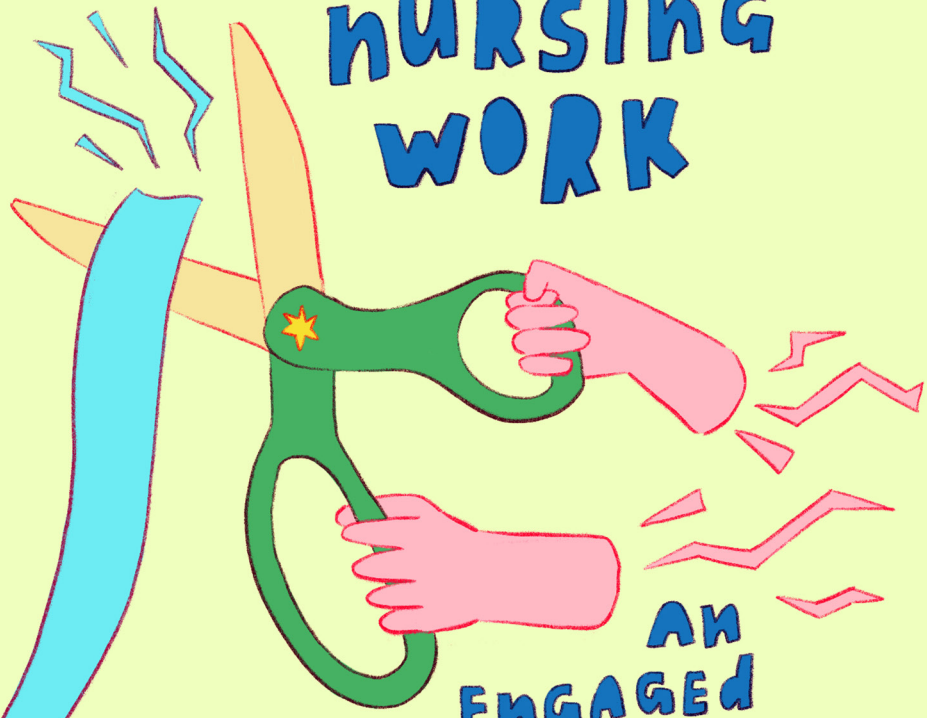
Politics of Reorganizing Nursing Work



An Engaged Ethnography

Syb Kuiper

Politics of reorganizing nursing work
an engaged ethnography

S.C. Kuijper

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Politics of Reorganzing Nursing Work
An engaged ethnography

Politiek van het reorganiseren van verpleegkundig werk
Een kritisch betrokken etnografie

Thesis

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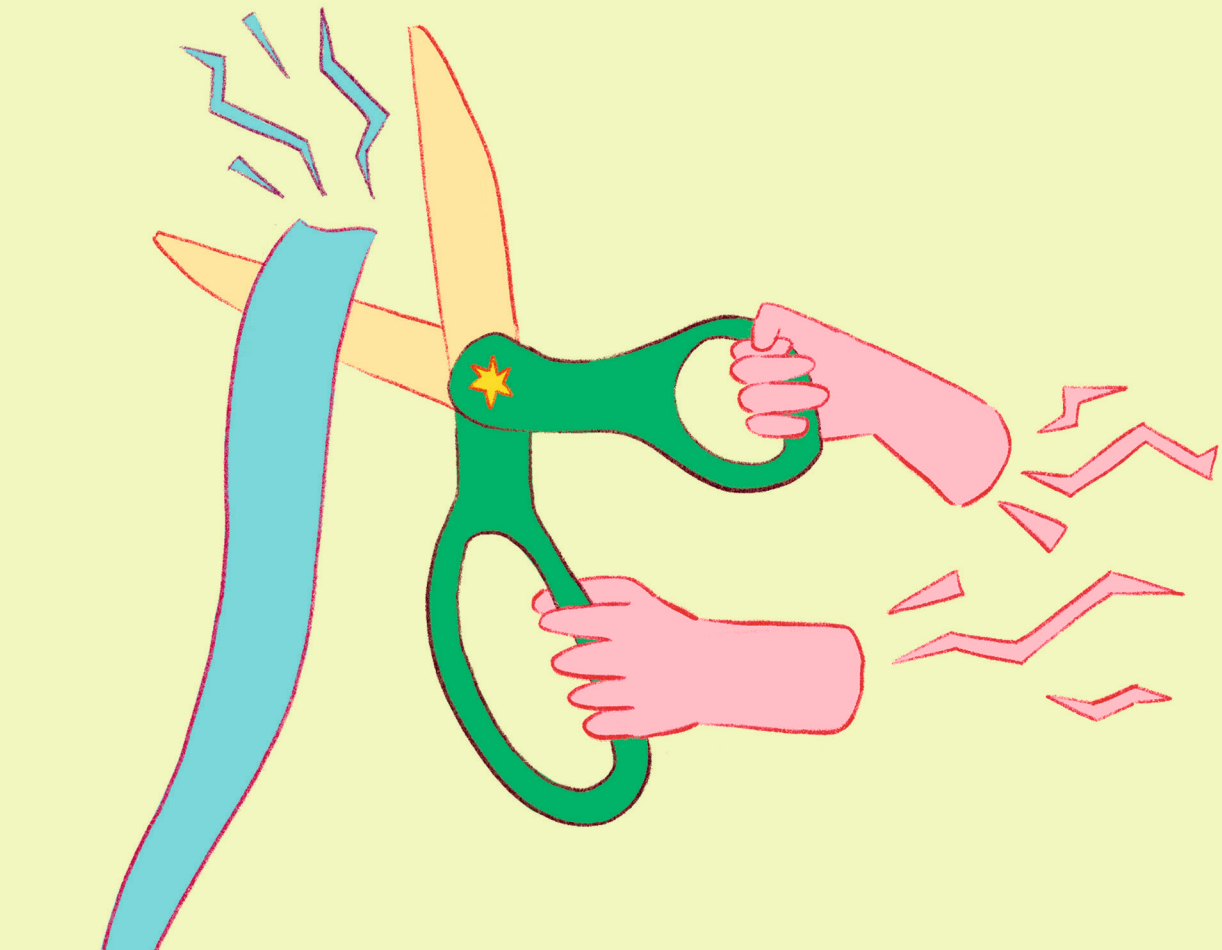
CHAPTER 1

Introduction



> *After lunch, I make my way to Emma's office, the local nurse manager, for a meeting convened with the nurses from the ward's pilot project team. When I enter her office, I find that all the chairs are taken and join two nurses standing behind the seated group. The atmosphere feels uneasy. As the door closes, Emma turns to her team and asks how things are developing in the change program. The nurses begin speaking over each other, expressing their uncertainties and feeling adrift in their project work. Emma listens attentively to the nurses, trying to appear calm, although her reserved smile hints at underlying impatience. She waits for a pause in the conversation and, to my surprise, shifts her focus from the group to me. I immediately sense the impending remark, one that I have been anticipating but also leaving me unsure of how to respond: "We really need practical direction, strategies, and some best practices, which is why we keep asking you to help us out. Frankly, we expected more from your research and guidance." (Fieldnotes, November 2021)*

Reorganizing nursing work is widely recognized as an urgent global priority for maintaining accessible and sustainable healthcare systems (WHO 2021, WHO 2024, OECD 2024, Buchan et al. 2022). The escalating shortage of nurses, combined with deteriorating and precarious working conditions, has led to urgent and widespread calls for change at both national and international levels (Boniol et al. 2022, Jackson 2022, Costa and Friese 2022). The challenges facing the nursing profession today are driven by economic, political and demographic pressures that have intensified in recent years. These pressures, combined with the longstanding peripheral position of nurses in healthcare systems and their limited control over the content of their work, have contributed to an alarming trend of nurses leaving the profession, adding to the already significant strain on the global nursing workforce (Wallenburg et al. 2023, Burau et al. 2022, Kuhlmann et al. 2024).

In the Netherlands, the empirical setting of this dissertation, nurse leaders, policy makers, and politicians are pushing for the reorganization of nursing work through innovative and experimental approaches (van Schothorst-van Roekel et al. 2020, Martini et al. 2023). In recent years, and within the scope of this dissertation, these reorganization efforts have taken various forms, including top-down legislative reforms aimed at introducing new nursing roles, and bottom-up experimental organizational projects aimed at promoting and learning about professional role development, redesigning care practices, and repositioning nurses within organizational and decision-making structures (Felder et al. 2024, Van Kraaij et al. 2022, van Kraaij et al. 2024).

However, change is not easy, nor is it easy to study through engaged ethnographic research, as the opening excerpt points out. Organizational change pursued in nursing deliberately aims to disrupt and modify established ways of working, knowing and organizing by venturing into new organizational territory and establishing novel practices

and professional relations (Clegg et al. 2005, Tsoukas and Chia 2002, Hadjimichael and Tsoukas 2023). In practice, organizational change typically involves multiple organizational members, each with their own interpretations, values, perspectives and expectations about the approach to change, the validity of different types of knowledge and learning methods, who should lead, the desired outcomes, and even the desirability of change itself (Buchanan and Badham 2020, Waring et al. 2016, Hardy and Thomas 2014, Hardy 1994, Lawrence and Buchanan 2017). This diversity makes organizational change both complex and inherently political.

Over the past four years, and in this context, I have conducted multi-sited and immersive ethnographic fieldwork in Dutch hospital practices to study organizational change processes in nursing 'from within' (Ybema et al. 2009, Marcus 1995, Lawrence and Phillips 2019). I conducted this research as part of a nationwide participatory research consortium called 'RN2Blend', commissioned by the Dutch Ministry of Health and Sport. The role of the consortium was to track, evaluate, and facilitate nurse change processes 'on the ground' in Dutch hospital practice. To this end, we developed a collaborative research process for and with nurses, with the aim of fostering and sustaining a collectively driven social research movement to promote professional and organizational change (Lalleman et al. 2020).

With this in mind, I have immersed myself in different nursing teams, temporarily becoming part of their daily practice to gain in-depth and contextualized insights into the 'lived experiences' of organizational change processes in nursing practice. Traveling between different hospitals, I engaged in daily nursing activities and specific change activities, observing nursing teams as they went about their daily care and organizational change work. To further explore the underlying agendas of change in nursing and how these changes are enacted and negotiated within the organizational and institutional environments of the nursing teams, I shadowed and interviewed a range of key stakeholders and collected relevant documentation from the participating hospitals. Beyond the hospital sites, and as part of our social movement, I co-organized and participated in research, learning and practice activities, including (online) knowledge exchanges, conferences and learning festivals. To refine and contextualize the ongoing data collection, I continuously and iteratively navigated between practical fieldwork and the literature (Timmermans and Tavory 2022, Timmermans and Tavory 2012). By engaging with different theoretical paradigms and perspectives, I aimed to consistently 'zoom in and out' to capture how everyday politics in nursing change initiatives influence and are influenced by broader organizational and institutional contexts (Nicolini 2009).

The opening vignette serves as a window into my early fieldwork experiences and highlights the complex socio-political realities of change in nursing practice. Specifically, it is drawn from my fieldnotes documenting a change program in one of the participating hospitals aimed at fostering bottom-up, nurse-led experimental innovation and

organizational change. Immersed in this setting, I soon discovered that 'becoming part of' organizational change processes not only meant experiencing firsthand the contested nature of change but also that, as a researcher, I could not avoid the politics of organizational change. In fact, I found myself deeply entangled in the politics that accompanied it. The nurses portrayed in the vignette faced significant challenges in navigating the program's uncertain, ambiguous and contested nature of the program and in building and maintaining legitimacy and support for their change work, both within their teams and in the broader nursing environment. In this complex and politicized environment, I found that while some nurses responded to my participation with indifference and skepticism, the expectations of others began to grow beyond my initial role of facilitating formative and reflexive learning through ethnographic observation, participation and reflection. Over time, these nurses increasingly expected me to lead and coordinate the change program, to inform their learning with best practices, and to provide 'upfront' planning and validation of their intended interventions.

But much like the nurses, there were many times when I felt just as lost and disoriented as they did, struggling with the different expectations placed on me. Being new to the field, I was in the process of defining and crafting my 'researcher self', exploring and navigating new areas of practice and study, in an environment where some nurses saw my participation as unwelcome, while others expected me to lead their change work in ways that I (and they) felt I couldn't. This put me in a difficult position. As I spent time on the nursing ward, my affinity and loyalty to the nurses grew, while the fear of damaging relations in the field, coupled with (un)spoken disappointment in my role as a researcher, as reflected in the opening vignette, casted moments and feelings of self-doubt, disconcertment, and failure.

My experiences of failure, however, also motivated me to draw out, unpack, and articulate my feelings of discomfort and the political tensions that surfaced during my fieldwork. It is widely acknowledged in the literature that conducting immersive and engaged ethnographic research is often accompanied by moments of discomfort and feelings of inadequacy and failure (Gains 2011, Weller 2022, Pandeli and Alcadipani 2022, Verran 2023, Borst et al. 2023). Rather than ignoring or glossing over these imperfect fieldwork experiences, ethnographers are encouraged to critically examine and use them as these 'backstage' emotions and experiences can provide valuable insights into the central social and organizational dynamics that affect, mediate, and govern professional and organizational practice (Pandeli and Alcadipani 2022, Wacquant 2002, Rhodes et al. 2007). Thus, an in-depth exploration of 'ethnographic failure' provides important analytical insights for understanding and theorizing organizational change in nursing.

The study of organizational change in nursing

This dissertation is about politics of organizational change in nursing. This focus is important because, in addition to its empirical relevance, the politics that accompany organizational change and its 'dark and bright' consequences have been largely marginalized and neglected in mainstream nursing and healthcare service research, as well as in health policy and practice (Fraser et al. 2019, Waring et al. 2016, Avelino 2021, Jones et al. 2019). In nursing, most research on organizational change fits into an apolitical 'technicist' tradition that is prevalent in healthcare service research (McMillan and Perron 2020, Petrovskaya 2022, Ayala 2020). Technicist approaches prioritize the instrumental and efficacy aspects of improving healthcare delivery, and rely on predefined, fixed and linear methods for implementing and evaluating change and improvement interventions (Bate and Robert 2002, Jones et al. 2019). These methods typically involve the evaluation of specific interventions through distant and summative assessments in predetermined and controlled settings. From a technical perspective, the objective of organizational change is to test and optimize work performance and operating procedures, and then to implement and 'roll out' best practices and evidence-based interventions (Zuiderent-Jerak 2021, Essén and Lindblad 2013).

This does not mean that organizational change in nursing literature is approached in a completely apolitical manner. In parallel with mainstream nursing literature, an emerging body of critical nursing literature is actively using political lenses to promote change by laying the conceptual groundwork for rethinking the foundational assumptions about how nursing is practiced, understood, and organized (Ernst 2020, Allen 2014, Traynor 2009, Yam 2004, Ayala 2020, Ihlebæk 2020). Through the application of critical sociological literature, this work aims to promote emancipatory change by reimagining nursing work, knowledge and professionalism. Scholars in this field examine and highlight issues such as the invisibility of nursing work (Ihlebæk 2020, Latimer 2018, Allen 2014, Krone-Hjertstrøm et al. 2021), epistemic hierarchies and injustices (Ernst and Tatli 2022, Betts 2009, Triantafillou 2015), and the gendered organization of care work (Yam 2004, Calás and Smircich 2006, Davies 2003).

This body of literature has, however, largely overlooked the politics involved in actual organizational change processes and the (un)intended consequences of efforts to reorganize and strengthen nursing. As a result, the broader literature on the politics of organizational change (Clegg et al. 2005, Hardy and Thomas 2014, Avelino 2021, Waring et al. 2016, Buchanan and Badham 2020, Fraser et al. 2019, Jones et al. 2019)—situated at the intersection of the Sociology of Professions, Organization Studies and Science and Technology Studies — has developed relatively in parallel and in isolation from (critical) nursing literature. Consequently, the politics and uncertain outcomes of organizational change remain understudied and undertheorized in critical nursing literature. Conversely, the literature on the politics of organizational change often

marginalizes nurses both empirically and theoretically. This literature is much more focused on the medical profession and, when discussed, nursing is widely depicted as an apolitical and powerless profession (McMillan and Perron 2020, D'Antonio et al. 2010).

This dissertation aims to cross-fertilize these two largely separate bodies of critical nursing literature and the literature on the politics of organizational change in order to I) explore the complex socio-political realities of change processes in nursing and II) enrich both literatures by broadening and deepening the theoretical basis for studying the political processes and implications of organizational change in the nursing context, with lessons for the broader field of healthcare. To this end, in this introductory chapter, I first describe the institutional and societal context in which the reorganization of nursing work is taking place in the Netherlands. I then present the key research questions that guided the analysis. I then outline the theoretical approaches that underpin this dissertation. Finally, I detail the research methodology and trajectory and provide an outline of the empirical chapters that follow.

Spotlight on change in nursing: heightened visibility and contestation

I began working on this dissertation in the early spring of 2020, a particularly tumultuous time to begin researching the reorganization of nursing work in the Netherlands. Just a few months earlier, in the summer of 2019, the Dutch nursing community had been forcefully stirred up by the announcement of a nationwide and legal reform, sparking the so-called 'Dutch nurse revolt' (Schalkwijk et al. 2024, Felder et al. 2022). This reform proposed legal changes to introduce and formalize new nursing roles by differentiating between vocational and bachelor trained nurses. Nurse leaders and policymakers had long advocated for these role differentiation and skill-mix strategies, seeing them as promising means of broadening nurses' career paths, repositioning them within healthcare organizations, and enhancing their professional legitimacy and authority (Schalkwijk et al. 2024).

The proposed law, however, provoked significant concerns within the Dutch nursing community and sparked unprecedented politically fueled confrontations both within the nursing community and against 'elitist' advocates of the new professional roles (Felder et al. 2022). Resistance came primarily from vocationally trained nurses, who felt deeply marginalized by the new law. They viewed the proposed the new stratification as a severe devaluation of their knowledge, expertise, and experience, as well as a threat to their position and status within their teams and organizations. The anticipated law quickly deepened divisions between nurses who supported the new roles and those who opposed them, creating a tense atmosphere of fear, hostility, and mistrust within the nursing community. By the summer of 2019, these growing tensions had turned into overt antagonism and populist actions. The grievances of vocationally trained nurses

garnered significant public attention and were widely shared in social and traditional media, making the new law highly politically visible and contentious. Following several weeks of fierce partisan opposition and revolt, fought out on social media and in nurses' everyday work environments, the proposed amendment was ultimately overturned (Schalkwijk et al. 2024, Felder et al. 2022).

In response to the ideological and political fragmentation in the field, nurse leaders, policymakers and politicians were forced to rethink their policies and strategies. This led to a significant change in approach, with the initiative to reorganize nursing work being handed over to employer organizations and unions. The Dutch government now promoted a practice-based and nurse-driven approach, urging the hospital sector and nurses to take the lead in experimenting with new roles, innovative practices, and approaches 'from the bottom-up' (Van Kraaij et al. 2022, Van Schothorst-Van Roekel 2022).

But before the dust could settle, on March 11, 2020, only a few weeks before I started working on this dissertation, the WHO officially declared the outbreak of the novel SARS-CoV 2 virus a global pandemic. The pandemic had a profound impact on healthcare systems around the world, particularly affecting the nursing profession (Jackson et al. 2020, Harrison et al. 2023). Change programs came to an abrupt halt as nurses worked at their full capacity to keep a severely challenged, and in some places overwhelmed, healthcare system on track. In the early months of the pandemic, nurses received widespread public and political acclaim and were celebrated as 'heroes', symbolizing the frontline response to the crisis (Croft and Chauhan 2021, Bennett et al. 2020, Mohammed et al. 2021). This portrayal contributed to a discursive (and contested) public and political recognition of nursing work, alongside other vocational groups, as an "essential and system-relevant" occupational category (Grenz and Günster 2022).

This discursive turn created political momentum and international advocacy for fundamental social and organizational changes for the 'heroes' of the pandemic response (Einboden 2020). However, several scholars critically noted that these discussions often degenerated into mere public applause and symbolic gestures. Fundamental change, in turn, continued to be denied, and existing professional power relations were maintained or even reinforced through new 'hero' narratives (Mohammed et al. 2021). This body of critical work has shown how heroic narratives imposed a moral obligation on nurses to accept the risks associated with their pandemic care work, while reinforcing a stereotypical view of nursing as feminized and beside care work. These one-dimensional portrayals of nurses during the pandemic restricted their ability to influence and control the conditions of their work, both during the crisis and beyond (Hennekam et al. 2020, Mohammed et al. 2021). These critical perspectives are supported by extensive research indicating that nurses had little or no input into pandemic governance and policy decisions (Taylor et al. 2022, Hedqvist et al. 2024, Schwerdtle et al. 2020, Verhoeven et al. 2024).

Today, and after the pandemic, nursing workforce shortages have reached critical levels. The pandemic has worsened longstanding workforce problems and intensified precarious working conditions in nursing, leading to increased rates of burnout, stress, and dissatisfaction among nurses that are driving many nurses to leave their positions (Bahlman-van Ooijen et al. 2023, OECD 2024, WHO 2024). This trend, compounded by anticipated waves of retirements, rising complexity of care, and shifting public and policy discourses, has resulted in a steep and growing demand for nurses. With no signs of reversal, the recruitment and retention of nurses has become the most important challenge facing today's healthcare system, making the reorganization of nursing work a priority on (inter)national policy agendas (Kuhlmann et al. 2024, Costa and Friese 2022, Boniol et al. 2022). In this context, the urgency to reorganize Dutch nursing work has increased over the course of this dissertation, with the scope and ambition of the desired changes expanding to meet the increased urgency and pressure.

This has manifested in a move away from pre-pandemic solutions that focused on role development through differentiation and skill-mix, to post-pandemic experimentation with new frameworks and organizational structures aimed at structurally repositioning nurses within healthcare organizations and redistributing decision-making power. These efforts seek to institutionalize and validate the role of nurses in organizational decision-making and agenda-setting. This 'empowerment' turn is supported by numerous government-sponsored initiatives. In addition to the 'RN2Blend' consortium, a new governmental action plan (Landelijk Actieplan Zeggenschap, LAZ) has been introduced that provided additional funding for hospitals to implement and sustain bottom-up and experimental organizational programs aimed at increasing nurses' involvement in organizational decision-making, which I studied in this dissertation. To support these efforts, numerous knowledge-sharing activities, such as webinars, conferences, and festivals are being organized for nurses and healthcare organizations. This ambition is further emphasized by new legislative measures, 'the Dutch Quality Act[1]' which legally mandates the involvement and participation of nurses in organizational decision-making structures.

This brief but event-rich overview highlights that the reorganization of nursing work takes place in a highly politicized context. Change efforts face significant political and public contestation, while expectations and goals for the reorganization of nursing work have been unstable, contested, and subject to change in recent years. In this dissertation, I

1 The Dutch quality came into effect on July 1, 2023, with the aim of promoting the rights of nurses in the Netherlands. This legislation ensures that nurses should have the opportunity to actively influence organizational policies and decision making processes. Under this legislation, healthcare organizations are mandated to create infrastructures that enable the institutionalization of nurses' participation in organizational decision-making and policy formulation, with the aim of improving the quality of care, enhance working conditions, and strengthening the legitimacy and authority of the nursing role. This initiative is further supported by substantial government funding to experiment with these new infrastructures.

empirically and conceptually explore how politics shapes and mediates processes of organizational change in nursing and their consequences for strengthening the nursing profession.

Research questions

Against this background, this dissertation explores how politics of organizational change impact on and shape the outcomes of organizational change processes in nursing. To this end, the following main research question guides this dissertation:

> *How do politics of organizational change impact the reorganization of nursing work, and what are the consequences for (re)positioning of the nursing profession?*

Sub question 1.
How do nurses respond to and shape societal challenges, and what are the implications for their organizational and political position?

Sub question 2.
How does the knowledge used and valued in organizational change processes reflect and shape power dynamics in the field?

Sub question 3.
How do organizational change programs affect existing organizational power relations in nursing?

Theoretical approach

To describe and draw out the politics of organizational change in nursing, I draw on a combined theoretical lens that includes critical nursing studies and the politics of organizational change literature. Below, I will outline some of the key notions from these bodies of literature that are relevant to this dissertation.

Critical nursing literature

Critical nursing literature is a body of work with a clear normative agenda that is committed to promoting change and challenging the oppressed role of nurses within social, organizational and political structures. Nurses have historically been viewed as having a low social and professional status within the healthcare hierarchy (Baumann et al. 1998, McMurray 2011, Ernst 2020) and often experience limitations in autonomy and authority (Yam 2004, Ihlebæk 2020, Verot et al. 2021). Critical nursing scholars explain this by several factors, including the historically formed portrayal of nursing as a predominantly female and helping vocation within the medical hierarchy that perpetuates

marginalizing power dynamics and stigma in the division of labor (Davies 2003, Traynor 2009), and the profession's ongoing struggle to articulate and institutionalize the specialized knowledge it possesses (Allen et al. 2023, Ihlebæk 2020), which is widely seen as undermining the recognition, valuation and compensation of nursing work (Zelizer 2011), as well as nurses' level of control over their work environment and organizational decision-making.

A key area of critical analysis revolves around the dominance of evidence-based practice which, based on the principles of evidence-based medicine (Timmermans 2010), has emerged as a key response to both organizational marginalization and the drive for nursing professionalization (Ernst and Tatli 2022, Hoff and Kuiper 2021, Wise et al. 2022, Betts 2009). The emphasis on developing a distinct, formalized, and validated body of nursing knowledge has intensified the focus on academic credentialing in the nursing field, leading to increased integration of scientific nursing theories and formalized research methods into nursing education and everyday nursing practice (Triantafillou 2015, Petrovskaya 2022).

In examining the entanglements of EBP and nursing professionalization, critical literature suggests that EBP may reinforce, rather than challenge, the existing biomedical institutional order in healthcare (Timmermans et al. 1998, Ernst 2019, Latimer 2018), which tends to sideline alternative nursing epistemologies that diverge from the dominant medical epistemic paradigms. According to this literature, the focus on evidence-based knowledge reinforces hegemonic organizational arenas in which the medical profession has a competitive and epistemic advantage, thereby placing nursing at a persistent disadvantage in knowledge legitimacy battles (Ernst and Tatli 2022). Furthermore, this literature argues that the shift toward EBP in nursing should be understood within the broader context of healthcare and societal trends that aim to make professional care more measurable and auditable (Power 1997, Jones et al. 2019). The paradox here, however, is that making nursing work more visible through categorization and evaluation simultaneously makes nursing practice more vulnerable to managerial control and top-down governance (Timmermans et al. 1998).

Scholars in this field therefore advocate for an alternative approach to strengthening nurses' epistemic and organizational position by emphasizing the importance of tacit, situated, and relational knowledge in nursing work and nurses' professionalism (Triantafillou 2015, Allen 2014, Latimer 2014). It calls for rethinking how nurses draw on complex assemblages of skills and knowledge, including both formal and informal knowledge, skills, and experiences, in the delivery and organization of care[2] (Strauss

2 Importantly, similar debates run simultaneously in the medical field, where critical literature draws attention to the importance — and yet the persistent invisibility — of physicians unspoken, experiential, and tacit knowledge, skills and logics (Greenhalgh, 1999; Mol, 2002; Timmermans & Kolker, 2004).

1988, Vernooij et al. 2022). The main emancipatory challenge identified in this literature is the need to recognize and validate the organizational and political logics of nursing alongside the bedside caregiving discourse (Allen 2014). Critical nursing literature is thus a political project in its own right, committed to creating and using critical social theory and political lenses to create change in the field of nursing by providing alternative lenses, vocabularies, and understandings of the current professional and practical realities of nursing.

In this dissertation, I draw on these insights from critical nursing literature to examine how nursing knowledge and work are valued and legitimized in everyday practice and in the context of organizational change programs. In doing so, I employ a practice-based approach (Nicolini 2012, Reckwitz 2002), that is common in this literature, to explore nurses' everyday sensemaking and their navigation of material and organizational environments, as well as the underlying knowledge that informs these practices (Hadjimichael and Tsoukas 2023, Cunha and Clegg 2019). However, as previously noted, critical nursing literature has paid less attention to the politics involved in organizational change processes and their (un)intended outcomes. For this reason, I turn to the literature on the politics of organizational change.

Politics of organizational change

Literature in this field focuses explicitly on the role of politics and power dynamics in organizational change processes, emphasizing the complex and contested nature of organizational change and its uncertain outcomes (Tsoukas and Chia 2002, Buchanan and Badham 2020, Clegg et al. 2005). In doing so, this literature stands in stark contrast to the 'technicists' approaches prevalent in mainstream healthcare service research, which have been critiqued for treating organizational change merely as a matter of evaluation and implementation. Such approaches tend to neglect issues of power, conflicting interests, and underlying normativities that arise during the enactment of change (Hardy and Thomas 2014).

While technicist approaches tend to overlook the organizational order and system that influence change, critical approaches emphasize that organizational change is mediated by and simultaneously disrupts existing organizational orders through a dynamic process of multiple interests and power dynamics (Bolman and Deal 2017). Consequently, scholars in this field conceptualize organizational change as a fundamentally socio-political process, in which organizational actors encounter or seek disruptions in established practices, routines and discourses, and respond by adapting, exploring and negotiating new meanings, practices, and professional relations (Avelino 2021, Cunha et al. 2020, Price 2019). Organizational change programs, in turn, are seen as specific political episodes that allow organizations and their members to experiment with and 'try out' new ideas, approaches and practices (Clegg et al. 2005, Sørensen 2013). These programs facilitate interactions, reflections and negotiations, that allow stakeholders

to either support or contest the legitimacy of new goals, interests and organizational practices (Ryghaug and Skjølsvold 2021).

The literature on the politics of organizational change exists at the intersection of three academic disciplines: Sociology of Professions, Organization Studies and Science and Technology Studies. It incorporates specific concepts and ideas from each of these literatures. Below I will discuss some of the key notions from these different literatures that are relevant for this dissertation.

Sociology of Professions

A first key body of literature is the Sociology of Professions, which offers insights into the politics of healthcare professionalism. Scholars in this field conceptualize professionalism as an inherently contested, unstable, and political construct that is shaped by the everyday practices, cultures, identities and broader institutional context of professionals and professional groups (Noordegraaf and Schinkel 2011, Fagertun 2021, Waring et al. 2022, Hallam 2012). This literature highlights how healthcare professionalism influences the valuation, demarcation and reward of different professions and their work (Evetts 2003, Denis et al. 2019).

Early literature characterizes professions as occupational groups that have achieved a high degree of social and organizational closure through legitimized bodies of formal knowledge and defined jurisdictions (Abbott 1988). This status confers authority, prestige, and control over decision-making processes (Currie et al. 2012, Wright et al. 2020). In the healthcare context, this literature provides a foundational understanding of the traditional hierarchical structure of healthcare organizations, characterized by established regimes and stratified professional relations (Carvalho 2014). Within this hierarchy, medical professionals traditionally hold the highest positions, with their professional authorities both legitimized and organized at the center of healthcare organizations. Nurses, in turn, are often classified and institutionalized as a 'semi-profession' (Yam 2004, Hoff and Kuiper 2021), which relegates them to the periphery of organizations and affects their voice, position and professional interactions within organizations.

Today, healthcare professionalism and professional practice have undergone significant changes. Multidisciplinary working environments, the flexibilization of services, changing client relations, complex regulatory frameworks, and shifting economic and political pressures have led professionals to increasingly work and collaborate across traditional boundaries and incorporating a wide range of logics and approaches from different fields (Noordegraaf 2015). Furthermore, while the nursing profession remains largely a female occupation, the medical profession has also become increasingly feminized. While acknowledging the fluidity of traditional organizational roles, structures and practices, this literature emphasizes the importance of analyzing the ongoing impact

of institutionalized inequalities and power dynamics within healthcare organizations. These forces persist in shaping professional practice and relations, although often (though not always) in more subtle and covert ways than before (Adams et al. 2020, Cunha et al. 2021).

Key ideas from this literature that are relevant to this dissertation include the notions that I) healthcare organizations are arenas of contested, unstable, and political professional orders, II) professionalism is an (inherently) politicized construct, III) political dynamics play out both within and between professional groups, IV) nurses often remain at the periphery of organizational attention and power, and V) institutionalized power asymmetries tend to influence who gets a say and under what conditions.

Organization Studies and organizational power

A second body of literature comes from Organization Studies. This dissertation draws specifically on the literature in this field that focuses on organizational power. In Organization Studies, power is a central concept, that is seen as an inseparable part of everyday practice and the organization of professional work (Clegg 2023, Haugaard and Clegg 2009). The study of power is also complex and broad, with many different definitions and approaches. Despite the lack of a single, definitive definition, a common thread in the literature is to conceptualize power as a relational phenomenon, that emerges, evolves, and increases or decreases over time in the context of relationships with others (Avelino 2021, Haugaard 2010). This relational approach highlights that power is not a fixed entity with essential qualities that organizational actors can simply possess and accumulate. Rather, power is seen as fluid, embedded within organizational contexts, relations, culture and structures, constantly in flux and shaped by organizational and institutional contexts (Lukes 1974, Lukes 2005, Clegg 2023, Lawrence and Buchanan 2017).

In this relational approach, two contrasting views of power relations can be identified. The first view conceptualizes power relations as asymmetrical organizational relations of domination and control in which A exercises power *'over'* B (Dahl 1957, Pansardi 2012, Göhler 2009). This perspective foregrounds the negative manifestations of power, emphasizing how power dynamics constrain and direct the agency of organizational actors according to the power exercised by others. Lukes' three-dimensional power approach (1974, 2005) is widely used for understanding and investigating how 'power-over' dynamics shape organizational practice and professional relations. This framework provides insight into the multifaceted ways in which power operates in organizations, extending beyond visible, direct confrontations to encompass more subtle mechanisms that obscure certain voices, issues and perspectives. In short, one-dimensional power, as described by Lukes (1974, 2005), manifests itself through overt and explicit acts in which actors mobilize their power resources to impose demands on others to influence outcomes and decision-making. Two- dimensional power, on the other hand, involves

more subtle forms of power, focusing on how organizational agendas are set and which actors are included or excluded from decision-making processes. Three-dimensional power, addresses the most covert forms, highlighting how hegemonic cultural and power structures normalize certain issues as non-issues and socialize organizational members to perceive existing orders as naturally given and inevitable.

In response to the 'power-over' perspective, a second perspective called 'power-to' has emerged. This perspective offers an alternative interpretation of power relations as the capacity to act and achieve goals within the context of interactions and relations among organizational actors, thus positioning power as a fundamental prerequisite for agency and change (Pansardi and Bindi 2021, Avelino et al. 2023, Clegg 2009, Hearn 2014). It conceptualizes power as emancipatory and facilitative, emphasizing its positive aspects (Haugaard 2012, Pansardi 2011). According to this perspective, power relations are not always destructive; instead, power can be a force for social and emancipatory change (Cunha et al. 2020). Without the power to effect change, change would not be possible.

Key insights from the power literature relevant to this dissertation reveal that power is manifested in various relations and multidimensional ways within everyday organizational practice and processes of organizational change. This facilitates an exploration of the power resources, underlying agendas, interests and normative frameworks that shape and mediate organizational change. It also provides a lens for understanding how decisions about the direction of change are made and enacted and how change processes (re)construct new and established professional relations and power coalitions within healthcare organizations.

Epistemic politics

A third body of literature that informs the study of politics of organizational change in this dissertation comes from the field of Science and Technology Studies (STS), in particular from the research on epistemic politics. In STS, the social construction of knowledge and its relation to power is a key theme (Sørensen and Traweek 2022, Doing 2004, Jasanoff 1996). In this field, research on epistemic politics examines the production, use and political role of knowledge in organizational practice and change processes. This body of literature challenges the idea that knowledge production is a neutral or objective activity. Instead, it explores how political processes and power dynamics shape knowledge production and validation, and how this, in turn, affects professional status, authority and control in healthcare practice and learning (Beaulieu et al. 2012, Hurri and Kestilä 2012). Importantly, such analyses in STS literature reflect a shared perspective with Organization Studies that power is a relational process rather than a fixed entity 'out there'. In STS, key questions include who determines what counts as 'valid' knowledge, who benefits from these decisions, who is marginalized, and how knowledge is used to promote certain forms of learning, innovation, and change while hindering others (Fricker 2007, Zuiderent-Jerak et al. 2009, Sørensen and Traweek 2022). Research suggests

that in practice conflicts over knowledge and the political dynamics that influence how knowledge and expertise are constructed, contested, and legitimized are ongoing among professionals and within organizations (Doing 2004, Carr and Obertino-Norwood 2022). This is referred to as epistemic politics.

Research on epistemic politics does not focus on the 'truth' or inherent value of any particular form of knowledge. Instead, it examines the cultural, symbolic, ideological and political dimensions and consequences of knowledge production and use (Hurri and Kestilä 2012). Within organizations, different professional groups tend to validate and frame certain forms of knowledge and practice as legitimate and can use this to protect and advance their position in the organization and in the field (Perrotta and Geampana 2020, Sheard et al. 2017). In other words, knowledge can be seen as a political tool that can be used for legitimacy, authority and control in organizational practice and change processes (Doing 2004, Karasti et al. 2016).

Epistemic politics in nursing, I will show, does not occur in a vacuum. Instead, it is shaped and mediated by broader epistemic conflicts and competing paradigms in the field on nursing and institutional environment of nursing practice (Ernst and Tatli 2022, Fraser et al. 2019, Jones et al. 2019). Nurses' struggles for legitimacy and control over epistemic practices are guided by the institutional context in which they are situated. As critical nursing literature has highlighted, there are different approaches to strengthening and validating the epistemic position of nurses, which has substantial implications for epistemic discourses, the valuation of knowledge, and knowledge production in nursing. This dynamic is further influenced by the dominance of evidence-based medicine as a clinical and policy doctrine in the broader healthcare field, which tends to sideline alternative perspectives, voices, and forms of learning within nursing (Greenhalgh 1999, Broom and Adams 2012, Betts 2009).

In this dissertation, I will show how different types of knowledge and learning used in organizational change processes are part of political contestation and are influenced and shaped by institutionalized epistemic hierarchies and discourses. Furthermore, I will use insights from this literature to demonstrate how knowledge can be used as a political tool to manage change and how processes of knowledge use and validation co-evolve with power dynamics in the field. This interplay can shape certain pathways of action and learning while constraining others.

In conclusion, the ideas, concepts and theories reviewed from critical nursing studies and the politics of organizational change literature are used in the following chapters to describe and draw out the politics of organizational change in nursing. In the following sections, I will outline the research methods and trajectory, as well as the structure of the empirical chapters.

Research trajectory

This dissertation draws on multi-sited and engaged organizational ethnographic research and was conducted as part of a nationwide participatory research consortium called 'RN2Blend', commissioned by the Dutch Ministry of Health and Sports. In this section, I unpack and justify the methods and research approach used and discuss the background, structure and aims of the research consortium.

RN2Blend

RN2Blend (2019-2024) was a research consortium established to study and facilitate change in the field of nursing. It consisted of a diverse group of researchers from various academic and educational institutions across the Netherlands, each bringing different backgrounds and research methodologies. This diversity facilitated the consortium to adopt a mixed-methods approach, integrating economic, health services research and sociological methods and concepts to capture the complexity of change processes in nursing. Initially, in 2019, the Dutch Ministry of Health and Sports commissioned the consortium to study the processes, effects, and outcomes of nurse role differentiation and skill-mix in Dutch hospitals as proposed in the 'Wet BIG II' legislation. However, as developments in the field progressed (as explained above, most notably the withdrawal of the legislative amendment itself), the scope and objectives of the consortium also changed, shifting to a more dynamic focus on tracking, evaluating, and facilitating the various ways in which the reorganization of nursing work was being approached.

Throughout this process, the consortium deliberately sought to develop a collaborative research process for and with nurses, with the intention of fostering and sustaining a collectively driven social research movement to promote professional and organizational change (Lalleman et al., 2020). Close collaboration with key stakeholders and organizations in the field was essential to achieving these goals. This included partnerships with different local hospitals, where we worked closely with nurses, hospital management, research and educational departments, and nursing management to design and conduct the research. The consortium was coordinated by the Dutch Hospital Association (NVZ), ensuring strong connections with the field. We also actively collaborated with other key stakeholders, including the Dutch Nurses Association (V&VN) and the National Action Plan and program on nurse empowerment (LAZ).

Within our research consortium, monthly meetings served as a platform for collaborative exchange among researchers, including PhD candidates and senior scholars. These gatherings provided opportunities to present and discuss a wide range of topics, including research methods, conceptual approaches, empirical findings, and the challenges and tensions encountered throughout the research process. This collaborative approach facilitated the triangulation and comparison of the findings and conceptualizations presented in this dissertation. The consortiums research findings were regularly

disseminated through presentations in hospitals, blogs, webinars, and at national and international conferences and symposia, contributing to the broader discourse and movement of change in nursing. These presentations and findings have been compiled on a website (www.rn2blend.nl) which serves as a knowledge platform for nurses and hospitals. In addition, as a research consortium, we organized three knowledge festivals, not only to present and reflect on research findings, but also to create opportunities for field actors to meet, exchange insights, and learn from each other's experiences.

Multi-sited organizational ethnography

As one of the participating research groups in the consortium, we were in the field with two researchers, my co-promotor and me, using ethnographic methods to explore and understand change processes in nursing 'from within' and from a grassroots perspective (Ybema et al. 2009). This approach enabled us to maintain the flexibility needed to adapt to the many unfolding events in the field. Unlike more rigid action research designs, which typically investigate predefined interventions through structured cycles of observation, reflection and action (Bryman 2016, Mortelmans 2020), assuming a certain stability in the perceived issues and goals of change — an assumption that does not hold in this dissertation — ethnographic research is inherently open-ended, exploratory and reflexive (Hertog and van Sluijs 1995, Van Maanen 2011). This approach allowed us to engage with the field in a dynamic way, allowing us to 'drift' with the fluid and complex political processes of change, and to allow for the emergence of new insights and understandings in response to evolving contexts and the dynamic enactment of change across time and space.

Our decision to adopt an ethnographic approach was further guided by the recognition that organizational change processes and activities are intricately situated within, and shaped by, the broader social symbolic and institutional contexts of healthcare organizations (Bryman 2003, Lawrence and Phillips 2019, Lawrence et al. 2011). In the following chapters, I will show how immersion in the everyday and 'business as usual' of nursing practice enabled me to develop a multi-layered understanding of how change processes unfold in the field and how they are influenced by broader social, organizational and institutional environments and contexts (Pandeli et al. 2022). As the literature reviewed earlier highlights, nursing practice is governed by a complex web of formal and informal rules, norms and discourses. This web includes not only formal and documented rules, routines and procedures, but also unspoken norms, values, interests, and power dynamics that mediate and shape nursing practice and organizational change. Ethnography provides a means of uncovering these overt and covert dimensions of professional interactions, organizational culture and politics in the field (Pandeli and Alcadipani 2022, Hammersley and Atkinson 2019).

