
CHAPTER 6

# Dancing with a Virus: Finding New Rhythms of Organizing and Caring in Dutch Hospitals

*Iris Wallenburg, Bert de Graaff, Jenske Bal, Martijn Felder, and Roland Bal*

## Introduction

When COVID-19 hit the Netherlands early March 2020, it was first tried to stop the outbreak at the border of 'the Great Rivers', separating the southern regions (Limburg and North Brabant) from the rest of the country. Against the backdrop of the fast and worldwide expansion of the virus outbreak, this, however, proved a hopeless endeavor—although the upper north experienced a much lower number of infections as it benefitted from stringent government measures that were taken to 'flatten the curve' in order to protect the healthcare system from an overflow of severely ill patients (Bal et al., 2020; Wallenburg, Jeurissen, et al., 2020). In the course of March, general hospital care was more or less dispelled by COVID care and hospitals turned into crisis-organizations: non-emergency care was postponed, nursing wards turned into COVID

I. Wallenburg (✉) · B. de Graaff · J. Bal · M. Felder · R. Bal
Erasmus School of Health Policy and Management, Erasmus University Rotterdam, Rotterdam, The Netherlands
e-mail: wallenburg@eshpm.eur.nl



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wards, and general practitioners (GPs) and nursing homes sought to keep hospital referrals at a minimum to soften the pressure on hospitals. Hospitals moreover faced a shrinking stock of personal protection equipment (PPE) and medical technical equipment (especially ventilators) (de Graaff et al., 2020). In the last weekend of March, hospitals in the south started to overflow nevertheless, sending out alarming requests to take over patients. A national and army-led coordination center was established to coordinate the redistribution of infected patients and equipment and to prepare for a possible worsening of the situation; one in which even more patients would need intensive care treatment. In the following weeks, the curve, however, flattened. Experts warned for a lack of non-COVID care, stating that lives were lost due to lack of regular care provision (i.e., cardiovascular treatment, diabetes care, cancer treatment). They stated that hospitals should prepare for dual care provision ('COVID and non-COVID care'), which would perhaps fluctuate over time following the yet unknown rhythm of the virus outbreak and development of clinical knowledge.

In this chapter, we study how hospitals in the Netherlands engaged in organizing and delivering care during the first months of the COVID-19 outbreak. We build on an extensive (and ongoing) ethnographic study in one university hospital that plays a key role in the Dutch COVID crisis.[1] As embedded researchers, we have been able to study the crisis 'from within'. In addition, we conducted semi-structured interviews with nurses in four other hospital setting to gain a better understanding of daily hospital practices. We use the metaphor of 'the dance' to show and reflect on how healthcare organizations (including healthcare professionals, managers, patients) have engaged with the virus and its emerging consequences, thereby reconfiguring vested hospital routines, socio-spatial interactions, and rhythms of organizing and providing care.

The analogy of the dance is appealing as it comprehends elements of rhythm, space, relationality, movement, and time; aspects that were all assembled in the organizational response to the virus outbreak. Dance as a metaphor and methodology has gained ground in the organization- and management literature in the past two decades (Chandler, 2011, e.g. Biehl, 2019; Hujala et al., 2016). It draws attention to the embodied

[1] We have also closely followed one of the safety regions in which this hospital is located. While our analysis is also informed by this data, we did not use it explicitly for this paper.

and relational practices of collaborative action, 'connecting spaces and contexts and each other, "leading" and 'following' and making sense of the spaces in-between' (Biehl, 2019: 20). In this paper, we use the analogy of the dance to envision how hospital organizations have sought to *move with* the virus in a fluid and open-ended manner, as a kind of modern choreography in which actions are emerging and improvised, responding to how other people and 'things' (not the least the virus itself) behave (Biehl, 2019). We use the dance analogy specifically to affectively describe how hospitals have engaged in finding situated solutions to emerging and often uncertain organizational and practical issues through improvising and creating new strategies and routines, and how rhythms and (inter)actions changed as the crisis unfolded.

