhat different outcomes. However, because professional associations are considered to significantly influence the development of professions (Noordegraaf, 2011), this data collected from the nurses' own trade journal can be considered purposeful.

The data were collected from the journal volumes published in 2014 and 2015, ending with the June 2015 issue (Issue 5), as the number of articles was already considerable. One author was responsible for gathering the data, while the analysis involved thorough discussions with all authors. Two of the authors have professional backgrounds in nursing, while one does not. This combination was considered useful as it enabled both "insider" and "outsider" perspectives in the analysis. Data gathering and analysis proceeded as follows.

In the first phase, every issue of *Nurse* was read thoroughly. *Nurse* covers different record categories, including editorial articles, news, reports, an at-work section, and a nurse-of-the-month section. Because all of these categories were included in the analysis, the total number of records was 232[3]. In the second phase, all records that were interpreted to either implicitly or explicitly address the nursing role were selected for further analysis. This resulted in 150 records.

In the third phase, the selected articles were analysed using content analysis. In this study, we were inspired by Graneheim and Lundman's (2004) approach to qualitative content analysis, which suggests that analysis can focus either on manifest or latent data content. Manifest content refers to the obvious and thus visible content of a text (what the text actually says), while latent content refers to the implicit and underlying meanings of a text and thus requires more interpretation and abstraction (Graneheim & Lundman, 2004). We focused mainly on the latent content, given that the nurse's role was mostly implicit in the data. Sometimes, however, the nursing role was also expressed explicitly in the text. For instance, when describing the formal tasks of nurses, the content was in many cases visible and obvious. Moreover, the actual term "role" appeared in the data several times. In some cases, it referred to the nursing role explicitly as it is understood in this study; for example, in one article, a nurse described her organizational role as that of an enabler and messenger. Moreover, the content analysis indicated that articles representing different data records were not systematically different from each other in depicting the organizational roles of nurses.

In the fourth phase of the analysis, the article phrases (or meaning units) that either explicitly or implicitly dealt with the nursing role were written down. This operation produced approximately 60 pages of text. The condensed meaning units were similar to the original meaning units but captured these using shorter expressions. The condensed meaning units were constituted by the content and included one or a few sentences. In the fifth phase, the meaning units were coded and then abstracted to higher-order categories. In the sixth phase, these categories were combined to form the overall themes (see Graneheim & Lundman, 2004), which were based on organizational role similarities. The coding framework is presented in Appendix.

While the data contained some articles where, for instance, patients or other actors described their (either implicit or explicit) organizational role expectations for nurses, the clear majority of the articles dealt with the nurses' own perspectives.

[3] *Nurse* contains several separate articles and article sections such as the News section that consist of several smaller items. However, in this study, these article sections are counted as one article.

Nevertheless, although nurses were discussing their own work in the articles, in most cases, the focus was not on their own role expectations but instead on role expectations set for them in the healthcare organization context.

In the seventh phase of the analysis, key stakeholders were identified from the meaning units. Some stakeholders, such as patients, emerged in the data constantly and explicitly, while others, such as the government and legislators, emerged more seldom and more implicitly. Those stakeholders that were central (either directly or indirectly) in the data were labelled key stakeholders (Blair & Fottler, 1990). Next, the key stakeholders were connected to the role expectations for nurses that appeared in the data. In most cases, stakeholders' expectations emerged in the data rather implicitly, and the actual terms of expectation appeared in the data only seldom. In the eighth phase, key stakeholders' expectations concerning nurses' organizational roles were further analysed for their salience. Following Mitchell et al. (1997), stakeholder salience was determined based on the power, legitimacy, and urgency of their claims, as is discussed in further detail in the Stakeholders setting organizational role expectations for nurses section of this article.

Types of organizational role expectations for nurses

According to Morgan (1986), metaphors create ways of seeing and shaping organizational life. We suggest, based on our empirical analysis in this study, that many of the nursing metaphors resonate with the organizational role expectations for nurses. However, the formal tasks and informal metaphors described in the extant literature do not adequately identify organizational role expectations. Instead, in nurses' own professional literature, organizational role expectations appear as manifold combinations of formal tasks and informal metaphors.

The empirical analysis of the data suggested five types of organizational role expectations for nurses. These originated from both formal and informal organizational role expectations and can be labelled as follows: "the alongside stroller," "the patients' advocate," "the reliable colleague and team member," "the expert and skills developer," and "the organizational underdog." Appendix illustrates the framework for the content analysis and provides examples concerning the organizational role expectations for nurses. The extracts presented were translated from Finnish into English by the authors.