The multi-sited approach (Marcus 1995), in turn, stems from the understanding that the reorganization of nursing is not an isolated initiative limited to a single institution or nursing department. Rather, it is a series of layered change processes involving a network of practices, policies, and actors that span different, but interrelated time-spaces. This was an important reason for our decision to have two researchers in the field. By building a rich data set and tracing the flows and patterns of ideas, practices, and the tensions of change generated across these sites, we sought to capture how everyday political dynamics manifest themselves in different nursing environments and how they interact with the broader organizational and institutional context of nursing.

Data collection

In practical terms, our research strategy involved prolonged and intensive engagement with organizational change processes in the field. To achieve this, we used a combination of methods, including participatory observations in a variety of settings such as in nursing wards, managers' and board offices, conferences, and numerous knowledge-sharing events. These observations were complemented by formal and informal interviews with key stakeholders allowing us to gain deeper insights into their perspectives and experiences. Additionally, we collected and closely analyzed relevant documentation, such as local implementation and strategy rapports and governmental documents.

The primary source of data in this dissertation are participant observations, most of which were conducted on nursing wards in four Dutch hospitals. In one hospital, we focused on studying the (re)organization of Covid care (discussed further below). In the other three hospitals, we followed and participated in specific change programs and initiatives. In agreement with these hospitals, we selected two nursing teams to observe each time, with one of us participating on each ward. In our ambition to study the change processes 'from within', we participated in both the everyday care activities of the nursing teams and the specific change activities they were undertaking. To facilitate our integration into the daily routines of the nursing teams, we were issued temporary staff passes, wore the local nursing uniforms, and were added to the work roster during our observation periods. By becoming (temporary) members of the different teams, we were able to shadow the nurses in their 'naturalistic' setting. We usually spent full shifts on the units, including 'early', 'late' and occasionally 'night' shifts. During these shifts, we participated in a variety of activities, including morning briefings, daily care activities, lunch breaks, multidisciplinary meetings, team evaluation meetings, physician visits, and informal gatherings at the nursing stations. As our fieldwork progressed, and in close consultation with local nurses, we began to strategically select specific nurses, shifts and meetings to shadow. This approach allowed us to gain a deeper understanding of the practices dedicated to organizational change and how nurses how nurses perceive and navigate these changes in their everyday work environments.

In addition, to gain a deeper understanding of change processes within the broader organizational and socio-political context of nursing, we shadowed key stakeholders in their work environments, such as quality managers and board members. This allowed me to develop a more comprehensive and contextualized understanding on how the reorganization of how nursing is perceived, imagined, and enacted by different actors across various organizational levels. During fieldwork, both structured and spontaneous moments of reflection and dialogue with participating nurses and involved stakeholders were held, both in dedicated sessions and in the flow of daily practice. Throughout my observations, we made it a point to regularly share our observations and interpretations with field actors we shadowed to confirm that they resonated with their perspectives.

Furthermore, to better understand the historical and institutional context of nursing and nationwide reorganization efforts, I attended and conducted observations at several knowledge sharing events. These events, organized by various organizations including hospitals, the Dutch nursing association (V&VN), the Dutch Ministry of Health, Welfare and Sport (VWS) and the Dutch Research Council (NWO) provided important insights into the key issues, values and challenges prioritized by actors in the field. Moreover, as part of the broader research consortium, we also co-organized and participated in our own webinars, conferences and festivals, and developed learning games centered on 'leadership, politics and change'.

The observational data are supported by formal interviews (n=32) and focus groups (n=10) with nurses, as well as interviews with a wide range of actors involved, including nurse managers (n=15), hospital management (n=7), and relevant experts (n=25) to further explore the institutional, epistemic and political landscape of (Dutch) nursing practice and professionalization agendas. In addition, we collected and analyzed relevant documents from various sources. These sources included, for example, documents from nursing departments and hospitals, publications from nursing associations, (inter) governmental reports and guidelines (n=36), as well as 'grassroots data' coming from online platforms such as blogs and social media (n=254). These documents provided additional insight into the practices, policies and discourses shaping the reorganization of nursing work. Overall, the data collection involved over 590 hours of observations, 95 interviews, 32 institutional documents and 254 online documents.

The ethnographic data presented in Chapter 2, which focuses on nurses' crisis work during the Covid-19 pandemic, deviates to some extent from the approach outlined above. At the onset of the pandemic, the constraints imposed by the Covid measures made it difficult to collect data in the field. In an effort to capture the experiences and work of nurses during the first weeks of the pandemic, we turned to digital research methods. We conducted a diary study in which participating nurses were asked to document their daily experiences working in Covid care through written reflections or recorded audio and video entries (n=6). We then conducted virtual interviews with the

participants, all of whom were frontline staff and reached out to other nurses who were open to interviews but not to keeping diaries. While online research methods have several limitations — such as the inability to fully capture sensory experiences and the nuances of social, emotional and political dynamics (Podjed 2021, Roberts et al. 2021)—digital technologies provided us with rare and valuable insights into the everyday realities of nurses during the early waves of the pandemic. As the Covid measures began to ease, we continued our research by conducting ethnographic fieldwork 'on the ground'.

The agenda of engaged ethnography

My participatory approach positioned me as an active participant in the research context, which required careful and reflexive consideration of the nature of my engagement, which can best be described as that of an 'engaged organizational ethnographer' (Ortner 2019, Juris and Khasnabish 2013, Ghorashi and Wels 2009, Clair 2012). This approach to ethnographic research is driven by two interrelated goals. First, it seeks to develop a critical, bottom-up and in-depth understanding of how professional work is organized as it unfolds in daily practice, including the social, symbolic, and political dynamics that shape it (Pandeli et al. 2022, Hertog and van Sluijs 1995, Lawrence and Phillips 2019). Second, it carries a normative agenda, focusing on how professional work should ideally be organized in more just and equitable ways, but without having an a priori understanding of what that might mean in practice (Clarke 2010). Engaged ethnographers acknowledge and embrace the subjective and normative dimensions and uncertainties inherent in their role and research (Weller 2022, Pandeli and Alcadipani 2022, Clair 2012). They view the research process as inherently social, shaped not only by interactions with research participants but also by the researcher's underlying assumptions, biases, and academic training and preferences. In this tradition, claims to objectivity or neutrality in the research process or academic output are seen not only as oversimplifying the complex and messy entanglements of ethnographers in the social fabric of organizations, but also as potentially complicit in maintaining existing power structures, rather than explicitly challenging them (Ghorashi and Wels 2009). Therefore, engaged ethnographers do not settle for merely exploring and understanding social and organizational phenomena; they see their research as a potential catalyst for social change.

Over the course of this dissertation research, my normative agenda evolved from an initial curiosity to a growing concern as I spent more time in the field. It is widely acknowledged in the literature that ethnographic fieldwork inherently transforms the researcher (Ybema et al. 2009), as they navigate, become familiar with, and are influenced by the initially unfamiliar organizational settings and socio-political dynamics that shape and govern the organizational lives and professional practices of the research participants (Van Maanen 2011). My engaged, immersive approach brought me into direct contact with the complex, and at times oppressive and stifling, political realities that nurses face and navigate in their everyday care practices and during periods of organizational change.

By approaching organizational change not only in technical terms but explicitly through a political lens, I aimed to intervene both in practice and in the literature. In practice, I worked to bring my political and often critical analyses back into the field through dialogue, presentations within and outside hospital sites, and academic and professional publications. In terms of the literature, this dissertation seeks to contribute to a reorientation in the rather apolitical discussions of organizational change in both mainstream and critical nursing literature, while pushing to position the nursing profession more prominently in debates in the literature on the politics of organizational change. In doing so, with this dissertation I aim to highlight and articulate the polyphony[3] (Kornberger et al. 2006, Belova et al. 2008, Hazen 1993) in the (re)organization of nursing work. Ethnography is particularly well suited to explore and uncover the margins and peripheries of professional and organizational life, providing a tool for voicing and drawing attention to less dominant, powerful, and articulated perspectives, knowledge and voices (Breda 2013, Castagno 2012). In doing so, it can contribute to more inclusive organizational change.

It is critically important to note, however, that my position and participation as an engaged ethnographer does not mean that I uncritically side with or celebrate nurses and their various projects for authority, voice and emancipation. Rather, the immersive approach I have used has allowed for a thorough and layered exploration of the complexities of change in this field. This includes a complex reading of the politics in the field, like the inclusion of the multiplicity of voices, contradictions, tensions and 'dark forces' at play — not only between nurses and their stakeholders but also within the nursing profession itself. In other words, my aim is not to be neutral about power asymmetries or in the (research) questions I ask, but rather to be critically reflective and nuanced in my engaged approach. In this spirit, the following chapters demonstrate how the critical arguments, ideas, and concepts presented and developed in this dissertation are firmly grounded in the complex and sometimes contradictory evidence from the empirical data, which I present in its full scope through a rigorous and detailed presentation of my ethnographic data, analysis, and interpretation (Ortner 2019, Bryman 2003).

3 I introduce and use the concept of polyphony in Chapter 5. In Organizations Studies, polyphony serves as a metaphor that helps to understand organizations as "*discursive spaces where heterogeneous and multiple voices engage in a contest for audibility and power*" (Belova, King, Sliwa (2006 p. 493). This literature aims to articulate and legitimize polyphony, creating avenues for alternative perspectives, narratives, and interests to emerge alongside traditional and hegemonic discourses (Kornberger et al. 2006; Hazen, 1993; Sullivan & McCarthy, 2006).

Outline of the chapters

Chapter 2 reconstructs how the Dutch nursing community responded to the proposed 'Wet BIG II' reform, which sought to reorganize nursing work by introducing and formalizing new forms of role differentiation and skill mix. The chapter describes how, against a background of representational deficits, a populist action frame was used to articulate and mobilize grievances, dissent, and opposition to these macro-level changes. Interpreting these strategies as a form of 'doing politics', the chapter critically explores the destructive and generative processes and implications of such political action for (future) organizational change initiatives and, importantly, for the positioning and legitimacy of the nursing profession.

Chapter 3, in turn, examines the layered and invisible (re)organizing work of nurses as they navigated 'uncharted territory' during the Covid-19 response. Using ethnographic data and nurse diaries from the early pandemic, this chapter foregrounds how nurses met pandemic pressures by reorganizing care 'on the fly' across different healthcare layers: in daily patient care, in coordinating care within and between hospitals, and at the level of the healthcare system. It specifically focuses on the complex assemblages of (in)formal knowledge, skills and logics driving nurses' 'experimenting' work and the political nature of their experimental practices, revealing the normativities, political strategies, and power dynamics implicated.

Chapter 4 then investigates the bottom-up change programs centered on nurse-driven, practice-based, and experimental learning that emerged in response to the failed 'Wet BIG II' legal reform. The chapter specifically analyzes these change programs from an epistemological perspective, emphasizing the epistemic politics implicated in local change practices. It critically examines how different forms of knowledge are used, valued, and politicized in everyday change practices. Specifically, it zooms in on how epistemic politics affect nurses' authority and control over learning processes, their experiences of epistemic injustice, and the potential of these programs to open up new avenues and challenge established practices in valuing, organizing and governing nursing work.

Chapter 5 examines the 'empowerment turn' in the reorganization of nursing work and the experimental change programs that have attempted to bring about power transitions. Against the background of rising empowerment discourse and policy, this chapter offers a critical analysis of the complex and everyday political dynamics of empowerment efforts, exploring how the politics of empowerment in local change practices are shaped by the multidimensional exercise of organizational power, and its (dis)empowering effects on the nursing profession.

Finally, **Chapter 6** answers the initial research questions asked, presents the final conclusions, reflects on the ethnographic failure portrayed in the opening vignette, and discusses the theoretical, methodological and practical implications of this dissertation.

1

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CHAPTER 2

The rise of the partisan nurse and the challenge of moving beyond an impasse in the (re) organization of Dutch nursing work

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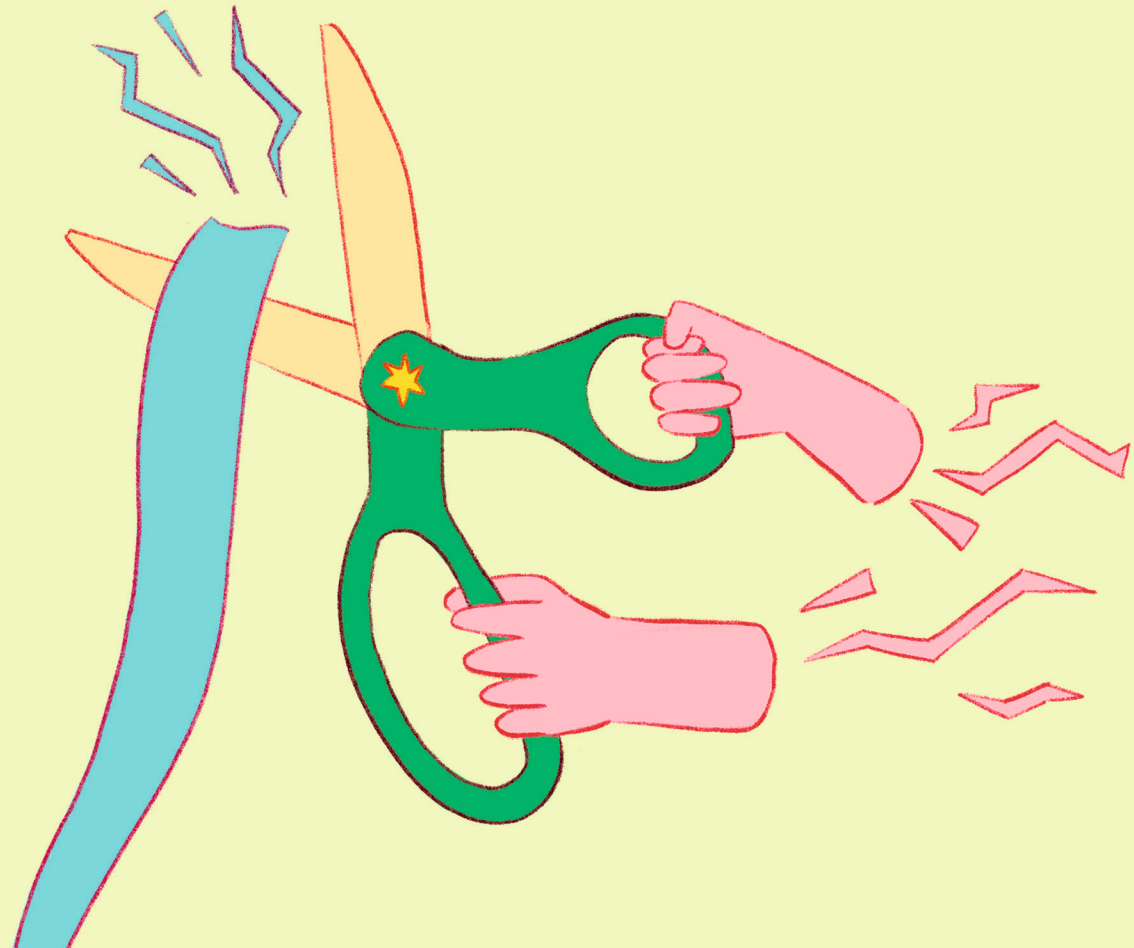

Abstract

In this paper, we reconstruct a Dutch case in which policymakers, experts and professional organizations proposed to amend a law so as to differentiate between different kinds of nurses and the work they do. In doing so, they specifically sought to support and reposition higher educated nurses. The amendment was met with fierce opposition from within the nursing community, however, and was eventually withdrawn. Drawing on interviews with key actors in the debate and an analysis of policy documents and social media platforms, we reconstruct what happened and how. Our reconstruction is informed by institutional theory, the sociology of professions and a body of literature that examines populism in its increasingly diverse modes of existence. By combining these bodies of literature, we have sought to expand on an analytical repertoire aimed at capturing the dynamics between individual professionals and their institutional environments. Our approach specifically allowed us to foreground a populist action frame through which opposition was organized and to discuss the destructive and generative potential it has had for future aspirations in the professionalization and (re) organization of nursing work.

Keywords: populism; professionalism; differentiated nursing practice; qualitative case study

Introduction

Contemporary studies into professional roles, identities and practice have foregrounded the institutional environments in which professionals operate and interact (Noordegraaf 2020, Noordegraaf and Brock 2021). An important theoretical concept that has informed these studies is that of 'institutional work'. This concept was coined by Lawrence and Suddaby in 2006 to describe the purposive work that actors invest in maintaining, creating, or destroying particular institutional arrangements (such as laws or standards) in order to protect or improve their institutionally 'privileged' positions (see further Dimaggio 1988, Fligstein 2001). Since then, there have been many case studies addressing different professions and their institutional environments (Wallenburg et al. 2016, Seremani et al. 2022) and identifying different forms of institutional work, each one demarcating a particular way in which institutionalized divisions of professional labour are defined, celebrated, policed, translated or modified (Hampel et al. 2017, Felder et al. 2018).

Productive as the concept of institutional work has been in foregrounding the dynamics between professionals and their institutional environments, it has also been problematized. We wish to highlight three points of critique that together form an important starting point for this paper. First, institutional scholars have focused primarily on the institutional work of a priori delineated professional groups (such as nurses, medical specialists and managers) in the context of specific policy implementation programmes or professionalization projects (van Wieringen et al. 2017, Felder et al. 2018, van Schothorst-van Roekel et al. 2020). Less attention has gone to how, within each of these groups, a relational politics can unfold that determines who belongs to the group and what actually matters to it (Maaijen et al. 2018). Consequently, in the context of institutional change, the emergent, divergent and sometimes contested nature of professional roles and identities remains cloaked. Second, these studies consistently conceptualize institutional work as purposive, rational and calculative (Lawrence and Suddaby 2006). This approach might resonate well with a reading of professionals as rational actors (see further Friedman 2019), but it simultaneously neglects the affects associated with making sense of and coping with a changing institutional environment (Lawrence et al. 2013, Ahuja et al. 2019). Third, and related to the former points, we have limited insight into how individual professionals actually make sense of the macro-institutional changes imposed on them (Smets and Jarzabkowski 2013, Felder et al. 2018). Some scholars have highlighted a 'micropolitics' in which individual professionals adapt macro-level institutional changes to fit their everyday practice (Bévort and Suddaby 2016) or resist such changes covertly, for instance by creating workarounds (Tonkens 2013). However, to our knowledge, scant attention has gone to how individual professionals' interpretations of macro-level institutional changes – and the associated emotions – can lead to open and collective resistance amongst professionals (Briskin 2012, Lok et al. 2017), and to how such collective resistance can be organized along

lines other than the conventional infrastructures associated with a priori delineated professional groups, positions and power relations (e.g. professional organizations or unions; see further Hardy and Maguire 2017; Schneiberg and Lounsbury 2017).

To study the emergent organization of (open) professional resistance, we draw on insights from the literature on populism and reconstruct the 'Dutch Nurse Revolt' of the summer of 2019. As we explain in our theoretical framework, the literature on populism, and especially the seminal works of political scholars Chantal Mouffe (2005) and Ernesto Laclau (2005), offer a useful lens for studying the interplay between: a) the grievances of individual professionals (in our case nurses); b) the politization of emergent professional group identities (in our case 'genuine nurses' versus 'nursing elites'); and c) the organization of collective professional dissent against macro-level institutional changes (in our case targeting the reorganization of the Dutch nursing profession).

The macro-level institutional change at stake in our reconstruction concerns a statutory amendment that sought to make a formal distinction between vocationally and bachelor-trained nurses. This distinction had been discussed on and off for over 30 years, particularly because, regardless of their initial qualifications, all Dutch nurses do similar work, bear equal responsibilities and receive similar wages (van Schothorst-van Roekel et al. 2020). By distinguishing between vocationally and bachelor-trained nurses, policymakers, expert committees, educators, professional organizations, unions and a plethora of public figures aimed to make the nursing profession more attractive, especially for higher educated nurses. They furthermore argued that it would improve the overall quality of nursing care, reduce the exodus of higher educated nurses and strengthen the position of nurses in healthcare organizations. The proposed statutory amendment was heavily criticized by some members of the nursing community, who positioned themselves in opposition to the 'corrupt elite' whose amendment would 'destroy' their profession. The attacks were fierce and widely covered on social media platforms, by conventional media outlets and in day-to-day conversations between nurses on the wards. After a few weeks of revolt, the Minister of Health withdrew the amendment, stating that it lacked support among nurses in general. He referred the issue back to field, leaving further reform to the hospital sector (Van Kraaij et al. 2022).

Informed by our case and theoretical framework, we pose the following research question: *how does a populist action frame shape responses to contemporary professionalization projects that seek to impose new stratifications in the organization of nursing work?*

The relevance of our reconstruction is twofold. First, it offers insight into the challenges faced in nursing in many northern countries – such as staff shortages and high turnover (Currie and Hill 2012) – and how governments seek to deal with them by intervening in nursing's occupational development. Our case specifically adds to a small but growing body of empirical research showing that legal interventions rarely help in the (re)

organization of nursing work (Currie et al. 2010, Briskin 2012, Matthias 2017). Second, our reconstruction foregrounds how professionals navigate increasingly complex political, social and workplace environments (Noordegraaf 2020) and challenge those who seek to intervene in *their* work. Whilst doing so, we move beyond some conceptual limitations of the conventional institutional (work) literature and highlight the changing relations between state actors, hospital organizations and professional groups 'in formation' (Hardy and Maguire 2017, Schneiberg and Lounsbury 2017), discussing the inequalities and stratifications challenged and sustained by such relations (Adams et al. 2020, Noordegraaf and Brock 2021).

Below, we elaborate on our theoretical framework and describe how we have gathered and analysed the data. Thereafter, we reconstruct how Dutch nurses successfully opposed the amendment. We close with a discussion recapitulating the consequences of a populist action frame for the professionalization of nursing and relating this to a literature that seeks to advance theories on institutions and professions in terms of emotions, identity formation and relational politics.

Theoretical framework

Nurses are an interesting occupational group when studying professional roles, identities and practices in a changing institutional environment. Many healthcare organizations currently face staff shortages and high turnover among nurses (Currie and Hill 2012), problems all the more pressing in the current pandemic. The causes include work pressure, limited career opportunities and little say in organizational and policy decision-making (van Schothorst-van Roekel et al. 2020, Van Wijk et al. 2022). Both nursing scholars and healthcare practitioners have therefore advocated that nurses should act more autonomously and confidently amidst other healthcare actors. Part of this agenda involves re-valuing the organizing work that nurses already do within healthcare organizations (Allen 2014) and emphasizing their unique knowledge (Yam 2004). Another aspect is to rethink nursing education (van Oostveen et al. 2017) and differentiate between different kinds of nurses (Currie et al. 2010, Van Kraaij et al. 2022), giving higher educated nurses more opportunities to take on new professional roles, such as 'expert' and 'organizer' (van Schothorst-van Roekel et al. 2020).

Given these ambitions, Van Schothorst-van Roekel and colleagues (2020) recently studied how nurses, managers and medical specialists cooperate to recraft nursing roles within different healthcare organizations. One strategy was to place more emphasis on – and clear space for – the organizing work of nurses. Drawing from their observations, the authors describe how such recrafting produced tensions in: a) the distribution of 'professional authority' amongst healthcare actors within the organization; b) the prioritization of tasks among nurses; c) the alignment of activities between nurses and others; and d) the remoulding of institutional arrangements. Van Schothorst-van Roekel

and colleagues (2020) describe the development of new nursing roles as a balancing act and as relational and political in nature. The new organizational roles they observed could therefore be considered preliminary outcomes of ongoing negotiations between nurses and other organizational actors such as managers and medical specialists (see also Currie et al. 2010, Ernst 2019).

Most scholars who study relational politics between nurses, managers and medical specialists focus on the shopfloor (Ernst 2019), the healthcare organization (van Schothorst-van Roekel et al. 2020) or a specific professionalization project (van Wieringen et al. 2017). However, scant attention has been paid to how individual nurses make sense of and cope with a changing institutional environment (Currie et al. 2010, Smets and Jarzabkowski 2013), or how such a micropolitics of professional sensemaking (Bévort and Suddaby 2016) can have consequences for macro-level institutional and professional ambitions (Hampel et al. 2017, Lok et al. 2017); for example, efforts to (re) organize nursing work by implementing specific healthcare policies or to establish or bolster a professional organization. We argue that the literature on populism has much to offer in this context. It is particularly adept at explaining how grievances experienced by individual professionals can be mobilized and turned into collective dissent (Hardy and Maguire 2017, Schneiberg and Lounsbury 2017). However, to avoid oversimplifying the connection between populism, institutional theory and professionalism, we must turn to some of the basic tenets of that literature. Whilst doing so, we specifically focus on the contributions of political scientists Chantal Mouffe and Ernesto Laclau.

Mouffe (2005) and Laclau (2005) aspire to better understand the conditions that drive populist mobilization and their political implications (for better or worse). Importantly, unlike scholars who study populism strictly as a (party) political phenomenon, Mouffe (2005) and Laclau (2005) conceptualize it as an 'expression of various acts of resistance against a post-political condition' (Demir 2019: 541). Mouffe (2005) explains the latter as a tendency in many Western states to: a) approach pluralism on an individual level, barring the existence of conflicting group identities and interests (Beck et al. 1994); b) try to overcome differences between individual perspectives and values through deliberation and consensus (Giddens 1998); and c) approach political problems as technical issues that can be solved rationally by scientists and experts (Centeno 1993).

Mouffe (2005) continues that there are some problems with this post-political condition. First, she renounces the idea that rational deliberation can turn pluralism into a harmonious and inclusive ensemble. Instead, every ordering (including that of professional roles and responsibilities) creates exclusions. Consensus is therefore always – and also – a form of silencing, with the possibility of silences being broken. Second, individuals (professionals) may not always feel represented by their consensus-seeking (professional) representatives, particularly so because they have limited insight into the deliberations in which *their* representatives engage. Meanwhile, these

representatives cannot be held accountable (by democratic means) for the outcomes of their representational activities, especially because these are often framed as negotiated, consensus-based and/or scientifically informed (Rancière 1999). Third, neoliberal policy agendas have led to new uncertainties, stemming from a retrenchment of welfare policies and a (misplaced) devotion to the regulatory qualities of markets and their experts (Crouch 2011). Having lost faith in (professional) representatives and facing new uncertainties, individuals (professionals) are sometimes disposed to search for new forms of political and professional representation. Mouffe (2018) refers to this as the populist moment.

Importantly, Mouffe (2005) and Laclau (2005) do not see populism as an ideology or a specific ideological programme. Instead, populism is defined as an action frame (see further Aslanidis 2016). In the words of Demir (2019: 542), 'It is a way of making politics that is compatible with various political structures and can take different ideological forms according to time and space'. Although a populist action frame can take different forms, there are some common mechanisms that underly populist expressions and mobilization. We argue that these mechanisms have analytical value when studying the politization of professional identities and the mobilization of dissent.

First, populism is about establishing *a political frontier* that divides society into two camps: 'us' the common people versus 'them' the corrupt elite (Mudde and Kaltwasser 2017). The words *common* and *elite* refer to a certain hierarchy between those who decide and those who have to deal with the consequences. The word *corrupt,* in turn, refers to the act of rational deliberation and the criteria – but whose criteria? – on which established consensus is based (Mouffe 2005). We wish to emphasize that both the 'us' and the 'them' are political constructs that can be reconfigured idiosyncratically (Mudde and Kaltwasser 2017). Second, the frontier is always constructed in response to a specific issue and can take on different forms in time and space. In the words of Žižeck (1993: 201), 'The bond of a group of members is always based on their shared relation towards a thing'. Different groups can thus come together at different times, for different reasons and in juxtaposition to different others (see further Dewey 1927). Third, the frontier established is based on an *emotional* and/or *antagonistic* us/them distinction. It is here that the word *partisan* is introduced. It refers to a reasoning in lines of opposing camps and the act of joining one of these camps to challenge a threating 'other'. Populist expressions are thus relational and constructed, the mobilization of populist movements and the delineation of group identities are dynamic and emergent, and both expressions, mobilization and delineation, revolve around antagonistic us-versus-them reasoning.

There are authors who treat the concepts of professionalism and populism as political opposites and approach populist expressions as illegitimate challenges to the rational leadership of professionals (from Diethelm and McKee 2009 to Friedman 2019). Authors

that do so tend to view professional groups as stable, with specific membership criteria and control over their work content. They furthermore insist that such criteria and content are inwardly oriented, rationally construed and based on established and officially recognized bodies of knowledge and skill (Friedman 2019). Framing professionalism in such traditional terms indeed seems the opposite of the constructed, relational and emotional nature of populist expressions and the dynamic nature of populist mobilization around emergent issues.

Yet professional groups are constantly reconfiguring around new issues (Wallenburg et al. 2016, Maaijen et al. 2018, Noordegraaf 2020) and must establish themselves in a field in which other occupational groups also operate or claim control over similar or overlapping issues (Adams et al. 2020, Currie et al. 2010, Ernst 2019). In healthcare, these can be other healthcare professions but also economists, managers or policymakers (Allen 2014, Waring 2014). From this perspective, professional groups can be seen as political and volatile groups themselves, and they too may engage in antagonistic us-versus-them rationales (Roberts and Schiavenato 2017, Fincham and Forbes 2019, Sweet and Giffort 2021). To better understand how professionals do the latter and its consequences, we argue that, far from being unprofessional or anti-professional, the mechanisms underpinning a populist action frame can in fact inform the study of professionalization in increasingly complex workplace environments.

It is important to note that our approach aims neither to celebrate populist action frames nor moralize them away. Rather, our purpose is to analytically dissect and discuss both their destructive and generative potential in (re)forming and (re)organizing professional groups in increasingly complex institutional environments. We illustrate this point by reconstructing the 'Dutch Nurse Revolt' in the summer of 2019. But before doing so, we first position this case in a broader historical, professional, and institutional nursing context. Thereafter, we explain the methods we used to study it.

Context of our case study

As in many Western states, the establishment of a legally protected nursing profession in the Netherlands has gone hand in hand with the establishment of specific nurse training programmes (Egenes 2017). A law introducing the professional title Healthcare Nurse was introduced in 1921; thereafter, only those who had completed a specified training programme had the right to hold this title. It meant that someone could only carry the title of Healthcare Nurse if they had followed a training program that met specific criteria. The emphasis was initially on in-house training, as it enabled nurses to quickly gain practical medical experience and helped employers deal with staff shortages (Van der Peet 2021).

The 1970s saw the first vocational and bachelor level training programmes being founded as part of a movement towards a more unified nursing profession with a more

generic training curriculum (compared to the training nurses received in-house, usually in a hospital). The law was amended in 1977 to encompass both vocational and bachelor training and the professional title Healthcare Nurse became Nurse. While the vocational and bachelor level training programmes were supposed to replace in-house training, pressure from employers and in-house training organizations meant that in-house training continued until 1997 (Van der Peet 2021).

In 1993, the law was replaced by a new act that sought to regulate and protect the work of various healthcare professionals (BIG 1993). The title Nurse was linked to a specific set of restricted or protected actions that could only be undertaken by those who had completed accredited training programmes and/or additional specialty training. It should be noted that it was this specific act that was to be amended in the summer of 2019.

Throughout the aforementioned period, political representation of nurses was fragmented. In the early 20th century, there was the Dutch Federation for Nursing (*Nederlandse Bond voor Ziekenverpleging*), representing the stakes of nurse employers concerned about securing enough nursing staff with proper qualifications, and Nosokomos, which acted more as a trade union for nurses. Fifty years later, many small nursing associations had emerged, organized by specialization (for example paediatrics) and dedicated to improving the quality of their specialized care. Towards the end of the 20th century, many of these smaller associations merged into a single professional organization, the Dutch Nursing Association (*Verpleegkundigen en Verzorgenden Nederland*). This organization has since devoted itself to strengthening the position of a 'unified' nursing profession and to raising the quality of nursing work (V&VN 2021). In the spirit of Nosokomos, another organization emerged that acted more as a trade union. Its name, NU'91 (short for Dutch New Union 1991), referenced one of the first nurses' strikes in 1991, when nurses openly challenged high work pressure, low wages, and lack of decision-making power (Van Vugt 2016).

By the turn of the 20th century, many actors had become involved in professionalizing Dutch nursing, including policymakers, employers' associations, educators (vocational and bachelor councils), professional organizations, unions, expert committees, and a plethora of public figures. They formed shifting coalitions supporting specific issues (e.g. quality improvement), or challenging one another's intentions (e.g. membership growth). Nevertheless, most of them agreed that something needed to change in the organization of Dutch nursing work. Particularly urgent was the high turnover among and haemorrhaging of higher educated nurses in hospital organizations (see further Terpstra Committee 2015). They realized that besides licensing and training, more attention should go to conditions of employment. One of the challenges was to make these conditions more attractive, especially for higher educated nurses (Terpstra Committee 2015). As we will elaborate further in the results section, formally differentiating between vocationally and bachelor-trained nurses was thought to be the way to do so. It was

supposed to create better career opportunities for higher educated nurses, improve the quality of nursing care and strengthen the position of nurses among other healthcare actors.

Methods

This research builds on an ongoing formative evaluation of differentiation in the (re) organization of Dutch nursing work. The evaluation is carried out by a consortium of several Dutch universities and hospital organizations. The consortium is called 'RN2Blend' and is subsidized by the Dutch Ministry of Health Welfare and Sport. Initially, it was established to facilitate the implementation of the beforementioned law amendment through action-oriented research; whilst simultaneously aiming to learn about nursing role development. However, the amendment was withdrawn before research had started. In response, the consortium adjusted its focus and aimed to better understand what was at stake in debates about nurse differentiation (Van Kraaij et al. 2022). More specifically, it wanted to learn from what had happened to the amendment and discern its consequences for future aspirations in the (re)organization and professionalization of nursing work.

As members of the abovementioned consortium, we started by interviewing key actors from the Dutch Nurse Revolt and others who had been involved in the professionalization of Dutch nursing over the past two decades (N=22). We asked our interviewees to reflect on the amendment (why was it needed and who initiated it), why it met with a critical reception, and how nurses had organized to oppose it. We also asked how their opposition had been received, interpreted and acted upon. All interviews were audiotaped, transcribed verbatim and coded. We also collected and analysed policy documents, blogs and articles posted on nursing platforms (including comments posted in their comments sections), chat-show broadcasts and Twitter posts (Table 1).

Data gathering and analysis occurred as an iterative process in which document selection and analysis complemented the interviews. For instance, blogs and comments posted on social media were used to identify nurses and other actors engaged in the discussion. In turn, we asked our interviewees how they had interpreted and experienced the discussions and whether there were relevant others to interview or documents to include. This allowed us to compile a comprehensive dataset to reconstruct what had happened and how (Varvasovszky and Brugha 2000).

Our analysis focused on: a) better understanding why the amendment had been proposed and challenged; b) identifying the different mechanisms involved in the establishment of a political frontier in opposition to the amendment; and c) reflecting on the consequences. Our analysis took the form of an iterative process in which we moved back and forth between data and theory (Tavory and Timmermans 2014). Table 2 provides an overview of the coding process.

Data gathered	N	Selection criteria	Aims
Policy documents	6	Reports produced by expert committees and policymakers targeting the reorganization of Dutch nursing (between 1991 and 2019) The amendment itself Letters from and to the Minister of Health	To capture the intentions behind nurse differentiation and how policymakers and expert committees sought to bring it about.
Blogs and articles on nursing platforms, including their comments sections	21	Blogs and articles on the amendment (BIG-II) published in 2019 and after the Minister of Health announced plans to introduce the amendment	To capture how the proposed amendment was received by nurses and other public figures who engaged in the discussion and how resistance was framed and organized.
Chat-show broadcasts	2	Covering the amendment's introduction and withdrawal	To capture how the discussion on nurse differentiation spread beyond dedicated nursing platforms and reached a broader audience.
Twitter posts	223	# functiedifferentiatie (job differentiation) # wetbig2 (title of the amendment)	To capture how individual nurses interpreted and experienced the proposed amendment and how resistance was framed and organized.
Interviews	22	Actors involved in the professionalization of Dutch nursing Key players in the debate about the amendment	To capture why interviewees wanted to work towards or opposed nurse differentiation and how they pursued their respective goals.

Table 1: Data gathered

To enhance the validity of our reconstruction, we combined different sources of data (documents, media outlets, interviews). Policy documents, for instance, helped us identify formal reasons for introducing the amendment. Comments sections of social media outlets provided insight into how nurses used social media platforms to organize a political frontier. Interviews helped us to unpack how the amendment was developed, to better understand why and how nurses engaged with others on social media platforms, and how this was received and acted upon within the broader professional and policy community. We furthermore worked with a team of five researchers from different backgrounds – e.g. in nursing, sociology and health policy – together reflecting on the research steps taken and materials analysed. Quotes taken from interviews and social media outlets are anonymized in the results section; quotes taken from public (policy) texts are referred to by author name and date of publication. All quotes are translated from Dutch by the authors.

First-order concepts (examples)	Second-order concepts	Aggregate themes
Being underpaid, overworked, and having no voice in decision-making… Feeling like a discarded Nokia [telephone], well built, reliable and knowledgeable, but no updates available…	Expression of grievances	Conditions for populist mobilization
The Dutch Nursing Association does not represent in-house trained nurses…	Problematizing formal representation	
Nurses versus the Dutch Nursing Association… Nurses versus politicians (The Hague)… Nurses versus the Bachelor council… Nurses versus bachelor-trained nurses…	Us versus them	Establishing an alternative political frontier (populist action frame)
The essence of nursing is that nobody is hierarchically superior, that you need one another… Authority comes with experience and should not be based on a piece of paper… They're bringing down (our) welfare state…	Charging both camps with meaning	
Being caught in the web… Having made a pact… Being deceived…	Antagonistic relations	
The launch of Actiecommittee Wet Big2…	Organizing resistance	Political entrepreneurship
Policing social media and comments sections… Reproducing the frontier on nursing wards…	Maintaining the frontier	
Publishing their concerns in conventional media outlets… Appearing on a popular chat show…	Connecting to a larger audience	

***Table 2**:* Overview of analysis

Results

We begin this section by explaining the key challenges involved in the (re)organization of Dutch nursing work and how the amendment was supposed to deal with them. We then reconstruct the way in which some nurses problematized the amendment and organized their opposition by establishing a political frontier between nurses and 'nursing others'.

Introduction of an amendment

Many nurses in the Netherlands have received vocational and/or in-house training, often accompanied by specialized in-hospital training (e.g. ICU care, oncology, wound specialist). As nursing work becomes more technically complex, however, healthcare organizations are increasingly looking to attract higher educated nurses (bachelor or master qualifications). 'Patients spend less time in the hospital but are simultaneously more ill. Caring for these patients requires more knowledge and skills' (former representative of the Dutch Nursing Association, interview 2020). Some have argued that more weight should be given to nurses who have received bachelor training and are thus able to connect nursing work to scientific literature (van Oostveen et al. 2017). Once part of nursing teams, higher educated nurses would be able to raise the quality of care provided by all team members, including those with a vocational qualification.

The number of bachelor-trained nurses entering the labour market has increased steadily since the 1970s. At first glance, then, the aims described above seemed feasible. It turns out, however, that these nurses have a rather difficult time applying their knowledge and skills in everyday nursing practice. In the words of a nurse manager (interview 2020):

> *When these [bachelor-trained] nurses enter with their little suitcase of knowledge, the team will say 'great that you are here and that you have a bachelor's degree, we really need someone like you. But leave that little suitcase of yours at the door and show what you can do in terms of basic care. Then we'll decide when you can open that little suitcase of yours'. We always expected bachelor-trained nurses to push the team to a higher level. Instead, the team pulls them down.*

This nurse manager is describing the experience of many higher educated nurses: their knowledge ('their little suitcase') is not really appreciated and 'they should first be able to fold the towels' (professor of nursing sciences, interview 2019). This has two main consequences. On the one hand, bachelor-trained nurses are asked to do things they are not necessarily trained to do. On the other hand, they simultaneously lose the status and position they need to change nursing practices based on their acquired knowledge and skills. Compounding this problem is the fact that some nurses only acknowledge work as 'real' nursing when it is provided at the bedside. In the words of an in-house trained nurse about colleagues who spend time doing research (interview 2020): 'They probably

do very important stuff [slightly cynical] and they are on our payroll, but they are not at the patient's bedside'. Consequently, bachelor-trained nurses either adapt and start providing care as dictated by their peers, or they leave the ward and their profession altogether for other work (former representative of the Dutch Nursing Association, interview 2020).

Many nurses with a bachelor qualification do not stay in nursing departments for long. As a nurse manager explains (interview 2020): 'What we have seen over the past few years is that there is a high turnover amongst bachelor-trained nurses. They leave healthcare and move on to more challenging jobs in management or policymaking, or they start studying nursing sciences. This exodus is at odds with the policy aim of attracting more nurses. Not only does it make it harder to improve the quality of care and meet future demand, but it also increases the pressure on the nurses who remain.

To tackle these problems, the Dutch Nursing Association, experts and policymakers attempted to force a transition in nursing practice. An expert committee proposed differentiating between two kinds of nurses: bachelor-trained nurses and vocationally trained nurses (Terpstra Committee 2015). Each would have specific tasks within a broader spectrum of nursing work, for example patient bedside care, coordination of care activities within and between wards, quality improvement and Evidence Based Practice (EBP). To support this differentiation, the committee proposed amending the law that regulates and protects the work of healthcare professionals (see previous section). It could be used to stipulate what nurses on either side of the vocational-bachelor divide would be called and which activities they would be allowed to do (Terpstra Committee 2015).

Providing titles for nurses on both sides of the divide proofed challenging. After long deliberation, policymakers and the Dutch Nursing Association decided on the professional title Supervising Nurse (*regieverpleegkundige*) when referring to bachelor-trained nurses, and Nurse when referring to vocationally trained nurses (former representative of the Dutch Nursing Association, interview 2020). However, the adjective 'supervising' became a sensitive issue because it implied a hierarchical relationship between vocationally and bachelor-trained nurses. Moreover, it did not appear to cover the actual differences in the skill sets of these groups (e.g. with considerable emphasis being placed on Evidence Based Practice [EBP] for bachelor-trained nurses). Another challenge was to identify which nurses – and which specific training and specializations – would qualify for which titles. Experienced senior nurses, many of whom had had additional (clinical or management) training, worried they would be graded as Nurses rather than Supervising Nurses. Moreover, not all bachelor-trained nurses had actually received EBP training (which only entered the bachelor curriculum after 2012). EBP was considered important to the work that Supervising Nurses should be able to do, however, and another expert committee argued that those who had earned their bachelor's before 2012 should take an exam showing that they were qualified to hold the Supervising Nurse title (Meurs Committee 2019).

Despite these hurdles, the Dutch Nursing Association and Minister of Health pushed forward with their plans for nurse differentiation. In early 2019, they announced that the amendment, known as BIG-II (referring to the original 1993 act, the BIG), would be introduced shortly. In addition to the amendment, they also announced a five-year transition period (Meurs Expert Committee 2019) to allow nurses who did not automatically qualify as Supervising Nurses to take additional training or sit a qualifying exam.