### *Dancing Organizations*

We adopt the definition of dance coined by Ortmann and Sydow (2018: 903). They apply dancing as a metaphor for '*moving with ease and facility, partly playing by, partly deviating from, the old rules and creating new ones as well*.' In doing so, Ortmann and Sydow use the notion of dance to envision the creativity of organizations working within self- and externally imposed constraints. Dancing, they argue, is about '*taking steps, turning around, moving (parts of) the body, improvising and relating to others following conventions and rhythm*' (p. 909). In organization science, the analogy of the dance is used to understand the dynamic, fleeting, and invisible structures of interaction in organizations and how they are negotiated and transformed (Biehl, 2017). It enables to foreground aspects of movement, appearance, and emotion, often in relation to the unknown. The metaphor of the dance draws attention to the rhythms, complex movements, and affective interactions in space and time. Dance also includes the material environment and how actors move through and alter space (Merriman, 2010). In doing so, it transcends the often-used metaphor of organizational improvisation (e.g., Weick, 1998) that focuses on the coordination of 'normal' and temporarily disrupted organizational procedures and rhythms, connecting 'clock time' (as a linear process) with 'event time'; an often sudden and temporal disruption of the normal order (e.g., Crossan et al., 2005; Orlikowski & Yates, 2002). This is particularly relevant in case of a virus that is unstable, invisible, and enduring. In a recent publication, and referring to the Ebola outbreak (a more often used comparison to COVID-19) Shrum et al. (2020)

depict the Ebola virus as a 'fire object' that generates fear because of its invisibility and possible presence, transforming spaces and humans (as well as 'stuff'—e.g., in the Netherlands some hospitals have forbidden postcards as these may carry the virus) in indeterminate dangers. The importance of moving through space, and the architectural features of (transforming) space into an (un)healthy place, has also been explained in the medical sociological literature. Recently, Brown et al. (2020) have shown how patients suffering from cystic fibrosis (CF) move through a hospital building to avoid physical contact with other CF patients (who carry other resistant bacteria) and how the building is (re)arranged to enable physical distancing to prevent (life threatening) cross infection. The authors reveal the politics of windows and air to show how dangers are accommodated in everyday hospital practice. In the case of COVID-19, we will demonstrate in this paper, the architecture of the hospital is part of the dance as well, as hospitals seek to facilitate a smooth transfer of patients from one department or hospital to another to optimize capacity and regulate work pressure among the medical and nursing staff, while also attempting to protect patients (and themselves) from contamination with the new and hardly known virus. Rather than a clearly scripted choreography of moving and acting, the uncertainties and different rhythms of care involved—e.g., due to the lack of knowledge about (the spread of) the virus and related diseases as well as adequate treatment; the nature and risk of cross infection; and financial uncertainties—require experimentation and improvisation at different organizational layers.

Building on running research projects and close contact in the field, we were able to quickly set up an empirical study when the crisis unfolded.[2] The ethnographic research in the university hospital started on March 5, 2020, just after the hospital had identified their first COVID patient and right before the first Dutch COVID fatality was reported. We engaged in non-participatory observation of policy-meetings on the level of the hospital boards, the staff, and the regional level (210 hours). We furthermore conducted 29 interviews with key actors and analyzed numerous

[2] Our research in the university hospital started directly after having received permission of the Board of Directors on March 4, 2020. Informed consent for observing meetings was derived always explicitly through the Board. Consent for interviews was obtained in writing from all respondents, and with some of our data being difficult to anonymize, quotes were approved by respondents before publication. Our research has been approved by our institutional ethical review board (reference IRB2020-08 Bal WMO, 25/03/20 and IRB 20-13 Felder, 08/05/2020).

internal documents (protocols, guidelines, notes of meetings). In the summer, when the crisis had slowed down, we organized three meetings in which we reflected on preliminary findings with key informants. Next to this specific hospital case, we approached nurse managers and nurses in four other hospitals in the Netherlands. Six of them were willing to keep a diary of their experiences working with COVID patients. Seven other nurses did not keep a diary but were willing to be interviewed. All of them were interviewed ($N = 17$ as some respondents were interviewed various times). We asked them about their role and the impact of the crisis on care provision and how hospitals organized and accounted for the care delivered.