As *the alongside stroller*, the central role expectation was for the nurse to provide emotional support to patients and their relatives. While many healthcare professionals naturally participate in a patient's care, the emotional support role was entrusted not only to mental health professionals (psychologists and psychiatrists) but also to nurses. The nursing role, in this case, was to share the patients' and relatives' burden. In the alongside stroller role, the nurse was expected to have good interpersonal skills and methods. When considering the nursing metaphors (see Fagin & Diers, 2011; Evers, 2003; Flinkman, 2014) introduced earlier in this article and in the case of this role, in particular, mothering types of behaviour clearly appeared in the data. In addition, formal caring tasks (Gibson & Bamford, 2001; Evers, 2003; Henderson, 2011) were part of this role (see Table 1). The analysis indicated that besides the metaphorical "strolling alongside" this role also manifested more concretely in nurses' work—nurses "walk along" the patient care pathway.

As *the patients' advocate,* the expectation was that nurses stood for patients' rights and ensured that each patient received the best possible care. In this study, this role was particularly evident in cases where a patient, due to his/her physical or mental condition, was unable to take care of him/herself. In addition, the nurse was expected to coordinate patient care and prevent possible malpractice and other undesirable outcomes. In addition to these preventive tasks, as the patients' advocate, the nurse was also responsible for educational tasks; nurses acted as counsellors to ensure patients receive the best care (see also Table 1). For example, in compiling a

specific treatment testament (i.e., one's will to continue treatment in the case of serious illness, injury, etc.), the nurse's role was to ensure that the patient was aware of the actual meaning of the testament in different situations. In some cases, the nurse was expected to empower patients to take a more active role in their own care. While working as a particular patient's advocate, a nurse needed good interpersonal skills given that s/he had to alter his/her behaviour depending on the situation and the patient.

In the role of *the reliable colleague and team member,* the nurse was expected to act in a collegial manner that dignifies others' work, provides needed support, and ensures equal treatment of co-workers. In the context of this study, nurses were also expected to play this role in relation to other healthcare professionals, such as physicians and students. The importance of the role as the reliable colleague and team member was underlined by the fact that the Finnish Nurses' Association had compiled collegiality instructions for its members. In the data, the role of the nurse in healthcare organizations was above all described as the physician's work partner.

The fourth organizational role of nurses is that of an *expert*. Besides being an expert him/herself, a nurse is expected to develop and spread his/her expertise at the organizational level, as well as sometimes at the professional level, as a *skills developer*. The nurse was expected to guide and advise both students and recently graduated colleagues using his/her expertise and experience. As an expert, the nurse has to develop his/her theoretical and practical skills continuously. In some cases, this leads to formal qualifications in certain specializations such as cancer nursing. In the data, the role of expert also included the ethics and values that guided the nurse's role.

The fifth role—that of an *organizational underdog*—appeared in the data to be particularly related to compensation and salary. For instance, the data suggested that nurses received only limited compensation for their job task enlargements. In addition, this role appeared in the case of nursing students who were reportedly occasionally treated as organizational underdogs in the workplace. The role of organizational underdog aligns with the class struggle nursing metaphor (see Table 2; Fagin & Diers, 2011) and the fact that the nursing profession has traditionally been considered a semi-profession in healthcare organizations and thus inferior, particularly to the full professional physicians (Etsioni, 1969). While clearly evident in relationship to other organizational roles, the role of organizational underdog received somewhat less attention in the data.

The analysis showed that nurses' organizational role expectations in some cases overlapped and that a nurse often acts in two or more roles simultaneously. In addition, sometimes the organizational role, such as in the case of the skills developer role, could even be shared with a patient (Lynn, Hirschkorn, & Sainsaulieu, 2011) or praxis expert (i.e., with a patient who is educated as an expert in his/her own disease). The analysis also suggested that organizational roles varied according to task, organization, and specialization area. In other words, contingency factors (see McGarvey et al., 2000; Salmela et al., 2011) had an explicit effect on nurses' organizational roles. Organizational roles were also expected to develop throughout career phases. For instance, the role of expert and skills developer was expected to vary depending on the career phase. The analysis, moreover, indicated that the organizational role expectations of nurses are in constant flux. Task delegation from physicians to nurses and from nurses to care assistants and patients was particularly highlighted in the data. Additionally, the development of information and medical technology, in particular, seem to be key factors in changing and facilitating organizational role expectations for nurses (Godin, 2013).

Stakeholders setting organizational role expectations for nurses

In this section, we attempt to deepen the understanding of the nature of identified organizational role expectations by applying the stakeholder theory perspective to the analysis. In this study, we not only identify stakeholders in the data but in order to better understand stakeholders' expectations, we also analyse stakeholders in light of their salience (Mitchell et al., 1997) and locus (Blair & Fottler, 1990).

