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Scholarly Article

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

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ABSTRACT

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

KEYWORDS nursing role development; division of labour; ethnographic study; organizing professionalism; management; professional and organizational logics

INTRODUCTION

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

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

We explore two empirical cases on nurse role development for: 1) nurse practitioners (NPs) in elderly care who partly replace elderly care physicians (ECPs) in nursing homes; and 2) nurses with a bachelor's degree (BSNs) in a general hospital obtaining a more prominent role in organizing and providing hospital care. We examine the mundane microlevel processes of daily practices, asking 'How do nurses give shape to an organizing role in healthcare practice?'

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

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

PROFESIONALS AND MANAGERS IN HEALTHCARE ORGANIZATIONS

The role of professionals in the organization of care has been theorized in several ways. In 'pure' or occupational professionalism, professional work is generally seen as coordination of knowledgeable, skillful tasks by autonomous workers, gaining authority in trust-based patient and collegial relationships, and profession-led training and regulation systems (Abbott 1988; Freidson 2001; Noordegraaf 2007; Evetts 2009). In this literature stream, doctors are postulated as the 'real' or 'classic' profession, while nurses are described as semi-professionals or 'lower status professionals' as they lack a strong and autonomous professional status (Freidson 2001). Davies (2003) points out that this resembles the traditional

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view on nursing as 'mothering', stressing how a certain type of femininity has been woven into the construction of the occupation (see also Dent 2003). Davies (2003) underscores how the caring/mothering view on nursing has contributed to the invisibility of nursing work, contrasting highly with the visibility and hence more appreciated work of doctors.

The early 1990s saw the introduction of a new form of controlled or 'organizational' professionalism, informed by the New Public Management (NPM) movement. In this perspective, professionals are governed top-down by managers who control and regulate professionals with external forms of regulation, standardized procedures, and measurable targets and performances (Evetts 2010; Numerato, Salvatore and Fattore 2012). The relationship between professionals and managers is seen as highly conflictual, based on the assumption that professional and organizational logics inherently compete and are accompanied by tensions between professional and organizational demands (Abbott 1988; Cohen et al. 2002; Greenwood et al. 2011). To bridge the gap between these competing logics and deal with both the shared interests and responsibilities dispersed among managers and professionals, scholars use the concept of hybrid professionalism. Hybrid professionalism refers to a range of professional and managerial roles and strategies in which 'pure' professionalism and managerialism become more entangled. Hybrid professionalism demonstrates how professionals take on managerial roles, forcing them to move between different organizational groups (Reay and Hinings 2009; Blomgren and Waks 2015; Andersson and Liff 2018; Breit, Fossestøl and Andreassen 2018). Witman et al. (2011) show how physicians must balance between the organizational and professional worlds and derive their managerial legitimacy from their up-to-date clinical experience. Others have described that physicians can play a key role in organizational change by supporting innovation and fostering legitimacy, underscoring the importance of clinical leadership roles in organizational transition (Currie and Spyridonidis 2016). Carvalho (2014) points out that nurses' careers often develop within a managerial discourse given that as nurses move into managerial and hierarchical positions they move away 'from the bedside'. Drawing on a study of nurses in Portugal, Carvalho (2014) states that the nursing discourse is shifting from 'caring' and 'nurturing' to the knowledge, skills and organizational features of nursing organizational work, and how this fosters their status. Others show that career nurses incorporate managerial tasks and develop new professional identities by assuming managerialism as part of their professional practice, hence positioning themselves as 'apart' from field-level nurses (Lalleman 2016; Allen 2018). Bresnen et al. (2019) point to the emergent hybrid professional/management identity, revealing a more variegated, situated, and dynamic interpretation of hybrid managerial identities in which hybrid professionals act as boundary-spanners connecting clinical and management practice. These forms of hybridization thus underscore the coexistence and distinctive nature of organizational and professional activities between and across professional and managerial domains, rather than providing insight into how professionals incorporate organizing activities and managerial responsibilities in their work and professional identity. The integrated organizing role is worked out further in the literature on organizing professionalism (Noordegraaf 2015; Kristiansen et al. 2015; Olakivi and Niska 2017).