The fieldwork in the university hospital and the diaries and interviews with nurses provided us with an elaborate dataset which we analyzed iteratively by moving back-and-forth between the data itself and the literature (i.e., organization studies and dance theory) (Timmermans & Tavory, 2012). Based on this analysis, we aim to provide a layered and in-depth account of how hospital organizations improvised and established new organizational rhythms of organizing and providing care in uncertain times.

## The Hospital/Acute Care Setting in the Netherlands

The Dutch healthcare system is usually defined as a social insurance system. It has a strong corporatist tradition in which the state highly depends on private healthcare providers and professional associations for the provision of care. In 2006, a system of regulated competition has been introduced to enhance competition among insurers as well as healthcare providers in order to enhance efficiency and quality of care (Bal & Zuiderent-Jerak, 2011; Helderman et al., 2005). However, the Dutch healthcare system is a layered system (van de Bovenkamp et al., 2014), in which 'the healthcare market' operates next to, and intermingles with, other institutional arrangements. This became highly visible in governing the COVID-19 outbreak (Wallenburg, Helderman, et al., 2021).

A setting important to this study is acute care provision that is organized at the regional level, and which more or less exists next to the model of regulated competition (although, as we will demonstrate in this paper, they also intermingle). Acute care provision (i.e., ambulance services, emergency departments, ICUs) is organized in 11 regions, directed by

Regional Acute Care Coordination units (in Dutch: Regionaal Overleg Acute Zorg, or ROAZ). Acute care regions cover both primary and hospital care and play an important coordinating role across healthcare providers that remain autonomous nevertheless. In the COVID crisis, the ROAZ has played a central role in coordinating care in the region, as well as in organizing collaboration with other regions through the National Network of Acute Care Regions.

Next to the ROAZ, which is focused on healthcare, Safety Regions are institutionalized in (geographic) infrastructures to foster public safety. In the Netherlands, 25 Safety Regions exist. They are usually presided by the mayor of the biggest town in the region. Based on the Public Health Act, a Safety Region can call on different 'crisis levels' corresponding with different levels of incidence in the region. In doing so, a Safety Region can centralize decision-making power when incidence levels are rising. During the COVID-19 crisis, all Safety Regions were (and, at the time of writing, still are) in level four, which means that decision-making is largely centralized on a regional level. National coordination between the Safety Regions occurs through the Safety Council.

At the national level much decision-making has also been centralized, with the Prime Minister's cabinet being in the lead, together with the Minister of Health and the Minister of Justice & Safety. A national Management Outbreak Team (OMT), led by the director of the infection prevention unit of the National Institute of Public Health and largely consisting of medical experts, advises the Prime Minister. Responding to the Dutch public debate (e.g., RVS, 2020) and to reports that have been published during the summer on a decline in public acceptance of stringent measures, the cabinet has endeavored to broaden the scope of the experts included in their advisory committees, like social scientists. However, when infection rates went up again after the summer, resulting in a second wave and with a probable third wave ahead, policy focus has again increasingly narrowed on curbing the spread of the virus again (Wallenburg, Helderman, et al., 2021).