A representative of the Dutch Nursing Association (interview 2020) explained why the professional organizations, experts and policymakers specifically made use of legal measures: 'We knew for years that nothing would happen if we left it up to employees [nurses] and employers [hospitals]. So we explored other ways to secure implementation [of nurse differentiation]'. Forcing that implementation through legal measures was not without risk, however. As a nurse manager reflected (interview 2020):

> *By introducing an amendment, you make use of force. It's a sign of weakness that the Nursing Association and hospitals were unable to arrange this themselves and required the support of policymakers and the law. And well, when you use force, you can expect it to backfire.*

Below, we reconstruct how the proposed amendment did indeed backfire.

Counter-mobilization and establishment of a political frontier

On 5 June 2019, the Minister of Health informed the House of Representatives of his plan to introduce the amendment and five-year transition period. He emphasized that the amendment had been developed with the help of professional organizations, unions, educators, expert committees and employers and that he expected broad support for it, particularly when combined with the transition period proposed by the expert committee. As the Minister stressed in a letter to the House (5 June 2019):

> *I am very happy that the expert committee's advice can count on the support of all parties in the sector… I intend to use this scenario to further elaborate the amendment… I expect it to be ready after the summer.*

Immediately after the announcement, some nurses posted critical remarks on social media and used the comments sections of digital nursing platforms to articulate their grievances (see below for examples). These comments would grow in frequency and intensity, eventually pushing out more nuanced responses. It was the start of a 'Nurse Revolt' against the amendment and those that supported it. Three months later, the Minister withdrew his plan to introduce the amendment due to lack of support amongst nurses (parliament in fact never discussed the amendment). In the following, we reconstruct how the nurses who opposed the amendment managed to establish

a political frontier and stop its introduction. Iteratively informed by our theoretical framework and our case, we distinguish between conditions for populist mobilization, the establishment of an alternative political frontier, and political entrepreneurship (see Table 2).

Conditions for populist mobilization

Right after the Minister had shared his plans, a nurse remarked on Twitter (6 June 2019), 'I feel like a discarded Nokia [telephone], well built, reliable and knowledgeable, but no updates available'. This nurse touched upon a sentiment shared specifically amongst vocationally and in-house trained nurses. They felt downgraded and that their years-long practical experience was no longer valued. It was particularly incomprehensible to them that bachelor-trained nurses 'fresh out of school' would qualify for the Supervising Nurse title. As a nurse representative reflected on this issue (interview 2020): 'The essence of the nursing arena is that nobody is hierarchically superior, that you need one another in the everyday delivery of healthcare'. According to these nurses, hierarchies do exist in the everyday coordination of nursing work, but 'they come with years of experience and should not be based on a piece of paper' (in-house trained nurse, interview 2020). Note that these nurses valued the knowledge and experience gained at the bedside more than the 'textbook knowledge' (e.g. quality management or EBP) obtained during bachelor training.

In response to the Minister's letter, several nurses challenged the idea that the amendment could count on the support of the nursing community *just* because the Dutch Nursing Association had been involved in its development. Even though other nursing unions (such as NU'91) had also supported the amendment, these nurses specifically targeted the Dutch Nursing Association (which positioned itself as a professional umbrella organization), pointing out that it incorrectly claimed to represent all nurses. They argued that the Association appeared to be specifically concerned with improving conditions for bachelor-trained nurses and had neglected the perspectives and needs of vocationally and in-house trained nurses. These critical remarks were soon shared on social media and nursing platforms (particularly in the comments sections). An example:

> *We have approached the Nursing Association because they do not appear to represent in-house trained nurses. Particularly in this discussion [the Association's attempt to legally differentiate between different kinds of nurses], they appear to only represent the bachelor perspective (letter to the Minister shared on Facebook, 5 June 2019).*

The author of this comment claimed to represent 28 500 nurses. A former representative of the Dutch Nursing Association reflected on this as follows (interview 2020): 'The Nursing Association had worked for years to integrate all the different nursing

associations into one voice. Last year, however, we saw that they were unable to connect and represent the diversity of interests that make up the nursing community'.

It is in these initial responses to the Minister's letter that key conditions appear leading up to a 'populist moment' as defined by Mouffe (2005). They include feelings of being discarded as (second-rate) nurses and of no longer being represented by the conventional institutions that claim to do so (see further Aslanidis 2016).

Establishment of an alternative political frontier

Nurses who rallied against the amendment organized into a resistance group (Actiecomité WetBig2). They launched a website (wetbig2.nl) and continued to share their concerns on social media and in the comments sections of nursing platforms. Here, they established a political frontier between *us* – caring, experienced, hardworking nurses – and *them* – the policy elites. Below are three examples:

> *That moment when the patient suddenly has an attach: his heart races, his blood pressure drops. No doctor in sight so you have to decide quickly: what's wrong? What do we do? Nurse … knows exactly what needs to be done. She's had 29 years' experience and I a specialized intensive care nurse. So much experience, but now she has to go back to school to continue doing what she's done for years. (nurse representative speaking out in a national newspaper, 7 June 2019)*

> *The nursing association has been caught in the web of bachelor-council. (blog on nursing platform [comment section], 27 August 2019)*

> *The chairman of the board of the Nursing Association has made a pact with the Minister. (blogging nurse representative, interview, 2020)*

These examples follow a narrative associated with a populist action frame (Aslanidis 2016). On the one hand, there are the hard working, experienced, lifesaving, patient-centred nurses. On the other, there is the Dutch Nursing Association, which has joined forces with policy elites and should not be trusted. The partisan nurses attempted to add more substance to this nursing identity that needed protection against the destructive will of the decision-making elite by tapping into sentiments shared by their nursing peers:

> *Have they lost their minds in The Hague [seat of the national government]? The amendment makes no sense and is only aimed at further dismantling our welfare state (Twitter, 6 August 2019).*

At first glance, this quote is just another accusation. By connecting the amendment to a broader debate about neoliberal governance and the future of the Dutch welfare state, however, these nurses tapped into a sentiment shared by many of their colleagues

(including bachelor-trained nurses): the sense of being underpaid, overworked and voiceless in decisions concerning their profession. In the words of a former nurse and nurse director (interview 2020), 'They put into words what we were all feeling, they were so right, nothing had been solved yet.'

Rallying nurses crafted a nursing identity informed by such principles as equality amongst nurses and a practical focus on care delivery. They contrasted this identity with the differentiated one proposed by policymakers, the latter being emblematic for the breakdown of the welfare state and the neoliberal politics of a policy elite. Here, we clearly see what Mouffe (2005) and Laclau (2005) call the establishment of a political frontier dividing the nursing community – and other actors – into two camps: caring, hardworking nurses versus the corrupt elite. Moreover, the antagonism that defined the relationship between the two camps was one in which you either belonged to the first camp, or you were suspected of having joined the second (making pacts or plotting behind closed doors). It is this reasoning in lines of opposing camps – and the suspected or projected act of joining one of these camps (you are either for us or against us) – that populist scholars call 'partisan' (see further Schmidt 1962).

Political entrepreneurship

The resistance group soon claimed to represent 60 000 nurses (wetbig2.nl). But while the ranks of partisan nurses seemed to be growing, there was always a chance that some of their nursing peers (especially the bachelor-trained nurses) would disagree with them. Disagreement amongst nurses could, in turn, endanger the political frontier established. To protect it, partisan nurses started to actively police social media and nursing platforms. They specifically searched for and criticized nurses who voiced more nuanced readings of the amendment, its value and its impact on the nursing community. Below is an example of an online dialogue between a bachelor of nursing student and a partisan nurse (nursing platform [comments section], 12-16 August 2020):

> *Bachelor of nursing student: Dear nursing peers. Please try to move beyond your personal emotions and interests. Also try to imagine what the amendment can mean for our profession and for the patient (that's who we do it for, right?). I do want us to continue to look at differentiation between roles and competencies in the everyday delivery of healthcare. The competencies that I gained in my training also matter. I want better care for the patient, and I want to emancipate our profession. Be honest, is that the case at this point in time?*
>
> *Partisan nurse: Your educator has deceived you. You learned things you do not need. The worst thing is that you, with your two years of training, will tell very experienced nurses what they should do. Your last point is arrogant and derogatory. Everybody wants good care. We have been providing that for many years. Obstructing factors are managers, policymakers and overzealous students.*

In many of these online discussions, more nuanced comments triggered a plethora of hostile responses. As the editor of a nursing platform commented (interview 2020), 'Everybody thought twice before posting a more nuanced comment. They [the partisan nurses] would respond with ten more comments, and more nuanced perspectives did not stand a chance'.

Yet such policing was not confined to the online world. In the words of a bachelor-trained nurse (interview 2020):

> *In the beginning, some nurses had a more nuanced perspective on the amendment. But they were silenced. I have spoken to many nurses who were afraid to talk about it within their teams. If you did, you could get bashed.*

It is clear that neither the nursing values (such as equality amongst nurses) nor the political frontier established ('us' nurses versus 'them' policy elites) were a priori facts. Instead, they were actively maintained both online and in everyday nursing practice. Such policing as a form of political action resonates with the institutional work literature and is associated with institutional maintenance work (Lawrence and Suddaby 2006), in this case to defend the notion that nursing knowledge and experience are obtained at the bedside and to defend the position of in-service and vocationally trained nurses within the nursing community.

Besides policing, the partisan nurses also sought to communicate their plight to a larger audience by attracting the attention of conventional media. Three nurses were invited to tell their story on an influential chat show on 7 August 2019, with the host introducing them as follows:

> *Tremendous upheaval amongst thousands of nurses. A new legal amendment invalidates the experience of nurses who have only had vocational training. They will be downgraded to basic nurses and lose their ability to make decisions or deliver care to complex patients…even if they have already provided such care for years.*

The three nurses had received vocational and in-house training and had been actively involved in the debate about the amendment. On the chat show, they emphasized that: a) they would no longer be allowed to make decisions or treat complex patients; b) it would tear apart the nursing community; and c) the amendment was only being introduced because trained nurses had failed to make a difference in everyday nursing practice. Their message was repeated in many news outlets.

The chat-show appearance gave partisan nurses access to a larger audience and other healthcare actors responded by writing about and commenting on the amendment. A

medical specialist, for instance, sympathized with the partisan nurses and problematized the amendment in a national newspaper (25 August 2019 [column section]). He likened nursing work to restaurant service and compared vocationally and in-house trained nurses to Cinderella and bachelor-trained nurses to illegitimate princesses. Every story covered in the conventional media – and every comment posted on social media – contributed to the political frontier established by the partisan nurses.

On 21 August 2019, the Minister of Health appeared on the same chat show that had hosted the three nurses. He explained that the amendment was a long-cherished wish of the Dutch Nursing Association and that he thought it could count on the support of the nursing community. Other guests on the show asked critical questions, for example 'Why do you want to differentiate between nurses against their will?' and 'Why is a piece of paper valued more than years of experience?'. The guests – none of whom had a nursing background – echoed the objections of the partisan nurses, whose frontier became firmly embedded in the public discourse. When the chat-show host finally asked the Minister what these criticisms meant for the amendment, he replied, 'I do not see a future for the amendment at this point in time. Differentiating between nurses, which many nurses still want, can be done in some other way' (chat-show broadcast, 21 August 2019). On 9 October 2019, the Minister officially withdrew the proposed amendment. Meanwhile, on 27 August 2019, the board of the Dutch Nursing Association had already stepped down, having lost the support of those they were supposed to represent.

Aftermath

In the months following the board's resignation and the amendment's withdrawal, many nurses reflected on what had happened. Below, we discuss some of their thoughts.

The partisan nurses felt that the revolt had demonstrated that nurses could organize and oppose policies forced upon them by experts and policymakers. This gave them a sense of control over the development of *their* profession. In the words of a hospital director concerned with the position of nurses in the Dutch healthcare sector (interview 2020): 'The nurses who opposed the amendment were able to organize and make themselves heard. This was something we always wanted, yet we never expected it to happen'. However, some actors stressed that the discussion had not unified Dutch nurses and especially seemed to have damaged the position of bachelor-trained nurses. As a nurse manager (interview 2020) commented, 'Bachelor-trained nurses have become very nervous. They are afraid they are no longer seen as loyal colleagues. They remain silent when someone asks them [about nurse differentiation]. Or they emphasize that they have kind, competent peers and that education doesn't necessarily make a difference'. In a similar vein, competencies associated with bachelor training, such as EBP, were rejected by some nurses as a useless part of the nursing profession.

A mediator appointed by the Minister of Health to calm the heated debate suggested transferring the nurse differentiation project to employer and employee representative organizations (letter to the Dutch Minister of Health, 4 October 2019). This indeed seems to be a logical choice: some employers (read: hospitals) have already experimented with differentiation in nursing work (van Schothorst-van Roekel et al. 2020), and nurses – as employees – can attempt to influence their employer's policies within the specific organizational context in which they work. In one hospital, for instance, nurses opposed several passages of a new job profile for Supervising Nurses through their local works council (nursing platform, 23 December 2019). However, it also means that nurses, as a professional group, are still not in control of their occupational development. Some nurses have in fact taken to identifying employers as the new elite that must be opposed (nursing platform [comments section], 23 December 2019). Meanwhile, the Dutch Nursing Association is hesitant to step in. It first wants to focus on reclaiming its role as nurses' representative before intervening in the (re)organization of nursing work.

Discussion

Institutional scholars have recently called to start scrutinizing how resistance towards institutional changes or pressures is organized along lines other than conventional groups and infrastructures and to discuss its consequences (Hampel et al. 2017, Hardy and Maguire 2017, Schneiberg and Lounsbury 2017). We aim to contribute to this research agenda by relating it to the populism literature (Mouffe 2005, Laclau 200) and by empirically addressing how populist action frames shape responses to contemporary professionalization projects that seek to impose new stratifications in the organization of nursing work. More specifically, we have unpacked how Dutch nurses managed to organize against the introduction of a statutory amendment.

The populism literature sensitized us to: a) conditions for populist mobilization (e.g. feelings of being discarded as experienced nurses and a perceived lack of formal representation); b) a particular action frame through which an alternative political frontier was established between 'us' (genuine, hardworking nurses) and 'them' (a corrupt elite, including anyone who supported the amendment); and c) specific acts of political entrepreneurship through which partisan nurses sought to strengthen their position (e.g. policing social networks and connecting with a larger audience). Some observed acts of political entrepreneurship resonate well with the conventional institutional work literature (e.g. policing) and can be interpreted as the institutional maintenance work carried out by vocationally and in-house trained nurses to protect their 'privileged' positions (Fligstein 2001, Lawrence and Suddaby 2006). However, in line with recent developments in the institutional (work) literature (e.g. Hampel et al. 2017; Hardy and Maguire 2017; Schneiberg and Lounsbury 2017), two points warrant further discussion.

First, in the rather antagonistic professional nursing environment that emerged, identity narratives portraying nurses as 'all equal' and whose place is 'at the patient's bedside' appear to have gained ground (Bévort and Suddaby 2016). Yet there are those within the Dutch nursing community who continue to work on establishing differentiated career opportunities for nurses, including opportunities for research and management within and across healthcare organizations (Van Kraaij et al. 2022). As scholars interested in institutional theory, professionalism and nursing, we should thus be very careful not to make a priori assumptions about nurses as a clearly delineated and intrinsically consistent group (Maaijen et al. 2018). Our reconstruction shows that relational politics unfolds not only between nurses and other healthcare actors (e.g. medical specialists and managers) within healthcare organizations (van Schothorst-van Roekel et al. 2020, van Wieringen et al. 2017), but also amongst different and emergent groups of nurses and their shifting aspirations (Currie et al. 2010). These observations are in line with Hardy and Maguire's (2017) position that institutional scholars should produce more inclusive and process-centred accounts of institutional entrepreneurship; accounts in which attention is paid to a variety of members of a group or field and to the production of frames as well as counter frames within such a group or field. If there is indeed one thing that we can learn from our case, it is that nurses should be considered a diverse occupational group with different routines, orientations, interdependencies, identities, imagined futures and experienced grievances.

Second, our reconstruction shows that individual professionals do not necessarily and coercively translate macro-level institutional changes to fit their micro-level everyday professional practices (Bévort and Suddaby 2016). Moreover, when professionals choose to resist such changes, they do not necessarily do so covertly (Tonkens 2013). Instead, our analysis shows that emotions and grievances – experienced at the micro-level of individual professionals – can hold latent political power (see further Steve Bannon in *American Dharma* [Morris 2019). It further shows that professionals are ready, willing and able to channel this power by drawing from a populist action frame (Friedman 2019). In our case, partisan nurses did so by explaining their grievances on social media platforms and on nursing wards, by openly questioning the claim to formal representation by the Dutch Nursing Association, and by establishing a political frontier that divided the nursing community between *genuine* nurses and those who held with an untrustworthy policy elite (who threatened what *genuine* nurses valued in *their* work). These observations support the thesis that emotions are very much complicit in institutional stasis and change (Lok et al. 2017). The case reveals how grievances of – and concerted actions amongst – members of a professional community can have destructive consequences for macro-level professionalization projects.

At first glance, the Dutch Nurse Revolt seems to exemplify a successful emancipatory project by nurses against state interventionism (Matthias 2017). However, we also witnessed a sharp politization of *the* nursing identity (Mouffe 2005) and argue that

the narratives pushed by partisan nurses reproduced intra-professional and inter-professional stratifications (Currie et al. 2010, Adams et al. 2020). For instance, partisan nurses argued that all nurses are equal and that their work revolves around patient bedside care (and therefore nowhere else within healthcare organizations). Meanwhile, medical specialists were allowed to compare differentiated nursing work with restaurant (waitstaff) service whilst sympathizing with the partisan nurses' battle against the amendment, reproducing the position of nurses as a subordinate professional group within healthcare organizations. Nurses who saw the amendment as an opportunity to strengthen their position amongst their peers as well as within healthcare organizations were actively sought out, challenged and othered by the partisan nurses. Currie et al. (2010) have observed the reproduction of similar inter-professional and intra-professional stratifications in the UK after the introduction of specialized nursing roles. There, nurses who aspired to take on such roles were seen by peers as peculiar individuals in naïve pursuit of a stronger position amongst other professionals. In our case, however, nurses who saw merit in role differentiation were castigated by their peers as enemies of *the* nursing community, making it even harder for them to speak out or do things differently.

Conclusion

To conclude, we posit that the literature on populism offers a useful lens for studying how professional stratifications and inequalities were articulated, challenged and reproduced during the Dutch Nurse Revolt of 2019. In sync with recent developments in the institutional (work) literature – which now tries to move beyond accounts of a priori delineated groups that purposively engage in institutional creation and maintenance work to improve or protect their privileged positions – the populism literature sensitized us to very specific political dimensions. For instance, it allowed us to foreground important conditions for the populist mobilization of professional dissent against the amendment (individual feelings of being discarded and not represented) and to capture how partisan nurses mobilized under these conditions and followed a specific populist action frame to protect occupational autonomy over the organization and content of their work (Aslanidis 2016; see further Briskin 2012; Matthias 2017). Therefore, we believe our approach helps to expand an analytical repertoire aimed at capturing and questioning the multifaceted political dimensions of the dynamics between professionals and their institutional environments (Adams et al. 2020, Noordegraaf 2020, Noordegraaf and Brock 2021).

Our reconstruction has some limitations. Most importantly, we focused on events that took place in the summer of 2019 and on the way in which opposition was mobilized, using the literature on populism as analytical framework. In doing so, we have skimmed over the fact that attempts to differentiate between vocationally and bachelor-trained nurses go back thirty years (Van der Peet 2021) and were made in various institutionalized settings. A more institutionally layered and historical analysis

of the reorganization of nursing work is needed to explain why nurse differentiation is both an enduring ambition and a persistent problem (Van de Bovenkamp et al. 2017). In addition, while there is a larger body of literature focusing on the emergence of social movements and their political consequences (e.g. Bennett et al. 2014), we focused specifically on the seminal works of Chantal Mouffe (2005) and Ernesto Laclau (2005). This choice has been iteratively informed by our case (e.g. the political frontier that was established and the way in which this occurred). We also believe, however, that this is only a first step in studying organized dissent amongst emergent professional groups and the mechanisms involved.

2

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CHAPTER 3

Assembling care: How nurses organize care in uncharted territory and in times of pandemic

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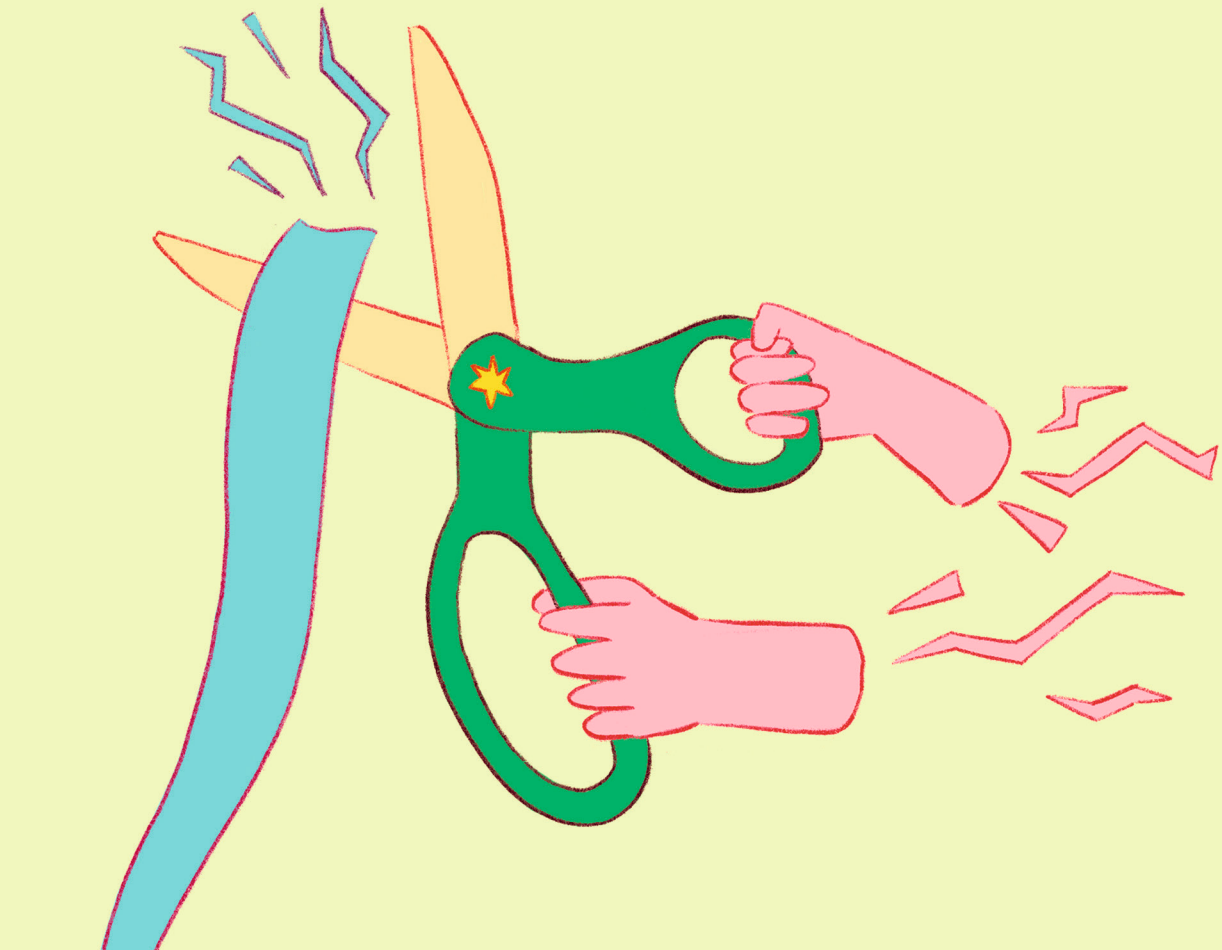

Abstract

This paper draws on ethnographic research to conceptualise how nurses mobilise assemblages of caring to organise and deliver COVID care; particularly so by reorganising organisational infrastructures and practices of safe and good care. Based on participatory observations, interviews, and nurse diaries, all collected during the early phase of the pandemic, the research shows how the organising work of nurses unfolds at different healthcare layers: in the daily care for patients and their families, in the coordination of care in and between hospitals, and at the level of the healthcare system. These findings contrast with the dominant pandemic-image of nurses as 'heroes at the bedside', which fosters the classic and micro-level view of nursing and leaves the broader contribution of nurses to the pandemic unaddressed. Theoretically, the study adds to the literature on translational mobilisation and assemblage theory by focussing on the layered and often invisible organising work of nurses in healthcare.

Key words: nursing, organising work, assemblage, COVID-19, materialities of care, ethnography

Introduction

> *The decision was made – we had to establish a cohort unit. Well, when you put these ideas down on paper and have it all figured out, it seems to work fine. But the moment they [the board] said 'Go for it!', well, I can still see the look in the eyes of the physician who thought, 'Okay then….' [clueless]. But also, the look in the eyes of the chief nurse, like 'Okay!' [decisive]. The chief nurse just took care of it, and in a blink of an eye, it was all set: the COVID unit was set up, everyone knew what to do, and the materials had been delivered. And the appreciation of the physician, who hadn't known what to do…To me, that moment revealed a huge difference in expertise. The physician might know everything about the disease, about the treatment, and what is known at that time. But organising care for a patient is a different profession, a different and true craft I'd say. (Nurse and secretary of the board of directors, February 2021)*

In March 2020, the World Health Organization (WHO) declared the outbreak of the novel COVID-19 virus a global pandemic (WHO 2020). A few days later, the Dutch prime minister spoke to the nation in a rare, televised address: 'Many people will recognise the feeling that we have been on a roller coaster in recent weeks that seems to be going faster and faster. You wonder, is this really happening?' Soon, the pandemic began to strain healthcare systems and put immense pressure on healthcare workers in the Netherlands, as elsewhere in the world (Bal et al. 2020). Before the outbreak, the WHO had designated 2020 as the 'Year of the Nurse and the Midwife' to mark nurses' essential work in challenging conditions. 'How prophetic that goal turned out to be,' commented the director of a pharmaceutical company later that year (Johnson and Johnson 2020). Since the surge of the virus, nurses have been at the forefront of organising and delivering COVID care and have come to symbolise the COVID-19 response (Bennett et al. 2020, Różyk-Myrta et al. 2021, Mohammed et al. 2021).

The Dutch and international media have displayed a rather one-dimensional understanding of nursing work that portrays nurses as 'heroes at the bedside', fostering 'classic' images of nursing work as a primarily passive and compassionate caregiving and feminised occupation (Stokes-Parish et al. 2020, Hennekam et al. 2020, Bennett et al. 2020, Mohammed et al. 2021). This image ignores other dimensions of nursing, such as the organising work performed to increase patient capacity and enabling care delivery in times of crisis – as we will show in this paper. Moreover, scholars argue that a one-sided hero discourse may even serve to legitimise and normalise the dangers nurses face and how these dangers are, in turn, used by politicians to legitimise restrictive COVID measures in mainstream and social media (Cox 2020, Einboden 2020, Mohammed et al. 2021). Nurses, however, have challenge these professional stereotypes by using the same (social) media platforms to promote the different and skilled aspects of their (crisis) work (Croft and Chauhan 2021) – underscoring that a one-sided hero discourse blurs our view of the role that nurses really play in health crisis containment and management.

From a sociological perspective, the emphasis on care and the invisibility of nurses' organising work are hardly surprising. Scholars have long pointed out how nurses' organisational competencies are essential to healthcare systems but an invisible and even a contested part of nursing work at the same time (Allen 2014, van Ewijk 2013). In our research, we noted that it was often nurses who re-invented and organised hospitals and healthcare delivery in the response to COVID-19 – as illustrated in our opening quote. In our observations and interviews, we furthermore saw how the organising work of nurses involves highly situated experimentation and emergent decision-making under critical uncertainty, and how nurses enacted different social and material entities to continue and support healthcare delivery. In this paper, we use the momentum of the pandemic to articulate how nurses organise and reorganise care at different organisational levels, both within healthcare organisations and across the healthcare system. In doing so, we seek to go beyond the current and rather normative framing of nursing work and envision how nurses give shape to, and care for, healthcare delivery during a pandemic crisis.

Our aim in this paper is to contribute to an emerging sociological literature on the organising work of nurses (e.g., Allen 2014) by illuminating how nurses mobilise, navigate, and adjust sociotechnical assemblages to deliver and organise COVID care. The following research question guides our analysis: *How do nurses mobilise and (re) assemble care in the Dutch COVID-19 response, and how does this organising work unfold at different organisational levels in times of crisis?*

We draw on insights from the fields of Science and Technology Studies (STS) and Sociology of Health and Illness (SHI) to conceptualise how nurses bring together and mobilise sociotechnical assemblages in organising and delivering COVID care. The concept of assemblage allows us to include human and non-human actors in the analysis and to study empirically how nurses assemble dispersed entities (e.g., the built environment, technologies, concepts, and people) so that they work together and mesh in various temporal orders to provide care (Sager and Zuiderent-Jerak 2020, Delanda 2016, Muller 2015, Nail 2017). In our analysis, we build on discussions in assemblage literature that have foregrounded the role of the material and the architectural in healthcare, and how this relates to the notions of affect, care and normative work (Brown et al. 2020, Buse et al. 2018, Latimer 2018, Driessen 2020). As we will show, the COVID-19 pandemic encompasses various individual and collective crises and related values and goals. In this paper, we scrutinise how these different 'goods' and 'bads' are mediated through nurses' work and inform the 'doings' of COVID care in daily healthcare practice. In the following, we first present the theoretical framework in which we connect assemblage literature to notions of (good) care. We then describe the research methods, followed by a results section in which we show how nurses mediate and move between different layers of the healthcare system and organise and assemble or reassemble care at different levels. We end with a discussion in which we reflect on the implications of our findings and how they contribute to a broader sociological understanding of nursing work.

Assembling nursing care

Nursing is traditionally seen as a caregiving occupation (Yam 2004, Gillett 2012), closely connected with ideas of nurturing and even 'mothering' (Davies 2003). Although the image of nursing has been discussed at length in the sociological literature, the profession continues to be characterised and evaluated by this somewhat one-dimensional caregiving image, which moreover continues to drive perceptions of nurses as well as their self-image and hinders the construction of nurses desired professional identity and nursing leadership (Croft et al. 2015). STS literature addressing nursing practices stresses the invisibility of nurses' organising work as both integral and essential to nursing, and how this invisibility downplays the importance of nursing work and hence the position of the nursing profession. In early work, Timmermans et al. (1998) have shown that making nursing work visible (i.e., through the categorisation and evaluation of their work) makes nurses prone to managerial control. They show that such visibility may hamper instead of improving the autonomous position of nurses and hence recognition of their work, because categorisation and evaluation often rest on traditional notions of care work, stressing nurses' hands-on work at the patient's bedside and overlooking the highly skilled and knowledgeable activities they undertake to enable smooth care delivery across various professional and organisational levels.

More recently, authors have foregrounded the organising work of nurses in the sociological literature on health and illness. For example, Allen's (2014) ethnographic study of nurses' daily organisational work and practices has laid a theoretical and empirical foundation for conceptualising how such organising work unfolds in evolving and complex healthcare settings. Allen (2014) illuminates how nurses shape individual patient care trajectories and bring together fragmented care processes by aligning constellations of both human and non-human actors across organisational boundaries and therefore mobilise and sustain sociotechnical networks in which patient care trajectories unfold. Allen (2014) coins the concept of 'translational mobilisation' to point out how nurses validate and interpret dispersed information and thereby piece together trajectory narratives, mediate relationships between various healthcare workers, and use their understanding of patients' psychosocial circumstances and intimate organisational knowledge to perform bed management and care transfers.

The concept of translational mobilisation makes it possible to articulate and understand nurses' emergent organising work. Doing so reveals the highly skilled and knowledgeable activities nurses undertake to enable healthcare delivery. This literature lays the groundwork for rethinking what nursing work entails and how different forms of expertise and care work are necessary to organise and deliver care in dynamic healthcare settings (Allen 2018). Emphasising the coordination and planning of care for individual patients or 'ward care', however, ignores the broader work nurses do to keep the healthcare system on track, particularly in a pandemic.

To envision this broader contribution of nurses and nursing work, we turn to assemblage literature (Delanda 2016, Guattari and Deleuze 1988). This literature allows us to articulate how nurses rebuild and organise hospital departments, reinvent and coordinate working routines and methods, perform critical roles in patient allocation between hospitals, and thereby shape care beyond hospital walls and across organisations.

Nursing work as an assemblage of care

Gilles Deleuze and Félix Guattari (1988) coined the notion of 'assemblage' as a theoretical concept and analytical tool. Assemblage literature analyses the social world as constantly in flux. It considers the interactions of various sociotechnical entities and how they come together in temporal and relational formations (Amironesei and Bialecki 2017, Delanda 2016). In line with this literature, healthcare organisations can be understood as adaptive, heterogeneous and dynamic organisations in which the role of both human and non-human actors is articulated. Assembling is therefore about bringing and holding together heterogeneous elements and shows the work needed to make this happen (Ivanova et al. 2016). Assemblage literature sensitises us to how nurses align, adjust, and tinker with social and material objects in the COVID-19 response.

Importantly, assemblage literature has envisioned the role of materiality and the built environment in healthcare practice (Brown et al. 2020, Brownlie and Spandler 2018, Heath 2018, Buse et al. 2018). In this body of scholarly work, both ordinary and innovative materialities act as a lens to (re)examine the intersection of care, things, and architecture (Buse et al. 2018). Heath et al. (2018), for instance, examine in detail how nurses in an operating theatre act on a diverse set of knowledges (e.g., clinical, practical, organizational) to manage and configure various objects used and exchanged during surgical procedures - such as swaps, hammers, drills and scissors – highlighting the role of objects and artefacts in healthcare practice and nurses' technical and organisational sensitivities. Brown et al. (2020), in their turn, stress the socio-materialities of care in a respiratory clinic for patients diagnosed with Cystic Fibrosis (CF), illuminating the dangers of airborne (and life-threatening) virus transmissions in the case of CF patients and the role of nurses and patients in reducing those dangers through social-material and situated solutions – something remarkably relevant to the current COVID-19 pandemic. The authors show that good air hygiene and careful aerographic management are critical to lung infections. They describe how patients' bodies are envisioned as surrounded by a 'cloud' of transmissible bioaerosols, rendering air visible, and how this spurs healthcare professionals to organise or reorganise and reshape the built environment to enhance ventilation and minimise gatherings of patients. Thus, instead of seeing materialities as static, they reveal how both nurses and patients – separately but also in their mutual interactions – reimagine and materialise socio-material entities (e.g., windows, fresh-air balconies) to make them manageable in everyday care practices, and hence how care for the environment is part of the assemblage of organising CF care. Hence, the focus on

this body of literature draws attention to how socio-material assemblages are managed and configured through nurses organising work.

Good crisis care

Assemblages include the notions of care work, affect and 'doing good' (Ivanova 2020). According to Tronto (1993), care 'includes everything that we do to maintain, continue, and repair our world so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web' (Tronto 1993, p. 103). Some scholars have made visible how actors, who are themselves embedded in the sociotechnical assemblages of care, seek to bring or keep values together in their daily practices (de La Bellacasa 2013, Mol et al. 2010). For instance, Jeannette Pols (2006) shows that 'good washing' may sometimes involve not washing patients to respect their autonomy, even when they smell, but at other times forcing patients to shower when their body odour is a cause of loneliness they suffer from. In line with assemblage literature, care is thus described as something to do, as a form of attentive, situated, and ongoing tinkering in dynamic entanglements with space, values, materialities, and technologies (Driessen 2020, Martin et al. 2015, Ivanova et al. 2016). These authors also emphasise that assemblages themselves are, by nature, normative (e.g., 'well as possible', 'good care') and require a constant weighing of what matters, what should and could be done, and what should be included and tied together. Hence, the focus on assemblage allows one to articulate how different values and perspectives of 'good care' come into play in nurses' daily care work (Latimer 2018).

The need to mediate different values became very apparent in the COVID-19 crisis, when hospitals overflowed with severely ill patients and healthcare professionals needed to tinker with both collective and individual patient needs (de Graaff et al. 2021). These different needs and values may conflict and require negotiation and mediation, in other words being 'tinkered with' (Mol et al. 2010). In the following sections, we analyse how different values of and perspectives on good care were enacted and navigated in the daily organising work of nurses during the pandemic, and what this teaches us about the role of nurses' organising work in healthcare.

Methods

This paper builds on an extensive data set stemming from the RN2Blend research programme. Nurses' role in the pandemic is a 'celebrated' and topical case that offers a new, sociological perspective from which to study nursing work and professionalisation. Ethical approval for the study was obtained through the internal review board of the Erasmus School of Health Policy and Management.

Initially, early in the pandemic, the constraints of social distancing and other COVID measures complicated in-person data collection. To capture the experiences and work

of nurses in COVID care, we set up a qualitative diary study in April 2020. We asked participating nurses to reflect, in writing or in recorded audio or video clips, on their daily work in COVID care. Although the study produced some valuable diaries and reflections, it was clear that keeping a diary was burdensome for nurses in times of crisis. Moreover, the diaries we did receive addressed a plethora of topics (e.g., physically restructuring hospital wards, establishing, and developing new care routines, decision-making in critical uncertainty) that we wanted to explore in greater depth. We therefore turned to other, online, research methods and interviewed the initial diary study participants virtually. These semi-structured interviews (N=27) with frontline staff were conducted from April 2020 to March 2021. All interviews started with open-ended questions about daily care work in the pandemic. Informed by the initial diary study, we then enquired into the disruptions of clinical routines and teamwork, and decision-making in the face of uncertainty. We furthermore asked participants to reflect on the quality and safety of care and how nurses contributed to the organization of care delivery. We recruited nurses working in different roles at various teaching and general hospitals, as shown in table 1, to capture a wide range of experiences and stories. Although online research methods present limitations and challenges compared to in situ research (e.g., socialising with respondents, taking sensory experiences into account) (Podjed 2021), digital technologies allowed us to gather rare and valuable insights about day-to-day nursing during the first wave of the pandemic. Verbatim transcripts were made of each interview.

Type of hospital	Nurse role
Academic	COVID coordinator (4), nurse & secretary of the board of directors (1), IC nurse (3), specialized nurse (2)
General	COVID coordinator (3), unit manager (3), specialized nurse (4), IC nurse (2), registered nurse (5)

Table 1. details of interviewed nurses

Soon after the first wave of the crisis, we continued our research by conducting ethnographic fieldwork in two Dutch hospitals and at the National Centre for the Spread of Patients (LCPS). From November 2020 to February 2021, the first author shadowed three nurse coordinators, as shown in table 2, as they went about their everyday work in COVID care. We spent six days (over 48 hours in total) observing nursing coordinators' daily work and meetings. In addition, in February 2021, we observed several other healthcare professionals, including nurses, working on patient allocation at the LCPS for three days (over 24 hours in total). Ethnographic research proved valuable for an in-depth understanding of the daily practices of COVID care and for observing how nurses shape and perform care in times of crisis. The participatory observations enabled us to unravel themes drawn from the diary study and interviews and how the organizing work of nurses (e.g., translational and repair work) unfolded in daily practice. Fieldnotes and informal conversations were written up into observational reports within 24 hours upon leaving the field. In addition, we held formal interviews with the participants (N=8) that were also transcribed verbatim.

Field work	Methods and respondents
General hospital (2)	Observations (48h), nurse COVID coordinators (3)
National Centre for the Spread of Patients ('LCPS')	Observations (24h), healthcare professionals, including nurses Interviews (N=8), nurse (1), chief medical officer (1), managers (4), mathematic modelers (2)

Table 2. Details fieldwork

The data we gathered was analysed abductively (Tavory and Timmermans 2014), allowing us to make several rounds of iterations between our data and theory (as described in the theoretical section above). Throughout the data analysis process, an iterative and reflexive approach enabled us to explore empirical findings in-depth. We started coding based on earlier theoretical insights on nurses organising work (e.g., coordination, translational, and articulation work) and different valuations that shape nursing work in the pandemic (e.g., safe, humane, timely, and efficient care).

Throughout data analysis, coding yielded new insights that we then investigated and member-checked with nurses in the field in formal and informal conversations and interviews. Based on what we found within the data, we developed new codes to capture our findings (e.g., organisation and establishment of (COVID-19) wards, coordination of socio-materialities across organisational boundaries, and caring repair work). Coding was primarily carried out by the first author and then discussed among all co-authors. All quotes and excerpts are translated from Dutch. In our analysis, we employ pseudonyms to maintain anonymity.

In the following section, we show quotations which are selected to reflect how nurses actively (re)configure social technical assemblages and to elucidate how this organising work of nurses unfolds at three layers: on the 'shop floor', in and across hospitals, and at the level of the healthcare system.

Results

> *It was a Wednesday. I remember clearly that it started abruptly with patients arriving in the emergency department. I helped that day when we moved our entire department on the spot and converted it into a cohort unit. (Nurse, interview 6)*

During the initial outbreak of the novel COVID-19 virus, healthcare provision had to change overnight. In the above quote, the nurse in question recalls how she and her colleagues were asked to abandon their usual work and help clear and transform specialised nursing wards into provisional cohort units. All of a sudden, this nurse found herself at the forefront of the Dutch COVID crisis response. The following three sections describe how nurses assemble and reassemble care in this new situation, and how this organising work unfolds

at different organisational levels. First, we demonstrate how nurses interact with and mobilise materialities, things, and technologies while rebuilding and reassembling wards. The second section discusses how nurses' organising work occurs across organisational boundaries and involves decision-making under critical uncertainty. In the third section, we work out these findings in more detail by demonstrating how nurses perform patient allocation, thereby contributing to the broader organisation and healthcare system 'in crisis'.

Reorganisation of hospital spaces of care

> *We had two wards. One of them was a COVID ward. That ward was cordoned off with tarpaulin, and the entrance closed off with zippers. When you went in, you had to wear a protective suit, and that's how we separated the 'dirty side' from the 'clean side'. That was also when we brought in the walkie-talkies. It allowed nurses on the dirty side to quickly ask nurses on the clean side to fetch something from the medicine room. Or when a 'clean' patient turned out to be infected, we used the walkie-talkies to inform nurses on the other side, after which the patient could go past the tarp. It made it possible to coordinate between the [physically separated] wards. (Nurse, July 2020)*

At the beginning of the pandemic, COVID care was unchartered territory, with no scenario available that described how to treat infected patients. The reorganisation of care involved a considerable amount of experimentation and improvisation. As the exact mechanism of transmission was still unknown, treatment involved exercising immense caution in the face of possible viral transmission through direct contact, aerosols, and droplets. This required careful aerographic management and the ability 'to envision the invisible' (Brown et al. 2020, p. 973), the incentive behind the opening of new wards, rearrangement of spaces of care, and ward assignments for COVID and non-COVID patients. At the hospital where the nurse above works, nurses established a coordination system and cordoned off certain wards so as to prevent COVID patients from infecting others. They mobilised gatherings between materialities (the architectural environment and tarpaulin), the social (working routines and division of labour), and technologies (walkie-talkies, personal protective equipment, and COVID tests) in an effort to continue caring for patients. Such tinkering and acting upon sociotechnical assemblages to rearrange spaces of care are central to many of the cases in our data.