During the data analysis, we identified the following stakeholders: patients, patients' relatives, the Finnish Nurses' Association, physicians and other healthcare professionals (including nurses with different specialty areas), the work community (and the organization's management), other healthcare organizations, the media, educational organizations, the local authorities, and the government and legislators (including the European Union). However, while most of these stakeholders would be salient (Mitchell et al., 1997), some of them, such as the media, educational organizations, the local authorities, only appeared in the data on a few occasions. From the perspective of nurses' organizational role expectations, these stakeholders could thus be considered secondary stakeholders; however, this does not mean they would in any way be insignificant in defining the practices, priorities, and goals of healthcare organizations in general (Blair & Fottler, 1990; Mitchell et al., 1997). From the perspective of defining organizational role expectations for nurses, based on our data, these did not seem to have that much at "stake" compared to the key stakeholders. Based on the analysis, the key stakeholders (Blair & Fottler, 1990), from the perspective of organizational role expectations for nurses, were patients and their relatives, physicians and other healthcare professionals, the work community, the nursing association, and legislators (see Appendix).

With regard to stakeholder salience, our analysis suggests two types of stakeholders. Definitive stakeholders seem to have mostly formal role expectations, whereas dependent stakeholders seem to have informal role expectations (see Mintzberg, 1979; Mitchell et al., 1997; Robbins & Judge, 2010; Verschuren & Masselink, 1997). The key stakeholders identified as definitive stakeholders in setting organizational role expectations for nurses were the Finnish Nurses' Association and legislators. Patients, patients' relatives, and healthcare professionals other than physicians belong to the dependent stakeholder category, as they lack at least some power but nevertheless have urgent and legitimate claims concerning nurses' organizational roles.

Physicians and the work community can be considered to belong to both categories; they can be both definitive and dependent, depending on the situation. For instance, in some patient care decisions physicians are in a superior position to nurses. However, in allocating nurses' work time or in determining their ethical codes, for example, physicians are dependent stakeholders, as in these instances the nursing profession possesses more formal power and autonomy.

Based on what is said above, our analysis indicates that the organizational role expectations for nurses originate from legitimate sources. Accordingly, even though sometimes role expectations were not considered to be positive—as in the role of organizational underdog—from the perspective of the nursing profession, no role expectation identified in the data analysis seemed to originate from a source that could be labelled as dangerous. This means that the role expectations do not pose an immediate threat to the nursing profession and that the nursing profession can resist, for instance, coercion, which would be considered a direct threat (Mitchell et al., 1997).

Following Blair and Fottler's (1990) categorization, the identified key stakeholders form three different types of groups—internal, external, and interface. The first group in our analysis, physicians and other healthcare professionals (including nurses with different specialty areas), as well as the work community, are internal

stakeholders, which means they are co-workers or operate inside the healthcare organization together with nurses.[4] Based on the data, physicians and other healthcare professionals set their expectations concerning nurses' roles within the organization mainly as reliable colleagues and team members, and as experts and skills developers. Physicians can be considered dependent, and occasionally also as definitive, stakeholders. As dependent stakeholders, physicians have profession-based informal legitimacy to guide the care process. As definitive stakeholders, formal legislation affords them the right to ultimately decide about a patient's care. Along with this right comes, for instance, physicians' role expectations for nurses as reliable team members and colleagues.

In the data, the work community referred to different facets of healthcare organizations. Typically, these facets were not explicitly defined. On those occasions that the work community was identified, it referred, for instance, to teams, organizational rules, and procedures. Sometimes the role expectations originating from the work community were more formal, as in the case of procedures and instructions concerning teamwork and responsibility areas in emergency situations. In these situations, the formal role expectations were related, for instance, to roles such as the reliable team member and colleague, as well as patients' advocate. However, in some cases, the work community also set more informal expectations, such as the nurse's role as an organizational underdog. Consequently, the work community as a key stakeholder can be salient both in dependent and definitive ways. Relating to rules and procedures, the work community (and the management as its manifestation) can be defined as a definitive stakeholder, while in the case of more informal expectations, as with the organizational underdog, the work community is a dependent stakeholder.

In the data, the second group, patients and their relatives, were nurses' customers who operated at the interface of the healthcare organizations.[5] While not actual members of these organizations, they are still not external to the organizations but inherent to their everyday operation (Bourgeault, Hirschkorn, & Sainsaulieu, 2011; Leemeijer & Trappenburg, 2016). Patients and their relatives are dependent stakeholders, as their claims possess legitimacy and urgency, but they typically lack the power to define expectations for nurses' organizational roles. Nevertheless, in the data, the needs of patients and their relatives were highly important for nurses, and it was part of nursing ethics to do the best to serve these customer groups. Patients and relatives mainly held expectations concerning the roles of alongside stroller and patients' advocate.