## Findings: Dancing with a Virus

We present our findings following the unfolding dance in the (early) spring and summer of 2020. In the first instance, hospitals were at risk of becoming overwhelmed with severely ill and (perhaps) highly infectious patients suffering from yet unknown diseases. In this first but rather

short phase (3–4 weeks, of which central actors said 'it felt like months') of immediate crisis, our participants 'learned how to dance'. This first phase was followed by a second phase in which a new choreography of organizing and caring emerged in which personnel, spaces, and materials were rearranged through both national and local infrastructures to make optimal use of the available capacity while attempting to mitigate the virus outbreak. We view this process as a 'dance-marathon', as our participants were making long hours, holding on to one-another, building new organizational structures. In this second phase, the ROAZ and the national government took in a more central role in governing hospital care. In the third phase, with the virus slowly under tentative control in the Netherlands, hospitals sought to engage with physical distancing, restarting non-COVID care and preparing for an expected second wave. Whereas the initial moments of the crisis seemed a focused affair, here we find participants' 'dancing to a cacophony' as different voices and rhythms started to intermingle.

### *Learning to Dance*

> We were kind of preparing that week, but we were mostly looking at what was happening over there (…) It was still far away. But that weekend my Italian colleague phoned me, saying that we should start preparing now, that it was much worse than we thought. Until then, we had still been thinking, chatting and planning what to do… (Physician ICU)

The dance started quite unexpectantly. Although physicians had informed themselves about China and (later on) Italy, the virus still seemed far away and something that might fly over. Hospital facility staff members in the university hospital had, however, already noticed a sudden and worrisome decline in the supply of PPEs and medicines from China as well as from southern European countries. The phone call from an Italian colleague the physician above refers to, which took place in the first week of March, made him realize that immediate action should be taken to prepare for an inflow of patients at the intensive care departments. This inflow indeed happened one week later in the south, where people had been celebrating Carnival two weeks before (a tradition in the Netherlands that is mainly restricted to the catholic south). Southern hospitals could not manage this sudden influx of patients, urgently requesting other hospitals to take

over some of their patients. When hospitals responded hesitatingly, some patients were put in ambulances and sent out to hospitals in the north:

> I was phoned by an ambulance nurse, saying that they had been circling on the Amsterdam motorway for quite some time, and that they would bring in the patient within 10 minutes. (Hospital manager)

The suggestion to put a severely ill patient in an ambulance without clear destination had been quite unlikely (and perhaps even considered a crime) just a few weeks before, but became real in this first phase of the crisis. It exemplifies the panic that (at least some) hospitals experienced during these first weeks in which they could hardly accommodate the inflow of patients. It made other hospitals realize that they had to act immediately. Some of our respondents recalled how hospital care was rearranged overnight; establishing special COVID wards to take in new patients. A manager recalled how they had first planned to use the isolation rooms for (possible) infected patients, but soon realized that these few rooms would never be enough. They subsequently cleared two nursing departments; cancelling operations and sending patients home or transferring them to other departments. The ward's architecture was furthermore adjusted in order to strictly separate positively tested and possibly positive patients:

> Patients who had tested positive we laid in the back, other patients [who might be infected and awaited test results] were in the front with 1.5 m distance between them and separated with curtains. Both parts (of the nursing ward) were separated by a plastic curtain with a zipper. When a patient appeared positive, (s)he was sent through the plastic curtain to the other side. (Nurse)

Improvisation was key in these first days, involving many uncertainties about treatment and safety. Protocols and guidelines were frequently (i.e., several times a day) 'written and rewritten' (Callon, 2002) to keep up with the latest insights while simultaneously dealing with the increasing problem of lacking test capacity and a quickly diminishing stock of PPEs, especially protective aprons and mouth masks. The threatening lack of protection caused great worries among hospital directors and staff:

> It [the troubles] only became more, more and more… at some point we discussed that we only had face masks for two more days. That was it! Each time I left the [local] OMT, I thought: 'What the f*ck is happening?!'