The prominent role of materialities and the built environment in reorganising spaces of care is illustrated in the following quote:

> *So, the doors of the isolation rooms are closed, without any windows. Well, then you can't see the patients. But they were very sick, you want to be able to see them all the time and watch them through a window, and not have to put on a [protective] suit every time. We had those windows made immediately. (Nurse, June 2020)*

Having windows installed in the isolation rooms' doors acted on the immediate need to observe patients closely without being in direct physical contact with them. This example illustrates how nurses experienced a mismatch between the unfolding needs of COVID treatment and established care practices in the built hospital environment. Hospitalised COVID-19 patients require close observation, as they run a high risk of sudden deterioration and critical disease (Cecconi et al. 2020). However, at the same time, severe resource shortages required nurses to economise as much as possible on personal protective equipment (PPE), time, and energy. Wearing protective clothing is also physically demanding and can be very uncomfortable (many nurses complained about headaches):

> *It was so hot working in protective clothing that we quickly asked for [thinner] surgical suits, but we never got them because they weren't available. We kept working on COVID wards for entire shifts while dressed in protective clothing, wearing face masks, glasses, and gloves. Our glasses were all fogged up while we were puncturing IVs and distributing medication. (Nurse, July 2020)*

The new windows are an example of how nurses reassembled their built working environment to enable pandemic care delivery (Driessen 2020, Mol et al. 2010). It also allowed nurses to limit direct patient contact, thereby also avoiding significant risks to their own health. This example also shows how they gained influence during the first wave. It has often been argued that nurses lack influence, control, and agency over the organisation of care (Allen 2014). In the tumult and extreme uncertainty of the pandemic, however, their requests were quickly met (e.g., other nurses mentioned how long wished-for and expensive safety monitoring systems now arrived within a few days). This exemplifies a general observation in our study, which is that established and layered governance systems were, temporarily, breached early in the pandemic, making it possible for nurses to engage in organisational decision-making and pursue organisational changes (i.e., architectural adjustments or more resources, staff, and equipment).

In the following quote, a nurse reveals how spaces of care and routines were reassembled and how this involved different valuations:

> *We decided that our wards would be used only for patients with an 'ICU plus policy' [i.e., who would not be sent to the ICU if their clinical condition deteriorated]. We moved those patients, who most likely would not be treated in the ICU, to another unit. We did this so that we could distinguish better between patient flows. That worked quite well. But at the same time, you had to drop your work suddenly and move patients ad hoc who… well, I can remember one patient who was dying and had to be moved to another ward where I later thought, should we have done that? (Nurse, September 2020)*

This quote demonstrates how decision-making is accompanied by high levels of uncertainty and organisational pressure. The upsurge of COVID patients forced nurses in this hospital to alter the normal coordination of patient flows. The ethical implications expressed by this nurse reveal the normativities involved in 'doing' COVID care. It shows the sometimes competing notions of good care that informed nurses' daily crisis work, and how nurses navigated potential value conflicts without knowing the consequences (Latimer 2018, Pols 2014). In the crisis, nurses needed to prioritise what mattered most in a specific situation without being able to fall back on predetermined courses of action, and to mediate between the immediate and urgent needs of an individual patient and broader organisational and societal goals and values. In doing so, nurses weighed several organisational affordances, such as staff availability, changing care intensities, and hospital admission rates. This tinkering with both collective and individual patient needs is a central observation in our study, which we will elaborate in the following sections.

Coordination of care across hospital organizational boundaries

> *It was chaotic and panicky at the ICU. To ease pressure on staff, we decided to set up a buddy system. Some argued that the buddies should be nurses, while others opted for physicians. In the beginning, the buddies were nurses, but the ICU staff was not satisfied. They were quickly replaced by physicians. However, this presented yet another challenge. For example, physicians were asked to assist patients with their personal hygiene, with washing. Well, they said 'yes, it's done' but actually they had no idea. In the end, it turned out that some patients had not been washed for five days because the physician did not know how to do it. Or that they had brushed patients' teeth with chlorhexidine. (Nurse, November 2020)*

The troubles accompanying the establishment of a buddy system reveal how patient and staff coordination was disrupted and needed to be reinvented. The reorganisation of COVID care involved not only epidemiological and clinical unknowns but also revealed that care coordination and care organisation were uncharted territory for healthcare workers, in this case physicians who lacked basic skills needed to perform daily hygiene care. In this section, we discuss and unravel nurses' organising work by showing how they allocate and organise staff, teams, resources, and working routines and methods within and across hospital departments. The next quote illustrates how the coordination of care involved decision-making in situations of critical uncertainty:

> *When the first cohort unit was set up, we monitored it closely. How would it all work? At that time, we didn't really know anything and needed to figure out how to organise care for COVID patients. One question was, for example, how do we organise food and nutrition services on these units? We were just constantly working on solving problems, setting up new units, and coordinating staff and materials. (Nurse COVID coordinator, December 2020)*

This nurse explains how staff, patients, and resources needed to be re-assembled and organised. Resource management involved situated experimentation and problem-solving. This organising work was further intensified by local and global healthcare shortages (Juvet et al. 2021). Beyond the examples that attracted considerable media attention, such as the redistribution of ventilators and surgical masks, this nurse explains that the reorganisation of care involves many more aspects of daily care, for example coordinating food and nutrition services. In our study, nurses point out staff shortages as one of the main challenges, for example in the following quote:

> *We were continuously confronted with all kinds of issues for which there was no answer yet. We didn't know what we were facing, and it was a process of learning and discovering what we had to do. The biggest challenge we encountered was that COVID care required a lot of nursing capacity. So, we had to figure out how we could staff cohort units. That was a major task, the numbers were growing, and we had to rearrange teams on a vast scale and ask everyone to cooperate. We tried to relieve nurses as much as possible by establishing 'combination departments', where nurses work both in the COVID units and within their specialism. Also, we set out to keep the teams together as much as possible so that nurses could share their experiences. (Nurse, March 2021)*

This quote reflects how nurses' organising work unfolded across departments in staff coordination and allocation. This nurse explains how she tried to staff cohort units while attending to various organisational, quality, and safety issues as well as the nurses' well-being. Efforts to keep teams together as much as possible are important not only for mutual emotional support, but also because quality and safety are embedded within teams and informal working structures and care routines (Mesman 2017). In our study, we noted several cases in which nurses expressed feelings of insecurity and anxiety about working with changing staff and in different departments, pointing out the consequences of working with and without embedded routines and methods:

> *We were experimenting, figuring out how to work with nurses from all different departments. We started working on a new kind of classification and established new 'types' of nurses. For example, Type 1 is a nurse who can perform care coordination. Type 2 is a nurse who can provide COVID care independently. Type 3 is a nurse who still needs to settle in or to be trained, and Type 4 is a nurse who has never worked in COVID care. We started using this classification system because we noticed that everyone has their own routines and methods. For example, something as simple as how you keep track of a patient's fluid balance. Some departments measured that at eight o'clock, and other departments at midnight. (Nurse, November 2020)*

The classification system was established to coordinate, differentiate, and align different 'types' of nurses during the COVID-19 upsurge. During the peak of the pandemic, COVID care required high levels of staff flexibility. The military, medical students, and civilian nurses were brought in to ease the pressure on hospitals and the nurse workforce. In the cases we observed, team composition varied greatly and depended on local circumstances. The above-mentioned system was used by nurses to onboard new staff, enhance interprofessional collaboration, and streamline working methods and routines. These seemingly mundane tools make visible how nurses deal with perceived hindrances in healthcare delivery and come up with temporal workarounds to manage care work in the crisis (Debono 2013). Such interventions are critical, as several nurses mentioned a decline in the quality of nursing care due to the absence of embedded routines and methods and the changing teams:

> *Our team often claims that the crisis was not at the expense of quality of care. But that is absolutely not true. I think we can hardly remember what the care we provided a year ago looked like. We are constantly working with people from different departments, and that causes problems. For example, the double-checking of medication. We do that in a computer system. However, not everyone understands this system. Recently a colleague asked me to double-check the medication he had prepared. Out of six syringes, four were wrong! In this case, the mistake was averted, but in other cases, and during all the commotion, those syringes were simply used. (Nurse, March 2021)*

The examples in this section illustrate how nurses' organising work goes beyond individual care trajectories and occurs across hospital departments. Central to the organising work of nurses is their ability to re-assemble nurse teams and routines so as to enable pandemic care delivery, especially when the demand for care surges. In this process, nurses mediate between different values and ideas of good care (e.g., keeping care accessible for as many patients as possible while letting go of patient-centred care delivery and knowing that mistakes could be, and were being, made). In the next section, we turn to how nurses operated within the broader crisis organisation and healthcare system to organise pandemic care.

Care with the allocation algorithm

> *Tim chairs the meeting and asks about the current situation: 'How many beds are available? How much capacity is there in the isolation rooms? How many unconfirmed patients are on the different nursing wards?' Nurses from different departments call out their numbers, some from memory, others reading the numbers from a sheet. 'I've discharged five and have eight beds occupied,' one of the nurses replies. 'We have no beds left and have already announced an admissions freeze,' another nurse responds. 'So did we! We also have a patient*

> *who tested negative, we have cleared the isolation room. I now have eight in and four out,' yet another nurse adds. Tim writes the numbers down while an ICU nurse has the last word: 'We can't discharge anyone to the cohort unit today, and we don't have any beds available, all patients are still in prone position.' (Fieldnotes, November 2020)*

This excerpt was taken from a hospital's daily crisis meeting. It reflects how hospital capacity is coordinated and how the virus has driven Dutch hospitals to the limits of their capacity. However, the timing and impact of the virus varied across different regions and hospitals. In the early pandemic, some regions, and most major cities, experienced high rates of infection, while other regions had lower infection rates. Infection rates continued to fluctuate well into the subsequent waves of the virus. To distribute the care burden and, later in the pandemic, to safeguard non-COVID care, a national coordination centre (the National Centre for the Spread of Patients, or 'LCPS') was established. The LCPS collects data on hospital capacity, regional infection rates, available ICU and other beds, and hospital admissions. This information is entered into a digital system and processed into models, prognoses, and scenarios that allocate patients equally. The Dutch Medical Association has drawn up the selection criteria for allocation, and the numbers are presented in daily spreadsheets and circulated several times a day (Wallenburg et al. 2022). In the Dutch COVID-19 response, the LCPS became an important new actor in the healthcare system, and the algorithm underpinning its predictions became a key tool. Nurses played an important role in working with the algorithm and coordinating patient allocation. We use the case of patient allocation to demonstrate how the organising work of nurses contributes to the national transfer system by translating the algorithmic decisions into real-life reallocation, bringing care into the crisis-transfer system:

> *It's good that we [allocation coordinators] are nurses. Physicians have medical expertise but have no idea how the clinic works. We have broad clinical knowledge but are also knowledgeable about what it entails and understand the whole picture. (Nurse coordinator, November 2020)*

This nurse explains how she and her colleagues consider 'the whole picture' when reallocating patients. Nurses are often referred to as 'the glue in the system', the passage points in hospitals, mediating relations between dispersed actors and synthesising the clinical, practical, and organisational knowledge of various departments and patients' psychosocial circumstances (Allen 2014). This nurse's argument is echoed in other cases in our study, complementing the critical role of nurses in coordinating patient allocation. In the Dutch context, this also involved managing patient transfers to other care facilities, such as nursing homes and rehabilitation care centres. The next quote shows a nurse COVID coordinator working on patient allocation:

> *Tim views the two new files. The first file appears to be in order, but the second file raises questions. Tim notes that the patient's partner has also been admitted to hospital. He picks up his phone and calls the department: 'Isn't this a bit sad? I mean, have you reviewed it?' At the other end of the line, the nurse enquires and says: 'No, the patient doesn't think it's a problem.' Tim rolls his eyes and looks at me: 'Okay, well then we'll register him after all.' He starts entering the patient's details in the system, but suddenly stops and reaches for his phone again: 'I just think it's a bit inappropriate, is there really no other option? I just want to double-check; I also see that there is already something about aftercare in the file. Isn't the patient about to go home?' Tim turns his chair to the window and waits for an answer. After minute or two, Tim is informed that the patient can stay in hospital. Tim puts his phone down and says to me: 'I didn't like it, it's just not friendly, the oxygen level is okay now, and she hasn't been given any supplemental oxygen at all.' (Nurse and COVID coordinator, November 2020)*

The negotiation described above shows the work needed to translate and do the reallocation work in practice and how nurses are normatively engaged. The nurse in question works with a centralised matching system established by the LCPS in which COVID coordinators register patients for transfers. The system, in turn, shows which hospitals have open beds. When there is a match, COVID coordinators are contacted by LCPS healthcare workers to manage the transfers. The LCPS then contacts the receiving hospitals and sends ambulances for transfers.

The above excerpt describes how the nurse tries to prevent the transfer of a patient whose partner is also hospitalised. It shows the nurse using different types of knowledge – for example of clinical needs (medical records, COVID-19 clinical features), of the organisation (aftercare, care trajectories, allocation process) and of the patients' psychosocial circumstances (the patient's wife is also hospitalised) – to figure out the 'right' place for this patient. This nurse hence mediates between different healthcare actors to repair and adjust the outcome of the algorithm and articulates a form of patient-centred care. He does so despite the models and algorithm showing that there is little capacity left and that the patient meets the criteria for transfer. We see here that the algorithms and LCPS models are not stable systems but involve hands-on professional work and continuous maintenance, repair, and translation (Denis and Pontille 2017). This example and many more in our data show how nurses using the allocation algorithm continuously navigate individual and collective needs and in doing so weigh up variable capacity within and across organisations, patients' sociopsychological circumstances, clinical features, and the ins and outs of various hospital departments in order to assess whether a patient should – or should not – be transferred.

The next step in coordinating patient allocation is the actual transfer of patients. In the following quote, we see how a nurse at the LCPS manages transfer logistics and coordinates ambulances for transfers:

> *Stef shows me a file in the system and says: 'This patient has had a brain haemorrhage, has COVID, and is registered for transfer. It is a complex case, which makes me think right away, what is important here? What is his neurological condition, does he have trouble swallowing, can he speak well, and how much does he weigh? Those are important questions because we need to provide a good and humane transfer and [ambulance] ride. I am the last checkpoint here, and I try to understand the broader clinical picture, not just COVID. That is essential for the type of ambulance we deploy.' (Nurse, February 2021)*

The data entered into the LCPS system determines whether a regular ambulance or a mobile ICU ambulance is called in to transfer patients. However, the above quote points out how ambulance coordination also involves critical articulation work (Star and Strauss 1999). It reflects how this nurse validates and interprets different types of information (i.e., clinical, organisational, practical) to determine which type of ambulance is suitable for this patient's transfer. We see how the nurse assesses the patients' clinical condition and connects this with available socio-technical affordances and, in doing so, articulates a form of 'good and humane' transfer care.

These examples further underscore how nurses set out to and succeed at influencing the organisation of crisis care and how they perform organising work across organisational boundaries and for the healthcare system. As the next quote shows, however, this work is not always acknowledged and appreciated in nursing practice. In our study, several nurses said that they felt their broader organising work went unappreciated, both by policymakers and managers, but also within teams and among nurses themselves:

> *Nobody on my own team said: you're doing a good job. No one! (Nurse, March 2021)*

This perceived lack of appreciation from peers is notable but unsurprising in light of the invisibility of nursing work. Nursing work is articulation work; the work that is needed 'to get things back on track' (Star and Strauss 1999), and that is played out at the patient's bedside or, in this case, behind a desk to coordinate an ambulance ride. It is work that is often unseen or unacknowledged. Nurses complain about this lack of public recognition – but also the lack of recognition from their nursing colleagues.

The examples in this final empirical section show how nurses play a critical role in allocating patients, and how different perspectives on good care are coordinated to accomplish 'good' patient transfers. They reveal how nurses make the algorithm and

allocation work concrete and applicable in daily crisis care and play an important role in coordinating patient transfers and in motivating, strategising, and convincing other healthcare professionals to transfer or to not transfer a patient. In doing so, nurses play a crucial role in maintaining and organising patient allocation in an overburdened system.

Discussion

Nurses have played (and are still playing) a crucial role in pandemic care delivery, not only by caring for severely ill patients but also by keeping the organisation of care and the broader healthcare system on track. In this paper, we show how nurses accomplish this by assembling organisational, material, and clinical knowledge as well as using their in-depth understanding of patients' psychosocial circumstances in their care work. We demonstrate how nurses act upon and organise the built environments in which COVID care is performed, and how they reinvent working methods and routines across hospital departments (e.g., by establishing temporal classifications, putting together 'combination teams', and allocating resources across wards). Empirical data on the allocation of COVID patients furthermore shows how nurses, as central actors in dispersed and fragmented hospital care, organise and perform patient allocation across organisations. These insights help to disclose how nurses actively mobilise and renegotiate the allocation algorithm and mediate different valued purposes (i.e., patient-centred care, timely care, the needs of the whole population) and connect this with the socio-technical affordances of hospital and other care (e.g., daily rhythms of the clinic, hospital capacity, staff, and resource availability).

In answering our main research question, i.e., how nurses assemble or reassemble care at different organisational levels in the Dutch COVID-19 response, we show in our analysis how nurses are experimentally inventing COVID care along the way and performing, translating, and rendering 'ideas on paper' applicable in daily care work. Nurses are knowledgeable and flexible organisers of care, mediating, bringing together, and mobilising heterogeneous elements (e.g., people, concepts, things, and technologies) in their real-world practice. By moving between different layers of the healthcare system, we demonstrate how nurses' organising and care work plays out and connects the patient, the family, the hospital, and the broader crisis organisation and healthcare system.

This study furthermore articulates how, in the COVID-19 pandemic, nursing work involves continuously tinkering with both individual and collective patient needs and the inherent normativities. In line with previous studies, we reveal how care involves situated and experimental tinkering (Mol et al. 2010) to bring together conflicting values (i.e. transferring a dying patient to make room for new infected patients in hospital). In the analysis, we outline how different values and goods, namely care for the individual, the organisation, and broader society, informs nurses' daily practice in the pandemic.

Our findings suggest that these values and normativities are highly situated and far from stable, and that tinkering with different values mediates between specific contexts, histories, and nurses' understanding of patients' psychosocial circumstances and hospital socio-technical affordances. Moreover, we demonstrate how notions of safety and quality are segmented and translated in times of crisis (e.g., by (not) ensuring safe medication dosing by double-checking, provisional implementation of buddy systems) and involve a constant weighing of what matters most and balancing of different valuations in constrained circumstances ('good' care or 'good enough' care, 'safety' or 'accessibility').

These findings put forward an alternative understanding and conceptualisation of nurses and nursing work. This is important because, in the words of Nassim Nicholas Taleb, 'Ideas come and go. But stories stay' (2007, p. 26). While the 'nurses as heroes discourse' frames nurses as compassionate helpers and confirms public images of nursing as primarily a hands-on and caregiving profession at the bedside, our findings reveal that nurses are active and critical actors in the COVID-19 response. We have used the metaphor of uncharted territory to describe the many unknowns, unpredictability, and uncertainties nurses are dealing with in the COVID crisis and through their organising work. Sticking with this metaphor, we argue that nurses in the Dutch COVID-19 response can be seen as explorers who renegotiate professional standards and guidelines, examining unfamiliar terrain with their experimental and reflexive practices and learning to deal with a new disease and new organisational circumstances. As illustrated in the opening quote of this paper, both managers and physicians' recourse to nurses' explorative work to lead the way in the COVID crisis.

The sociological literature on healthcare organisations generally ignores nurses' organising work, but that work is also unseen and unappreciated in daily healthcare practice. It took months before nurses were added to crisis management teams in Dutch hospitals, and only in the second COVID-19 wave were they invited to crisis meetings and allowed to contribute to organisational decision-making. Unfortunately, this broader appreciation of nurses' organisational competencies appears to have been short-lived. While staff shortages are growing, nurses still appear to be struggling to position themselves as critical and active organising agents in the COVID-19 response. This is further complicated by a powerful counterforce within the nursing profession itself that values patient work above organisational work (Felder et al. 2022). It is therefore important to add a nursing political and organisational discourse to the dominant micro-level care discourse (Tronto 1993). The framing of nurses as heroes is increasingly at odds with frontline nursing work in the COVID-19 pandemic. We argue that our conceptualisation of nurses as explorers who mediate and move between different layers of the healthcare system, thereby assembling and reassembling care at different organisational levels, calls for an alternative acknowledgment and appreciation of nursing work in the crisis, and beyond.

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CHAPTER 4

"We don't experiment with our patients!" An ethnographic account of the epistemic politics of (re)designing nursing work

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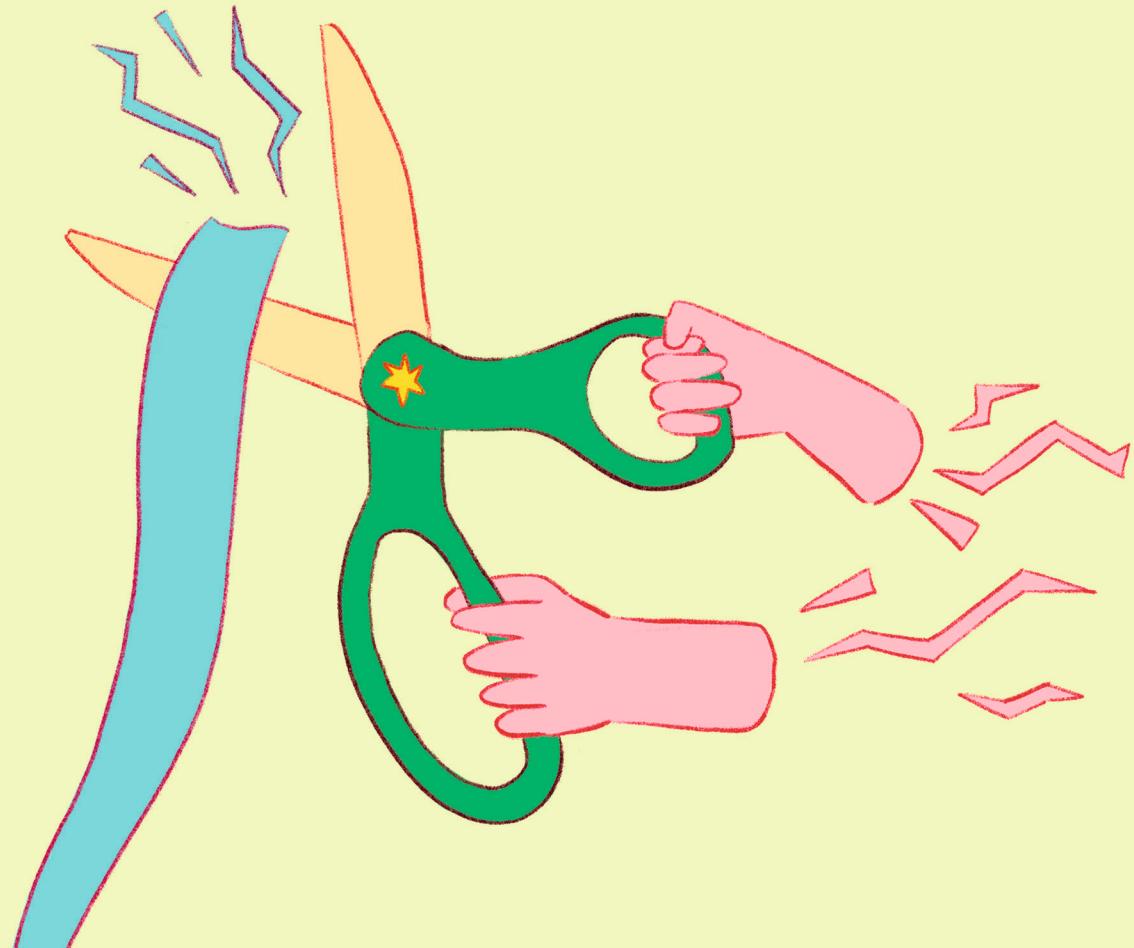

Abstract

This article draws on ethnographic research investigating experimental reform projects in local nursing practices. These are aimed at strengthening nursing work and fostering nurses' position within healthcare through bottom-up nurse-driven innovations. Based on literature on epistemic politics and critical nursing studies, the study examines and conceptualizes how these nurses promote professional and organizational change. The research draws on data from two pilot projects to show how epistemic politics frame the production and use of knowledge within reform efforts. The study finds that knowledge produced through such experimenting is often not considered valid within the contexts of broader organizational transitions. The nurse-driven innovations fail to meet established legitimate criteria for informing change, both among stakeholders in the nurses' socio-political environment, as well as within the nursing community. The research reveals that the processes inadvertently reinforce normative knowledge hierarchies, perpetuating forms of epistemic injustice, limiting both nurses' ability to function as change agents and healthcare organizations' capacity to learn.

Keywords:

Epistemic politics, experimenting, organizational learning, invisibility of nursing work

Introduction

In the summer of 2022, the Dutch Minister of Health, Connie Helder, attended a national conference of nurses to discuss their shared attempts to reform and empower nursing practice in the Netherlands. In her opening speech, Minister Helder stated that nurses desperately need to change healthcare to sustain the future of healthcare delivery: "Changes can only occur from within the profession. You know what is required. You are now in the lead. Use that well!". The minister's call for change came at a moment of ongoing and persistent shortages in nursing staff (Lopez et al. 2022). The nursing workforce faces multifaceted issues, including an aging population and workforce, rising and increasingly complex healthcare demands, structural overload of work and limited career opportunities, as well as a lack of voice in healthcare decision-making (Buchan et al. 2022). The recent Covid-19 pandemic exacerbated the situation further as a dramatic increase in the number of nurses leaving the profession occurred (Nowell 2022), underscoring the need for change and rapid policy strategies to recruit, support, and retain nurses (Jackson et al. 2020, Costa and Friese 2022).

To counter these trends, pilot projects have been introduced in Dutch hospitals to make better use of nurses' ambitions and ideas to strengthen the nursing workforce and profession. In these pilots, nurses are reshaping and reorganizing their practices and working routines (van Kraaij et al. 2021). Examples include the development and implementation of new nursing roles (e.g., supervising nurses and nursing assistants), enhancing the role and position of nurses in healthcare decision-making, altering working routines, and redesigning care practices to improve patient satisfaction, resource usage and increasing the quality of care.

To facilitate this 'movement of change,' a nationwide, government-subsidized action-oriented research program 'RN2Blend' was introduced. We contributed to this program through multi-sited participatory ethnographic research, facilitating, evaluating, and investigating how nurses implemented and ran pilot projects designed to improve nurse professionalization and retainment. We studied the pilots 'from within' by observing day-to-day nursing practices and by attending project meetings, as well as by co-organizing (national) events (e.g., webinars, conferences, festivals), designed to facilitate knowledge exchange and collective learning (Schuurmans et al. 2023).

In the sociological literature, situated and experimental innovations are widely recognized practices to promote organizational learning from inclusive, bottom-up forms of knowledge production (Kuhlmann et al. 2019, Regeer et al. 2016). Pilot projects, in turn, are typically conceptualized as specific time-spaces that allow for collective exploration and reflexive learning, facilitating a general openness 'to try out new things' in local practice (Muniesa and Callon 2007, Clegg et al. 2005). From a critical viewpoint pilot projects can be seen as political episodes that enable social actors to introduce

new ideas, gain support, leverage resources, and establish legitimacy around specific goals, interests, and novel decision-making structures (Sørensen 2013, Ryghaug and Skjølsvold 2021).

Through our extensive ethnographic examination of the pilot projects in the nursing program, we observed nurses expertly improvising, creatively innovating, and improving care practices in their daily nursing work. For instance, through skilful articulation work (Strauss 1988) and first order improvisations (Edmondson, 2004) they aligned and improved complex systems of work. However, we also noticed that when nurses used this working style to navigate unfamiliar terrain in the pilot projects, they met a lot of resistance, both from other organizational actors and from their peers. In this paper, we seek to understand such dynamics from an epistemological perspective, examining how the experimenting approach was counteracted by an evidence-based approach which conditions were hard to meet in the rather underexplored territory of nurses' organizing and caring work. We show how gradually, as nurses were producing knowledge and pursuing professional ambitions in pilot projects, many of them began to question the legitimacy and validity of both their own roles and the experimenting approach used. Despite the minister's deliberate encouragement for nurses to engage in experimental learning and disrupt established routines and the status quo in healthcare, our ethnography demonstrates that, to this end, nurses' experimenting failed to meet established legitimate criteria for informing change. Instead, the projects paradoxically served increasingly to demonstrate the lack of legitimacy of nurses' expertise it was intended to remedy.

In this paper, we analyse this paradoxical situation by empirically examining how different forms of knowledge are used, valued, and legitimized in local nurse reform efforts, as well as their broader implications for fostering nurse professionalization and healthcare improvement and change. The research is informed by insights from the field of medical sociology and Science and Technology Studies (STS) on epistemic politics (Doing, 2004, Beaulieu et al., 2012, Sørensen and Traweek, 2022), evidence-based practice (EBP) (Broom and Adams, 2012, Timmermans, 2010, Zuiderent-Jerak, 2021) and organizational learning (Cunha and Clegg 2019, Waring et al. 2016). Building on the ethnographic study of two pilot projects, we provide insight into how epistemic politics framed the production and use of knowledge within local nursing practice, promoting certain pathways of action while hindering others – and the tensions that emerged from this. The central question guiding this research is to inquire *how epistemic politics have an impact on reforming nursing work*.

In answering this question, we aim to contribute to the growing body of critical sociological literature on nurse professionalization processes and epistemic politics in nursing (Hallam 2012, Allen 2014, Triantafillou 2015, Betts 2009, Timmermans et al. 1998, Ernst and Tatli 2022, Ernst 2020), as well as the epistemic politics of reorganizing

healthcare and improvement work more generally (Waring et al. 2016, Allen et al. 2016). We do so to deepen the understanding of the epistemological position and legitimacy of nurses (as well as the lack thereof) in fostering professional and organizational change, and how broader epistemic and institutional frameworks for evaluation within healthcare shape local improvement work and learning.

In what follows, we first discuss and review literature from the field of medical sociology and STS on epistemic politics and organizational learning through different (and more or less opposite) epistemologies: practice learning through experimenting, and the use of evidence-based practice (EBP), the 'holy grail' of evidence-based medicine in medical care (Timmermans 2010). We then present the research design and methods, followed by an analysis and interpretation of the ethnographic data. We conclude with a critical discussion of the implications of the research for both nursing practice and critical sociological scholarship on nurses and nursing work.

Experimentation and experimental learning

Learning through experimenting is seen to unfold through iterative and shifting processes of improvisation, collective exploration and reflexive learning (Regeer et al. 2016, Tsoukas and Chia 2002). In this view, innovation and learning are considered as laborious and emergent processes, requiring "space for experimentation, foolishness and randonnée" (Clegg, Kornberger, and Rhodes, 2005 p. 157), rather than relying on fixed structures and predetermined measures to control and evaluate change processes. Experimentation and improvisation, defined as intentional and innovative actions taken in the moment in response to changing and uncertain organizational circumstances, are important sources for organizational learning (Hadjimichael and Tsoukas 2023, Wiedner et al. 2020, Cunha and Clegg 2019). By creating and reconfiguring novel designs and actions through trial and error and reflection, they embed learning in context.

Scholars identify convergent and divergent improvisations as two different approaches to learning. On the one hand, convergent improvisation concerns 'fixing' disruptions in organizational processes to keep systems functioning. Convergent improvisation (sometimes referred to as 'first order learning') primarily focuses on repair work to deal with problems that arise in the course of daily professional work. It can lead to new and improved routines and processes (e.g., Edmondson, 2004). On the other hand, divergent improvisations involve more systematic and deliberate exploration of new ways of working, problem solving and innovation. Divergent improvisation deliberately differs from current organizational processes and routines, often requiring cooperation between actors in various parts of healthcare organizations ('second order learning') (Cunha and Clegg 2019).

As such learning challenge established ways of working, divergent improvisations are typically likely to provoke resistance as a part of the politics of change. Prior research has shown how learning, in practice, tends to be interwoven with local (power) dynamics, interests and (epistemic) legitimacy struggles within organizations (Zuiderent-Jerak and Berg 2010, Nugus et al. 2010). Already existing institutional norms and values often have an impact on how knowledge gets produced and which knowledge counts as valid and valuable (Muniesa and Callon 2007). Different actors involved in learning may uphold different epistemic realms, potentially questioning the legitimacy of experimenting (Chimenti and Geiger 2023) and the credibility of the knowledge derived. Where there are distinct epistemic positions in a situation, decision-making and subsequent actions becomes framed by epistemic politics.

Epistemic politics

Epistemic politics refer to the processes through which knowledge and expertise are constructed, challenged, and legitimized in policies and practice. They do so by defining what forms of knowledge and expertise are privileged in the production of knowledge and decision-making. Different professional groups tend to validate and frame specific forms of knowledge and practice as legitimate (Sheard et al. 2017, Perrotta and Geampana 2020, Carr and Obertino-Norwood 2022). Consequently, certain actors are considered (more) legitimate producers of more legitimate knowledge, while others are marginalised or excluded (Doing 2004, Beaulieu et al. 2012, Sørensen and Traweek 2022, Zuiderent-Jerak 2007).

Examples of research on epistemic politics include Doing's (2006) research on the identity work of 'scientists' and 'operators' in a physics laboratory setting. Scientists use technical knowledge to legitimize their professional roles, allowing them to assert control within the laboratory. Similarly, Sørensen & Traweek (2022) researched academic work in two universities, focusing on how academic knowledge is produced within local institutional contexts. Informed by performativity studies, their research linked metrics, such as publication ranking systems, with the valuation of academic work. Hierarchies of academic expertise were influenced by the interaction effects of these, shaping practical outcomes of scholarly writing and authors' strategies in conforming with journal requirements. While these examples relate to the politics of scientific work, in this study the concept of epistemic politics is used to conceptualize knowledge work within the context of healthcare and organizational learning.

Research into epistemic politics frames issues of the interconnectedness of power relations, the opportunities for voice and organizational control as central to complex processes knowledge work. Organizationally, certain forms of knowledge can become privileged over others, while others are treated as marginal (Fricker 2007). According to Doing (2006 p. 315), "*negotiations and antagonisms/contests over who has what kind of access to different epistemic realms are also justifications for who should be in charge*

of whom and what." Hence, epistemic politics not only involves debates on knowledge (production) but also who has legitimate authority and control over (future) actions and learning.

Significantly, struggles for legitimacy and control are shaped and guided by the institutional context in which they unfold. In healthcare, EBM as both a clinical and policy doctrine tends to dominate the framing of quality and safety of care. This, in turn, validates medical and safety science as the most valuable and legitimate knowledge to guide interventions, while potentially side-lining other perspectives, voices, and forms of learning (Zuiderent-Jerak et al. 2009). In this paper, we are concerned with the question of how such politics works out in the context of nursing efforts to change practices and policies in healthcare.

Epistemic politics in nursing

The core epistemic politics in nursing relate to plural dominant knowledge systems concerning how nursing is practiced and understood. Traditionally, nursing has been viewed as a feminized care-giving occupation or vocation (Baumann et al. 1998, Yam 2004, Ernst 2020). The strong emphasis on the nurturing aspect of nursing work reinforces stereotypes of nursing as a "feminine" profession and as relatively "un-skilled" labour (Hallam 2012, Hoeve et al. 2014). The complexity of nurses' professional skills and knowledge often goes unrecognized, both among nurses and by many other disciplines in the health service, thereby overlooking nurses' situated and knowledgeable organizing work performed to enhance and integrate care delivery (Allen 2014), a long-standing issue that continues to hinder nurses' position within the healthcare hierarchy, lessening their participation in decision-making processes (Croft and Chauhan 2021).

In recent years, there has been a strong push to strengthen and legitimize the knowledge nurses possess in two ways. First, in accordance with dominant medical and safety paradigms, there is an approach that involves promoting evidence-based practice (Salhani and Coulter 2009, Ernst 2020). Informed by the 'gold standard' in the medical profession of randomized clinical trials and evidence-based medicine (Timmermans 2010), EBP is increasingly regarded as a privileged way to establish nursing as a scientific and research-based profession with more authority, autonomy and prestige vis-à-vis other healthcare professionals, quality managers and policy makers (Triantafillou 2015). Consequently, EBP has become an authoritative source of knowledge, guiding not only the daily work of nurses but also decision-making and innovation processes more generally (Ernst and Tatli 2022, Betts 2009).

Second, and slightly in contrast to the former, a critical nursing approach proposes an alternative route to strengthening the epistemic claims of nurses by emphasizing the importance of tacit, situated, and relational knowledges in nursing work and nurse professionalism (e.g., Allen, 2014, Krone-Hjertstrøm et al., 2021, Kuijper et al. 2022).

Nurses are seen to draw on an assemblage of skills and knowledge, including informal knowledge, skills, and experience (Strauss 1988, Traynor 2009, Vernooij et al. 2022). Scholars argue that tacit knowledge enables nurses to make rapid and accurate decisions in complex and unpredictable situations, for instance, by 'feeling' that a patient is deteriorating before the vital signs demonstrate a clinical issue (Dresser et al. 2023). Consequently, tacit knowing links closely to professionals' improvisational work. Critical nursing literature makes visible this often unnoticed and unspoken tacit work, legitimizing the knowledge produced through such work.

While critical scholarship generally recognizes the capacity of EBP for clinical decision-making and medical treatment, it also raises concerns about relying solely on technical solutions to healthcare problems and innovation while obscuring healthcare's social, cultural and political dimensions (Jones et al. 2019). Furthermore, the evidence-based paradigm has been criticized for relegating healthcare professionals' clinical experience and expertise beneath the authority of evidence derived from the literature, coupled with a tendency to overlook the local preferences and values of both patients and practitioners (Greenhalgh 1999). EBP is seen to affect the use of knowledge in local nursing practice empirically, by defining what knowledge (production) is considered valid and legitimate. The privileging of EBP can lead to tactic, relational and organizationally contextual knowledge being slighted. Hence, EBP is seen to reinforce dominant hierarchies in healthcare (Broom and Adams, 2013) through its alignment with dominant normative frameworks for admissible evidence in healthcare (e.g., Berwick 2005).

To conclude, the view that there is a political dimension to knowledge production and evaluation processes in local nursing practice is supported by the literature. Recognizing this allows us to examine and understand how epistemic politics shape and inform change processes, as well as the credibility and authority of nurses in their role as change agents. Before discussing our empirical findings, we will first outline our methods.

Methods

Data collection

In this article, we focus on pilot projects implemented in two general hospitals in the Netherlands. These pilot projects took place amidst growing workforce issues of retention and satisfaction, forcing healthcare managers, policymakers, and politicians to explore new ways to reform and reorganize nursing care. In the Netherlands, as part of broader workforce optimization and retention strategies, hospitals are reorganizing nursing work and developing new nursing roles to foster healthcare resilience (van Kraaij et al. 2022). In this context, hospital directors (supported by the Ministry of Health and nursing associations) encourage frontline nurses to develop and strengthen their practice and position through innovative plans and pilot projects (e.g., van Schothorst-Roekel et al., 2020; van Kraaij et al., 2022).

Ethnographic data was collected from a dialysis department at hospital A and a surgical department at hospital B (pseudonyms are used to protect the anonymity of the participants and participating organizations). We conducted ethnographic case studies to gain detailed empirical understandings of the dynamics at work in the pilots. We studied the pilot projects 'from within,' meaning that we observed both the day-to-day work in the two departments and specific pilot project activities, as well as participating in different knowledge exchange initiatives. Our approach was driven by the recognition that the work done in the pilots was part of broader (knowledge) activities shaped by the social symbolic and institutional contexts of organizations (Lawrence et al. 2011, Lawrence and Phillips 2019) as well as by epistemic legitimacy struggles in the field of nursing (Ernst and Tatli, 2022). Using this approach allowed us to construct a situated and relational account of nurses' change project efforts.

The two pilot projects that we investigated had similar designs. Both were in operation for a period of one year, at the start of which project teams were formed to lead the projects in conjunction with nurse ward managers. The project teams met on a regular basis, discussing their progress and the implementation of interventions, both amongst themselves, with the team leaders and in collaboration with learning networks within the hospital. The hospital management selected the respective wards to be pioneers in exploring and evaluating new ways of working for the broader organization. From a managerial perspective, the selection of the nursing wards was motivated by the aim of resolving pressing local issues (such as high nurse turnover, poor job satisfaction, and limited career opportunities) for which no standard solution existed.

The first and second author engaged in participant observation at the two hospitals. We observed nurses working in various roles, including students, vocational, and bachelor trained nurses, for over 180 hours during different shifts, including day and night shifts. During these observations, both formal interviews (N=21) and informal 'chats' were conducted. The formal interviews covered topics such as the nurses' perspectives on professional development, the objectives and progress of the pilot programs, and the challenges and opportunities presented by the pilots. In addition, we conducted interviews with the nurse managers involved (N=5) to discuss and further explore these topics. Additionally, we attended more than 25 hours of project meetings and presentations to gain insight into specific pilot project activities. After conducting our observations, we wrote individual fieldnotes that were subsequently discussed collectively.

Our participation in the pilot project encompassed closely tracking pilot project progress by working closely with local nursing staff, managers, and administrators. Based on our observations, we organized several sessions, both within and between the two hospitals, to engage key stakeholders in discussions about the pilot's advancement, objectives, and goals. Additionally, insights from our research were shared through presentations, both

within and outside the hospitals, and through professional and academic conferences and publications.

Furthermore, as part of the broader nursing program, we organized and participated in several knowledge sharing initiatives (n=6), including webinars, festivals, and conferences. Notes were taken and reported in observational reports. During these events, we engaged with and informally interviewed different professionals, hospital managers and experts, conversationally. Subsequently, we conducted formal interviews with relevant experts in the field (N=9) to explore further the emerging themes identified in our research. In these interviews, we deepened our understanding of the institutional and epistemic landscape of (Dutch) nursing practice, of nurses dealing with and training for (un)certainty and discussed how local reforms relate to ongoing debates about and efforts to improve nurse professionalization. The data that has been gathered is summarized in table 1 below:

Fieldwork site	Methods and respondents
Hospital (2)	Observations of daily nursing work (180h) Observations of pilot project meetings and activities (25h) Member checks and focus groups (N=6, 10h) Formal interviews nurses (N=21), nurse managers (N=5)
Knowledge sharing activities (N=6)	Observations and participation in knowledge sharing activities (32h)
Formal interviews with expert (N=9)	Professors of Nursing (N=4) Leading figures Dutch associations for nurses (N=5)

Table 1. Methods and respondents.

Data analysis

We used abductive methods for our data analysis, allowing us to make several iterations between data and theory. Abduction is particularly useful for studying complex controversies and problems (Tavory and Timmermans, 2014). Initially, we coded our material inductively and identified key themes such as 'uncertainty,' 'improvisations,' and '(evidence-based) knowledge.' We member-checked our findings through informal conversations, interviews, and focus groups at the wards (Heller, 2019). Through these member-checks and ongoing observations, additional and recurring themes emerged, encompassing uncertainty and insecurity related to authority, jurisdictions, and the legitimacy of experimenting. This led us to compare our findings to insights from the literature on epistemic politics and develop new codes to capture dynamics in the field, including codes such as 'voice', 'control' and 'negotiations of legitimacy.' The coding process is summarized in table 2.