The third group, the nursing association and legislators, are external stakeholders: they operate outside the borders of the healthcare organization. The nurses' own professional association, both according to the data and theory (see Loversidge, 2013), defines organizational roles for nurses more profoundly than any other stakeholder. Accordingly, as suggested by Mintzberg (1979) in his seminal work, the coordination of professional bureaucracies, such as hospitals, in many ways take place outside institutional borders through professional associations. This happens, for example, when nursing associations publish recommendations that formally guide nurses' behaviour—just as the Finnish Nurses' Association has done in the case of its instructions for ethical guidelines (Ethical Guidelines of Nursing, 2014).

Professional control (or professional self-regulation) can be much stronger than formal managerial control (De Bruijn, 2011; Mintzberg, 1979). Being a part of a

[4] When healthcare professionals work together in networks or via the internet, they may be defined as external stakeholders.

[5] Blair and Fottler (1990) suggest that patients and their families are external stakeholders of healthcare organizations. We disagree and, similar to Parsons (1961) and Bourgeault et al. (2011), instead see patients and their families as recipients of healthcare services and thus operative members of healthcare organizations.

profession requires members to accept the values of the professional group (Abbott, 1988). Professional values and ethical principles are central to the nursing profession and are thus taught and internalized as early as during the nurses' training and indoctrination phase (see Lurie, 1981). Mutually shared ethical codes are also a tool for maintaining a profession's internal and external legitimacy (see Kitchener, 2002). Legislators set expectations for nurses primarily concerning their knowledge and competence requirements; along with these come the nurse's role as an expert and skills developer.

Conclusions and suggestions for future research

In the study, five different organizational role expectations for nurses were identified: "the alongside stroller," "the patients' advocate," "the reliable colleague and team-member," "the expert and skills developer," and "the organizational underdog." Furthermore, based on the analysis, there are seven key stakeholders that are particularly active in setting role expectations for nurses: patients and their relatives, physicians and other healthcare professionals, the work community, the nursing association, and legislators. All the mentioned stakeholders were important from the perspective of the organizational role expectations for nurses; however, the nursing association, legislators, and occasionally physicians and the work community were identified as definitive stakeholders. The organizational role expectations of these definitive stakeholders can be seen as mostly formal, whereas those of dependent stakeholders can be seen as informal.

The organizational role expectations identified in this study are not completely new. For instance, Evers (2003) has made somewhat similar identifications for nurses in his presentation of nurses' roles as complementary to that of physicians. However, compared to previous studies, this study identifies a range of expectations connected to each role in current nursing work and illustrates more comprehensively the set of nurses' organizational roles. Unlike the extant literature, this analysis provides empirical evidence of nurses' organizational roles based on professional nursing literature and thus offers a new perspective on the topic. This study also links the stakeholder perspective (Mitchell et al., 1997) and nurses' organizational roles (Mintzberg, 1979) for the purpose of highlighting the multiple sources of these expectations.

When professions are understood as changing systems (see Abbott, 1988; Muzio et al., 2013), it becomes important to identify and understand the expectations that stakeholders have towards a professional group. This study contributes to research literature on professions by introducing stakeholder expectations as a mechanism that can change nursing professionals' organizational roles. The extent to which professionals and professions adapt to these expectations is related to, for instance, professional associations. According to Noordegraaf (2011), professional associations can bring external expectations to professional education and therefore affect professional roles.

This study also contributes to the literature by expanding understanding of nursing roles using trade journal literature and by triggering a much-needed exploration of nursing roles that clarifies nurses' identities, functions, and responsibilities. Of course, this study is based on data collected from nurses' own trade journal, and one should perceive the results in light of this.

The results of the study can benefit, for example, nursing education, and can also be utilized in nursing management, especially when redesigning nurses' work tasks. It is important, both for educational and managerial purposes, to recognize the role expectations for nurses and the stakeholders behind them. This is also important from the perspective of the professional identity of nurses (Johnson, Cowin, Wilson, & Young, 2012). While this study describes stakeholders and their organizational

role expectations specifically for the nursing profession, it is likely that other professions will also find food for thought and might consider identifying their own organizational role expectations derived from specific stakeholders.