> Then we decided that we could put two patients in the same room, so we rewrote the protocol. (…) and then finally there was a decrease in the number of new patients. This gave us some air. But I kept on thinking; who [of us] will get sick? We had some infectious disease specialists who were really ill… It all was so very close. (Hospital director 2)

The shortage of PPEs stood central in this first phase in which all actors had to learn to dance with a hardly known virus, threatening the health of patients, nurses, and physicians, as well as the continuity of care. Hospital directors struggled with the severe shortage of PPEs, seeking to use them as efficient as possible. In some hospitals, whole wards were declared 'dirty' so that practitioners could move from one patient to the other without having to change (and hence throw away) disposable cloths; in other hospitals, like the one mentioned in the quote above, single rooms were refurnished to accommodate two patients. In yet others, corridors were declared 'clean', meaning that nurses and physicians had to use more PPEs but also had space where they could pull off protective equipment and have some time 'in between' to relax a bit. Many nurses complained about headaches, and there was a lot of emotion involved as patients passed away suddenly and often in loneliness—visitors were strictly limited due to the danger of cross infection as well as to save PPEs for the staff.

It was heavily discussed who exactly needed to wear PPEs and with what level of protection. At first, healthcare professionals but also cleaners had worn high-level surgical masks offering optimal protection. However, when these masks became scarce, it was decided to 'scale off' and offer a different kind of face mask or to no longer use one at all in specific circumstances (for instance when no patient was around)—causing a lot of fear and frustration among practitioners. In one hospital, nurses resisted a new protocol stating that, following new insights, disposable hats were no longer needed. They insisted on wearing the hats as they felt they deserved optimal protection as they had already put themselves and their loved ones at risk. Being a fire object (Shrum et al., 2020), it was felt that the virus and maybe 'death' could catch them or their loved ones without noticing. Some nurses confessed how they had slept separately from their spouses these first weeks and did no longer hug their children. However, at the same time respondents underscored the solidarity they had experienced, and that it has also been 'a very special time period'. Nurses recalled how hierarchical relationships seemed to disappear, as physicians and nurses had to figure out together how patients responded

to treatment, and how and when clinical situations deteriorated and an immediate transfer to the ICU was needed. They furthermore received all kinds of public support—e.g., citizens hang up banners in front of the hospitals thanking 'their heroes', and local shop owners brought in food and presents.

In sum, the music had started abruptly—leaving actors not yet knowing how to dance. Learning to dance involved lots of improvisation (e.g., can PPE be disinfected, and will they then still work?), the redesigning of nursing wards to separate patients and save scarce resources, and clinical reasoning to figure out how to treat patients and protect hospital personnel. This learning involved both situated probing and tinkering (i.e., how to deal with the virus in this hospital?) and collective learning—as almost the whole medical world was involved in uncovering the threatening mystery of the disease. The rhythm of the first wave was quick and unpredictable, rendering it hard to anticipate on a next move. This resulted in collective action at the ward level, the hospital management level, and in the contact with other hospitals (e.g., training films how to pull on protective gear safely were quickly shared among neighboring hospitals) and national agencies.

### *Dance Marathon—Hanging in There*

Respondents all referred to the first weeks as incredibly difficult and tiresome (some worked 24/7, almost literally). Hospital directors and managers struggled with the pressure that was put on the nursing staff[3]:

> The chair is closing the meeting. Yet one of the infectious disease specialists wants to add something. 'We need to organize psychological assistance. A social worker had visited a nursing ward and four of them had started crying immediately'. One of the managers agrees; they are trying to organize things, like serving croquettes.[4] Others underline the heaviness of what's going on. (field notes university hospital)

Hospital directors worried about their healthcare professionals who were put under a lot of pressure, struggling to find some way of offering relief

[3] Interestingly, it's only about the pressure that is put on nurses and not medical doctors, also in the media.

[4] A quite popular snack in the Netherlands.