First order codes	Second order codes	Aggregate themes
Ad hoc repair work Articulation work Unplanned action Creativity Openness to deviate from routines and rules	Improvisation in daily care work	Creative experimental work done to foster imaginative, and nurse driven learning
Identifying areas for innovation and improvement Implementing learning infrastructures Gathering input from nursing teams Creating support Training and peer supervision	Bottum-up/nurse driven learning	
Role development Restructuring care routines Collective reflection Refining interventions New job profiles and competences Quality boards Situated issues and improvement work	Experimenting	
Involvement other professionals Compelled to uphold established safety and regulatory standards Accounting for actions	Barriers to divergent/second order improvisation work	Determining and negotiating the boundaries of experimenting
Unfamiliar terrain Deferred decision-making Resistance to uncertain outcomes	Uncertainty	
Nurses want firm evidence Best practices Tools Measurements Seeking legitimacy	Evidence-based decision making	Institutionalized methods, norms and values as barriers for improvement work, knowledge legitimacy battles
Wait-and-see attitude project teams Rendering experimenting discursively illegitimate Skepticism within nursing teams	Problematizing experimenting	
Criticism Hierarchical enforced boundaries Competing interests and demands Turf issues Lack of support within the team Lack of support within the broader organization	(Lack of) legitimacy and authority of nurses	Politics of change, epistemic politics of improvement work
Top-down decision making Emphasis on numbers Compelled to enforce ideas and vision Interference in learning Power relations Disinterest	Voice and control over learning, negotiations of legitimacy	

Table 2. Overview coding process

The initial coding was led by the first author, and subsequent interpretation sessions with all co-authors were held. The coding evolved as we built on these discussions. Collectively, the authors each employed and refined themes and codes for data analysis, followed by additional sessions to discuss and compare perspectives. All quotes and excerpt were translated from Dutch. To maintain anonymity, we used pseudonyms in the paper. Ethical permission was obtained through the internal review board of the Erasmus School of Health Policy and Management.

Results

The research findings are presented in two sections. The first section provides insight into how an experimenting improvisational approach that was intrinsic to nurses' daily work was used to inform learning during the pilot projects' initial phases. The second section describes how evidence-based practice gained increasing prominence in the pilot projects, ultimately clashing with the experimenting approach. It shows how the underlying epistemic politics embedded as elements of the power relations in the hospitals created barriers to change processes and hindered nurses in their role as change agents.

Experimenting and improving nursing practice

> *"In order to continue providing high-quality care in the future with an expected shortage of specialized [dialysis] nurses, it is necessary to investigate the work processes that need to be changed. Nurses must take the lead in this to come up with innovations that improve quality of care for [dialysis] patients and strengthen nurses' position within the organization. The project team [comprised of nurses from the department] plays a leading role in the pilot project. The team creates the conditions for the implementation of the pilot, motivates the nursing team, and is responsible for learning and experimenting on the work floor." (Internal document, Fieldwork, September 2022)*

The excerpt comes from the implementation plan for the pilot project at hospital A. The plan reflects the Minister of Health's statements (outlined at the beginning of the paper) emphasizing how nurses should lead change in their departments. The plan positioned an experimenting approach as central to changing nursing work processes during the initial pilot projects' stages. In the pilots, nurses in the project teams were responsible for selecting and improving local work processes:

> *Together with Jana, the team leader, I carefully arrange the chairs in a large circle. The first meeting of the pilot project team is about to begin. As the nurses come in, I count fifteen in attendance. Jana takes the floor, "Today, our goal is to identify themes for the pilot and to form corresponding working groups." In the discussion*

> *that follows, nurses share their ideas and concerns. As the discussion continues, three themes emerge – enhancing expertise (clinical reasoning), professional role differentiation, and increasing patient participation in their dialysis care. The nurses form three working groups to explore the themes and refine them to address specific challenges faced by the nursing unit (Fieldnotes, hospital A, September 2021)*

The fieldnote conveys how the experimenting approach taken in the pilots granted nurses considerable autonomy in designing and implementing interventions. The project team collectively decided on specific work themes and developed a strategy for potential interventions. Nurse-driven bottom-up learning was encouraged, in which nurses drew on situated local organizational knowledge to tackle specific nursing unit challenges and issues:

> *Our team can't seem to agree on what makes a 'healthy' work schedule. Some of my colleagues like to work during the day, while others prefer night shifts. And then there are those who prefer to work four consecutive shifts, while others don't. It's been causing a lot of tension, so our [pilot] working group is working on a new schedule that offers more flexibility, allowing people to sign up for certain shifts they prefer. We started by identifying specific complaints and issues with the old schedule and we're now trying out the new one to see if it works better. We'll be making changes along the way to make sure everyone is satisfied (Interview, nurse, hospital A, August 2021)*

The nurse described how the project team worked on improving shift working conditions through the experimenting approach. The project team collated issues encountered by the nursing team, searching for actions to resolve the issues identified. More flexible approaches to work, gradually refined through ongoing improvements, were introduced. These interventions, given the challenges that the nursing unit encountered in retaining and recruiting new staff, were especially important. Flexible work schedules are a critical factor in nurse retention (Buchan et al., 2022).

Improvisation and nursing work

An approach of collectively searching for solutions parallels the practice-based mode of improvement and learning intrinsic to nurses' daily care practices. In the various nursing departments, we often observed an experimenting style of working and learning. Nurses used a proactive and resourceful attitude in fixing and enhancing care practices in the course of their daily work. Such knowledgeable and ad hoc improvisational work, or 'translational mobilization' (Allen, 2014), which points out the coordination and organization of constellations of sociotechnical networks in which patient trajectories unfold, created 'convergent improvisations' (Cunha and Clegg 2019), and are the heart of nursing work and professionalism. This, we also observed in our fieldwork:

> *As the day shift draws to a close, Marie assists a patient about to go home. The patient is given his second chemotherapy of the day, which he can take home to administer through his "Portocath" [a medical device implemented beneath the skin to draw blood and administer treatments like intravenous fluids or chemo]. The chemotherapy is in a balloon that needs to be carried in a flashy shoulder bag provided by the pharmaceutical company. However, the bag is too small for the balloon to fit. This is a problem because the patient is eager to leave, and Marie needs to attend to other patients before her shift ends. Marie cuts off the end of the bag, places the balloon inside, and wraps it all up with duct tape. (Fieldnotes, hospital B, January 2022).*

The example illustrates the importance of nurses' immediate situated responses to problems arising in daily care. An experimenting approach, as a way of improvising creative and feasible solutions to deal with immediate problems, is a critical aspect of mundane nursing practice. As this example reveals, improvisation takes considerable rapid thinking and creativity, resting on tacit and situated knowledge. It comprises a combination of specialized organizational and clinical knowledge and skills that nurses use to resolve problems and improve care practices amidst unpredictable settings (Allen 2014, Kuijper et al. 2022). Leveraging this knowledge, Marie, the nurse, balanced both the organizational conditions (workflows, demand patterns, recourse availability), the technical issue (the balloon not fitting into the bag), professional values (timely care, patient-centred care, patient safety) and the patient's needs (who wanted to go home) and ad hoc resolved an emergent disruption in the care process with implications for healthcare quality and maintenance.

We observed nurses continuously drawing on this knowledge, navigating challenges encountered in daily care provision. Observing daily care work reveals the intricate work performed by nurses coordinating and aligning complex systems of work. The process of 'articulation work' (Strauss 1988) involves ensuring that "people, resources, and knowledge are effectively configured and ordered across time and space" (Vernooij et al. 2022 p. 299), as illustrated in the following example:

> *As the multidisciplinary meeting ended, Laura, a nurse, immediately turns to a medical resident named Naomi and asked, "Are you rounding on unit 3 today?" Naomi gives a nod of affirmation. Laura continues, "Mrs. van de Bee lost a significant amount of blood when she came home on Tuesday. She thought it was just her vest getting wet, but it turned out her stent was leaking. Just a heads up, her vital signs might be a bit skewed. We noticed it this morning, but she seems fine." (Fieldnotes, hospital A, October 2021)*

In fragmented care systems, nursing work needs to be alert to the treatment process (Allen, 2014). Various forms of knowledge combine, such as familiarity with organizational

routines, procedures, and clinical expertise, as well as understanding the patient's socio-psychological circumstances. The data highlights nurses' emergent coordination work ensuring a 'smooth' continuation of care across different staff members (Allen, 2014, Kuijper et al. 2022). Importantly, such improvisational work emerges not to disrupt the healthcare system but rather to repair and sustain its operation, typically performed in a manner that goes unnoticed (Vernooij et al. 2022).

Making visible the experimenting approach

In a similar vein, the experimenting approach initially enabled nurses to explore innovative ways of working in the pilots. Working collaboratively on current routines, nurses were able to identify areas for improvement and implement new approaches, in successful interventions. These interventions were, however, closely tied to the nurses' working situation (Klemsdal and Clegg 2022); as such, they were developed outside the wider organizations' oversight. The situatedness of the improvements, grounded in practices, had consequences for the visibility and legitimacy of nurses' experimenting work. How nurses sought to restructure their daily routines and introduce new roles and responsibilities in hospital B to enhance their practice, provides an example:

> *Do you know what's interesting? The role of day coordinator is so new, we only recently implemented it, but it has become essential in no time. The other day, we were without one due to low staff numbers, and it was like missing a piece of the puzzle. Esther explains how they used the pilot to implement the role: "The day coordinator is responsible for coordinating things like bed management, break scheduling, and chairing the daily start meeting, as well as supporting and directing colleagues. We had to figure out what this role was all about. And let me tell you, it is not as simple as it sounds. As a day coordinator, you're not directly working with patients and there was a danger, for example, that you would end up doing various unpleasant tasks when things were slow. But we found ways to overcome that." (Interview, nurse, Hospital B, January 2022)*

Nurses on this ward decided to implement a new daily structure, including the creation of a 'day coordinator' role, restructuring the daily start and handover procedures, using quality boards as a tool for improvements. As this example illustrates, these interventions required incrementally adjusting and defining interventions and role development, drawing on local and situated knowledge (e.g., of daily rhythms of the ward, current routines, and teamwork), reflexively monitoring the introduction of the day coordinator through sharing experiences in the team.

The interventions' success, including the introduction of new and flexible work schedules, is partially attributable to the fact that they did not require legitimacy and support from actors outside the nursing team. Despite being part of explicit learning through the pilot projects, the interventions maintained rather than disrupted more

widely vested organizational routines and hierarchies, minimizing the politics associated with reorganizing work. One consequence was that the legitimacy of the knowledge developed in the pilots remained rather limited, mainly concerning the nursing team. As such, it was epistemically invisible in the organization, despite the considerable efforts made by the involved nurses to establish local legitimacy and ensure that new practices were viewed favourably by their fellow nursing colleagues. The importance of this was made clear:

> *Nurses are quick to judge. No matter what we send out, they just reject it without even reading it. Trying to make changes is a constant battle. It's all about choosing the right words and finding the right timing. We can easily get shut down if we're not careful. (Interview, nurse, Hospital B, January 2022)*

Nurses knew how to create situational legitimacy by 'choosing the right words and finding the right timing.' It worked the more self-contained within nursing routines were the changes. However, as the scope of legitimacy expanded, to include other healthcare professionals within the hospital, as nurses began to challenge and incorporate broader organizational processes and vested interests, creating and maintaining legitimacy became increasingly challenging, as we will elaborate in the following section.

Challenging experimenting and evidence-based nursing

As the pilots progressed and broadened in their implications, nurses found it increasingly difficult to push for change through the experimenting approach. In this section, we examine how nurses' creative and innovative work became challenged both among nurses themselves (as indicated in the quote above) and among engaged stakeholders, when interventions initiated by nurses were 'divergent improvisations' (Cunha and Clegg 2019) presenting structural changes that were more disruptive and challenging of broader organizational processes. Consequently, nurses increasingly limited the experimenting approach to local, convergent, and 'invisible' changes.

Attending several project meetings across both hospitals over time revealed changes in interventions nurses aimed to implement. There was a shift in the forms of knowledge used and validated in the pilots. We observed an increasing tendency toward an evidence-based approach, as illustrated in the following vignette derived from observing a project meeting in hospital A:

> *I showed up at the meeting room where the project team and the nurse manager gathered to evaluate and discuss the implementation of nursing assistants on the ward. The meeting began with Juliet, one of the nurses and leaders of the project addressing the nurse manager: "Basically, we feel like we are running into a brick wall. The issues at hand are so complex." A heated discussion ensues, in which the team discusses the importance of measuring future actions and incorporating*

> *best practices, "preferably we should conduct some complexity measurements" one of the nurses argues, "however, to be honest we have no idea how to do that." The two nurses then turned to me and asked me whether there are any tools or best practices available. Unaware of such tools, I replied by mirroring that the pilot also allows for experimenting and trying things out. After a moment of silence, Helen, another nurse, concludes my contribution by stating: "Yes, but hey, we do not experiment with our patients!" (Fieldnotes, Hospital A, October 2021).*

The proposed introduction of nursing assistants to the nursing ward, these nurses felt, required something different to changing established and formal operating procedures (e.g., safety regulations and standards, changes in medication administration). Furthermore, the nurses perceived that the involvement of other healthcare professionals, such as physicians, managers, and HR officers, was required for such changes, which they perceived as potentially disruptive to established routines, standards, and regulations. Considering the many unknowns, nurses felt that reorganizing nursing roles would make it difficult to predict and hence to take responsibility for the outcomes of proposed interventions. The situational experimenting approach, they felt, did not suffice in cases of a broader and 'divergent' organizational transition.

Furthermore, the example conveys ongoing epistemic politics at work and makes explicit the norms framing the pilot projects. Our attempt as participatory ethnographers to highlight the opportunities for experimenting within the pilot was met with a fierce "we don't experiment with our patients!" The nurse's outcry underlines the risks of experimenting that involves breaking with current routines and task distributions and engaging various other actors. Venturing into uncertain outcomes with potential consequences for patient safety and quality of care led nurses to shift epistemic realms and enact EBP narratives. These were familiar and legitimate means with which to navigate uncertainties accompanying change processes and to account to stakeholders outside their nursing teams (Carr and Obertino-Norwood 2022).

Nurses repeatedly expressed experiencing a particular sense of fragility in their authority when acting beyond the boundaries of their immediate work environment:

> *There are certain things we can do within our own team that don't need a lot of changes, but other interventions involve many different parties, and it can be unpleasant and demotivating to coordinate with them all. Despite our efforts, we receive constant criticism. That is especially frustrating because we don't get much feedback or help from our own team. (Interview, nurse, hospital A, February 2021)*

The epistemic shift to EBP was observed by actors in the field as progress in the pilots slowed down. For instance, at one of the project meetings, the team leader at hospital B provided feedback to the project team, highlighting this change:

> *It seems like you [the project team] are all persistently searching for frameworks and scientific proof. In our department, we typically think in terms of standards and rely heavily on protocols: how much of something is needed, how to handle a particular problem? However, there may be times when you can make a decision by simply saying, 'we'll do it this way'. (Fieldnotes, quoted nurse team leader, hospital B, February 2022)*

The emphasis on EBP, as a way for nurses to establish greater legitimacy and authority vis-à-vis other healthcare actors (Betts 2009, Salhani and Coulter 2009, Ernst 2020), is echoed in our broader study. Experts, policy makers, and healthcare managers alike consistently promoted the importance of EBP to elevate the role of nurses within the field of healthcare, highlighting how local epistemic disputes and politics are shaped and guided by broader institutional contexts in the field of healthcare. This is illustrated in an interview with a leading nurse figure in the Netherlands:

> *I have been trying for years for nurses to have more voice and a seat at the table in shaping agendas and decision-making. But that also means that the nurses who are selected to speak on our behalf must be able to speak up and have a solid understanding of the evidence. They must understand what a 'pico' [a framework for formulating clinical and evidence-based research questions] and 'outcome' are and when they matter most. This requires knowledge and therefore more nurses who can do more than just insert an IV, administer medication and bathe patients. (Interview, expert, March 2022)*

Such a view of nurse professionalization reflects an ideological reorientation in the nursing field, encouraging nurses to use evidence-based practice to inform decision-making processes and actions (Traynor 2009). The expert's argument shows a clear understanding of what it means to be taking on nurse leadership roles. These roles, enacted amongst other clinicians, mean that, ideologically, in terms of legitimate discourses in use, scientific and methodological knowledge was the key to fostering nursing roles. In the expert's view it is essential for nurses to have a solid foundation in scientific training and knowledge with which to assert themselves as credible experts in decision-making. They should articulate their expertise in line with medical knowledge systems, thereby strengthening their professional expertise, credibility, and legitimacy.

Knowledge legitimacy struggles in pilot practice

As the pilots unfolded, clashes increasingly surfaced between the nurses local experimenting approach and the dominant use of evidence-based knowledge within the

field of healthcare (Broom and Adams 2012). These clashes posed challenges to nurses' credibility within the wider socio-political context of the pilots, as well as the value of the experimenting approach in enforcing change. To illustrate the politics involved, the following excerpt of a meeting between hospitals A's project team and board of directors serves as an example:

> *Today, Anna and Susan, two nurses from the project team, provide an update on the pilot project's progress to two members of the board. The nurses use some sheets to discuss the interventions they have implemented, and progress achieved in the pilots up to this point, such as reorganizing quality workgroups and role development efforts. When they finish, Floor, one of the members of the board, says "nice presentation!" She continues, "But it is not entirely clear. What are your expectations, what are your goals, where do you want to be in a year?" After some hesitation, Susan replies and talks about the objectives to increase patient and staff satisfaction. There is a moment of silence, and Susan quickly adds, "But maybe that's difficult to measure and research." Floor responds, "Yes, those goals are not really clear or 'SMART.' I mean, patient satisfaction can be quantified, for example by stating that it is currently at 7.0 and our objective is to reach at least 7.4. My concern is that it we're all now focused just on trying things out, but upon reflection we may realize that it has not achieved any meaningful results." (Fieldnotes, hospital A, January 2021)*

The nurses presented their work in the change project to the hospital board during a meeting that took place against the backdrop of post-pandemic discussions, highlighting the importance of nurse involvement in healthcare decision-making and critical nurse leadership (Kuijper et al. 2022) in the context of a strong nursing profession. In contrast, however, the excerpt illustrates that the work accomplished, and the knowledge and experimenting methods used in the pilot were not valued by the members of the board of directors. Their focus was on measuring interventions to prove their effects, as represented by Floor. Although the potential benefits of measurements should not be disregarded, the board's emphasis on numbers and evidence-based evaluation overshadowed the contributions of the nurses and the experimenting approach used – and silenced the nurses.

Furthermore, the language used in response to the proposals (e.g., 'nice presentation', 'just trying things out', lack of 'meaningful results') demonstrated the prevalent normative values, revealing a glimpse of the discursive practices whose legitimacy articulated top-down control and authority over the pilot project and the knowledge production processes (Doing, 2006). For the board, evidence-based knowledge was the valid foundation informing actions relating to change. From this perspective, experimenting could be dismissed and characterized as 'not really clear.' The nurses could be seen as derelict in not incorporating evidence-based evaluation for proper, 'SMART' decision-making.

The episode shows the fragile authority of the nurses involved in the pilots once findings were articulated in the wider hospital system. This mirrors a broader observation within our study that once experimenting applied not just to local and daily nursing practice but to wider organizational contexts, nurses often lacked the voice, interpretative resources, and credibility to legitimize their divergently improvised knowledge. Instead, there was a strong tendency for interventions to be measured for actions and proposed changes to be validated and legitimized. These tendencies reinforced the lack of support nurses received for an experimenting approach within their own teams. In addition, due to pressures exerted by actors in the broader organization to conform to the norm of using evidence-based knowledge to inform change, their proposals were not persuasive. As a result, pilot projects stagnated because there was limited legitimated evidence available to reorganize nursing practice. Consequently, nurses gradually lost confidence in their ability to bring about meaningful change.

Discussion

The Minister charged nurses with a significant responsibility to ensure the reform of nursing practice in the Netherlands. For nurses to assume this leadership position, our ethnography has shown, it became necessary for them to consider and navigate epistemic politics if they were to lead the reorganization of nursing care in response to growing workforce issues.

Our research question was how epistemic politics have an impact on reforming nursing work. The analysis shows that while the experimenting approach was key during the initial phases of the pilots, it increasingly lacked the necessary legitimacy to drive change in the context of broader organizational transitions, both among engaged stakeholders and the nursing community. The analysis that nurses made, one that was realist in context, led them to shift to different epistemic repertoires in situations of uncertainty and in attempts to maintain and safeguard legitimacy among their peers and in those areas of healthcare organizations where, traditionally, they had less voice.

Our findings draw attention to underlying institutional power relations. They reveal how claims made by actors, including CEOs, within nurses' socio-political environment were skewed in terms of the agenda set by the Minister. Nurses' ability to generate knowledge through experimenting was limited because of institutionalized norms. These norms linked power, knowledge and learning in ways that favoured dominant actors' authority over the nurses. It did so by undermining the legitimacy of the knowledge claims that they made through the a priori legitimization of only certain types of knowledge, types that formed the intellectual capital valued institutionally. In hospitals, clinical trial-based knowledge is the 'north star' for legitimacy. Evidence-based practice and its apparatus of protocols appears to be a handy discursive device for disregarding other forms of knowledge and methods of learning. Consequently, dominant hierarchies of

knowledges were reinforced, while experimenting as a valid means to effect change was easily dismissed. Knowledge claims generated through alterative epistemologies were slighted, leading to the reproduction of the 'invisibilities of nursing work' (Allen, 2014).

The ongoing epistemic politics in nursing reform efforts, as identified in this study, tend to perpetuate forms of epistemic injustice (Fricker, 2007) by favouring certain knowledge and knowledge production methods in healthcare organizations over others. Fricker (2007) identified two types of epistemic injustice: testimonial and hermeneutical injustice. Testimonial injustice occurs when the credibility of a speaker is undermined due to identity prejudice on the part of the hearer. In the context of this study, testimonial injustice can explain how nurses' contributions to knowledge production processes may be underrated because of preconceptions about their identity. Other healthcare actors, such as CEOs or physicians tend to perform condescendingly in their treatment of nurses' knowledge, not because of the merits of what nurses say or do but rather due to the preference for forms of knowledge substantively different from that produced by the nurses' pilot projects.

Hermeneutical injustice, in turn, refers to a type of injustice that occurs when actors are unable to articulate and make sense of their own expertise, experience and identity due to a lack of interpretative resources. Our study presents compelling issues in this regard. Our findings highlight how nurses often lack the interpretative resources to articulate and make sense of the knowledge and expertise that underpins their experimenting in terms that dominant authorities would recognise as legitimate. This, in turn, creates barriers for nurses to validate and legitimize experimenting in organizational settings where certain, and often more powerful, actors can determine what knowledge is considered legitimate and which knowledge can be ignored. As specialized tacit and situated knowledge as knowing remains poorly understood in practice and policy, we suggest the need for alternative conceptual resources for talking, thinking about, and engaging in experimenting. Without the institutionalization of such resources, nurses are likely to continue facing challenges in accounting for and legitimizing their work and expertise in their organizations.

The irony is that the lack of institutionalization is made hermetic by the stress on a quantitative evidence-based approach. Nursing, as a profession, is aware of this; in recent years, EBP has emerged as a specific approach to build a scientifically informed language and nursing knowledge base to foster nurse's position in the field of healthcare. Critical nursing studies, however, highlight how such technical knowledge repertoires perform a lack of inclusivity with the potential to overshadow other forms of knowledge that inform nursing work and expertise (Baumann et al. 1998, Ernst and Tatli 2022, Betts 2009, Allen 2014, Triantafillou 2015), with repercussions for nurse professionalization processes and epistemic politics in the field.

Earlier research has suggested that deep entanglements between EBP and nurse leadership and professionalization may create a precarious situation (Timmermans et al. 1998). While EBP can strengthen nurses' clinical, technical, and scientific knowledge, it may only give them more professional jurisdiction in established areas of their work. Timmermans et al. (1998) show that for nurses to account for the full complexity of their professional skills and knowledge and to take jurisdiction over them is limited by evidence-based approaches as these cannot capture the deep creativity and imagination involved in socially integrated nursing work as a complex assemblage of skills.

Furthermore, our findings empirically highlight how everyday practices of healthcare improvement, as observed locally, are shaped by broader epistemic frameworks institutionalized in the field of healthcare. In healthcare, traditional, and mainstream approaches to improvement, grounded in a positivist approach to research and innovation, are hegemonic. Quantitative evaluations and evidence-based decision-making have conviction in a way that interpretative understanding does not (Allen et al. 2016). Consequently, alternative strategies and methods concerning learning and innovation, such as improvisational experimenting, face difficulties in gaining acceptance (Bate and Robert 2002).

Returning to the minister's call for nurses to act and take responsibility, our study underscores a discrepancy between such a call made by those overseeing change programs and the actual participation and leadership of change at the local level. In the implementation of reform efforts, the politics of improvement and healthcare change are often overlooked. Reform is not easy; not only must it counter the opposition of those that dominate organizations and systems; the knowledge that seeks to enter decision-making arenas must be accepted as legitimate, which means acknowledging the epistemics of that knowledge.

Our findings highlight that, in local practice, alongside navigating power differences and professional hierarchies, the work of change agents becomes entwined with and influenced by conflicts stemming from competing institutional ideologies and epistemic paradigms within the context of quality improvement and healthcare innovation (Bate and Robert 2002, Waring et al. 2016). Importantly, while our findings underscore EBP's role as a frontstage political strategy for facilitating or impeding actions and learning, further empirical research is needed to explore the dynamic interplay and translation between different knowledge systems (Bal 2017).

The implications for policy and management are evident. Nursing workforce shortages are widely recognized as a significant challenge in healthcare systems globally, with the Covid-19 pandemic further highlighting this crisis. Epistemic politics and injustice are firmly intertwined with the inability of healthcare systems to sustain healthy and resilient workforces. A major task and challenge for organizations is to legitimize

different knowledges that inform nursing work and activate critical nurse leadership, to expand nurses' opportunities to contribute to healthcare decision-making and establish themselves as critical and authoritative change agents.

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4

CHAPTER 5

Modalities of power: an ethnographic account of a nurse empowerment movement and its (non)performativity

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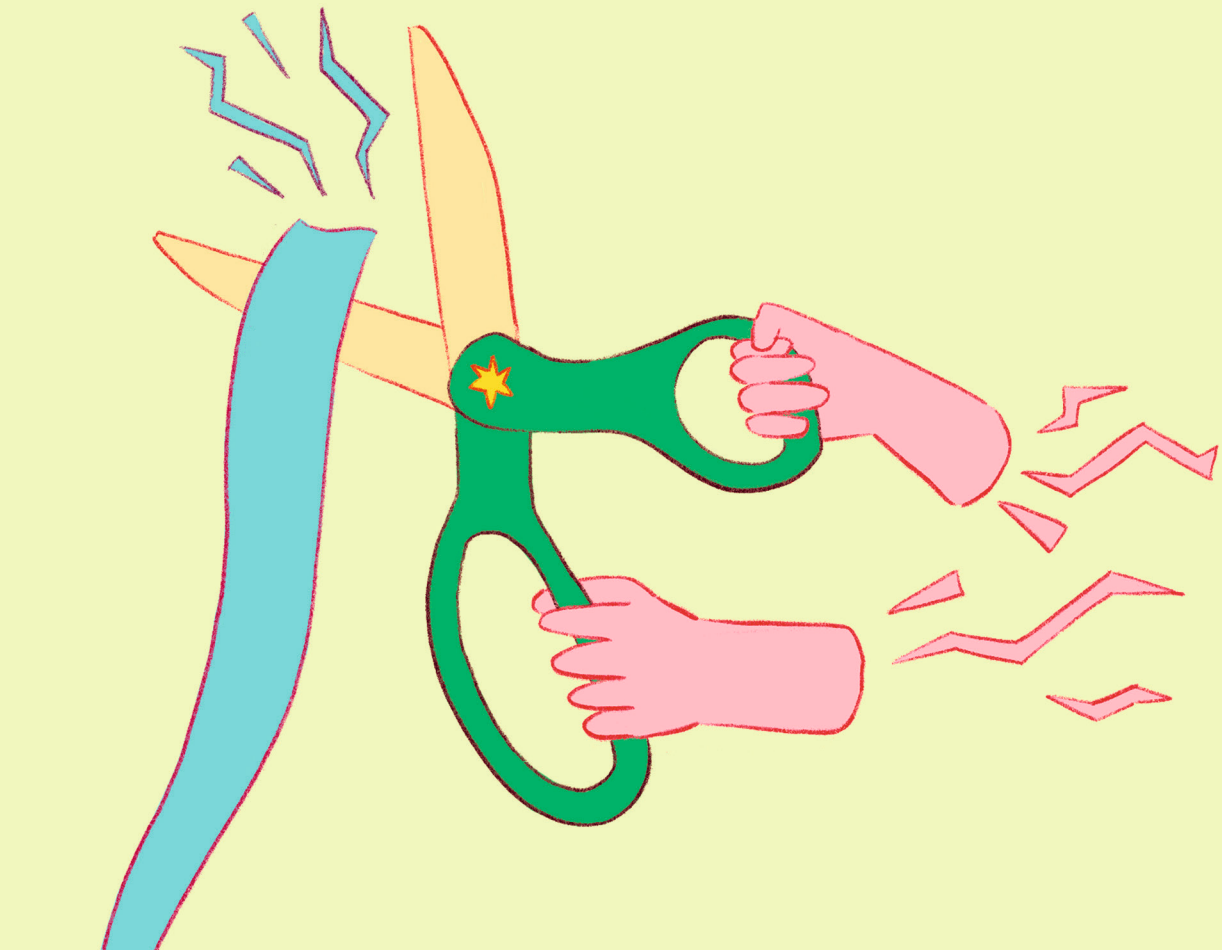

Abstract

Globally, the care sector faces precarious working conditions and workforce shortages, prompting numerous empowerment programs to counter power imbalances and foster resilient workforces. Using the nursing sector as an entry point to explore the power-related tensions and the politics of empowerment through the lens of power literature and sociological research on empowerment, this study draws on ethnographic research investigating a nurse empowerment movement in the Netherlands. We build on a framework that distinguishes three types of power relations: 'power-over', 'power-to', and 'power-with', and contribute to this debate by incorporating Lukes' (1974, 2005) three-dimensional view of power. We demonstrate that nurse empowerment initiatives exhibit different manifestations of power relations, co-existing locally in tension and simultaneously reproducing and reshaping professional relations through three-dimensional power. Our findings highlight that power transitions require changes across different dimensions of power and are closely tied to delegitimization actions in empowerment efforts aimed at countering hegemonic discourse and meaning within institutional frameworks, thereby disrupting existing ways of organizing professional relations and working towards emancipatory futures.

***Key words**: Precarious work, empowerment, nursing, power over, to and with, three-dimensional power, circuits of power, healthcare change*

Introduction

Precarious work within healthcare has unfolded as a prominent theme in both policy discussions and among scholars in the field of critical social science (Kalleberg 2009, Rubery et al. 2018, Quinlan et al. 2001). Precarious work is a multi-dimensional concept, referring to uncertainty and social vulnerability experienced at the workplace. It is characterized by workers having limited control over their working conditions, lack of social protection, and restricted voice and representation within organization levels (Campbell and Price 2016, Kalleberg and Hewison 2013, Vallas and Christin 2018). Care workers' precariousness has drawn particular attention (Fagertun 2021, Duijs et al. 2023, Khan et al. 2023, Baines et al. 2019). Their precariousness is increasingly understood as insecurity extending beyond older debates about systemic and gendered injustices, low wages, and the informal and invisible nature of work (Calás and Smircich 2006, Hatton 2017) to include how the flexibilization of services, the rapidly expanding gig economy, assetization of care and new forms of hierarchical organization of work contribute to precarious working conditions (Atzeni et al. 2023, De Vaujany et al. 2021).

Research on precarious work has co-evolved alongside governmental policies at local, national, and international levels. Recently, international bodies have united in advocating decisive action against precarious work in healthcare (WHO 2021, OECD 2023, European Commission 2023, WHO 2024), resulting in a plethora of resolutions and policy recommendations to empower marginalized (care) workers and build more just working conditions. Governments and national organizations have responded by initiating or supporting empowerment initiatives aiming to redistribute decision-making power by incorporating new participants and issues into agendas to foster workers' autonomy and control in achieving both individual and collective goals (Rothman et al. 2019, Bartunek and Spreitzer 2006).

Prior research, however, shows that empowerment initiatives often have limited success in achieving desired objectives (Harley 1999, Weidenstedt 2016, Hardy and Leiba-O'Sullivan 1998, Dykstra-DeVette and Canary 2019). These initiatives are projected on to fields typically harboring entrenched hierarchical power relations and conflicting interests, resulting in paradoxical practices producing unintended outcomes (Berti and Simpson 2021, Ivanova and von Scheve 2020, Sauer and Nicklich 2021). For instance, Saur and Nicklich (2021) found that attempts to empower workers through self-managed teams paradoxically led to a heightened sense of strain and disempowerment. Their study exposed ongoing managerial oversight, growing peer pressure, and increased demands for work accountability, much as Barker (2002) did in his earlier research on organizational empowerment processes.

In this study, we draw on insights from literature on power (Clegg 2023a, Avelino 2021, Pansardi and Bindi 2021) and sociological work on empowerment (Booth 2019, Hardy

and Leiba-O'Sullivan 1998, Roth and Bruni 2022) to investigate the power-related tensions and changes involved in processes of empowerment, with a particular focus on their implications for addressing precarious work in healthcare. To achieve this, we draw on a framework that distinguishes three types of power relations: 'power-over', 'power-to', and 'power-with' (Clegg 2023a, Pansardi and Bindi 2021) and combine it with Lukes' three-dimensional view of power (1974, 2005).

Organizational empowerment is commonly conceptualized as a change from traditional power-over relations, (characterized by asymmetrical relations, coercion, and domination) towards power-to relations (characterized by the capacity to act and achieve goals) that facilitate individual agency and autonomous decision-making (Haugaard 2012, Van Baarle et al. 2021, van den Berg et al. 2022). However, in parallel, some scholars previously argued that while implementing power-to relations, there is a risk of paradoxically reinforcing power-over relations and regimes, albeit in subtler forms through the exercise of 'soft-power' (Cunha et al. 2020, Courpasson 2000). This scholarly work, in turn, links power-with dynamics to positive-sum outcomes and the empowering effects of empowerment initiatives, involving genuine and collective exercises of power-to behavior to achieve shared goals (Pansardi 2011, Rye 2015, Avelino 2021, Pansardi and Bindi 2021). These ongoing discussions point out that empowerment initiatives are politically contested sites, in which power manifests in dynamic and multidimensional ways.

However, when it comes to using the power over, to and with framework to analyze the day-to-day politics of empowerment, two challenges emerge. First, while the conceptual focus on the (changing) nature of power relations is crucial for understanding empowerment processes, the framework is less suited to analyzing the multidimensional exercise of power within these relations, as well as how power shifts are contested and negotiated in everyday organizational practice. Second, there is a notable lack of empirical research on the politics of implementing power-to relations. We aim to contribute to this theoretical gap by innovating Lukes' (1974, 2005) three-dimensional view of power. Lukes' power schema conceptualizes how power can achieve its effects through three dimensions, from explicit forms of control to more subtle political behavior and the management of institutional discourse. Incorporating Lukes' three-dimensional power schema (1974, 2005) enables us to empirically explore not only the multidimensional manifestations of coercive and dominant power relations and the political dynamics that (re)produce organizational subordination but also the pathways through which shifts toward 'power-with' regimes can occur — an analysis rarely explored in the existing literature. The few studies that do examine the emancipatory potential of organizational empowerment initiatives through Lukes' (1974, 2005) framework remain largely conceptual in nature (Gilbert 1995, Hardy and Leiba-O'Sullivan 1998, Dowding 2006, Avelino 2021). This study advances the literature by moving beyond conceptual analysis to empirically examine tangible practices that enable multidimensional changes in organizational power.

We use these integrated lenses to report on empirical research that focuses specifically on recent efforts to shift power balances in nursing work. Nurses are of particular interest due to their historically subordinate position within healthcare hierarchies and the pressures they face that cause many nurses to leave the profession. Nurse workforce challenges are recognized globally as threats to professional well-being, healthcare resilience and public health (Buchan et al. 2022, Gilbert 2023, Bahlman-van Ooijen et al. 2023, WHO 2021, WHO 2024). In response, the United Nations (UN) prioritizes investing in the workforce and empowering nurses as part of its Sustainable Development Agenda, encompassing the 17 Sustainable Development Goals (SDGs). We use the nursing context to study initiatives addressing precarious work in healthcare through power and empowerment scholarship and ask the question: *how are (Dutch) nurse empowerment initiatives changing professional power relations?*

To address this, we draw on ongoing participatory ethnographic research, focusing on a nursing empowerment movement in the Netherlands. Recent policies of the Dutch Ministry of Health encourage healthcare organizations to improve working conditions, recast the nursing role and promote active nurse participation in agenda-setting. Consequently, many Dutch hospitals have initiated change programs centered on empowering nurses (Kuijper et al. 2024, Van Kraaij et al. 2022). Within the scope of ongoing reform efforts, a nationwide action-oriented research program RN2Blend has been introduced, in which our research group participates. This study draws on data from our multi-sited ethnographic research in Dutch hospitals facilitating and investigating the empowerment movement in nursing practice.

Our findings reveal that nurse empowerment initiatives exhibit different manifestations of power over, to, and with relations, leading to complex (dis)empowering effects and outcomes that stem from the exercise of power through three dimensions, that is through management and control over resources, decision-making processes, and meaning and discourse. Our analysis highlights that transitions in power require changes across these dimensions, with the effects of implementing power-to practices on (dis)empowerment closely tied to how organizational meaning is managed, either reinforcing elite interests or disrupting existing power relations. Below, we begin with outlining literature on empowerment and power, followed by discussions on research design, methods, and analysis of findings with implications.

The power behind empowerment

Power is a fundamental concept in organization studies and an inescapable feature of organizational life, as well as being one of the most debated concepts in the field (Haugaard 2010, Haugaard and Clegg 2009, Clegg 2023a). Although lacking a singular, definitive definition, one common thread in the literature is to conceptualize power as a relational phenomenon, emerging, evolving, and diminishing over time within the context of relationships with others (Avelino 2021, Haugaard 2010, Haugaard and Clegg 2009). In this relational approach, two essentially contrasting views of power can be identified: one characterized by control and dominance, commonly termed as 'power-over', highlighting power's negative manifestations; the other, 'power-to', conceptualizes power as emancipation, as facilitative, and emphasizing the positives of power (Haugaard 2012, Pansardi 2012, Avelino 2021). These concepts were coined by Hanna Pitkin (1972), who introduced these terms while challenging the traditional and consensual understanding of power as a social relation involving coercion and violence ('power-over'). Pitkin (1972) proposed the concept 'power-to' as an alternative interpretation of power in terms of the capacity to act and getting things done, thus positioning power as a fundamental prerequisite for agency (Göhler 2009, Avelino et al. 2023).

More recently, this dichotomic framework has evolved to encompass a third perspective on power, termed 'power-with' (Pansardi 2011, Cunha et al. 2020). This concept refers to coactive forms of power-to where groups of actors collaborate to achieve shared goals and objectives (Hosking 2011, Pansardi and Bindi 2021, Cunha et al. 2020). These evolving conceptualizations of power can be integrated with the three-dimensional view of power developed by Lukes (1974, 2005). Lukes distinguishes between three modes of power to identify the different ways in which power operates in daily organizational practice, including direct power behavior and more subtle forms such as agenda setting and the management of meaning. Combining these perspectives allows us to include in the analysis not only who has power and the nature of these power relations but also to articulate and specify *how* power operates.

A one-dimensional view of power emphasizes direct and overt power behavior, typically seen in decision-making arenas during clear conflicts of interests. It involves actors mobilizing resources to impose demands on others to influence outcomes and decision-making (Lukes, 1974, 2004; Clegg, 2023a). The two-dimensional view of power expands the analysis by considering how power may operate through more subtle means, including the extent to which actors have control over the agenda, determining acceptable issues for discussion in decision-making arenas, and who is involved or excluded. When certain issues or perspectives are sidelined, non-decision making applies (Bachrach & Baratz, 1970), suppressing overt conflict. This structuring of decisional and political processes can become performative, preventing marginalized actors from raising their concerns. Avoidant political behavior may stem from fear of reprisal or a perception that raising

certain issues is futile, with little chance of their voices being considered (Haugaard, 2008). Consequently, these dynamics can reinforce the status quo while avoiding explicit conflict (Clegg, 2023a). The third-dimensional view delves even deeper into power's subtleties by considering how issues or conflict may remain unrecognized in the first place because involved actors have been socialized not to perceive them as such or to perceive no alternative (Lukes, 1974, 2005). Through the production of everyday perceptions and cognitions, embedded power structures may lead actors to internalize hegemonic discourses to the extent that they accept their roles within the existing order and become politically inactive (Clegg, 2023a).

In the following, we first further discuss the perspectives of power over, to and with, alongside Lukes' three-dimensional model of power, situating these discussions within the field of healthcare.

Power over and the healthcare hierarchy

The power-over perspective represents a traditional and predominant view of power, essentially conceptualizing power as asymmetrical social relations of domination and control in which A exercises power 'over' B (Dahl 1957, Clegg 2023a). Power-over viewpoints focus on hard authoritative power and posit that power is deeply embedded in organizational structures and their bureaucratic systems. It finds legitimacy in formal organizational hierarchies and policies, exercised through instructions, routines, and obligations (Göhler 2009, Pansardi 2012). This can result in power imbalances that allow certain individuals, groups, sections, or departments to exert control and dominance over those positioned lower in the organizational hierarchy (Hosking 2011). Power-over behavior is, therefore, often viewed negatively, seen as a zero-sum game and a conflicting process that seeks to constrain or channel the actions of another. It has adverse consequences for those subjected to it because it limits their autonomy (Guérin et al. 2013).

The power-over perspective fits well with how, traditionally, hospitals are bureaucratically organized, with well-established regimes and hierarchical relations (Carvalho 2014). Being among the most complex and institutionalized organizations in contemporary society, hospitals exhibit a high level of division of labor, involving various professional groups contributing to patient care (Strauss 1988). Interactions among these professional groups are organized hierarchically, marked by a gendered division of labor (Yam 2004), and are shaped by differences in knowledge, professional cultures, power, and prestige (McCann and Granter 2019). They are further distinguished by subtle differences in uniform and attire as well as forms of address, symbolic elements denoting privileges and responsibilities, which are embedded in the routines, policies and regulations that govern the healthcare setting (Cunha et al. 2020).