ORGANIZING PROFESSIONALISM

Organizing professionalism is a relatively new concept to describe the role of professionals in streamlining processes aimed at better service provision, intertwining the professional and organizational logics as natural aspects of professional action (Noordegraaf 2011, 2015). The growing body of literature on organizing or organized professionalism (both terms seem to be used interchangeably) presents various practices of intertwining professional and organizational logics. Postma, Oldenhof and Putters (2015) use 'articulation work' to show that coordination of clients and professionals meshes the professional and organizational tasks as part of nursing work. Similarly, Allen (2014: xiii) describes the organizing role of nurses as 'making connections across occupational, departmental and organizational boundaries and mediating the "needs" of individual patients with the needs of the whole population'. Allen (2014, 2018) shows how nurses are enrolled in bed management to match the patient's need of

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

Beside the theme of organizing levels, two other issues require attention. First, to what extent is organizing 'new' to professionalism? Noordegraaf (2015), who focuses on physicians, calls organizing professionalism something new, while Postma, Oldenhof and Putters (2015) argue that it has long been part of the nursing role, albeit underexposed or neglected (see also Allen 2018). On the one hand, organizing work in nursing is largely taken for granted or neglected as the focus is on the direct patient–nurse relationship. On the other hand, scholars argue that organizing work has been 'captured' by managers, leaving the question of (the degree of) 'newness' undecided (Newman and Lawler 2009; Allen 2018). Secondly, how do professionals take up an organizing role, or what is needed to do so? Organizing professionalism pays special attention to professionals 'actively reconfiguring their professional work and reshaping organizational policies' (Postma, Oldenhof and Putters 2015: 64). Meanwhile, Noordegraaf (2015) argues that professionals should be empowered to consider organizing a natural part of their work. Noordegraaf (2015) and Postma, Oldenhof and Putters (2015) both suggest that managers could facilitate the uptake of an organizing professional role. It would require coordination, both between professionals (intra- and interprofessionally) and between nurses and managers, as organizing professionalism does not mean 'a strict return to autonomous or un-organized professional practice' (Noordegraaf 2016: 792). Oldenhof, Stoopendaal and Putters (2016) and Van Wieringen, Groenewegen and Broese van Groenou (2017) elaborate on this management role in developing and fostering professionalism by organizing tasks. Describing decoupling practices, Van Wieringen, Groenewegen and Broese van Groenou (2017) discuss how managers sometimes engage in professional work-level practices and at other times refrain from intervening to provide space to ground-level workers to craft a new role. Oldenhof, Stoopendaal and Putters (2016) similarly show how middle managers engage in shaping new professional roles, reconfiguring professional practice through professional talk. Our study contributes to the further understanding of how nurses take up this organizing role and how it affects their interactions with managers in daily nursing practice.

METHODS

Setting

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

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training levels, nurses carry out similar tasks and bear equal responsibilities.

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

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

Data Collection

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

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

Data analysis

Data analysis involved analysing the individual research projects and comparing and contrasting the findings from both (Creswell 2014; Polit and Beck 2008). We performed abductive analysis on each project, using both inductive and deductive analysis by combining the codes emerging from the data with the codes based on theory (Tavory and Timmermans 2014). This abductive strategy brought together insights from the data and theory on organizing professionalism, organizing work, and hybridity. Letting the data and theory 'talk to each other' (Stoopendaal and Bal 2013) provided situational- and theoretical-derived findings. Instead of limiting the process to a number of planned subsequent 'phases', the strategy of going back and forth through data and theoretical concepts allowed for a rich understanding of both theory and empirical phenomena (Dubois and Gadde 2002). Codes included nurse, medical, and management tasks; collaboration; independence/interdependency; power differences; interests; conflict; and legitimacy. Initial codes were grouped into subcategories revealing the micro-level processes. Subsequently, these lead to three main themes on the development of nursing organizing roles and the dynamic relationship between nurses and managers (see Supplementary Data). During the coding process and analysis, all authors discussed the themes and categories until consensus was reached.