(like serving snacks, as is suggested in the above). Nurses who had not been trained for ICU care assisted ICU nurses, and medium care nurses and nurses from the operation theater received a speed course in ICU treatment. As a consequence, regular surgeries were canceled, also because ventilators and other technical equipment were needed for the COVID patients. This shift in care provision did not only have clinical and practical consequences, but also impacted on a hospital's financial position as it was unclear if and how COVID care, and the loss of normal care production, would be reimbursed. Hospitals struggled to keep regular care-delivery going. A solution was to divide COVID patients among the hospitals. However, hospitals that treated COVID patients were afraid that regular patients could be lost to other hospitals in the region—underscoring the ongoing competition between hospitals:

> Already at the very first meeting we have been thinking about the post-COVID crisis; we can't turn into a COVID-hospital. We must keep working on our patient portfolio. If we now shift care to [name hospitals], we lose it. (…) We have some hospitals in this region that like to offer more specialized care. We have negotiated about this; who does diabetic care, or transplants. Others [non-university hospitals] won't do the heart transplants, but there still is a grey area they might step in. If they take it now, we won't get it back after the crisis. (Staff member university hospital)

At this point in time (late March, early April), the pressure on hospitals and especially ICU care was reaching a peak. Physician associations as well as politicians in parliament feared a 'Code Black' in which choices had to be made who could go to the ICU (and have a chance to survive) and to whom access would be denied. At the same time, the problems in nursing homes heavily increased. Many residents were infected and died,[5] often through nurses that had to work without PPE, nursing homes did not have enough at stock, and the PPEs that were imported were sent to the hospitals, which was increasingly criticized in the media. To get a grip on the distribution of patients as well as PPEs and technical equipment, and to soften the pressure on some of the hospitals, a national coordination

[5] In this paper we focus on hospitals, which perhaps is a bit painful as we now may make the same choice as policymakers did during this phase of the crisis; not paying enough attention to the severe and rather undefined problems in nursing homes. It would have been interesting to include the nursing homes as the nursing home-hospital discussion is a dance in itself, particularly regarding the use and distribution of PPEs.

center for patient distribution (*Landelijk Coördinatiecentrum Patiënten Spreiding*, or LCPS) was established. The Dutch army was involved in establishing the LCPS, which was located in one of the university hospitals. It aimed to establish a national patient logistic center exceeding local interests:

> It had to be done in a such a short notice. We first had to solve the acute problem in Brabant, as they were overwhelmed with patients. We searched for other spots [in other ICU departments, also across the border in Germany], and asked hospitals to reveal their capacity. That way, we knew where to send the patients. The army and local consultants were involved, and we had it going in just a couple of days. It all happened under a lot of pressure. We started during day time and in the evening, and within a week it was running 24/7. (Hospital director 1)

Staff members of the LCPS requested the numbers of ICU patients of each hospital (COVID and non-COVID) on a daily basis. Based on these numbers, patients were redistributed. Physicians, however, complained that these figures did not meet the real number of patients, and that national bed-coordination was moreover unwanted as they also wanted to keep some space for local citizens that were sent in by their GPs. They admitted to 'save' some spots to have room for patients already admitted to the hospital who might clinically deteriorate, or patients that would be brought to the emergency department late at night.

In short, the eclectic dance of the first weeks turned into a tiring dance marathon in which multiple dances had to be performed at the same time—each with its own rhythm, dancers, and music. Nurses and physicians worked long shifts to care for the increasing number of patients, and gradually became more familiar with the rhythm in which disease symptoms developed. The protocols and guidelines that had been quickly drawn up and endlessly revised in the first phase now guided patient treatment as well as the distribution of patients among hospitals. The dance also involved precarious movement, attempting to mitigate the ongoing crisis by offering help while at the same time protecting the hospital's competitive and financial position as well as care for local citizens; hence seeking to synchronize acute, elective, and future care.