In the sociology of professions, scholars have dedicated much attention to professional hierarchies and power dynamics, studying how professional groups endeavor to define, protect, and establish their roles, authority, and expertise within their respective fields (Freidson 2001, Ahuja et al. 2017, Abbott 1988). Professions are traditionally seen as occupational groups that maintain a high level of social closure with a legitimized body of expert knowledge, granting professionals elevated levels of authority and control over their work that is coupled with occupational prestige (Denis et al. 2019). In the healthcare hierarchy, nurses have historically occupied a position of low social status (Ernst and Tatli 2022). Portrayed and institutionalized as a 'semi- or quasi- profession', nurses often experience limited clinical autonomy and authority (Yam 2004, Hoff and Kuiper 2021). Additionally, there are gendered patterns of professionalization stigmatizing nursing in the division of labor (Calás and Smircich 2006), further contributing to nurses' subordinate power position compared to other (powerful) healthcare actors, such as physicians, whose authority and decision-making are legitimized and structured within the organization (Davies 2003).

While contemporary studies problematize and provide nuanced perspectives on these idealized depictions of professions and traditional agnostic power relations (Noordegraaf 2015, Maaijen et al. 2018, Andersson and Liff 2018, Hoff and Kuiper 2021), this literature provides insight into how hierarchical and authoritative power relations become institutionalized in healthcare organizations. Their institutionalization in the past has fused power relations in the mould of one-dimensional power (Lukes, 1974, 2005) premised on what Weber (1978) referred to as 'imperative command', legitimated by both formal and informal rules of bureaucratic practice. Asymmetrical power recourses and hierarchical and gendered structures within healthcare have, in recent times, prompted the emergence of numerous empowerment movements and initiatives — such as the one we study in this paper — aimed at establishing more equal and inclusive decision-making and power relations.

Power to and empowerment in healthcare organizations

An alternative and second key conception of power, referred to as 'power-to', represents a departure from the view of power characterized by dominance and coercive power dynamics. Instead, power-to conceptualizes power as the capacity to take actions and achieve objectives independently of others (Göhler 2009, Pansardi and Bindi 2021). Organizationally, power-to refers to the capacity of organizational members to be in control over their work and decision-making (Avelino et al. 2023). For this reason, in organization studies, power-to is generally equated with the notion of empowerment and regarded as the result of the process of emancipation from the dominating power of others (Allen 2008, van den Berg et al. 2022). The underlying notion is that fostering power-to relations nurtures professional autonomy and encourages the expression of one's voice, which can subsequently lead to increased feelings of self-efficacy, motivation, creativity, and overall well-being among professionals (Bartunek and Spreitzer 2006).

Empowerment is a popular and frequently used concept across different disciplines and professional domains. While appealing, it is also a concept that is ambiguous and loosely defined (Bartunek and Spreitzer 2006). In healthcare, organizational empowerment broadly refers to the organizational strategies and efforts undertaken to enhance professional working conditions and patient experiences by transferring power resources to those that previously lacked them (Lincoln et al. 2002, Rothman et al. 2019). Conceptually, empowerment can be broadly categorized into two forms of transfer: grassroots self-empowerment, which occurs in social movements or through activism, which contrasts with top-down 'working life enhancements', often the case in organizational empowerment efforts (Weidenstedt 2016, Booth 2019). In top-down organizational empowerment, change is typically initiated from senior management levels. This form of empowerment has been subject to much criticism in the sociological and organization literature, highlighting the paradoxical nature of empowerment. Critical perspectives shed light on the unintended consequences and paternalistic practices that tend to accompany empowerment initiatives such as increased workloads and symbolic empowerment, in which disadvantaged groups are given only limited decision-making authority without genuine influence or power (Berti and Simpson 2021, Jasanoff 2004, Hardy and Leiba-O'Sullivan 1998, Booth 2019).

In this view, the paradox of empowerment is that "the very existence of circumstances that place one group in a position to 'provide' another group with power implies that power is a finite commodity controlled by a sub-set within the organization" (Eylon 1998, p. 7). In other words, as long as empowerment is imposed rather than enabled, implying that certain actors have the authority to decide when, how much, and in what way others are empowered, existing power relations and imbalances remain intact, potentially upholding 'power over' regimes (Booth, 2019). Hence, critical scholarship argues that despite the prevalent assumption in the literature that power-to is a value-neutral or positive concept, its practical implications are often ambiguous (Pansardi and Bindi 2021). This view perceives the notion of power-to as having much the same objectives as power-over behavior, including domination and control. While power-over primarily relies on hard one-dimensional power (Lukes 1974, 2005) for the exercise of control, power-to is seen to achieve a similar effect through the use of two-dimensional power (Lukes, 1974, 2005), namely by controlling the decision-making arena to advance a specific perspective or organizational agenda, to contest and hinder issues getting raised and initiatives put forth by others (Cunha et al. 2020). By empowering actors previously not so empowered, new issues for agendas may emerge embryonically; however, if they do so they are liable to die an early death if they do not accord with the normative assumptions and rules of the game that are already well-institutionalized.

Empowerment initiatives, in this view, are seen as introducing and exercising 'disciplined autonomy' (Sauer and Nicklich 2021), potentially cultivating a dedicated and committed workforce, one that takes initiatives within the parameters and constraints set by

management, within a framework of everyday sensemaking about the indirect control mechanisms that enable legitimacy. Rather than emancipating professionals from managerial controls, the power that is delegated by powerful actors can only be used in constrained ways. The 'voice' that is given tends to be limited to that which management wants to hear (Cunha et al. 2019).

Moreover, these scholars emphasize that managements' real concerns, in fact, are often not about redistributing power. Rather, motivations for implementing empowerment programs typically stem from more instrumental reasons, that involve, for example, mitigating nurse workforce turnover. Such views point to the gap between the 'democratic' rhetoric of empowerment in healthcare and the everyday realities of relative powerlessness of those 'empowered' in organizational contexts (Booth 2019, Dykstra-DeVette and Canary 2019, Roth and Bruni 2022).

Empowerment through power-to seemingly empowers hitherto excluded actors to be able to participate in decision-making, agenda-setting, and self-management, but they often do so in a context sufficiently defined by two-dimensional power that it inhibits their preferences (Lukes, 1974, 2005). These preferences become limited through learning that certain types of initiatives are defined by others as in some ways 'deviant'. In this way, they learn, if they did not already understand, what it is to be acceptable in the institutional context. Power has its limits, and these can, in important ways, be self-constraining.

While it is important to remain critically alert to potential disempowerment consequences of reform initiatives, a nuanced understanding of the complex dynamics at play is required. Empowerment can offer new and meaningful experiences and opportunities for improving professionals' autonomy and working conditions, rather than being only a façade for ensuring fundamental authority relations remain unchallenged in their inclusions, exclusions and legitimacy. On the ground, empowerment initiatives are usually uncertain and complex projects; rather than outright dismissing their potential, participatory researchers can explore how empowerment might affect organizational actors in specific ways (Jasanoff 2004).

Power with and the polyphonic organization

Some authors have proposed a more generative understanding of power that surpasses situations wherein dominant actors exercise control and authority over others using either power-over or power-to behavior. To capture co-active and genuine power-to relations, a third form and concept of power, referred to as 'power-with', has gained prominence. This concept encompasses collaborative exercises of 'power to' and a group's ability to exercise power and work together towards common goals and objectives by sharing power with others (Pansardi 2011, Avelino 2021). This perspective focuses on the positive-sum and empowering effects of implementing power-to relations

as a means to build consensus, collective strength, and the recognition of diverse perspectives through inclusive decision-making (Cunha et al. 2020, Haugaard 2012).

Within the organization literature, such authentic forms of empowerment are associated with adopting a polyphonic perspective on organizations (Sullivan and McCarthy 2008, Cunha et al. 2020). Derived from the Greek words meaning 'many' and 'voices', the idea of polyphony originated in literary and music theory and practice. In organization studies it represents the idea that organizations are discursive spaces in which numerous voices and perspectives, both dominant and peripheral, exist simultaneously, interact, and collectively constitute organizational practice (Hazen 1993, Vaara and Rantakari 2024). It is argued that within organizations "polyphony is always present, even though it may be silenced by a dominant discourse" (Kornberger et al. 2006, p. 4).

The concept of polyphony metaphorically "assists in understanding and allowing for inclusive change in patterns of organizing among people who perceive, value and act from different appreciative systems and speak with diverse voices" (Hazen, 1993 p 24). In other words, managing polyphony involves recognizing the reality of organizational (sub)cultures and organizational practice as multi-centered, non-linear, and dynamic. At the same time, the metaphor orients organizations to confront three-dimensional power regimes and hegemonic organizational orders (Lukes, 1974, 2005) and benefit from harnessing the potential for inclusivity in decision-making processes, the organization of care, and the conflicts and tensions that may arise from it (Berti & Simpson, 2021).

Practically, managing the polyphonic organization is seen to be achieved through two processes, namely through acts of deconstruction and translation (Kornberger et al. 2006). Deconstruction involves acts of problematizing taken-for-granted organizational narratives and hierarchical power structures. It involves breaking open the dominant organizational discourses and provide a means to unsettle how consensual organizational discourses influence professional interactions and decision-making while opening space for enacting divergent voices and perspectives (Kornberger et al. 2006). Translation, in turn, refers to deliberate actions taken to establish and strengthen new heterogeneous networks to constructively manage polyphonic organizations (Kornberger et al. 2006). This entails efforts to bridge gaps, facilitate communication, and promote collaboration among various organizational actors, each operating with their own logics, rules, and contexts. From this perspective, organizations are encouraged to deliberately create time-spaces that welcome a wide range of voices as well as exploring means to connect and legitimize different perspectives and intersubjective experiences. Doing this can be achieved by developing institutional channels for expressing professional voice, interprofessional dialogue, and representation on organizational levels (Berti and Simpson 2021). By employing translation as a tool for negotiation and alignment, organizations can foster more inclusive and innovative decision-making processes and collaboration among their members. In terms of three-dimensional power (Lukes

1974, 2005), these practices weaken tendencies towards hegemony forming, situations in which certain dominant views are unquestioned and widely accepted or simply understood as the way things are, and not likely to change.

The framework of power over, to, and with can be placed in a matrix with the three-dimensional view of power developed by Lukes (1974, 2005), as shown in Figure 1. The reviewed literature underlying this integrated framework provides a lens to analyze the power-related tensions involved in processes of empowerment and change and their implications for addressing precarious work in the nursing context and beyond. Before discussing our empirical findings, we first outline our methodology, the data that we collected and the use of this conceptual framework.

	'Power-over' practices	**'Power-to' practices**	**'Power-with' practices**
One-dimensional power (mobilization of recourses and direct power behaviour)	A exercises power over B by getting B to do something that they would not otherwise do.	Actors strive to use power to make a difference through offering specific benefits to interest constituencies.	Actors explicitly work by sharing power with others to achieve a common strategic purpose.
Two-dimensional power (management of (non)decision-making processes)	Agendas and decision-making are organized in such a way as to create non-issues. When some things are defined as non-issues then nondecision–making applies.	New issues can be introduced to the agenda by introducing new participants into strategic decision-making with the power to challenge implicit understandings in crucial decision-making arenas.	By sharing power with others from outside normal fields of practice fresh issues and participants can enter strategic decision-making.
Three-dimensional power (management of structuration, meaning and discourse)	When subaltern interests are discursively aligned with those of elites, then the world is viewed in ways that reflect elite interests.	Power to points out the fallacies in what is accepted in everyday strategic thinking, when exposed to different theoretical understandings of what strategy might be and do.	When diverse interests do not coincide, they can be reframed by sharing power with others through deliberative democracy.

Figure 1: Modalities of power in theory (Clegg 2023b).

Methods

This paper is based on data gathered through longitudinal and multi-sited participatory ethnographic research, examining three empowerment programs in Dutch hospital practice. Transitions in the workforce, characterized by souring workforce shortages and turnover, along with recent societal shifts, including heightened attention in policy and public discourse, and the post-pandemic reclassification of care workers like nurses as 'system-relevant' (Grenz and Günster 2022), have given momentum to new legislative measures aimed at elevating and empowering nurses in the organization of care and healthcare agenda-setting. In this context, the Dutch Ministry of Health and Sports encourages hospital organizations to implement subsidized experimental empowerment programs. These programs provide nurses and stakeholders involved with opportunities to experiment with reorganizing nursing work, professional development through developing new nursing roles and repositioning nurses in organizational decision-making structures.

Ethnographic data was collected over a three-year period, between September 2020 and January 2023, across three general hospitals that implemented empowerment programs. Although the local programs slightly differed in their designs and infrastructure, all three centered on experimenting with reorganizing nursing work and roles, and repositioning nurses in clinical networks and organizational decision-making arenas. At each hospital, specific nursing wards were chosen to experiment with new methods, roles and approaches. Additionally, new infrastructures were established to enhance the engagement of nurses in organizational decision-making, for example through new organizational roles for nurses (quality, supervising, research roles), multidisciplinary clinical networks and project teams, and nurse councils.

We conducted in-depth ethnographic case studies to investigate power transitions in the different programs. We observed both day-to-day nursing work across six nursing wards in the three hospitals and specific project activities related to the programs. The first and second author engaged in participant observations, spanning various nursing shifts, including both day and night shifts, for over 450 hours. During these shifts, informal chats were conducted, to check and verify interpretations of our observations and further explore practices and experiences. Additionally, we attended more than 50 hours of project meetings and presentations. After our observations, we wrote down our fieldnotes within 24 hours, to be used for later analysis. In addition to our observations and informal interactions, we conducted formal interviews with key stakeholders in each hospital to gain in-depth and holistic insights into the development and dynamics within the programs. We interviewed various stakeholders, including participating nurses (n=23), nurse managers (n=7), project managers, (n=3), and board members (n=3). These interviews explored topics such as the challenges and opportunities associated with empowerment, the goals and progress of the programs, and perspectives on nurse professionalism and leadership.

Our participation involved evaluating progress and change work within the programs, collaborating closely with local nursing staff, managers, and administrators. Drawing from our data, we furthermore facilitated several sessions and presentations within and beyond the three hospitals, fostering dialogue and reflexive learning. Additionally, we disseminated findings from our research through various other channels, both internally via local and organizational communication platforms and externally through professional and academic publications. As part of the broader nursing program, we also organized and participated in several knowledge sharing initiatives (N = 8), including webinars, festivals, and conferences (> 60 hours). Detailed notes were recorded and incorporated into observational reports. Throughout these events, we engaged in informal conversations and interviews with diverse nurses, hospital managers and field experts. The data that has been collected is shown in table 1.

Fieldwork site	Location, methods, and respondents
Hospital (3) Pseudonyms: A, B, C	Nursing wards: dialyses, oncology, surgical, maternity, gastroenterology, neurology Observations of daily nursing work (> 450 h) Observations of pilot project meetings and activities (> 80 h) Formal interviews nurses (n=32), nurse and project managers (n=3), board members (n=7) Focus groups with nurses (n=10)
Knowledge sharing activities (N=8)	Observations and participation in knowledge sharing activities (> 60 h)

Table 1. Methods and respondents.

Data analysis

Given the prolonged duration of our ethnography, as well as the complexity of power transitions in the field, we employed abductive methods for our data analysis, enabling us to make several iterations between data and theory (Tavory and Timmermans 2014). Initially, we coded our data inductively, which pointed out the ongoing political dynamics of empowerment. The codes that emerged from our data identified 'political skills and strategies', 'conflict and interference', and 'bottom-up and top-down learning'.

During our ongoing fieldwork, and multiple member checks through informal conversations, interviews, and focus groups, we recognized the added value of adopting additional conceptual frameworks to conceptualize and better understand the nature of underlying power relations structuring the empowerment efforts and their local politics. This led us to compare our findings to the existing literature on power, specifically, the concepts of power over, to and with, and to develop codes capable of capturing changing power relations in the field, such as 'force and impede', 'getting things done', and 'collective capacity and coaction'. However, in later stages, during the analysis process and drafting of this paper, we encountered challenges in fully

unraveling and articulating the different types of power practices encountered within the nursing context. Acknowledging this, we returned to the literature, specifically to the work of Lukes (1974, 2005), which provided our analysis with new momentum. A three-dimensional view of the underlying mechanisms of power equipped us with the vocabulary and perspective necessary to articulate and portray the complex and layered dynamics of power we had long observed within the nurse programs, data set, and attempts to change power relations in the field. The codes we employed, drawn from the work of Lukes (1975, 2005), included 'resources', 'control over decision-making', and 'discourse and meaning'.

The coding process was conducted individually, supplemented by collaborative sessions for discussion and comparison of approaches, themes, and perspectives. To safeguard anonymity, we used pseudonyms in the paper. Ethical permission was obtained through the internal review board of the Erasmus School of Health Policy & Management.

Results

In this section, we present our key findings. First, we portray the empowerment movement in the Netherlands. Subsequently, employing our power framework and a focused lens of deconstruction and translation (Kornberger et al. 2006), we demonstrate how the programs encompass different dimensions of power over, to, and with, and reveal the underlying mechanisms of power that mediate and shape pathways of nurse empowerment and disempowerment.

The nurse empowerment movement

> *Under a bright sun, nurses from all corners of the country gather at a nurse knowledge-sharing festival. The venue features different stages, food trucks, and live music. About 500 attendees have come, each wearing a festival wristband and carrying a program booklet outlining the day's thematic focus: professional development, leadership, and voice. In one festival tent, a nursing director delivers a call to action: "Nurses must stand up and stake their claim. Equally important is the need for others to create that space for us. In our own hospital, for instance, this means getting a fair share of research funding, which mostly stays within the medical field." In a neighboring tent, researchers discuss current societal views of nursing: "In the last decade, the acknowledgment of nurses as experts has sharply declined, a trend prominently evident amid the Covid pandemic. Why the scarcity of nurses as guests on talk shows?" [Fieldnotes, June 2023]*

The knowledge-festival is part of a plethora of recent events, programs and policies that emerged on a national level to shift and improve power dynamics and relations within nursing practice. These efforts aim to emancipate nurses from traditional power-

over relations and regimes and to reposition nurses within healthcare hierarchies and decision-making structures, bringing them into decision-making and agenda-setting roles, thereby fostering their organizational power to enact from within a legitimate position in healthcare decision-making.

These objectives are mirrored and have received formal recognition through new legislation that legally establishes the involvement and participation of nurses in the organization of healthcare:

> *Since July 1, 2023, healthcare professionals' voice and participation in organizational and policy decision-making have been formally incorporated into the Dutch 'Quality Act.' This legislative update mandates increased control for nurses over their working conditions and active contributions to healthcare agenda-setting and policymaking. To effectively track progress, a monitoring tool, developed under the guidance of the Ministry of Health, Welfare, and Sports (VWS) and informed by nurses' input, provides hospitals with valuable insights into the perceived degree of influence and participation in organizational decision-making (Rijksoverheid, 2023).*

The new legislation was launched with a national action plan that offers substantial funding opportunities for hospitals to embark on empowerment programs and initiatives focused on the development of nurses' roles, repositioning them and their opportunities for voice. In recent years, within this context, most Dutch hospitals have initiated experimental change programs and pilot projects aimed at promoting nurse empowerment. While these programs differ in their infrastructures and focus, they share an interest in reorganizing nursing work, advancing the development of the nursing role, and repositioning nurses within organizational decision-making.

In hospital C, for instance, the implementation of the 'future-proof nursing' empowerment program introduced a new role of 'supervising nurse'. This role aims to provide nurses with expanded career opportunities and enable them to exert greater influence on organizational affairs:

> *In March 2021, the Board of Directors formally created the position of 'supervising nurses.' This role involves overseeing the provision and coordination of high-quality nursing care. Additionally, supervising nurses play a vital role in initiating and monitoring quality improvement. The introduction of supervising nurses marks a cultural shift in the hospital, requiring substantial attention, consideration, and ongoing communication across different organizational levels and stakeholders (Internal documentation, hospital C, 2022).*

Together, these initiatives form a multifaceted movement aimed at rebalancing power balances within the Dutch field of nursing. These efforts actively seek to emancipate nurses from laboring under power-over relations while enhancing their autonomy and authority through implementing power-to practices (Pansardi and Bindi 2021). In the following section, we delve into and present the local progress of the three empowerment programs we studied, and the power-related tensions entangled within.

Deconstructing institutionalized power orders

> *In the lecture hall of the hospital, members of the board, physicians, clinical and quality managers, and controller staff convened for the hospital's strategy meeting. Rosa and Sophie, both nurses, arrive a little late. Rosa is the project leader for the "Future-proofing nursing work" program and Sophie chairs the nursing advisory council. After a brief introduction, Pieter, the hospital CEO, takes the stage. "Let's use this strategy session to develop a plan for the upcoming years, one which puts healthcare professionals at the forefront of the agenda." Rosa and Sophie are the first to present, using slides to outline their efforts in setting up the nurse change program. After handling a few questions from the audience, Pieter thanks them for their contributions. Rosa and Sophie appear visibly relieved as they return to their seats. However, to our surprise, they swiftly gather their belongings and leave the room as the next speaker is introduced (Fieldnotes, hospital B, October 2022).*

This data excerpt highlights how local programs, upon initiation, become embedded within political environments characterized by established power dynamics and institutionalized hierarchical structures within hospitals (Avelino et al. 2023). Despite the clear emphasis in hospital B on involving nurses in organizational decision-making, a point underscored by both nurses in their presentation and the CEO's opening remarks, and evident in the empowerment program's implementation, Rosa and Sophie adhered to normative expectations by leaving the strategy meeting after making their presentation. Their presentation was an event within a normalized frame of hierarchy and decision-making in the hospital (Berti and Simpson 2021). Invited to speak, the nurses spoke and departed. They had made their contribution, as a distinct event in a program of activity, but they could not speak as co-active participants in a discourse dealing with strategy for changing organizational power relations. No explicit one-dimensional power was exercised over nurses Rosa and Sophie, and they had been given an opportunity for voice; however, in two-dimensional power terms (Lukes, 1974, 2005), they were aware of the self-constraint required of them. Furthermore, even within a context where explicit strategies are deliberated upon for engaging nurses in the organization of care, involved stakeholders acquiesce to these dynamics 'as the way things are', highlighting how two and three-dimensional power (Lukes, 1974, 2005) can normatively sideline alternative actions and practices.

In the early stages of the programs, we observed specific challenges associated with deconstructing such hegemonic organizational cultural and power orders (Kornberger et al. 2006). While on a break from the meeting, we asked one of the hospital's quality managers why the nurses had left. Her response was brief:

> *"This [the strategy session] is way too complicated for nurses. Besides, they don't have any authority; they can only provide advice [through a nursing advisory council]. And when you see how that happens, well, it's not convincing at all." (Fieldnotes, quote Quality management, hospital B, October 2022).*

Such (implicit and explicit) organizational views and discourses of nursing professionalism, as articulated by the quality manager, remained largely unquestioned during the program's initiation while influencing power behavior, interprofessional interaction and the authority of nurses.

Co-optation in service of others

In our observations, we noted how, from the initiation of the programs, existing and normalized frameworks of meaning, including paternalism and dominance, had an impact on opportunities for emancipation. This is illustrated, for instance, in a meeting of the hospital's C Quality team where the introduction of the previously mentioned 'supervising nurse' and the empowerment program is discussed:

> *This morning, the quality expert group, comprising healthcare directors and managers, convened. The primary agenda item is the hospital's recent poor performance in various national rankings. The discussion evolves around improving key performance indicators and the role of nurses. "With the expanded role of nurses quality [as part of the empowerment program], we must involve them in managing these indicators," one manager explains. "We should motivate nurses to emphasize their significance within their units and promote behavioral change among colleagues," she continues. Another manager asks how to achieve this, to which she responds, "We need to provide training and raise awareness. There's much for them to learn about quality, and the barrier is high. (Fieldnotes, hospital C, January 2023).*

In this quality meeting, a top-down interpretation of empowerment is articulated in which management advances their agenda, using two-dimensional power (Lukes, 1974, 2005) to strategically harness the agency of empowered nurses and align them with organizational goals. This is often referred to as strategic alignment achieved through top-down communication of a 'shared' vision, training, and education (Hardy and Leiba-O'Sullivan, 1998). Meanwhile, paternalistic approaches persist (e.g., nurses are expected to learn about quality), and asymmetries are upheld and accepted as part of the status quo.

In hospital C, 'supervising nurses', created by the empowerment program, were eventually tasked with enhancing performance scores and external indicators on their respective nursing wards, responding to the hospital's performance and an impending accreditation audit process:

> *While Ines and I are sitting at the table, my attention is drawn to the quality board. It prominently displays the national standardized patient safety indicators along with the corresponding registration percentages for various themes, color-coded as green, yellow, or red. Most scores are red or yellow. Ines notices my gaze and says, "I know, those scores could be better. As supervising nurses, we receive updates on scores monthly and we need to improve the scores." She continues, "not all our colleagues feel accountable for these scores. They feel that there are more pressing matters that require their attention. However, as supervising nurses, we do feel that responsibility. It has become an integral part of our role, and the team management holds us accountable. Our manager consistently sends us weekly emails underscoring how the scores are falling behind and emphasizing the need for action." (Fieldnotes, hospital C, January 2023).*

The fieldnote conveys how the responsibility for the indicators is placed on the nurses, motivating them to sensitize their peers to modify their work practices and foster dedicated teams. The implementation of power-to practices has, in this case, counterintuitive effects of reinforcing power-over behavior through restrictive two-dimensional power practices (Lukes, 1974, 2005) and encouraging nurses to mobilize the power delegated to them within a specified framework set by management (Cunha et al. 2019, Ivanova and von Scheve 2020), which, in turn, closely governs the behavior of empowered nurses.

Nursing culture and change

Challenges associated with deconstructing power relations and organizational expectations of the nursing role and nurse leadership were apparent not only among stakeholders in the nurse's socio-political environment but also within the nursing community itself. The legitimacy of nurses to exercise newfound power through the programs faced challenges stemming from a nursing identity deeply rooted in bedside patient care and a commitment to equality (Felder et al. 2022, Felder et al. 2024). In this context, expressing ambition can be risky, as conveyed by a nurse in hospital A, who serves as one of the project leaders for the local empowerment program in her nursing ward:

> *As a team, we initially and collectively decided to explore [in the context of the program] working with dialysis assistants [to reorganize and improve care work]. However, over time, the project has evolved into primarily my responsibility. I receive minimal feedback or assistance from my project group or team, and it's*

> *now cynically referred to as 'Project Emma.' The challenge lies in our team being at an impasse, encountering resistance to change and reluctance toward nurse leadership, impeding our progress (Interview nurse hospital A, September 2021).*

The quote highlights the vulnerabilities and uncertainties that empowerment programs can bring for those nurses involved. Insights from our broader study indicate that these challenges arise not only through overt exercise of one-dimensional power Lukes (1974, 2005) but also through withdrawing from action and commitment on the part of the team members and then, in this case, the stigmatizing of Nurse Emma as a 'tall poppy', possessed of ideas and practices thought inappropriate for her status by others.

Implementing the empowerment programs in local practice proved not to be easy. From the outset, our observations reveal that the empowerment programs were shaped by existing power and hierarchical structures, clearly incorporated among a large group of nurses. Often, the legitimacy of hegemonic orders was maintained rather than confronted, affecting the structures, expectations, objectives, and opportunities for altering power balances within the empowerment programs. As the programs evolved, existing power-relations persisted, impeding the legitimacy and voice of nurses in organizational areas in which they collaborated with other healthcare professionals, thereby hindering translation processes aiming at changing the status quo and establishing more inclusive decision-making.

Translating the nursing perspective

As the programs unfolded, and new coalitions and alliances were explored, the empowerment of nurses increasingly began to clash with wider and vested power structures in the hospitals, leading to issues related to turf conflicts with other healthcare professionals (Buchanan and Badham 2020). Alongside these conflicts, nurses confronted challenges in legitimizing their expertise and perspectives because of existing organizational stratification status levels, impeding the unfolding of processes of translation (Kornberger et al. 2006).

Turf games and nurse empowerment

Turf issues encountered are illustrated in the following example, taken from a nurse peer supervision meeting, in which nurses gathered to share and exchange experiences regarding their efforts to improve and reorganize nursing care through the empowerment program. In the meeting, two nurses deliberated on their recent experiences in developing and implementing educational quality games:

> *"We created a digital game. Every day, our [nurse] colleagues encounter two questions upon logging into the system, which they must answer. We received much positive feedback about the game." Other nurses respond enthusiastically and ask about sharing it on their wards. Later, in the Quality staff office, two*

> *managers discuss quality games. One says, "I arranged a meeting with the nurses who launched it. I asked whether anyone from the Quality department had reviewed the content and confirmed that the questions align with our protocols and guidelines. Personally, I find their game below our quality standards and unsuitable for organization-wide sharing. I told them that the game we developed in our unit is more suited for hospital-wide implementation." (Fieldnote, hospital B, 2022)*

Turf issues and power play typically arise during changes in organizational structures and fields of authority (Buchanan and Badham 2020). The proposed sharing of the quality game interfered with established roles, domains, and decision-making authority in the hospital. The fieldnote conveys how the game is rendered invalid as it lacks authorization from the quality department, falling short of meeting legitimized quality requirements. The quality manager leverages available resources (such as formalized authority, reputation, and framing) to interfere with nurse-drive learning and exerts explicit one-dimensional power (Lukes, 1974, 2005), setting limits on nurses' autonomy, with consequences for achieving organizational and empowerment goals.

Nurses refraining from action by being muted at higher organizational levels

The restricted influence and authority of nurses become even more apparent in our data as they articulated their perspectives at higher organizational levels. This is illustrated in the following fieldnote, portraying a meeting of the empowerment program's project team at hospital A with the board of directors:

> *Today, Anna and Susan, two nurses involved in the local project team, provide an update on the program's progress to twomembers of the board. Using some sheets, they discuss achievements and activities such as reorganizing quality workgroups and role development efforts. When they finish, Floor, a board member, said, 'nice presentation! But it's not entirely clear. What are your expectations, goals, where do you want to be in a year?" Susan hesitates and then talks about the objectives to increase patient and staff satisfaction. There is a moment of silence, and Susan quickly adds, "But maybe that's difficult to measure and research." Floor responds, "Yes, those goals are not really clear or 'SMART.' I mean, patient satisfaction can be quantified, for example, stating its currently at 7.0 and our objective is to reach at least 7.4. My concern is we're focused on just on trying things out, but upon reflection we may realize that they haven't any meaningful results." (Fieldnotes, hospital A, January 2021)*

The normative language used (e.g., 'nice presentation', 'just trying things out', lack of 'meaningful results') shows the discursive practices aimed at shaping and framing the understanding of nurses about how they should approach the reorganization of their work (by focusing on measurements, accountability and working evidence-based). It

reveals how empowerment is imposed, rather than enabled, with management retaining the authority to determine how and in what way nurses are empowered (Eylon 1998, Weidenstedt 2016). From a two-dimensional power view (Lukes 1974, 2005), a form of disciplined autonomy' (Sauer and Nicklich, 2021) is leveraged to encouraged nurses to take initiative but to do so within specific frameworks set by management, which constrain that initiative. Moreover, viewed through a three-dimensional power lens (Lukes, 1974, 2005), the epistemic politics of organizational decision-making becomes apparent. Debates about which knowledge and methods hold validity in change work contribute to conflict between nurses and board members and are settled by vested power structures, cementing managerial control over the programs (Kuijper et al. 2024).

In sum, our observations on the progression of the empowerment programs revealed notable ambiguities in translation processes (Kornberger et al. 2006). As new coalitions, alliances and spheres of authority began to take shape and transition, turf conflicts typically arose, impeding the legitimacy of nurses and leading to power-over behavior. Additionally, when nurses' perspectives were articulated at the organizational level, they were often disregarded, and nurses were encouraged to initiate actions dictated by managerial figures.

Towards power-with

Our findings align with critical scholarship perspectives, such as those of Barker (2002) and Sauer and Nicklich (2021), which associate empowerment with power-over behavior by colleagues. For Barker (2002), it was peer pressure that became the source of power over; in our data it was the political, ideological, and institutional hindrances to power transitions within nursing programs that acted as hierarchically placed roadblocks expressed and understood discursively, halting translation and limiting autonomy.

In this final section, we delineate how adopting power-to practices can also extend beyond power-over dynamics, encompassing coactive power, yielding positive outcomes, and pointing to emancipatory alternatives. In the programs, we observed 'tipping points' in power balances, witnessing a shift from power being merely 'given' top-down, to a more dialectical process in which power is actively 'taken up' by nurses, changing the circuits of power in small but meaningful ways (Clegg, 2023a). Ongoing processes of deconstruction and translation (Kornberger et al. 2006) moreover presented opportunities for bottom-up approaches to complement managerial interpretations of empowerment.

Nurse politics and bottom-up learning

We noted instances in which nurses leveraged newly found resources within the context of the programs to engage in grassroots improvement work, experimenting with new approaches, practices, and politics (Waring et al. 2022, Buchanan and Badham 2020). To illustrate, Sara, a nurse working in a new quality role, focused on improving care routines through a bottom-up approach:

> *Sara stands in front of the quality board in the team room, removing a list detailing physician handover dates and times. She asks colleagues to note these details. Sara explains, "Physicians' rounds are in the morning, and we're agreed to receive handover no later than 2:00 pm because there are always follow-up actions required, such as conducting scans, blood transfusions, or preparing for examinations or discharge. However, we often get feedback late, leaving the evening shift with a challenging backlog that is nearly impossible for them to catch up on. To address this, we started a pilot project. We call physicians at 12:00 pm to check for discharges or issues, helping us anticipate the day. However, the process isn't perfect. Some physicians are too busy or lack the motivation to communicate. Therefore, I'm gathering insights to substantiate the challenges we face to stress the importance of sticking with our work agreements" (Fieldnotes, hospital C, February 2023).*

The excerpt highlights a traditional hierarchical power-over dynamic between nurses and physicians. The dominant taken-for-granted view is that physicians work to their own speed and demands; the nurses must accommodate these, leaving them dependent on physicians' punctuality, in an acceptance of past hegemony. In this context, however, Sara mobilizes one-dimensional power (Lukes, 1974, 2005) and is political savvy in two ways: first, by constructing a case to address the physicians. Sara' counter-hegemonic strategy is 'gathering insights' and building an empirical case 'to substantiate the challenges we face'. With this case, the necessity and importance of 'of sticking with our work agreements' can counter the physicians' behaviors that undermine these, as a legitimate move in the ongoing turf war. Second, Sara purposefully selects a highly visible quality improvement initiative (it is causing significant frustration) to demonstrate the value of her new role. This reinforces a broader observation in our study, where nurses in new roles often strategically choose specific interventions to demonstrate their added value to their peers. Doing so increases their chances of overcoming resistance (as mentioned in the earlier section) and legitimizing their new role and expanding their power resources (Reay et al. 2006). From a two-dimensional power view (Lukes, 1974, 2005), Sara's engagement in organizational politics presents an opportunity for the organization of care to incorporate broader interests and preferences. Articulating such a clash of interests and interpretations makes those normalized hierarchical structures and fallacies accepted in everyday care practices more visible and vulnerable to disruption, in terms of a three-dimensional power perspective (Lukes, 1974, 2005).

Nurse politics and organizational decision-making

As the programs advanced, we observed how increased conflicts also led to increased political mobilization and activity among nurses, encompassing organizational matters and decision-making. The following excerpt depicts how, as hospital C's empowerment program concluded, nurses politically mobilized as they perceived the reemergence of challenges that could undermine the consolidation of their newly empowered roles and organizational influence:

> *During today's self-organized and interdepartmental peer meeting, emotions run high as nurses discuss the looming expiration of hours allocated for 'supervising' tasks with the [empowerment] program's conclusion. One nurse emphasizes: "without those hours, we can't do any improvement work, and justifying other tasks beyond direct patient care becomes an uphill battle." Another nurse adds, "I get that there's pressure on the hospital [a bankruptcy was narrowly averted six months earlier], pushing for more efficiency and production, but this is outrageous. To make their concerns and demands clear, the nurses distribute tasks to inform team leaders, HR, and the board. (Fieldnotes hospital B, March 2022).*

Nurses perceived a looming threat where consensual organizational priorities, decision-making structures, and institutional contexts (e.g., financial pressure on the hospital) could marginalize their newly found power. In response, nurses unified across departments, forming a collective political front to navigate organizational channels and challenge empowerment processes, resulting in nurses trying to assert their empowerment rather than merely receiving it on managerial terms. When having the resources (first-dimensional power) and knowing how to maneuver in political arenas (second-dimensional power), our ethnography shows how articulated asymmetries and conflicts of interests can foster delegitimating actions and 'tipping points' in power balances. These instances suggest a shift towards a more processual approach to power, using power-with to reinforce the innovation in techniques of discipline and production, in the circuit of power that is facilitative and system integrating (Clegg, 2023a).

We noticed nurses increasingly seizing power. For instance, through formalized nurse councils established as part of the programs, as reflected in the following quote where nurse Ella reflects on the initiation of the council and her position as chair:

> *As the chair, I suddenly found myself amid managers, doctors, and board members, initially struggling to assert my voice. There's a distinct language spoken in these circles, and I quickly realized how a hospital is essentially a massive corporation, with myriad interests at play. Unable to pinpoint those interests, I felt uncomfortable. Taking initiative, I sought clarity on monthly reports from the financial department and engaged with management to understand operations. This was crucial; initially, we were only consulted when others deemed it appropriate; copied in emails but unable to contribute. Unsolicited advice, like in budgeting, caused friction as others deemed it beyond our purview. Encouraged by the new law [Quality act], we turned this around. Decisions are no longer predetermined in the boardroom, but we independently determine our areas of influence. (Interview nurse, December 2023)*

The nurse diligently worked to challenge prevailing two-dimensional power practices (Lukes, 1974, 2005) (such as being invited but feeling unable to contribute), by adapting managerially discursive repertoires and learning 'the rules of the game' of participation in decision-making politics. By deconstructing (Kornberger et al. 2006) normalized decision-making patterns, the nurse burrowed a way into the council's role in these processes. The nurse used the system innovation of being chair of the council to become more informed and better able to participate in the discourse defining political struggles in the organization. She built alliances enabling her to speak in the discursive terms that were appropriate to the arena; they translated what was arcane into her understanding which she, in turn, was able to translate back into the terms in use. The newly introduced Quality act, as discussed in section one, provided support for her claims, and facilitated processes of translation (Kornberger et al. 2006).

These examples show that, through the programs, the acquisition of recourses, access to the decision-making arena and processes of deconstruction and translation (Kornberger et al. 2006), can give more space to engage in politics to counter hegemonic frameworks and can yield empowerment in the nursing context, creating tipping points in power balances, with nurses actively engaged in the circuits of power, rather than being bystanders (Clegg, 2023a).

Discussion

Against the backdrop of concerted advocacy to counter precarious work in the nursing sector by empowering nurses and addressing entrenched power imbalances, and subsequent investments to change power-over regimes in the nursing context, our ethnography shows that, in practice, nurse empowerment programs are uncertain and ambiguous in their local performance and yield contradictory effects. The different programs, often introduced as experimental projects to learn about nurse empowerment (Kuijper et al. 2024), faced complex power, political, and institutional hindrances and opportunities, structuring transformative attempts at fostering pathways of empowerment.

In answering our research question, how power relations are changed through nurse empowerment initiatives, our findings show that nurse empowerment initiatives simultaneously reproduce and reshape power relations in the nursing context by exhibiting different manifestations of power over, to, and with. In doing so, the empowerment programs present pathways for emancipatory futures, while, paradoxically, also (re) producing lived experiences of social insecurity, vulnerability, and marginalization among nurses, thereby fostering experiences of precariousness. We have shown how these experiences stem from, for instance, by being subjected to disciplinary procedures and normative control, and facing hostility from nurse peers and involved stakeholders.

While such power-related tensions have been revealed in prior research (Berti and Simpson 2021, Sauer and Nicklich 2021, Barker 2002), our application of Lukes' power (1974, 2005) schema allowed us to empirically demonstrate that such tensions typically stem from the exercise of power-over through three dimensions in empowerment efforts, that is through management and control over resources, decision-making processes, and meaning and discourse. In addition to demonstrating how these dimensions serve as mechanisms for exercising and solidifying existing power relations, this study further innovates prior research by ethnographically demonstrating how organizational and emancipatory change can emerge from multidimensional power practices and transformations. The (dis)empowering processes and outcomes are discussed in turn below.

In terms of disempowerment, the nurse empowerment programs were introduced in fields characterized by everyday asymmetrical hierarchies, power structures, and regulatory discourses, sources of strong legitimacy reluctant to yield and acknowledge the legitimacy of other professional interests. Our analysis demonstrates that these vested organizational conditions made the programs prone to co-optation and top-down management of empowerment processes. Our findings reveal how newly established infrastructures aimed at fostering power-to relations therefore faced ongoing power-related challenges, such as turf conflicts, epistemic politics, positional power plays, and resistance from a stagnant nursing culture. As a result, the emergence of new networks and coalitions to facilitate nurses' participation in the organization of care, was frequently impeded by ongoing power-over dynamics, curtailing nurses' ability to acquire genuine political and organizational influence. Our ethnography suggests that when the fundamental legitimacy of hegemonic and normalized organizational imperatives remains unchallenged, with polyphony oppressed, power-over relations are at best transformed in terms of their operation, namely through more discreet forms of two- and three-dimensional power (Lukes, 1974, 2005).

These findings draw attention to the non-performativity of the nurse empowerment initiatives. Non-performatives are "reiterative and citational practices" that neither produce the effects the practices identify nor adhere to predefined goals and norms (Ahmed, 2012: p. 177). As noted in prior critical scholarship (Ivanova and von Scheve 2020, Courpasson 2000, Roth and Bruni 2022), by non-performing their stated goals of shifting power balances, empowerment initiatives risk being reduced to symbolic and instrumental tools to attract and retain nurses, address workforce turnover, and cultivate a committed workforce while maintaining the status quo. From this view, the performativity of the programs may furthermore lie perpetuating power-over regimes while simultaneously creating an image of the national bodies and hospitals as being committed to nurse empowerment measures and discourse, thereby giving way to new and ongoing forms of governance and experiences of precariousness.

In terms of the empowerment effects, our research shows that the programs saw nurses' acquiring more formal power resources and enhanced access to decision-making platforms. With their involvement in these new power relations, instances where there were conflicts of interest and interpretation became increasingly apparent and articulated (Mouffe 2005). Involvement in organizational politics facilitated incremental changes in subjective attitudes on the part of nurses as well as existing stakeholders. Normalized decision-making patterns and power balances were challenged, weakening the legitimacy of existing power relations and the status quo.

In a complex interplay, control over and access to resources (e.g., Dutch 'Quality Act', new roles and councils) (first-dimensional power), involvement in decision-making arenas (e.g., in interprofessional clinical networks, and higher organizational decision-making structures, as a second-dimensional power), left nurses increasingly dissatisfied with vested interests' power-over relations as they were embedded in discourse and organizational imperatives and reflected in daily practice and decision-making processes (third-dimensional power). Their dissatisfaction motivated resistance and deconstruction of dominant power discourses as they strove to establish themselves as legitimate actors in decision-making politics. We have demonstrated various ways in which nurses attempted this, by strategically engaging in improvement work to fix persistent and visible issues in care work, thereby enhancing their legitimacy, as well as by learning the rituals, language, and rules of political games, within and through the nurse councils for instance. We have shown how nurses mobilized collective action through the formation of political alliances and fronts within the empowerment project groups and leveraged changing institutional frameworks, for instance, the Dutch 'Quality act' to affect change.