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

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

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RESULTS

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

Creating and constraining space to develop an organizing nursing role

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

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

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

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

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

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

Nurses' initiatives in organizing and managing their work processes did not automatically find a way into daily practice. The nurses were bogged down by

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mundane obstacles, such as a lack of BSNs to shape the new role or having to prioritize direct patient care above organizational tasks due to a heavy workload. We noticed that embedding the new role demanded consultation and coordination between nursing and management. This was also apparent in the nursing home case. Here, too, NPs hesitated to take the lead:

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

Managers struggled to support the development of a nursing organizing role. They tried to give the nurses space, but sometimes fell back on traditional top-down decision making when frustrated by the nurses' limited progress (see Van Wieringen et al. 2017 for similar observations). In the nursing home, the top manager took over the lead to resolve persistent disagreement on task division between NPs and ECPs (for more detail, see below). However, this steering role hindered the nurses from taking on the responsibility to give shape to their new role:

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

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

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

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

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

> Near the end of the meeting, the manager brings in her finding: 'I noticed in the schedule that [BSNs] mainly work the day shift. I wish you'd consider what that means for the evening and night shifts. What impact does it have on quality of care for example?' [. . .] The BSNs discuss this and decide that it has a minimal effect on quality of care. They note other

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> consequences for themselves: being unhappy with regular day shifts and missing out on the extra salary for working irregular hours. (Observation report, BSN oncology ward meeting, 6 September 2018)

The findings in this section have shown that nurses in both cases were given the space to develop a nursing organizing role, yet soon felt lost doing this as it required knowledge and skills about organizing care they did not own yet. Developing an organizing role also required coordination between nurses and managers to align corporate practicalities and responsibilities, as organizing remains part of the managerial role. Managerial interference, however, also evoked conflict as nurses felt it restricted their developing space. Our findings show that managers need to perform a balancing act in giving nurses space for role development (Van Wieringen et al. 2017). Managers balance between supporting nurse leadership in steering their own role development and steering nurses in a specific direction to align with organizational policy, thereby restricting their space. Our findings underscore this balancing act, yet also expand insight by showing the tensions, interests, and power differences this involves, often bringing both managers and nurses in complex, conflicting situations and negotiation processes. This is what we will turn to next.

Prescribing and negotiating nursing roles

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

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

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

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

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

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

> NP1: 'If you're competent, just do it'.
> ECP1: 'For years [NPs have had to] ask the elderly care physician to clean a pessary. It's simple, so easy to learn. It's annoying that I still have to do it.'
> NP2: 'The motive can't be: I don't like the job.'
> NP3: 'We [can] settle this matter between us. The task is simple and easy.'
> ECP2: 'If it gets complicated, we can work [on it] together.'
> ECP3: 'We don't have any real agreement on this. If someone doesn't dare, they can ask us. If someone wants to learn [how to do] it, they can. There's a huge variation in NPs.' (Field notes, dilemma discussion, nursing home, 16 February 2017)

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

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

And:

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

Initially, the top manager's involvement did not solve the conflict. Conversely, she became part of the problem, as both parties tried to convince her to choose their side. The ECPs used their powerful position (i.e. certified ECPs are needed to maintain funding for rehabilitation programs) to narrow the NPs' role. The NPs appealed to the top manager's former strategy policy and personal commitment to give NPs a formal position with independent authority. The lack of mutual agreement on tasks and responsibilities not only forced the top manager to put a stop to the ongoing struggle, but it also led to tension among NPs. Some NPs feared losing their job if they did not go along with the persistent complaints of the ECPs and the seemingly increasing support of the top manager for their claim to hand over more clinical responsibility to the ECPs. Other NPs felt frustrated and humiliated and preferred to play it the hard way, proving their crucial and autonomous role to ECPs. This situation reveals the tensions caused by different perspectives and different power positions. It uncovers this manager's balancing act on a tightrope of tensions, needing to choose between what was considered best for the whole organization, and a personal vision on supporting nurse role development.

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

> In a NPs' meeting on role development, the top manager asks NPs about their role and responsibilities. One NP says that they bridge

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

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

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

Balancing between external requirements and internal demands

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

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

External views on the organizing role of nurses—within professional associations or advisory boards—enlarged the differences between professional groups internally, as professional groups adopted and defended these views within the organization. The

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ECPs' fear of malpractice and being held ultimately responsible for clinical affairs, and the opportunity to defend themselves in the Disciplinary Court were often mentioned especially as factors hindering agreement on the new organizing role of NPs. Even if 'management says it's an organizational decision to give the NPs end responsibility.' (Field notes, dilemma discussion nursing home, 16 February 2017).