### *Dancing to a Cacophony*

> You can see it in the time line, how the curve was flattening. The week after, you could feel the urgency fading away. Maybe as quick as it had appeared, peacefulness returned. On Monday we thought 'let's see what will happen', and on Wednesday we said 'it's really flattening'. Immediately, the tone was changing. (staff member 2, university hospital)

In the second half of April, the number of admitted COVID patients started to decrease; 'the curve was flattening'—which, until then, had been the main policy concern: mitigating the pressure on the healthcare system (instead of fighting the virus) (Wallenburg, Jeurissen, et al., 2020). As the staff member in the quote above points out, the decreasing number of patients evoked a change of rhythm. Some experienced this as a loss as they had enjoyed the solidarity. Others argued that the high-speed organization was doomed to fail in the long run: '*You can do all this driven by emotion; it provides the energy to keep going. But you can never hang on to it, that would be utopian, I'd say. I don't even think it'll be healthy*' (staff member 3, university hospital).

The tone and rhythm of the music changed. Actors no longer served one main goal, and in the discussions many old and new interests popped up, sometimes as a result of decisions that had been taken in the heat of the moment. A striking example is the opening of a hospital unit in a big events hall that the Safety Region had turned into a shelter for infected patients. The events hall opened just after the peak was reached and hence was no longer necessary. However, after all the preparations and investments the Safety Region had made, the directors of the university hospital felt they had no other option. It was decided to engage in the municipality's initiative, although the events hall remained empty and the consensus was that it would deliver sub-optimal care if a patient was to be admitted. Events like these happened in other regions as well and led to many discussions about responsibility (also financially).

At the same time, a new dance unfolded between regional hospitals about starting up (profitable) non-COVID care while also preparing for the expected second wave of the virus outbreak. Preparations especially concerned scaling up ICU care. The government generously invested in expanding the number of ICU beds, which made it attractive to establish a few more beds:

> The director (and chair of the meeting) stresses the regional agreements that are already in place: the university hospital will scale up with 92 ICU-beds. Yet, other hospitals now want to have 'a few beds more' as well. It is said that scaling up with 2-5 beds per hospital won't make the difference, and that it embarks on plans to employ more nurses. Yet all hospitals seem to want to have their share. The numbers are discussed but are confusing to the participants. One of them points at Hospital X, one of the smaller hospitals in town. 'Increasing the number of ICU-beds will enable them to upgrade their ICU-level' [which would be a significant change in the task division in the acute region]. (field notes university hospital)

A cacophony of voices emerged in this third phase of the crisis, in which 'back to normal' was no option. Hospitals, like the rest of Dutch society, had to deal with national measures like 1.5-metre physical distancing (hampering their goal of increasing regular care provision to treat patients that had more or less been excluded in the months before) and prepared for a new phase in which COVID and non-COVID care had to exist next to each other. Here, 'quick wins' could be made. This is exemplified in the quote above in which the ICU of a small hospital could 'level up' and, through that, employ another ICU physician to enable 24/7 ICU services and, as a result, conduct more complex surgical procedures that require high-level ICU care—also revealing the politics of the COVID hospital crisis.

Whereas especially during the peak of the crisis, work routines as well as expert opinion had been authoritative and more or less unified, flattening the curve seemed to be inversely related to the number and diversity of opinions coming to the fore. Both in the media and in the regional coordination structures, more and more voices were heard, and also explicitly called for (RVS, 2020; Wallenburg, Helderman, et al., 2021). Within the hospitals, different disciplines tried to start up non-COVID care and were calling for attention and resources. Within the Safety Regions, more emphasis was placed on long-term, primary and social care. Here, next to the ROAZ-structure, non-acute care coordination teams were erected. The media, in addition, started staging experts arguing for more and for less stringent measures. Last but not least, in the House of Parliament, the COVID crisis increasingly became politicized, with the opposition calling the leading government parties to account for measures taken. In the cacophony of voices, hospitals still had to function—now serving both COVID and increasingly more non-COVID patients—and learn how to deal with this mixture of (dance) styles and rhythms.