Empirical and conceptual exploration of the (dis)empowerment consequences of shifting to power-to structures remains underexplored in studies of power and the wider critical social science literature. The contribution of this study lies in empirically demonstrating how implementing power-to practices requires reflexive changes across three-dimensional power. As noted in earlier research by Hardy and Leiba-O'Sullivan (1998), this implies, both analytically and practically, an emphasis on whether key power resources are allocated to marginalized organizational actors or largely retained by those in power (first-dimensional power), and ensuring access and inclusive representations in decision-making arenas, and whether parameters that reproduce top-down managerial decision-making are reflexively monitored (second-dimensional power). Moreover, and most fundamentally, our findings highlight that it concerns considering whether empowerment initiatives encompass confronting organizational imperatives and the status quo through processes of deconstruction and translation (Kornberger et al. 2006) to manage meaning in a manner that fosters resistance among both marginalized actors and involved stakeholders to counter hegemonic and oppressive forms of governance and organizing (third-dimensional power) and to translate new values, practices, and

coalitions around new power balances, potentially leading to co-active forms of power-to, referred to as power-with (Pansardi and Bindi 2021, Clegg 2023a).

We represent the points made above graphically, in Figure 2, where we summarize the data that we have discussed and present the structure that guided our interpretation and sensemaking of the ethnographic data. We do not want to imply that power transitions are as tidy as they are presented as being in the figure. Organizational life is always intrinsically fluid and complex, and enforcing change often demands iterative, messy, and uncertain political work. Circuits of power are a process always in play (Clegg, 2023a). The significance for policy and management is the aim of our clarity; when empowerment programs are sites of ongoing political contestation such an approach can help to undermine ossified three-dimensional power, changing the circuits of power, by achieving 'small wins' (Amabile and Kramer 2011, Reay et al. 2006) in addressing power imbalances and precarious working conditions in the care sector and beyond.

	'Power-over' practices	**'Power-to' practices**	**'Power-with' practices**
One-dimensional power (mobilization of recourses and direct power behaviour)	A exercises power over B by getting B to do something that they would not otherwise do. *Data examples:* *Overt interference in empowerment and nurse driven learning.* *Preventing sharing quality games.* *Influencing behaviour around indicator registration.* *Managerial decisions on what methods and approaches used in the reorganization of nursing work*	Actors strive to use power to make a difference through offering specific benefits to interest constituencies. *Data examples:* *Quality act.* *Introduction of new nursing roles;* *Setting up pilot studies and change programs to experiment with new practices and politics;* *Infrastructure for organizational decision-making*	Actors explicitly work by sharing power with others to achieve a common strategic purpose. *Data examples:* *Improving care practices and 'second-order' learning through interdisciplinary co-operation (physicians, pharmacists);* *generative and inclusive decision-making politics*

Two-dimensional power (management of (non)decision-making processes)	Agendas and decision-making are organized in such a way as to create non-issues. When some things are defined as non-issues then nondecision–making applies. *Data examples: Non-decision making. Positional power plays in interprofessional meetings; Parameters to constrain nurses' agency. Strategic alignment of nurses with organizational goals*	New issues can be introduced to the agenda by introducing new participants into strategic decision-making with the power to challenge implicit understandings in crucial decision-making arenas. *Data examples: Repositioning nurses in organizational decision-making structures. Setting up nursing councils and interdisciplinary clinical teams*	By sharing power with others from outside normal fields of practice fresh issues and participants can enter strategic decision-making. *Data examples: New organizational decision-making processes with broader nurse representation. New alliances and networks;*
Three-dimensional power (management of structuration, meaning and discourse)	When subaltern interests are discursively aligned with those of elites, then the world is viewed in ways that reflect elite interests. *Data examples: Everyday perceptions of nurse professionalism by nurses and involved stakeholders. Epistemic politics; Normalized frameworks of exclusive decision-making*	Power to point out the fallacies in what is accepted in everyday strategic thinking, when exposed to different theoretical understandings of what strategy might be and do. *Data examples: Awareness and challenging of asymmetrical decision-making processes. Nurses problematized and recognized clashes of interests and interpretations*	When diverse interests do not coincide, they can be reframed by sharing power with others through deliberative democracy. *Data examples: \mergence of political fronts to protect acquired gains and interests. Tipping points in power balances and generative conflict to amplify diverse voices and enhance inclusive decision-making*

Figure 2: Modalities of power in practice (Clegg 2023b).

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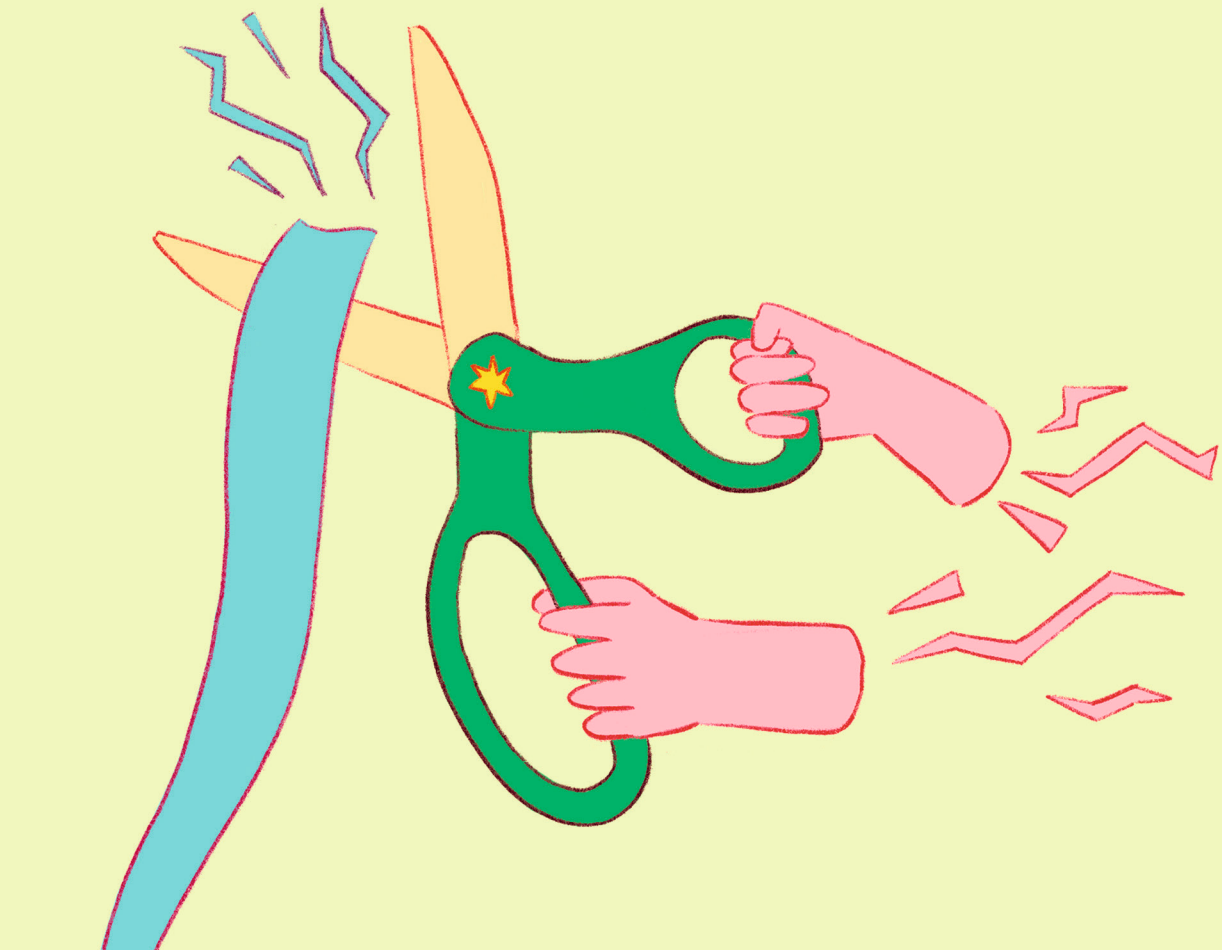
CHAPTER 6

Discussion



General introduction

In the introductory chapter of this dissertation, I outlined how the global nursing workforce is in a precarious state, rendering the reorganization of nursing work a critical policy priority (OECD 2023, Costa and Friese 2022, WHO 2024, Buchan et al. 2022). In the Netherlands, calls for new ways of working and organizing have led to a spectrum of reorganization initiatives in recent years, including both top-down legislative changes and the initiation of bottom-up and nurse-driven organizational change and empowerment (Martini et al. 2023, Van Kraaij et al. 2022, van Schothorst-van Roekel et al. 2020). This dissertation critically examined the political complexity of such organizational change processes in the context of nursing.

I opened the introductory chapter with a fieldwork vignette that illustrated how my engaged ethnographic research into nursing change practices entangled me in politics of organizational change. This immersive approach allowed me to experience firsthand the normativities, interests and power dynamics that underpin organizational change in nursing. I recounted how navigating these complex experiences led to moments of failure and feelings of being adrift in the field. The previous empirical chapters revealed that the nursing team's and manager's sense of 'expecting more from me and my research' not only reflected the limitations of my own inexperience and methodological approach but also pointed to a broader political narrative. The central aim of this dissertation was to unravel and critically investigate this narrative. In this final chapter and by building on the previous chapters, I present the key findings that emerge from this analysis. In doing so, I discuss how the politics of organizational change affect the reorganization of nursing work and use these findings to reflect on the underlying dynamics of the opening vignette, which mirror the broader political themes observed throughout my ethnography.

In the introductory chapter, I argued that a focused examination of the politics of organizational change is important not only because of its empirical relevance — as highlighted throughout this dissertation — but also because such politics have been largely marginalized and overlooked in nursing and healthcare services research, as well as in health policy and practice (Fraser et al. 2019, Jones et al. 2019, Waring et al. 2016). By bringing the political dimensions of organizational change to the forefront, this dissertation challenges the prevailing apolitical and technicist approaches found in both the literature and practice. In this endeavor, this dissertation is positioned at the intersection of critical nursing literature (Ernst 2020, Ihlebæk 2020, Ayala 2020, Allen 2014, Traynor 2009, Yam 2004) and literature on politics of organizational change (Clegg et al. 2005, Hardy and Thomas 2014, Avelino 2021, Bolman and Deal 2017, Buchanan and Badham 2020).

To recapitulate, this dissertation addresses the following main research question:

> *How do politics of organizational change impact the reorganization of nursing work, and what are the consequences for the (re)positioning of the nursing profession?*

The main research question contained the following sub questions:

1. *How do nurses respond to and shape societal challenges, and what are the implications for their organizational and political position?*
2. *How does the knowledge used and valued in organizational change processes reflect and shape power dynamics in the field?*
3. *How do organizational change programs affect existing organizational power relations in nursing?*

This final chapter is organized as follows. First, I answer the subquestions in chronological order, which then allows me to answer the main research question and unravel the failure portrayed in the opening vignette. The implications of this research for methodology, theory, and practice follow.

1. Nurses navigating change: different challenges, common grounds

To address the first subquestion — *how do nurses respond to and shape societal challenges, and what are the implications for their organizational and political position* — I examined two key events discussed in the first two chapters of this dissertation: the collapse of the legislative amendment 'Wet BIG II' (Chapter 1) and the Covid-19 pandemic (Chapter 2). Examining these events is important for understanding how nurses navigate macro institutional and societal changes and pressures, the political dynamics that mediate these efforts, and the impact of these changes on nurses' legitimacy and authority in healthcare organizations and organizational change processes.

The first two chapters share a common focus on how nurses leverage the power, agency, and political opportunities embedded 'on the ground' in their practice and community to address societal pressures and challenges. However, they do so in markedly different ways and contexts. Chapter 1 examines nurses' political mobilization and how nurses used a populist action frame to organize resistance to 'Wet BIG II', a macro institutional and legislative change perceived to be imposed on nurses. Chapter 2, in turn, examines how nurses ad hoc (re)negotiated and (re)organized healthcare during the Covid-19 pandemic to manage unprecedented pressures and conflicting valued ends. In what follows, I will present how nurses responded politically to each event and discuss two additional implications learned from their response in terms of nurses' organizational

legitimacy, positioning and power that are relevant for addressing the main research question.

Partisans and explorers: nurses' political power and entrepreneurship

In Chapter 1, we demonstrated how the proposed legislative change 'Wet BIG II' significantly disrupted and fractured the nursing community. Despite its emancipatory agenda, the plans and actions of nurse leaders, experts and policymakers, inadvertently intensified feelings of inclusion and exclusion, accentuated sensitive differences, and exacerbated existing grievances within the nursing community (Schalkwijk et al. 2024). From the perspective of the politics of organizational change literature, this outcome is consistent with the idea that the introduction of new stratifications in professional work are political acts that impose new and normative boundaries and order in fluid organizational ecologies where competing identities, interests and ideologies are at play (Kornberger et al. 2006, Tsoukas and Chia 2002, Belova et al. 2008). From this viewpoint, 'imposed' change inevitably creates 'winners and losers', depending on how these (new) boundaries align with the interests and perspectives of various stakeholders (Clegg 2023, Mouffe 2005). As a result, resistance from those seeking to protect or enhance their institutional and organizational positions emerges almost as a natural outcome of these power dynamics (DiMaggio 1988, Lawrence et al. 2011). This is exactly what happened in the nursing context, as I will detail below.

A key contribution of this dissertation is to show how nurses organized their resistance to anticipated macro-level changes by leveraging alternative lines of communication, authority and power to circumvent the conventional political and organizational infrastructures typically used for political mobilization by established professional groups (Denis et al. 2019, Carvalho 2014). Drawing on theories of Mouffe (2005) and Laclau (2005), we argued that nurses resorted to these alternative pathways in response to the traditionally and contemporarily fragile institutional and political representation of the nursing profession in healthcare, policy and politics. Drawing on insights from all the chapters in this dissertation, I identify at least two key representational deficits that profoundly affected the nature, processes and outcomes of nurses' resistance to 'Wet BIG II'.

First, the nursing profession is diverse and heterogeneous, encompassing groups with a range of educational backgrounds, identities, aspirations and grievances. This diversity complicates efforts to mobilize and represent the different interests, values and envisioned futures in nursing because they are not fixed but rather divergent, emergent and inherently contested (Ayala 2020, Hallam 2012). Formal professional nursing associations in the Netherlands, which advocate for and represent the wide range of interests within the profession, are relatively new and not very powerful (Schalkwijk et al. 2024). The support at that time of the largest association, the V&VN, for the proposed

new nursing roles and legislation further undermined its credibility, legitimacy and support within the nursing community. Many nurses criticized the association for 'joining forces' with policy elites and for failing to represent the diverse roles and interests within the nursing profession. *Second*, within healthcare organizations, nurses are typically marginalized from organizational decision-making processes and have little influence, voice and control over the content and organization of their work. This marginalization is well documented in critical nursing literature (Verhoeven et al. 2024, Taylor et al. 2022, Allen et al. 2023, Jackson 2022, Schwerdtle et al. 2020) and empirically examined in chapters 2, 3 and 4.

Chapter 1 shows how certain subgroups in the nursing community viewed the proposed legislation and new nursing roles as an existential threat. They perceived these changes as imposing new hierarchies that not only restructured the formal organization of their work but also disrupted and rearranged the norms, values, and knowledge fundamental to their practice. These nurses felt that the proposed changes were unjust, while they lacked conventional means to voice their unsatisfied demands. As a result, they resorted to alternative strategies and employed a populist action frame. In their attempts to resist and influence the system to achieve their goals, these nurses demonstrated a notable degree of creative — though, as will be discussed later, ambiguous in terms of outcomes — political entrepreneurship (Buchanan and Badham 2020). This political entrepreneurship was evident in several ways, including: (I) articulating and disseminating their grievances on social media and in hospital settings, (II) establishing a political frontier between the genuine nursing community and the 'corrupt' elite, (III) policing digital and organizational networks as well as nursing teams in daily care practices, (IV) openly challenging the legitimacy of the formal representation of the Dutch nursing associations, and (V) engaging a broader public through traditional media channels.

These political actions were complex and multifaceted. In our analysis, we attempt to refrain from moralizing or celebrating nurses' use of populist action frames in organizing resistance and professional mobilization. Instead, we interpret it as a distinct form of 'doing politics' (Mouffe 2005, Mouffe 2018, Laclau 2005), which allows us to explore both the dark and bright processes and outcomes of nurses' embracing this political strategy. On the one hand, this case demonstrates how nurses' turn to a populist action frame provided them with agency and a distinct way to challenge top-down policies that they perceived as imposed and unwelcome. On the other hand, as will be detailed later in this section, the more destructive consequences of their partisan strategies on organizational change programs and initiatives extended far beyond the immediate context, with significant implications for fostering the acknowledgement and appreciation of the variety of nursing knowledge, roles, and work.

Nurse explorers

The Covid-19 pandemic revealed a different facet of nurses' political agency and entrepreneurship (Buchanan and Badham 2020). In Chapter 2, we described how nurses innovatively renegotiated and reinvented hospital operations and healthcare delivery 'on the fly' in the face of unprecedented pandemic pressures. Drawing on a practice-based approach (Nicolini 2012, Reckwitz 2002) and assemblage literature (Deleuze and Guattari 1988), we spotlighted the experimental organizing work (Allen 2014) that nurses engaged in as they navigated and learned about the many uncertainties and unknowns of their daily pandemic crisis work. In this chapter, we demonstrated that such experimenting work is inherently political, highlighting the normativities, political strategies, and power dynamics that underpinned nurses' organizing work during the pandemic.

We used the metaphor of 'uncharted territory' to capture the new organizational terrain that nurses navigated, which included not only epidemiological, clinical and ethical unknowns but also a lack of knowledge about how to coordinate and organize Covid care in the absence of established scenarios, best practices, formal strategies and crisis accountability structures. Extending this metaphor, we characterized nurses as 'explorers' to highlight their ad hoc improvisational and strategic organizing work within healthcare organizations that lacked (in)formal structures, routines and resources. Our analysis revealed that in their exploratory work, nurses made complex and real-time decisions about the organization of care and the allocation of limited resources and attention. In the process, they adeptly balanced conflicting values and the needs of individual and collective patients against available organizational capacity. These decisions were made well informed — without suggesting that the decisions made were always right — as nurses sought to make sense of new terrain by drawing on a complex assemblage of phronetic, relational, organizational, and clinical knowledge (Ihlebæk 2020, Allen et al. 2023, Wise et al. 2022). This enabled them to engage in normative and experimental tinkering, a practice that played a crucial role in keeping healthcare 'on track' during the pandemic.

In discussing the Covid case, we also showed that managers, physicians, policymakers, politicians and the wider society heavily depended on nurses' innovative organizing practices to navigate the crisis. Nurses seemed to be aware of this. Our analysis showed how nurses leveraged their changing organizational and institutional position — marked by the sudden visibility of the profession, their central role in the crisis and new organizational dependencies — to (re)negotiate various advantageous organizational changes. One salient example, as discussed in Chapter 2, is how nurses successfully reconfigured the circuits of power (Clegg 2023) within their organizations to effect architectural adjustments on their wards. This included, for example, the installation of new windows and access doors to allow for remote patient monitoring and visitor regulation — changes they had long advocated for but had previously and consistently

been denied. This case illustrates how nurses mobilized their power, at least temporarily, in agentic and politically savvy ways (Buchanan and Badham 2020) amidst the temporary breaches and changes in entrenched governing systems within hospitals caused by the shocks of the pandemic.

In conclusion, I argue that while partisan politics (Mouffe 2005, Bolman and Deal 2017) usually is about the struggles and conflicts between groups of 'people' and 'elites', the politics of explorers, in contrast, is about the normative and strategic management of valued ends, interests and organizational dependencies that shape and mediate the (re) organization of (constrained) care work. It sheds light on the political and normative choices, assumptions and interests that underlie the allocation of scarce resources and attention, as well as how nurses leverage (new) organizational power dependencies to negotiate, steer and control organizational change.

Politicalization of the nursing identity

My retake of Chapters 1 and 2 above highlights that the nursing identity is inherently unstable, contested and diverse. This instability became particularly pronounced in the responses to 'Wet BIG II' and the Covid-19 pandemic, with implications for both organizational change processes and the position and legitimacy of nurses in the field. In Chapter 1, we demonstrated how nurses, through their partisan efforts, politically constructed and leveraged a 'genuine' nursing identity to create a political frontier. This politicization of the nursing identity sharply divided the nursing community into 'genuine' and 'elitist' nursing groups, with different positions on the proposed changes. In the process, partisan nurses normatively cemented a nursing identity that equated 'real nursing' with bedside work, celebrated the hardworking, patient-centered nurse, and asserted that 'all nurses should be equal'—implying that moving away from the bedside and caring for the organization policies was 'unequal' and elitist. The findings across all chapters of this dissertation reveal that this constructed discourse is so pervasive that all nurses and organizational change projects must either strategically align with it or challenge it in their everyday practice.

Ironically, in a manner similar to the exclusion and silencing experienced by partisan nurses, the discourses and meanings articulated in nurses' populist action frame have introduced new forms of normative control into nursing practice, obstructing and silencing nurses who deviate from this micro-care giving identity (Chapters 2, 3, and 4). In the 'bedside' discourse, nursing work beyond the bedside, along with the wide diversity of knowledge that informs this type of work, is rendered unimportant or 'not really nursing work'. Both prior critical nursing literature and this dissertation (see chapters 2, 3 and 4) highlight this as potentially harmful, not only to organizational change processes and quality of care but also to the position and legitimacy of the nursing profession within the wider healthcare ecology.

The bedside nursing identity was not only emphasized by partisan nurses but was also mirrored in public, media and political contexts, as well as within healthcare organizations during the Covid-19 pandemic. In line with critical literature on the representation of nursing work during the pandemic and nurses' participation in pandemic decision making (Verhoeven et al. 2024, Mohammed et al. 2021, Grenz and Günster 2022, Einboden 2020, Croft and Chauhan 2021), Chapter 2 demonstrates how nurses, despite their active and frontline organizing roles, struggled to overcome the stereotypical representations of their pandemic care work. Although their visibility increased (Croft and Chauhan 2021), the representation of nurses often remained reductionist (i.e. reducing the nursing role to one of heroically caring for patients), rendering their authority and control over the content of their pandemic work invisible — or leaving it to a few lone others (i.e. some nurses were frequently featured on talk shows and in the newspapers). We showed that this reductionism was evident, for example, in the initial exclusion of nurses from most formal crisis decision-making structures, whether within hospitals or at the national policy level (Chapter 2).

Against the background of the partisan revolt, we furthermore observed that moral imperatives within the nursing community, that centered on equality and modesty, led some nurses to temper their visibility and ambitions. The fear of being 'othered' (Roberts and Schiavenato 2017) and thus associated with 'elite' groups made several nurses in this study hesitant to take on leadership roles and to build new alliances and networks both within and beyond the hospital to influence decision making. Nurses who did stand out often faced considerable pushback from within their own profession. For example, in Chapter 2, we feature a nurse who became a prominent representative of the profession in national pandemic decision-making forums and a frequent media contributor. She voiced her frustration at the general lack of support and the hostility she faced from her colleagues in her ward. According to her, her involvement in the governance and organization of Covid care led her peers to see her as more aligned with organizational and political elites than with the nursing profession itself, creating tensions and placing her in a precarious position within her own team and organization.

New organizational power

A second observation is that various forms of 'new power' (Buchanan and Badham 2020) play an important role in shaping nurses' political mobilization, voice and action in response to societal and organizational challenges and pressures. Expanding on traditional perspectives of organizational power (see Chapter 4), 'new power' is theorized as organizational power that is "*generated by many, through group participation, and is open, participative, and peer-driven. It [new power] is more dispersed and is based on our technological ability to participate, through social media in particular*" (Buchanen & Badham 2020, p. 41). This dissertation demonstrates how new power expands the power resources available to nurses within organizations, influencing their organizational position and change processes. These shifts in communication and representation

channels not only redefine the ways in which nurses can voice their unsatisfied demands, but also demonstrate the potential for new power structures to alter traditional hierarchies and modes of influence, as I will detail below.

Today, digital media and technologies are fundamentally transforming the nature and exercise of power in organizations (Avelino 2021, Anwar and Graham 2020, Dencik and Wilkin 2018). This dissertation demonstrates how these technologies provide new political opportunities for professional groups, such as nurses, who have traditionally occupied the periphery of organizational attention, representation, and decision-making. By politically mobilizing and articulating their grievances and perspectives through digital platforms, nurses are able to circumvent the traditional authority structures and communication channels that they perceive as exclusionary or misrepresentative, as discussed in Chapters 1 and 2.

For example, in Chapter 1, we demonstrated how social media provided nurses with innovative forms of dissent and political mobilization, offering a platform for grassroots resistance and 'collective action' against 'Wet BIG II'. By engaging with and strategically using these platforms, nurses found new ways to overcome traditional challenges in constructing, organizing, and expressing collective nursing identities and resistance to organizational and institutional change and power. In addition, by sharing their perspectives and lived experiences on social media, nurses gained greater access to conventional media outlets, thereby expanding their reach and influence in both professional and public arenas. Similarly, in Chapter 2, while discussing the public media portrayals of nursing work during the pandemic, we reference sociological research that explores how other groups of nurses intentionally used the same social media platforms to challenge the micro-bedside identity promoted by partisan nurses and public media. These nurses strategically used their social media accounts to highlight the diverse and multifaceted nature of pandemic nursing work, contesting what they perceived as a reductionist 'bedside' identity propagated by partisan nurses and reproduced in practice and media outlets (Croft and Chauhan 2021).

Our observation that new technologies and digital media are introducing forms of 'new power' (Dencik and Wilkin 2018, Buchanan and Badham 2020) into healthcare is important because it changes the nature of organizational politics and change. In the nursing context, we have shown how new power has redistributed (some) control away from formal and traditional authorities (e.g., organizational structures, professional associations) to frontline nurses. This shift provides nurses with new opportunities for agency and voice in organizational contexts where vested power structures often tend to limit their capacity to act. Consequently, the resistance to change by nurses seeking to protect or improve their institutional and organizational position (DiMaggio 1988; Lawrence and Suddaby, 2000) is becoming more spontaneous, peer-driven and emergent. However, our analysis, in line with emerging literature on new organizational

power (Avelino 2021, Dencik and Wilkin 2018, Anwar and Graham 2020, Buchanan and Badham 2020), cautions against interpreting these developments as leading to more democratic forms of professional mobilization. We show that such movements can also produce 'dark forces' and processes of inclusion and exclusion. As our analysis of the different identities articulated and leveraged by partisan nurses and nurses in the pandemic showed, the use of social media in nursing did not lead to a unified or democratic political project but instead highlighted and deepened divisions and tensions within the nursing community and around (future) agendas for change.

2. Epistemic politics and organizational change

In answering the second subquestion — *how does the knowledge used and valued in organizational change processes reflect and shape power dynamics in the field* — I examine the interplay of power, knowledge, and politics in organizational change processes in the nursing context. This dissertation demonstrates that the production, use and valuation of knowledge in organizational change processes has an inherently political dimension (cf. Hurri & Kestila, 2019, Doing, 2006). By examining the unstable, diverse and contested role of knowledge in nursing (change) practice, the preceding chapters highlighted how epistemic hierarchies, norms and power dynamics intricately shape organizational change processes and impact the construction of nurses' professional identity, professionalism and organizational legitimacy (cf. Ernst & Tatli 2022, Traynor, 2009). This analysis is important for addressing the main research question because it uncovers how epistemic politics (Doing 2004, Beaulieu et al. 2012, Sørensen and Traweek 2022) determines what knowledge is considered valid and valuable for guiding organizational change, who controls epistemic agendas, and how the underlying politics impact the level of control, authority and legitimacy that nurses hold in both daily practice and during periods of change (Allen et al. 2023).

Knowledge is a central theme throughout the chapters of this dissertation, as it lies at the heart of political contestation in organizational learning and change (Hardy and Thomas 2014, Hadjimichael and Tsoukas 2023, Zuiderent-Jerak et al. 2009) and in the shaping of nursing professionalization agendas (Yam 2004, Hoff and Kuiper 2021, Ernst 2020). Chapter 1 reveals, for example, how knowledge has been used strategically in partisan struggles to delineate a political frontier between nurses and elite groups, both within and outside the nursing community. In this quest, partisan nurses celebrated hands-on and experiential knowledge as the hallmark of 'real and genuine' nursing work, while positioning 'textbook and evidence-based' knowledge' as elitist and less relevant to genuine nursing practice and professionalism. Chapter 2, in turn, shows how this partisan discourse around practice-based knowledge is overly reductive and one-dimensional, failing to capture the complexity and diversity of nurses' tacit and relational knowledge, skills and logics as applied to different roles, contexts and goals (Allen, 2015). It demonstrates how much of nurses' complex tacit epistemologies typically

remain obscured not only in partisan 'bedside' discourses but also in healthcare policy, professionalization agendas, and everyday practice.

Chapters 3 and 4, in turn, addressed how epistemic politics (Doing 2004, Beaulieu et al. 2012) significantly impact the bottom-up and nurse-driven organizational change programs. I will discuss this further below.

Epistemic politics in experimental change programs

Following the overturning of the legislative amendment 'Wet BIG II', nurse leaders, policymakers and politicians revised their strategies not only in respect of responsibility for reorganizing nursing work but also regarding the methods and knowledge to support these efforts (Van Kraaij et al. 2022). Chapters 3 and 4 describe how this shift fostered a nurse-driven and practice-based approach that encouraged nurses to take the lead in experimenting with new roles and innovative practices from the bottom up. This approach explicitly aimed to harness the wide range of knowledge, expertise and ideas of nurses to reorganize and strengthen the profession.

Nurses were now positioned at the forefront of change, a role strongly emphasized at a knowledge conference organized by our RN2Blend research consortium. At the conference, the (now former) Dutch Minister of Health and Sports proclaimed: "Changes can only occur from within the profession. You know what is required. You are now in the lead. Use that well!" (Chapter 3). In practical terms, nurses' responsibility and leadership were organized through the implementation of experimental change programs. These were designed as formative, open-ended and reflexive pilot programs aimed at fostering experimental learning (Regeer et al. 2016, Kuhlmann et al. 2019). The programs provided time and space for nurses to engage in the creation and reconfiguration of new practices and approaches through cycles of trial, error, and reflection, embedding learning in their local work context (Muniesa and Callon 2007, Clegg et al. 2005). Below, I will critically discuss these bottom-up change programs from an epistemological perspective.

Improvisational learning and organizational power

In Chapter 3, we illustrated how nurses initially and inventively adopted a practice-based experimenting approach to learning in their change programs to explore new ways of organizing their work. This experimenting approach — defined by in-situ improvisation and the development of creative, practical solutions for care delivery, organization and coordination (Tsoukas and Chia 2002, Cunha and Clegg 2019)—enabled nurses to use a wide range of improvisational, tacit, and relational knowledge to innovate and trial innovative roles, practices and approaches. This experimenting mode of learning, and the tacit knowledge it employs, closely mirrors nurses' exploratory efforts observed in nurses' daily practice and during the pandemic, as discussed in Chapters 2 and 3. However, both chapters also reveal that the tacit epistemologies supporting this experimenting approach are contested and shrouded in a cloak of invisibility (Allen 2014). This research

brings to light the significant implications of this epistemic invisibility, particularly in relation to nurses' legitimacy, authority, and control over learning and their ability to challenge the prevailing circuits of power (Clegg 2023), as I will detail further below.

In Chapter 3, we discussed how the literature identifies two ways in which experimenting contributes to learning: through convergent and divergent improvisation (Edmondson 2004, Cunha and Clegg 2019). This conceptual sensitivity allowed me to reveal that in the change programs, successful nurse innovations emerged predominately from convergent learning (Cunha and Clegg, 2019)—characterized by ad hoc innovations and solutions developed 'below the organizational radar' to smooth, repair and maintain the functionality of everyday systems of care and power (Edmondson 2004). Yet, in a twist of irony, as the experimenting change programs progressed and their impact expanded, the very experimenting approach that made these innovations possible was itself sidelined by the demands of divergent learning. Divergent learning, which intentionally seeks to challenge entrenched organizational practices and routines (Cunha and Clegg, 2019), quickly led to the experimenting approach and its foundational tacit epistemologies being discredited and dismissed by stakeholders and nurses themselves.

To unpack these dynamics, we referred to the literature on epistemic politics (Doing 2004, Hurri and Kestilä 2012, Beaulieu et al. 2012). This literature allowed me to highlight three key dynamics that drove nurses to increasingly adopt EBP amidst divergent learning contexts. EBP offered nurses with a familiar and institutionally legitimate framework for guiding learning and justifying innovative actions (Zuiderent-Jerak and Berg 2010, Nugus et al. 2010, Sheard et al. 2017), even as it marginalized improvisational and tacit approaches and epistemologies. First, in the context of divergent learning, we observed strong stakeholder pressure on nurses to conform the norms of evidence-based knowledge and institutionalized evidence-based approaches to healthcare innovation and change (Broom and Adams 2012, Bate and Robert 2002). Second, in the midst of these confrontations, nurses faced significant difficulties in legitimizing their experimenting approach. They often lacked the voice, credibility and interpretive resources necessary to validate tacit and improvisational approaches within the dominant institutionalized accountability regimes (Allen et al. 2023). Third, many nurses themselves viewed the experimenting approach as insufficient to address the complexities of broader and divergent organizational changes. Concerns about the uncertainty associated with these changes — including concerns about care quality and safety, accountability for proposed interventions, and the political ramifications of disrupting established norms, routines and regulations — led nurses to favor more conventional epistemic approaches.

Power implications of epistemic politics

In addition to the practical implications of epistemic politics — namely the stalling of change programs due to the lack of legitimized evidence-based knowledge and approaches for reorganizing nursing work — this research reveals three power-related implications:

First, processes of epistemic politics shifted control over change and learning away from nurses and concentrated these into the hands of other organizational stakeholders. In Chapter 3 and 4, we demonstrated how these stakeholders interfered with nurses' experimenting work through epistemic politics in ways that conflicted with the ministerial agenda for nurse-driven and practice-based learning. Ironically, despite hospital management's responsibility and initiative for implementing the change programs, and hence their presumed support for this agenda, they did not always recognize the legitimacy of this learning approach in daily practice. Instead, hospital leaders undermined nurses' knowledge claims through directive, discursive and a priori devaluations of nurses' tacit epistemologies, knowledge that is not well valued institutionally (Allen 2014, Ernst and Tatli 2022). Literature widely acknowledges that, in hospital settings, EBP serves as the 'north star' for legitimacy (Greenhalgh 1999, Timmermans and Berg 2003, Broom and Adams 2012), rendering alternative knowledge claims and approaches almost inherently contested, unstable and subordinate. This dissertation adds to this literature by showing how, in everyday nursing practice, higher-level actors tend to leverage the dominance of certain epistemics to control and direct the learning of others in ways that align with their own perspectives, epistemic norms and interests (Doing 2004). These actors linked power, knowledge and learning in ways that favored their own authority over the nurses' learning processes. Thus, they used knowledge as a political tool to confine nurses' leadership, participation, and control within the parameters they set for organizational change (Courpasson 2000, Berti and Simpson 2021, Cunha et al. 2019, Ivanova and von Scheve 2020).

The *second* power related implication arising of the processes of epistemic politics in the change programs concerns the perpetuation of forms of epistemic injustice (Fricker 2007). The increasing invalidation of nurses' experimenting approach paradoxically exposed the lack of legitimacy of the tacit dimensions of nursing knowledge, professionalism and work that the change programs intended to address. In Chapter 3, I used two forms of epistemic injustice observed in the change programs as introduced by Fricker (2007): testimonial and hermeneutical injustice. Testimonial injustice allowed me to show how nurses' practice-based contributions to learning are often undervalued due to stereotypical perceptions of nursing professionalism. This highlights the inherent risks and consequences of stereotyping and politicizing the nursing identity according to one-dimensional care-giving norms, a theme that runs through the chapters of this dissertation. However, a more profound and distinctive contribution of this research is the identification of hermeneutical injustice faced by nurses in organizational

change processes. This form of injustice arises when organizational actors lack the interpretative resources to articulate and make sense of their expertise, experience, and identity. In the context of nursing, this interpretive deficit appears to hinder nurses' ability not only to legitimize their experimenting skills and knowledge to themselves but also to articulate their tacit knowledge in terms recognized by dominant authorities and stakeholders. This has serious implications for nurses' role and engagement in the politics of organizational change as it creates barriers to validating and legitimizing the alternative tacit epistemologies in organizational settings where more powerful actors tend to determine which knowledge is considered legitimate and which can be ignored.

To conclude this second implication, this dissertation demonstrates how organizational power dynamics shape the epistemic politics, injustices and hierarchies that pervade nursing (change) practice. As we have shown, these dynamics have both profound implications for organizational change processes and for efforts to validate and reposition the nursing profession. Firstly, epistemic politics impact organizational change by determining which knowledge and knowers are considered valid and valuable for guiding learning, and who holds the control and authority to make such decisions. Secondly, these politics reinforce entrenched and asymmetrical power dynamics and sustain hierarchical epistemic paradigms in nursing practice, professionalism (Latimer 2014, Yam 2004), and organizational learning (Waring et al. 2016, Fraser et al. 2019, Jones et al. 2019). In Chapters 3 and 4, we showed that despite the leadership role assigned by the Dutch minister to foster change towards more equitable and emancipated professional environments, the change programs intended to achieve these aims paradoxically (re)produced experiences of epistemic injustice (Fricker 2007), legitimacy deficits, and marginalization among nurses.

The final and *third* power related implication concerns the inherent risk of exploiting existing systems of care and power in convergent learning (Edmondson 2004, Cunha and Clegg 2019). As previously explored, entrenched epistemic and professional power relations have channeled nurses' experimenting work in the change programs toward convergent learning. However, this creates a paradoxical situation when trying to shift organizational power relations and balances as part of the agenda of change.. Divergent learning, which involves taking deliberate action to push boundaries and change the organizational status quo, contrasts with convergent learning, which is inherently more exploitative in nature because it involves maintenance and repair work to 'fix' problems within the existing organizational and power structures, even if this involves temporarily and creatively deviating from established practices, routines and relations (Edmondson 2004). In doing so, convergent learning tends to enhance existing capabilities instead of upsetting the system's power balance (Cunha et al. 2021, Hadjimichael and Tsoukas 2023, Cunha and Clegg 2019, Micelotta and Washington 2013, Graham and Thrift 2007). This means that when nurses' experimenting work is confined to and framed within convergent learning, they risk reinforcing an asymmetrical and unfavorable

organizational status quo through their 'exploitative experimenting work'. Thus, nurses in change programs who are motivated to break existing chains of domination but find themselves constrained by epistemic politics, may inadvertently strengthen the capabilities of exploitative systems, thereby reinforcing the very structures of asymmetry they seek to dismantle.

3. Changing organizational power relations as part of the agenda of change

Power has been a recurring theme in the examination of previous subquestions, notably in the analysis of the grassroots power of the partisan nurses (Chapter 1), new forms of organizational power (Chapters 1 and 2), the power embedded in the bedside discourse (all chapters), and the epistemic politics that reflect and define power structures (Chapters 3 and 4). This final subquestion — *which asks how organizational change programs aimed at shifting power balances affect organizational power relations in nursing* — brings the theme of power even more to the forefront by explicitly addressing different 'modalities of power' (Chapter 4) that accompany organizational change processes in nursing. This focus on organizational power is important because the organizational change programs in nursing have increasingly centered on nurse em*power*ment with the objective of shifting power balances in nursing and redistributing decision-making authority in organizational governance, as discussed in both the introductory chapter and Chapter 4.

In healthcare organizations, power is typically organized by affording some organizational members superior access to decision-making arenas than others, with both formal and informal routines, rules and practices governing decision-making within these arenas (Cunha et al. 2020, Clegg 2009, Gilbert 1995). The organizational change programs I studied in this dissertation actively sought to integrate nurses into new arenas and challenge established decision-making structures. In this dissertation, I have applied a conceptual power framework based on organizational power literature (Clegg 2023, Haugaard 2012, Haugaard and Clegg 2009, Pansardi and Bindi 2021, Avelino 2021) and critical sociological perspectives on empowerment (Hardy and Leiba-O'Sullivan 1998, Barker 2002, Sauer and Nicklich 2021, Ivanova and von Scheve 2020, Weidenstedt 2016) to examine how institutionalized decision-making structures are contested, how power transitions are shaped and enacted in practice, and their (dis)empowering effects on the nursing profession. Specifically, I used this framework to highlight and understand the everyday political dynamics in nurse empowerment processes and how these dynamics interact with, and are mediated by, three-dimensional power (Lukes 1974, Lukes 2005). Discussing such politics (of empowerment) is important for addressing the main research question because it reveals how power functions during organizational change and how its complex and multidimensional operation in everyday change practices can lead to both empowering and disempowering outcomes for nurses, as I will detail below.

Change agenda: empowerment!

As outlined in the introductory chapter and Chapter 4, the interplay of nursing shortages, widespread dissatisfaction among nurses, the heightened visibility of nursing work during the pandemic, and shifting public and political discourses has led to a surge of empowerment initiatives in the Netherlands, which we have collectively referred to in this dissertation as an 'empowerment movement'. This movement, which my colleagues and I in the RN2Blend consortium have both studied and actively promoted, has been supported and funded by the national government, which sees nurse empowerment as an innovative response to the acute and escalating nursing shortages, and as a strategic intervention in nurses' sociopolitical struggles, aiming to promote more equitable nursing practices. Accordingly, in recent years, the Dutch Ministry of Health has reoriented its policies to better facilitate power transitions within nursing. At the hospital level, this policy shift has resulted in an increased focus on redefining the role of nurses within organizational structures and increasing their involvement in organizational decision-making and agenda-setting. This drive towards empowerment has been further reinforced by recent legislative measures mandating the inclusion and active participation of nurses in organizational decision-making structures (the 'Dutch Quality Act').

In Chapter 4, I introduced how empowerment is commonly conceptualized in the power literature as a shift from 'power-over' relations, which are marked by asymmetry, coercion, and domination (Göhler 2009, Pansardi 2011), to 'power-to' relations which emphasize the capacity to act, achieve goals and foster individual agency and autonomous decision-making (Haugaard 2012). In this chapter, I examined how the uncertainty and ambiguity prevalent in organizational change programs that aim to facilitate shifts in power relations, can be understood in terms of their exposure to the three dimensions of power (Lukes 1974, Lukes 2005). To recapitulate, these three dimensions include: the organizational management and control of resources (one-dimensional power), the management of decision-making processes (two-dimensional power), and the management and framing of meaning and discourse (third-dimensional power).

In what follows, I will detail how the dynamics and enactments of three dimensions of power shape power transitions in nursing, either by reinforcing or disrupting existing power relations and coalitions.