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

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

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

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

DISCUSSION

Our study focused on the development of an organizing role for nurses and how this occurs in interaction with professional groups and managers. We show that developing a new nursing organizing role is a balancing act as it involves resolving various tensions concerning professional authority, task prioritization, alignment of both intra- and interprofessional interests, and internal versus external requirements. Building on these findings, we take the debate on nursing as an organizing professionalism (Allen, 2014; Postma, Oldenhof and Putters 2015; Van Wieringen, Groenewegen and Broese van Groenou 2017) a step further and show how nursing roles have been shaped in interaction with their own ambitions, organizational needs (i.e. shortage of physicians, the need for more nurse-driven care) and external stakeholders. The development of this organizing role goes beyond the traditional caring role in daily nursing practice (Carvalho, 2014) and the enabling work of managers (Van Wieringen, Groenewegen and Broese van Groenou 2017), supporting the development of nursing as an organizing profession. The findings reveal that a nursing organizing role plays out at four levels: the individual patient level, the patient group level, the organizational level, and the policy level. At the *individual patient* level, nurses have an important role in organizing care and guiding the patient through the healthcare system. While Noordegraaf states that organizing professionalism is a new phenomenon, our findings resonate with Postma, Oldenhof and Putters (2015) and Allen (2014, 2018) that organizing patient care is inherent to the work of nurses. Yet, by discerning levels of organizing, we showed that the role at the departmental, organizational and policy levels is

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rather new for NPs and BSNs. At the *patient group* level, nurses have an organizing role in the distribution of patient groups according to the complexity of the care required (e.g. Allen 2014, 2019). We have shown that this form of organizing may suffer from many and varied tensions between professionals, as it encroaches on both intra- and interprofessional professional boundaries. On the *organizational* level, we show an enlarging nursing role, which considers not only quality improvement activities (Noordegraaf 2015), but includes all kinds of practicalities required to run patient care smoothly on the ward (i.e. multidisciplinary collaboration, bed management, quality improvement projects, as well as scheduling and allocating nursing staff) and which are shared by a larger group of nurses. Particularly the hospital case placed great emphasis on this level, as it offered opportunities to enhance the appeal of the BSNs' role and to position nurses to meet the challenges of dealing with growing complexity in healthcare. Yet this also has consequences for the organizational budget and logistics—revealing the impact of an emerging organizing professional role for healthcare organizations. Organizing at the *policy* level, finally, concerns professional role development, both internally and externally, leading for example to the adjustments made to national job profiles and touching upon traditional jurisdictional domains. This finding is in line with Alvehus, Eklund and Kastberg (2019) on teaching and Waring (2014) on medicine. Arranging the organizing role of nurses on these four levels creates a sharper distinction between different types of organizing within nursing, and shows how the nurse's focus on an organizing and meanwhile knowledge-extensive role becomes part of the further professionalization of nursing (see Carvalho 2014 for a similar observation) and a more profound role for nurses in the healthcare system in general. We have shown that nurses are able to blend organizing with caring tasks in a nurse professional role, and that developing an organizing role entails a shift from a carer's to an expert's position for nurses. Further research should shed more light on the significance of an organizing role for nurse professionalization.

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

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

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constellation of diverse forms and practices of managing healthcare practices.

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

This study has limitations that also require further research. Our findings rely on two different management levels due to the different positions of nursing groups in the two cases. In the hospital case, we described the nurses' relationship with middle management. In the nursing home case, we dealt with top management, because they had no middle management level. Further research is needed to underpin or enrich our findings on the differences in managements' relationship with nurses, in terms of support, focus on professional roles, or action repertoire. Besides this, our study focused on growing organizing roles. Although the organizational logic that nurses and managers share can be counted on to maintain their close relationship, further research could shed light on a changing nurse–manager relationship when the organizing role for nurses is largely embedded or institutionalized in nursing practice. Secondly, by focusing on the nurse–manager and nurse–medical relationship, we largely left aside relationships with other actors, both internal and external. Research on the nursing relationship with internal and external policy makers, for example, would be of great interest to gain more insight into the development of a nursing organizing role at the policy level. As Alvehus, Eklund and Kastberg (2019) suggest, further development of organizing professionalism on different organizing levels is related to the level of organizing in nursing. Studying this might generate new insights and tools for nurses to develop their own profession in a professional–organizational context.

CONCLUSION

Nurses and managers play an important role in developing a nursing organizing role, seeking to align (emerging) nurses' ambitions, organizational needs, and external requirements. The development of the

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

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

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