## Discussion

Few were expecting to have to learn how to dance with a new virus, yet the COVID-19 pandemic thoroughly changed the rhythms of Dutch healthcare delivery—as well as life in general. Despite early warnings, the surge of COVID-19 patients, particularly in the south, almost overwhelmed the Dutch healthcare system, as it had done in other countries. Such fate, for now, has fortunately been abated, among others by the effort of the board(s) of directors, nurses, and other healthcare professionals to make healthcare work in pandemic times; yet with great cost, particularly among vulnerable groups (Wallenburg et al., 2020). In this paper, we have aimed to offer an in-depth account 'from within' healthcare practice on how hospital organizations have improvised and established new organizational rhythms of organizing and providing care in uncertain times. To do so, we have used the analogy of the dance, offering a perspective on how actors felt about, worked with and through disrupted and new spatial-temporal orders of organizing and caring.

In a beautiful essay in *The New York Review of Books*, Clair Wills (2020) describes dancing as reading and being read, as dance partners constantly must relate to each other in order to not only move together but also engage in an affective interaction to produce a performance. In this paper, we have envisioned the dance in three phases. In the first phase, we found our participants and respondents learning how to dance—uncertainty about the virus and about the availability of PPE triggered an immediate crisis which, next to negative affect, also engendered feelings of camaraderie and trust. Rhythm was sped-up, fast-forward and improvisation at all levels was key. In the second phase, the speed of the crisis slowed down to a 'dance-marathon'; long hours, fatigue, and new organizational structures emerged to deal with the virus and its diseases. The third phase occurred when the 'first wave' of COVID-19 patients in the Netherlands had fallen to such a level upon and government-imposed measures were loosened. Hospitals worked hard to implement social distancing, and to prepare for a next wave of COVID patients. Different and conflicting rhythms, such as that of COVID and non-COVID care, started to intermingle, engendering new or re-living old goals like leveling up an ICU ward.

The analogy of the dance is powerful and we find it particularly productive to provide an affective story of how hospitals operated at different levels and in various ways to accommodate a new group of patients while

finding new ways of organizing and caring in a highly political and uncertain context. It enables to account for the tensions between the loose acts of improvisation, such as the quick clearing of whole nursing departments, and the emergence of coordination efforts such as the LCPS. The first phase we identified necessitated healthcare organizations to improvise and act quickly—there was little room for hesitation nor reflection requiring high levels of trust. In the second phase, the rhythm stabilized and became enduring. Nurses sometimes sighed that providing intensive care to COVID-19 patients proved in fact to be 'rather boring' because of the numerous repetitions. The dance marathon is tiresome. The cacophony that ensued when the first wave subsided mixed-up the now newly established orders. New (e.g., long-term COVID patients) and old (competition between hospitals) voices problematized how our participants had learned to dance with the virus, offering among others the reflection that was missing previously, but also necessitating the actors to learn to dance with an increasing amount of participants, albeit according to different and sometimes conflicting rhythms.

Dancing as a metaphor focuses attention on the relationality, reflexivity (e.g., 'reading and being read'), materiality as well as the rhythm with which actors move through organizational life. It makes us researchers aware of the changes in organizational choreographies and creates space for providing an affective narrative of these changes. In our case, changes in choreographies include the different waves of the virus but also the interactions between the different 'levels' of the healthcare and political system in which the dance is embedded and needs to respond to. Learning to dance to the different rhythms and choreographies then also becomes the challenge that actors within such a layered system must respond to.

The dance of healthcare organizations with COVID-19 has not finished yet, but its sudden emergence has offered us researchers of the organization of healthcare a historic opportunity to do empirical research. Thus far, little in-depth empirical work such as we provide in this paper is available, but the need to reflect concretely on what happened—emphasized by the great willingness of our informants and respondents to share their experiences—and the need to offer concrete, lived, reflections on the effects and consequences of this pandemic is great. In this paper, we focused on the organization of healthcare, but the consequences of decision-making structures and practices, the mediatization of the pandemic, the organization of healthcare systems, and the role of expertise are similarly urgent matters to which research should attend (Bal

et al., 2020). Learning to dance to the different rhythms that will emerge in subsequent phases of the pandemic will remain imperative.

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