In the future, additional perspectives could be gained by gathering supplementary data from other healthcare professionals' trade journals or by conducting observations and interviews with nurses or other actors who set expectations for nurses (such as patients or other healthcare professionals). It should also be noted that this study focuses on nurses' organizational roles and stakeholders' role expectations in the case of nurses conducting general nursing work. For future research, it may be useful to study nurse managers' and advanced practice nurses' roles separately. Furthermore, while reading the extant literature, the conceptual ambiguity of the term role in professional nursing became evident. We, therefore, suggest the importance of conceptual analysis in future research.

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Appendix

Stakeholders' organizational role expectations for nurses, their locus, and salience

Stakeholder	**Condensed meaning unit**	**Code**	Organizational role expectations	**Stakeholder locus**	**Stakeholder salience**
Physicians	We know each other´s ways of working and I can trust her. She takes a lot of responsibility for the patients. (Vol. 2014, issue 1)	There is confidence between the physician and the nurse.	Reliable colleague and team member	Internal	Dependent stakeholder and occasionally definitive
	Physicians work as trainers. Passing exams authorizes nurses to keep their own reception. (Vol. 2014, issue 6-7)	The nurse's organizational role is enlarging.	Expert and skills developer		
Other healthcare professionals	Nurses and other healthcare professionals work in close co-operation. There is mutual emotional and discussion support. (Vol. 2015, issue 3)	Nurses work in close co-operation with colleagues, and they support each other.	Reliable colleague and team member	Internal	Dependent
	Comprehensive treatment of the patient requires multi-professional co-operation with e.g., nurses, physicians, a nutritionist, and a social worker. (Vol. 2014, issue 9)	Comprehensive treatment results from multi-professional co-operation.	Expert and skills developer		
Work community	The advanced practice nurse nurse has time for the patient. S/he has time to explain any issues and provide patient guidance. (Vol. 2014, issue 9)	The nurse's job description is enlarged.	Alongside stroller	Internal	Definitive stakeholder and occasionally dependent
	The aim is to guide patients to the groups that serve their needs. We also have groups tailored for certain diseases. (Vol. 2014, issue 2)	The work community provides to patients the groups that meet their health needs.	Patients' advocate		
	When an intensive care patient is brought to the hospital, multi-professional teamwork proceeds fluently thanks to the organization's operational protocols. (Vol. 2014, issue 5)	The operational protocols of the organization support the nursing role as one of a reliable colleague.	Reliable colleague and team member		
	In addition to other tasks, nurses provide guidance in schools, day-care, and in meetings where the patients' matters are discussed. (Vol. 2014, issues 11−12)	The nurse provides expert guidance to various actors.	Expert and skills developer		
	There has been some debate about how job enlargement should manifest itself in nurses' salaries. (Vol. 2014, issue 9)	Compensation for increased accountability does not manifest in nurses' salaries.	Organizational underdog		
Patients	The patient expects a confidential and safe relationship with the nurse. (Vol. 2015, issue 1)	Nurse's interpersonal attitude in patient care	Alongside stroller	Interface	Dependent
	In the middle of the lunch break, a	The patient comes to the nurse	Patients' advocate		

	colleague comes to say that a patient is asking for the nurse. "The patient does not have reservations about his/her treatment but brings other worries to the nurse"? (Vol. 2014, issue 4)	with his/her worries.			
Patients' relatives	Taking care of family members is part of the patients' treatment. Relationships and interaction between family members are supported. (Vol. 2014, issue 4)	Nurses support patients' relatives.	Alongside stroller	Interface	Dependent
	Loved ones can find decision making hard and may need the support of the nursing staff. (Vol. 2015, issue 3)	Relatives need support from nurses to make decisions.	Patients' advocate		
Nursing association	The Nurses' Association participates in a project creating a case manager model for patients that requires several health services. (Vol. 2014, issue 8)	Nurses' Association is involved in developing the case manager model	Alongside stroller	External	Definitive
	Nurses have an important task as a profession. Nurses play a critical role in caring for patients and ensuring better healthcare. (Vol. 2014, issue 2)	The nursing profession's task is to take care of patients and healthcare	Patients' advocate		
	The Nurses' Association asked a nurse to join a workgroup that would compose collegiality guidance for nurses (Vol. 2014, issue 3)	Nurses' Association contributes to writing collegiality guidance for nurses.	Reliable colleague and team member		
	The Nurses' Association created a new web service with the priority of providing interesting professional content for nurses. Nurses also play a role in creating this content. (Vol. 2014, issue 11–12)	Nurses create content in a professional web service.	Expert and skills developer		
Legislators	The upcoming law related to self-determination will cause challenges for the education and expertise of nursing staff. (Vol. 2015, issue 1)	The law of self-determination will change nurses' expertise requirements.	Expert and skills developer	External	Definitive