The dark side of 'power to': managed voice and participation

The different chapters of this dissertation have demonstrated that considerable one-dimensional power resources have been (re)allocated to nurses as part of the nurse empowerment programs with the aim of promoting 'power-to' relations. This is evident in several developments, such as the creation of new nursing roles (e.g., supervisory, research, quality roles), improved access for nurses to decision-making arenas through enhanced participation in interdisciplinary clinical and organizational networks and

platforms, and the formation and strengthening of nursing councils (known in the Netherlands as "Verpleegkundig Adviesraad" and "Verpleegkundig Stafbestuur").

However, consistent with a growing, albeit still marginal, body of literature on the 'dark side' of implementing 'power-to' relations (Courpasson 2000, Haugaard 2012, Pansardi and Bindi 2021), Chapter 4 reveals that these empowerment programs are being introduced into organizational environments characterized by entrenched asymmetrical hierarchies, vested power structures and regulatory discourse — sources of strong organizational legitimacy that are reluctant to cede authority or recognize the legitimacy of nurses' newly acquired one-dimensional power (Chapters 3 and 4). In other words, despite the (important) gains in one-dimensional power that nurses have achieved through these programs, such as increased access to resources and decision-making processes, essential two- and three-dimensional power often remained firmly concentrated in the hands of more powerful organizational actors. This dissertation demonstrates how such power dynamics can adversely affect nurses by rendering empowerment programs prone to co-optation and top-down management of empowerment. Specifically, Chapters 3 and 4 detail how involved stakeholders, often with more power, selectively interpreted elements of the empowerment programs and agendas in ways that undermined their initial emancipatory objectives.

Chapter 4 provides several illustrative empirical examples of this, including a case where the introduction of a new 'supervisory' nursing role at one of the participating hospitals was co-opted by hospital management in response to strong financial and performance pressures and an impending accreditation audit. In this hospital, 'empowered' supervising nurses were tasked by management with improving performance scores and ensuring rigorous registration of external quality indicators on the nursing wards. Faced with different pressures and persistent slack and resistance from the nursing staff, supervising nurses were encouraged by the local quality department to motivate and persuade their peers to adjust their work practices and commit to improving and recording performance indicators. The intent of this example is not to engage in the extensive (and informative) debates in the sociological literature about the value, performativity or governmentality of performance indicators in healthcare practice (Wallenburg et al. 2019, Triantafillou 2015, Dahler-Larsen 2014), but rather to highlight how subtle political strategies are being employed to direct the actions of 'empowered' nurses in ways that align with broader organizational objectives. This is often referred to as 'strategic alignment' in the critical empowerment literature (Andersson and Liff 2018, Ivanova and von Scheve 2020, Hardy and Leiba-O'Sullivan 1998, Sauer and Nicklich 2021).

Such alignment ties into a broader observation of this dissertation about how asymmetrical and hierarchical power relations are reproduced in the change programs through three-dimensional power: while nurses are provided with new power resources

(one-dimensional power), their use is often directed by frameworks established by more powerful figures (two-dimensional power). As a result, the management of nurses' voice, autonomy, and authority is vulnerable to being constrained by familiar cultural and organizational scripts (three-dimensional power). Based on the ethnographic findings in this dissertation, I would then argue that that just as the exclusion of certain organizational groups tends to go hand in hand with processes of extraction (Liboiron 2021, Hatton 2017, Hatton 2020), that the inclusion and 'uplifting' of nurses through empowerment can also reproduce or deepen similar extraction dynamics, albeit through more subtle and multidimensional means.

Other examples in this dissertation that illustrate the reproduction of 'power-over' dynamics through the exercise of three-dimensional power include processes of non-decision-making, in which issues raised by nurses are constrained or sidelined through formal and normative control of decision-making processes (Bachrach and Baratz 1970) (Chapters 3 and 4), turf games (Buchanan and Badham 2020) in which stakeholders strategically intervene in nursing innovations and initiatives to protect or expand their own boundaries and influence (Chapter 4), processes of epistemic politics (Doing 2004, Beaulieu et al. 2012, Hurri and Kestilä 2012), and resistance from a stagnant nursing culture that impedes nurses voice and participation in organizational structures and decision-making (all chapters).

In conclusion, examining the implementation of power-to relations in nursing through the lens of three-dimensional power (Lukes 1974, 2005) shows that while these empowerment programs facilitate the redistribution of decision-making power and create new channels for nurses' voice, influence and representation within organizations (one-dimensional power), they also simultaneously constrain nurses actual exercise of this power. This constraint arises because nurses' voice and influence are regulated and shaped by what dominant actors and cultural scripts consider appropriate and desirable (two-and three-dimensional power) (Lincoln et al. 2002, Ivanova and von Scheve 2020). This analysis leads me to argue that unless institutionalized power dynamics and relations are challenged in a multidimensional way (Lukes 1974, 200), power asymmetries will be at best be transformed in terms of their operation, manifested through more subtle and covert forms of two-and three-dimensional power rather than being resolved. From a critical viewpoint, this suggests that the empowerment programs risk becoming merely symbolic and technocratic tools aimed to align nurses with marginalizing organizational objectives. In this way, change agendas may lose their critical content (Booth 2019, Jasanoff 2004, Ahmed 2012), while maintaining the outward appearance of commitment to nurse empowerment measures and discourses by national bodies and healthcare organizations.

The bright side of 'power ~~to~~ with': deconstructing patterns of domination

This dissertation, however, has also made clear that reducing the empowerment programs to merely disempowering effects would not only diminish the substantive work and accomplishments of the nurses and other stakeholders in the field but also represent an oversimplification of the complexity of power transitions in practice and their multifaceted outcomes. Therefore, in this section, I will discuss the 'bright' empowering outcomes associated with the 'empowerment movement' and the local change programs through the lens of Lukes' (1974, 2005) three-dimensional view on power.

Beyond its empirical relevance, this focus is important for addressing a notable gap in the literature. Lukes' three-dimensional power framework, with its emphasis on power in terms of domination (Dowding 2006), has primarily been used to analyze the manifestation of coercive and dominant power relations in organizational practice and the political dynamics that (re)produce organizational subordination (Lawrence and Buchanan 2017, Allen 2008, Maclean et al. 2010, Mulinari and Vilhelmsson 2020, Edwards 2006). As a result, there is limited literature that conceptually and/or empirically explores how organizational and emancipatory change can emerge from multidimensional power practices and transformations. This dissertation aimed to address this gap. We did this by drawing on critical literature on 'power-with' (Pansardi and Bindi 2021, Pansardi 2011, Haugaard 2012, Cunha et al. 2020) to spotlight the positive and empowering effects of changing power relations within the empowerment programs. This literature distinguishes between power-to and -with relations in order to differentiate between situations in empowerment programs where power is 'handed down' from higher authorities to subordinate members — often under specific and pre-determined conditions that can (re)create power dependencies — and situations where more co-active and circular power relations emerge. In the latter, 'empowered' organizational members actively shape how, when and where they acquire and exercise their power (Guérin et al. 2013, Hazen 1993).

In observing the change programs, we found that incrementally, the resistance nurses encountered when engaging in (new) decision-making arenas gradually did more than merely highlight conflicts of interest and differing interpretations. It also made these conflicts more articulate and visible, along with the power dynamics that typically suppress or settle such conflicts (Bolman and Deal 2017, Clegg 2009). In other words, incorporating nurses into decision making platforms (one-dimensional power) created opportunities for political conflict and brought to light the often hidden two- and three-dimensional power dynamics that govern nursing and nurses' participation in decision-making. According to the foundational work of Mouffe (2005) and Laclau (2005), which we used in Chapter 1, introducing and embracing conflict in decision-making processes fosters democratic engagement and emancipation by challenging hegemonic tendencies and encouraging the engagement of adversaries in the public forum, rather than

relegating conflict to suppression or neglect. In Chapter 4 we refer to this as processes of translation (Kornberger et al. 2006), which involve deliberate organizational actions taken to establish and strengthen heterogeneous networks that welcome a wide range of voices, interests and perspectives while constructively accommodating professional conflict within these emergent arenas.

Consistent with this literature, this dissertation demonstrates how increased conflict and visibility of three-dimensional power had significant implications for the legitimacy and dominance of existing power structures and catalyzed increased resistance and political entrepreneurship (Buchanan and Badham 2020) among nurses against forces that constrained their participation. In chapter 4, I introduce this form of political entrepreneurship as a type of deconstruction (Kornberger et al. 2006). Deconstruction involves politically charged acts of problematizing and destabilizing taken-for-granted organizational practices and hierarchical power structures. It entails challenging dominant organizational discourses and disrupting the prevailing norms that shape professional work, interactions, and decision-making (Berti and Simpson 2021).

In Chapter 4, we identified different ways in which nurses have attempted to do this. Examples include among others, organizing collective action across nursing departments to form a unified political fronts that allowed nurses to negotiate empowerment on their own terms, learning the necessary rituals, rules and managerial discursive repertoires to build alliances and articulate their perspectives and knowledge in ways that were recognized by other decision-makers, leveraging changing legislative frameworks ('Dutch Quality Act') to worm their way into decision-making, and strategically engaging in grassroots improvement work to fix persistent and visible issues in care work in attempts to build legitimacy and support for the variety of new nursing roles among peers and other healthcare professionals (Reay et al. 2006).[4]

Importantly, these political activities led not only to changes in the nurses' own subjective attitudes but also, to some extent, to changes in the subjectivities of the stakeholders involved. In the field, we observed that nurses' participation, along with the articulated conflicts and political acts that followed, triggered a process of delegitimization of normalized practices and meanings that resonated with the stakeholders involved. These changes in discourse and subjectivities helped to distribute responsibilities and foster a broader base of support for emancipatory change (Ghorashi and Wels 2009). This, in

4 It is important to note here that the deconstruction lens (Kornberger et al. 2006) applied in Chapter 4 can be applied to other contexts discussed earlier in this dissertation. For instance, in a different but comparable way, the partisan nurses in Chapter 1 deconstructed familiar organizational and institutional practices of (re)organizing nursing work, as well as their peripheral position within these processes. The lack of deconstruction among nurses and involved stakeholders in Chapter 3, in turn, allowed epistemic politics to powerfully impede innovative experimenting within the pilot studies.

turn, opened avenues for translating new values, practices, and coalitions around new decisions-making processes and practices, potentially leading to co-active forms of power-with (Pansardi and Bindi 2021).

In conclusion, my ethnographic findings lead me to articulate a rather intuitive argument: if patterns of domination and power-over dependencies are shaped and enacted by three dimensions of power, then emancipation requires changes across all three dimensions. Practically and analytically, this means focusing on whether key resources are allocated to nurses or largely retained by those in power (first-dimensional power), ensuring inclusive representation and access in decision-making arenas, and reflexively monitoring parameters that reproduce top-down managerial decision-making (second-dimensional power). Moreover, and most fundamentally, this dissertation demonstrates that the empowering effects of empowerment programs are closely tied to the creation and translation (Kornberger et al. 2006) of spaces for professional conflict (Mouffe 2005) that foster processes of deconstruction (Kornberger et al. 2006) that challenge hegemonic discourses and meanings within institutional frameworks (three-dimensional power), disrupting existing power relations and the organization of professional work.

However, in no way do I wish to present such an approach as a linear or orderly process. If this dissertation has made one thing clear, it is that organizational change and nurse empowerment demands iterative, messy and uncertain political work. Nonetheless, our findings show how such an approach has shifted power balances in small but meaningful ways. And, as institutional theory widely suggests, these 'small wins' (Reay et al. 2006, Amabile and Kramer 2011) are crucial for legitimizing and institutionalizing new ways of organizing and working (together) in nursing practice.

Politics of reorganizing nursing work: conclusions

The above insights gained from answering the three sub-questions now allow me to answer the main research question of this dissertation. After doing so, I will conclude the analysis by revisiting the vignette on the very first page of this dissertation.

In answering the main research question — *how do politics of organizational change impact the reorganization of nursing work, and what are the consequences for the (re) positioning of the nursing profession* — I have identified different ways in which politics of organizational change impact nursing reorganization efforts and the (re)positioning of nurses as an outcome of envisioned change. The following is a brief outline of the main findings.

The ethnographic findings of this dissertation highlight that reorganization initiatives target a nursing community deeply engaged in political contestation over its identity, aspirations, and desired outcomes of change. In the face of external pressure, crisis

and organizational change, internal instability and contestation became increasingly pronounced, leading to a contentious change movement that divided the nursing community and (re)introduced (new) forms of moralization, social insecurity and normative control into nursing practice. Together, the conflicted nature and politicization of both the change agenda and nursing identity and professionalism significantly impacted the support, legitimacy and enactment of organizational change. The moral imperatives surrounding bedside care, equality, and modesty in intraprofessional political identity struggles moreover affected how the diversity of knowledge, roles, and ambitions within the profession are perceived and valued. This had important and adverse implications for nurses' opportunities, authority and legitimacy to experiment with new practices, roles and frameworks within hospital organizations.

In line with the above, this dissertation further shows that nurses are assertively engaging in organizational politics to shape, negotiate and enact the reorganization of their work. The political entrepreneurship highlighted in the different chapters challenges the stereotype that nurses are merely passive recipients and implementers of organizational change — a view often perpetuated by apolitical constructs of the nursing profession (McMillan and Perron 2020, D'Antonio et al. 2010, Allen 2014) and organizational change processes (Hardy 1994, Hardy and Thomas 2014, Waring et al. 2016). Instead, this dissertation reveals multiple forms of political entrepreneurship (Buchanan and Badham 2020) practiced by nurses that produced diverse and complex outcomes. Examples include strategically crafting and policing political frontiers and leveraging new forms of organizational power to achieve valued ends, using the conditions and new dependencies created by the pandemic as leverage for negotiating organizational change and critically deconstructing (Kornberger et al. 2006) taken-for-granted organizational practices and hierarchical power dynamics that limit their voice and participation in learning, decision-making and the (re)organization of their work.

This research furthermore highlights that organizational change processes in nursing are shaped by epistemic politics. In nursing practice, epistemic politics adversely affects the legitimacy of experimenting learning approaches central to the bottom-up reorganization of nursing work, impacting nurses' authority and control over learning processes. As illustrated, epistemic disputes in local change practice over what is valid and valuable knowledge and learning methods for guiding organizational change are not merely technical or ideological in nature. Rather, they represent an assertion of power that allows different stakeholders to negotiate and assert control and authority over nurse-driven change processes (Doing 2004). Beyond everyday struggles over control and learning, the observed epistemic politics reflect and define the cultural authority of evidence-based practice (Epstein and Timmermans 2021) in nursing (Latimer 2014, Ernst and Tatli 2022) and organizational learning (Fraser et al. 2019, Jones et al. 2019), further marginalizing the legitimacy of tacit epistemologies integral to nurses' everyday (care, change and crisis) work and professionalism (Allen et al. 2023). In doing so, epistemic

politics (re)produce experiences of epistemic injustice (Fricker 2007), legitimacy deficits, and power asymmetries, that further entrench inequalities in the field of nursing.

Finally, organizational change in nursing is further shaped by the multidimensional exercise of organizational power in change practice (Lukes 1974, 2005), leading to complex (dis)empowering effects and outcomes. In nursing, institutionalized power structures hold significant legitimacy, and the exercise of covert and multidimensional power makes change programs vulnerable not only epistemic politics but also to the co-optation and top-down management of 'nurse empowerment'. This, in turn, undermines the agency and authority of 'empowered' nurses and reproduces the very power dependencies and relations they aimed to transform. However, by introducing more conflict into nurses' organizational environments, these programs also, to some extent, delegitimized established power practices, relations and discourses, creating opportunities for both objective and subjective change among nurses and stakeholders. In other words, the conflict manifested in processes of change also was experienced as emancipatory, facilitating the development of new values, practices, and coalitions focused on more inclusive ways of organizing and governing nursing.

Revisiting failure

Finally, now that both the sub questions and the main research questions have been addressed, it's time to revisit the opening vignette that introduced this dissertation. In what follows, I will first zoom in, through the political lens and themes developed in this dissertation, on the 'broader' narrative of failure that unfolded between me and the nurses in the field, as captured in the opening vignette. Following this, I will reflect on the lessons learned and the methodological implications of my engaged ethnographic approach.

The nursing team portrayed in the vignette, whose representatives had gathered that day in the office of the nurse manager Emma, was caught in a deep divide over the desirability and direction of change. The earlier 'partisan revolt' had fractured the team into opposing 'camps', creating tensions and entrenched divisions in the way the change program was received on the ward. At the same time, and from the outset, the program suffered from a lack of time, resources and attention to learning, as both the nursing team and the wider organization struggled under the pressures of the lingering Covid-19 pandemic. In this context, the nurses leading the change program — nurses whom I had closely shadowed in recent weeks but from whom I now felt an uncomfortable distance, as if I no longer belonged — found little time to advance their experimenting work, and the limited time they were able to devote to the program was met with indifference and, at times, with fierce antagonism, moralizing and obstruction from their peers.

The conflicted nature of change, however, was not only the product of internal divisions; it also mirrored broader tensions in the nurses' professional environment. Navigating a tangled web of legitimacy deficits, epistemic norms and politics, turf games, top-down management of learning and co-optation, nurses' agency and ambitions to learn and innovate was increasingly shaped and constrained by organizational politics. Over time, and in response to the political dynamics they encountered, the team abandoned their experimenting approach in favor of the more institutionally legitimized and familiar evidence-based learning. This approach, however, failed to guide the complex, situated and politicized interventions the team had envisioned, leading to frustration, stagnation and a growing sense of being adrift — sentiments echoed by those overseeing the program. This included nurse manager Emma, who made it clear in her office that day that she was losing patience — not only with the slow progress of the change program but also with my role in it.

In a way, I had been expecting her comment, as it had been hanging in the air on the ward for a while, waiting to be spoken. Over the past few weeks, I had sensed growing tensions and conflicting perspectives and values regarding my role in the change program and realized that my ethnographic participation was not immune to the political reality of change in the hospital. During my observations, I often found myself engaged in identity work to avoid being 'othered' by some nurses as part of an opposing camp and as an 'elitist scientific' researcher. At the same time, and with the shift in learning approach that was occurring, other nurses increasingly viewed my same 'scientific' status and participation as a promising way to inform, guide, and validate their evidence-based learning. This added another layer of pressure as I struggled to balance these expectations with my ethnographic intent. In other words, my ethnographic approach became entangled in the epistemic politics that framed the change program. While I do not assert that one mode of learning or research is a priori superior to another — indeed, the nurses' shift toward evidence-based learning was reasonable, understandable, and perhaps strategically realistic given the circumstances — this entanglement proved particularly challenging because it pushed me into the role of a 'technicist' researcher, a role for which I was neither trained nor aligned with my academic expertise, position, and (normative) agenda.

As a result, our collaboration slipped into an impasse that was frustrating for all involved. For the nurses leading change, my participation only seemed to reinforce their sense of being adrift rather than provide the guidance they had hoped for in navigating the complexities of organizational change. Conversely, the lack of progress and tangible outcomes gave rise to new narratives among those who had opposed the change program from the start. For these nurses, the stagnation not only diminished the perceived threat of the program but also stripped it of any substantive meaning, leading them to view it as yet another symbolic gesture by management — an 'elitist' ritual that created the illusion of change (and perceived as only for some), while leaving real

power, control and inequalities untouched. For my part, as someone relatively new to ethnography and still learning about the 'doings' of ethnographic research, I struggled to make sense of the situation and the political undercurrent that shaped my participation and engagement in the change program. I was somewhat overwhelmed by a sense of professional failure — feeling that the research process had gone off track, that I had lost the relationships I had built in the field, that I couldn't 'give back' my findings in a constructive way, and that I couldn't use and legitimize my ethnographic approach in a way that would help them to address the pressing realities they faced.

However, after (many) moments of reading, reflection, and discussion with field actors, colleagues and supervisors, I came to understand that rather than dwelling on my failures or pushing them aside, I could turn these experiences into valuable learning opportunities. By positioning my ethnographic failures as an entry point and springboard (Borst et al. 2023, Verran 2023, Wacquant 2002, Pandeli and Alcadipani 2022, Verbuyst and Galazka 2023), I was able to explore, uncover, and challenge the socio-political realities of organizational change in nursing, as I have done throughout this dissertation. Looking backward, then, this moment of disconcertment formed the starting point for my research into the politics of reorganizing nursing work.

Methodological implications and lessons for (failing) engaged organizational ethnographers

This brings me to the methodological implications and lessons from my engaged organizational ethnography that I will discuss in this section. I want to emphasize that these implications are relevant not only to ethnographers in the fields of nursing and healthcare, but also to those (failing) in related fields of engaged organizational ethnographic research.

Organizational ethnographic research is widely recognized as a deeply social process (Hertog and van Sluijs 1995, Ybema et al. 2009, Van Maanen 2011, Hammersley and Atkinson 2019). From the moment an ethnographer begins fieldwork and walks into an organization, they become part of its everyday socio-political interactions and social fabric (Ghorashi and Wels 2009). My fieldwork experiences in this dissertation research showed me that, from these very first encounters, organizational members — which in this dissertation included, for example, patients, nursing teams, (nurse) managers, and board members — actively expect you to define, position and clarify your research role and agenda. In practice, I have found that field actors often have their own assumptions and expectations about your role, shaped by their own life worlds, agendas, and interests. This, in turn, shapes the complex socio-political organizational research environment that you must navigate as an ethnographer. I would argue that this makes ethnography not only a social process, but also a political one, in which ongoing role negotiation and management becomes a central part of the ethnographer's daily research practice.

However, as the earlier discussion of the opening vignette highlighted, establishing, negotiating and maintaining one's position in the field does not always go as planned. In line with the growing, though still marginal, literature on ethnographic failure (Verran 2023, Weller 2022, Verbuyst and Galazka 2023, Borst et al. 2023, Koning and Ooi 2013) the analysis of my own discomforts, mistakes and tensions in the field underscores the analytical importance of reflexively attending to the 'black box of failure' (Koning and Ooi 2013) that often accompanies ethnographers' everyday efforts to make sense of and navigate their positioning in the socio-political complexities of organizational life. Throughout this research, as a relative outsider to what was initially a largely unfamiliar social and organizational environment, I learned much about the 'world' of nursing through the discomfort and tension that arose from not meeting expectations — and thereby breaking and challenging — the (in)formal rules that tend to dictate what is considered acceptable, valued or discouraged in nurses' daily practice and in organizational change processes. Prior literature argues that in moments of struggle to fit in or meet established norms and expectations, the cultural scripts and power dynamics that usually remain hidden beneath the organizational surface become more visible and articulated (Pandeli and Alcadipani 2022, Hammersley and Atkinson 2019, Borst et al. 2023). It is through critical engagement with moments when 'the way things are done around here' is disrupted that deeper, often subtle, layers of organizational life are revealed — and, crucially for engaged ethnographers, become more open to challenge (Ortner 2019, Clarke 2010, Juris and Khasnabish 2013). For me, it was also through failure that I became more intimately, albeit sometimes painfully, familiar with the nursing community and environment and the central organizational forces at play. Failure proved to be a powerful lens through which I could observe, explore, understand, and ultimately critique the (in)formal socio-political dynamics and interactions that shape organizational change processes in nursing.

Revisiting the travel metaphor from the introductory chapter, I would argue that my fieldwork experiences demonstrate that preparing for the ethnographic journey into organizational life requires both an acceptance and a reflexive awareness of setbacks and failures. These often arise as much from inevitable personal and practical missteps as from the political complexities of engaging with and navigating one's research position and role in (new) fields of practice. While this openness to failure, and the uncertainty and precariousness it entails, may seem counterintuitive or even risky in academic cultures focused on excellence and competition (Abdellatif et al. 2024, Halberstam 2011), the research trajectory of this dissertation underscores that ethnographic methods are particularly well suited to handling the unexpected and challenging twists and turns of the research process.

Unlike 'mainstream' action research approaches, ethnography is inherently open-ended and exploratory (Bryman 2016, Hertog and van Sluijs 1995). As such, 'doing' ethnography requires a certain degree of creativity and improvisation (Ortner 2019, Ybema et al.

2009) that allows ethnographers to adapt their methods and focus not only to seize new exploratory insights, but also to anticipate and navigate setbacks, slow progress or other unanticipated challenges. Throughout this research trajectory, this flexibility has been crucial. It has not only helped me to navigate failure but has also allowed me to 'drift' and adapt to unforeseen events, such as the Covid-19 pandemic, and to the changing ways in which the reorganization of nursing work has been approached, normatively envisioned, and enacted throughout this dissertation research.

Theoretical implications

This dissertation conceptually builds on, and bridges, two largely separate bodies of literature: critical nursing studies and the politics of organizational change literature. In the following, I will discuss how this dissertation research contributes to and advances these respective fields.

In the introductory chapter, I wrote how the role of politics is often overlooked and marginalized in (critical) nursing studies when discussing and examining organizational change. Whereas mainstream nursing literature adopts an apolitical and technicist view of organizational change, treating it as a neutral and linear process, critical nursing studies, though engaging with issues of power and politics in its advocacy for change, also have paid less attention to the complex socio-political realities of change processes. In contrast, and in response to calls for a 'sociological turn' in the study of healthcare change (Waring et al. 2016, Fraser et al. 2019, Jones et al. 2019, Hardy and Thomas 2014, Allen et al. 2016), this dissertation cross-fertilized ideas, concepts and theories from critical nursing studies and the politics of organizational change literature to critically and explicitly investigate the political dynamics involved in tangible organizational change initiatives and processes and the complex and (un)intended consequences of recent efforts to reorganize and strengthen nursing.

This approach allowed me to contribute to existing (critical) nursing literature by empirically and conceptually examining how issues of power, conflicting interests, and underlying normativities emerge in the practical enactment of change within nursing, with significant implications for the outcomes of change. The previous chapters have illustrated many examples of the political dynamics central to the reorganization of nursing work. Specifically, this dissertation extends prior nursing literature, for example, by ethnographically demonstrating that organizational change is shaped and mediated not only by political dynamics and power struggles between nurses and more dominant and powerful healthcare actors but also by strong internal politics within the nursing profession itself. This renders the enactment, direction and desirability of change in nursing precarious, complex, and anything but stable.

This dissertation further enriches existing literature on nurses' tacit epistemologies, organizational logics, and invisible organizing work (Allen 2014, Ernst and Tatli 2022, Latimer 2014). By shifting attention to the ad hoc, improvisational and specialized organizing work that nurses perform across — and at the margins of — different levels of the healthcare organization and system, it provides critical insights and analysis into the processes of epistemic politics and injustices ethnographically observed in this research. While prior research on nurses' articulation work (Strauss 1988) and emergent organizing work (Allen 2014) has focused on the hidden work of coordinating, ordering, and 'fixing' care at the patient or ward level, this dissertation empirically reveals the wider everyday acts of 'experimenting', improvising, and organizing care that extend beyond the bedside to the broader healthcare organization and system. This expanded focus, which attends to the complex assemblages of (in)formal knowledge, skills and logics that underlie this work, allows for a deeper understanding of how institutionalized epistemic norms, hierarchies, and power dynamics, combined with nurses' limited interpretive resources for validating their situated and tacit expertise, can create and maintain non-inclusive knowledge systems that exclude nurses 'invisible' knowledge and work from being recognized, valued and integrated into decision-making processes.

This dissertation, in turn, also allowed me to contribute to the politics of organizational change literature by shifting empirical and conceptual attention to the nursing profession, a professional group often overlooked in this field. In this literature, most studies tend to focus on more powerful professional groups, such as the medical profession, while paying less attention to those professional groups in subordinate and peripheral positions in healthcare's professional hierarchy. This dissertation adds, for example, by empirically showing how nurses navigate their relative lack of power and representational deficits by turning to alternative forms of political action and organizational power — such as populist action frames (Mouffe 2005, Laclau 2005) and digital media and technologies or 'new organizational power' (Buchanan and Badham 2020, Dencik and Wilkin 2018)—to organize resistance, expand their power recourses, and create new political opportunities. While this dissertation shows that this has allowed nurses to redistribute and gain (some) control over the reorganization of their work, we have also shown ethnographically that this can intensify processes of inclusion and exclusion and can deepen divisions and tensions around change processes, initiatives and agendas. Importantly, such patterns may well be relevant to other 'invisible' professional groups in comparable positions and highlight the need for future conceptual and empirical research.

Finally, in contrast to most research in the politics of organizational change literature, this dissertation empirically explored how organizational and emancipatory change can emerge from multidimensional power practices and transformations, something that is largely absent in previous research. The existing literature predominantly applies Lukes' three-dimensional power framework to analyze the manifestations of

coercive and dominant power relations and the political dynamics that (re)produce organizational subordination. The few studies that do address the emancipatory potential of organizational empowerment initiatives through Lukes' (1974, 2005) framework are largely conceptual (Gilbert 1995, Hardy and Leiba-O'Sullivan 1998, Dowding 2006, Avelino 2021). This dissertation contributes to this literature by moving beyond conceptual analysis to empirically examine the actual practices through which multidimensional change in power occurs.

Practical implications

The analyses presented in this dissertation have several implications for both practice and policy. Although closely related, I have organized these implications into specific recommendations for nurses, hospital management, and policy makers, which are presented in turn below.

Nurses

This dissertation first underscores the critical importance for nurses to sustain and invest in their political entrepreneurship to institutionalize new practices, roles and decision-making authority in healthcare organizations. In line with this, it also highlights the need for the profession to develop and equip itself with the language and interpretive resources necessary to translate and articulate its tacit, situated, and specialized organizational knowledge and logics for organizational and policy decision-making (cf. Allen 2023, Ernst & Tatli 2022; Ihlebæk 2020). Furthermore, it emphasizes the emancipatory importance for nurses to recognizing and leveraging the wide diversity of nursing roles, epistemologies, and work across different areas of the organization and healthcare system, whether at the bedside, in research, management, or policy.

Healthcare organizations

This dissertation highlights the need for hospital management to accompany organizational change initiatives with training and learning infrastructures for nurses. Some, but not all, participating hospitals established new training programs and learning networks to foster critical leadership competencies, organizational literacy skills, and peer networks. These infrastructures can provide critical spaces for nurses to share experiences, reflect on challenges, build new coalitions and alliances, and mobilize interests. Furthermore, healthcare organizations would benefit from broadening their cultural, technical, and material knowledge systems to harness nurses' tacit epistemologies for developing innovative roles, practices, and approaches. In other words, organizations should address the gap between promoting critical nurse leadership and experimental learning and the legitimacy deficits and devaluation that the experimental approach and its underlying epistemologies face in practice. This can also pave the way for more interdisciplinary quality and strategic decision-making, countering the social and cultural authority (Epstein and Timmermans 2021) of medical

knowledge and roles in these arenas. Such considerations and efforts matter not only for organizational change processes and the quality of care but also because epistemic politics and injustices are intimately linked to healthcare systems' inability to sustain healthy and resilient workforces.

Policymakers

Reorganizing nursing work has emerged as a top priority on the (inter)national agenda of policymakers. This dissertation, however, reminds policymakers that change is not simply a matter of implementing quick fixes. Rather, this research showed empirically that, in practice, organizational change is complex and political, marked by setbacks and small wins that underscore its unstable, ongoing, and laborious nature. For change to be meaningful, policymakers must therefore recognize the political and incremental nature of organizational change, which requires sustained and structural investment, support, and attention.

Final thoughts

Attention, however, is a scarce resource. While the reorganization of nursing work has been at the center of political and public debate in recent years, in writing this final chapter it has become clear that, contrary to initial intentions, ministerial funding for the R2NBlend consortium has been withdrawn, while many other government-sponsored initiatives are facing similar challenges. I bring this forward in the final lines of this dissertation to highlight an apparent tendency and tension in policy to projectify challenges and change in nursing through temporary funding and time-bound interventionist projects and programs, and how this is at odds with the politics of reorganizing nursing work that this dissertation has explored. It also draws attention to how, amidst today's many challenges and trouble competing for attention and legitimacy in healthcare and society at large, the prioritization of repositioning and strengthening the nursing profession may already be at risk of (re)losing momentum on public and political agendas. At this point, the responsibility for change appears to be increasingly shifting toward healthcare organizations and the nursing profession itself. Their task is clear: while some (yet meaningful) gains and changes have been made, this research also shows that ongoing attention, investment, and effort are critical to maintaining the movement and building more sustainable, just, and resilient futures in nursing, and by that, in healthcare at large.

6

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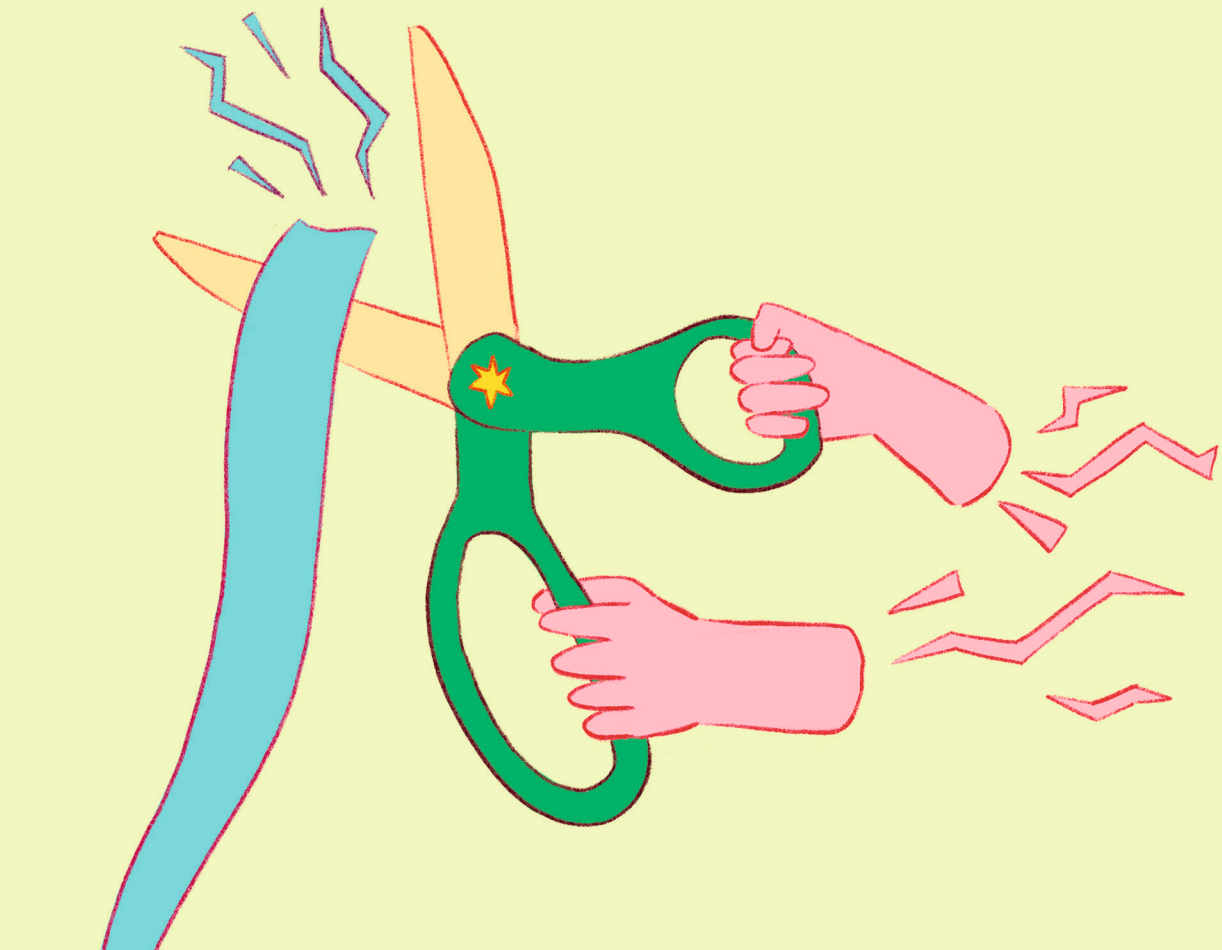
APPENDICES



Summary 'Politics of reorganizing nursing work'

Nurses and nursing practice are key in health policy and professional debate, and in healthcare organizations struggling with nurse shortages. In this context, the reorganization of nursing work is increasingly framed — politically and discursively — as an urgent global policy priority. In the Netherlands — the empirical setting of this dissertation — this felt urgency has, in recent years, given rise to a strong push for reorganizing nursing work through innovative and experimental approaches. These include both top-down legislative changes and bottom-up and nurse-driven organizational change and empowerment. Central to this thesis is one such effort, the 'RN2Blend' participatory research program — in which I was one of the participating researchers — commissioned by the Dutch Ministry of Health, Welfare and Sports to study and facilitate change in the field.

Change, however, is not easy. More than that, it is fundamentally political. Organizational change pursued in nursing is intentionally disruptive and multifaceted, requiring collaboration and interaction among multiple stakeholders with different interests and priorities. Adding to this complexity, the reorganization of nursing work is taking place in a highly politicized context, shaped by the Covid pandemic's exposure of longstanding workforce challenges, nurses' restricted voice and lack of representation within organizational and policy levels, and systemic healthcare vulnerabilities. Moreover, there is a high degree of disagreement and political debate within the (highly diverse) nurse occupational group itself, particularly regarding the meaning and direction of professionalization — something I was often confronted with during my PhD research. In the recent past, debates have intensified due to the felt urgency for change in the face of increasing shortages and work pressures and ongoing contestation over the direction and approach to change. This has made the expectations and goals for the reorganization of nursing work highly unstable and contested.

The controversies and politics of organizational change are, however, all too often pushed aside by those studying and working on change in healthcare practice, policy, and research. Across fields, there is a widespread tendency to treat organizational change as an apolitical and technical process devoid of competition, conflict and power dynamics in the organizational, institutional and political arenas in which changes are negotiated, contested and ultimately decided. The focus of this dissertation, in contrast, lies with providing a critical and focused examination of the politics of reorganizing nursing work. By bringing the political dimensions of change processes to the forefront, this research aims to offer a more comprehensive and 'realist' account of the complex socio-political nature of reorganizing nursing work, with broader lessons for healthcare policy and research.

To this purpose, this dissertation is positioned at the intersection of critical nursing literature and literature on the politics of organizational change, with the latter drawing

from three academic disciplines: Sociology of Professions, Organization Studies, and Science and Technology Studies. Together, these bodies of work provide a critical lens through which to examine how political dynamics emerge, become embedded, and shape the practical enactment of change and its multifaceted outcomes in nursing.

The main research question is: *How do the politics of organizational change impact the reorganization of nursing work, and what are the consequences for (re)positioning the nursing profession?*

In my research I have explored this question through engaged and multi-sited ethnographic research. As part of the research consortium 'RN2Blend', I was positioned to examine the politics of reorganizing nursing work 'from within'. Over four years, I immersed myself in different hospital practices and in the broader change movement supported by RN2Blend, which contributed to this movement by fostering a collaborative research process with and for nurses — aimed at initiating a collectively driven social research effort to promote professional and organizational change. In this vein, I moved between wards and nursing teams, local conference halls where focus groups and workshops were organized and nurses and managers gathered, participated in daily (and pandemic) nursing and change initiatives and activities, gathered policy and practice documents and shadowed and interviewed a wide range of key stakeholders. In addition, I co-organized and participated in a wide range of local and national knowledge exchange events, conferences, and learning festivals focused on change and nurse empowerment.

This dissertation highlights how navigating a researcher's engaged positionality amidst the political complexities of organizational change is demanding, complex and vulnerable to 'ethnographic failure'. Yet such experiences of disconcertment and failure are, as this research shows, as uncomfortable as they are insightful. Rather than being dismissed, this research uses early and imperfect fieldwork experiences as a critical entry point for engaging with organizational change processes in nursing from a position of situated critique.

After elaborating on the theoretical and empirical approach taken in the first chapter, **Chapter 2** reconstructs how the Dutch nursing community responded to a proposed law amendment, 'Wet BIG II', which sought to reorganize nursing work by introducing and formalizing new forms of role differentiation between educational levels and skill mix. The chapter describes how, against a background of layered representational deficits, nurses used a populist action frame to articulate and mobilize dissent and opposition to top-down changes perceived as imposed upon them by a (nursing) elite. Interpreting these strategies as a form of 'doing politics', the chapter critically explores the destructive and generative processes and implications of such political action for organizational change initiatives and, importantly, for the (re)positioning of the nursing profession.

The analysis shows how nurses' adoption of a populist action frame provided them with a particular agency and way to challenge top-down policies that they perceived as unwelcome. It offers a close examination of the creative — though ambiguous in terms of its outcomes — political entrepreneurship of nurses in organizing their resistance to 'Wet BIG II' by leveraging alternative and new forms of power and authority to circumvent the more conventional organizational and political infrastructures typically used for professional mobilization.

At the same time, the chapter shows how, in their partisan quest, the nursing identity became increasingly politicized, sharply dividing the community into 'genuine' and 'elitist' nursing groups, with different and conflicting positions on the proposed changes. This division gave rise to new forms of moralization, social insecurity and normative control within the change movement, as well as within healthcare organizations, significantly affecting the support, legitimacy and enactment of (future) organizational change.

Chapter 3 examines the invisible and layered reorganizing work of nurses as they navigated and dealt with 'uncharted territory' during the Covid-19 pandemic response. Using ethnographic data and nurse diaries from the early pandemic, this chapter foregrounds how nurses met pandemic pressures by reorganizing care 'on the fly' across different healthcare layers: in daily patient care, in coordinating care within and between hospitals, and at the level of the healthcare system.

It specifically lays bare the complex assemblages of formal and informal knowledge, skills and logics — often not explicated and hence invisible — driving nurses' experimenting work, that is, improvisational and innovative actions taken in situ as in response to uncertain, dynamic and changing organizational conditions and demands. Through focused attention to the specialized and knowledgeable experimenting work nurses perform across — and at the margins of — different levels of the healthcare organization and system, this chapter provides critical insights into the processes of epistemic politics and injustices ethnographically observed during processes of change in this and subsequent chapters.

It explores the political nature of nurses' experimenting work, highlighting the normativities, political strategies, and power dynamics implicated. Findings show how, during the pandemic, nurses were typically sidelined in formal decision-making but also leveraged their changing organizational and institutional position — marked by the sudden, yet short lived, visibility of and applause for the profession, their central role in the pandemic and new organizational dependencies — to (re)negotiate and steer organizational change in politically savvy ways.

Chapter 4 focuses on bottom-up change programs centered on nurse-driven, practice-based, and experimental learning that emerged in response to the failed 'Wet BIG II'

legal reform. In this context, the policy rationale behind grassroots learning was to shift responsibility to nurses and hospital organizations to 'depoliticize' change and to empower and harness the wide range of knowledge, expertise and ideas of nurses to reorganize the profession from 'the bottom up'.

Specifically, this chapter analyzes these change programs from an epistemological perspective, highlighting the epistemic politics at play in local change practices. It critically examines how different forms of knowledge are used, valued, and politicized in everyday change practice. In doing do, it ethnographically reveals how the tacit epistemologies supporting nurses' experimental learning in the change programs are shrouded in a cloak of invisibility and subject to epistemic politics. This not only channeled nurses' learning away from intended improvisational learning approaches but also created opportunities for stakeholders to intervene in nurse-driven learning by mobilizing the cultural and discursive authority of evidence-based knowledge — deploying it as a political tool to steer, demarcate and control learning, and thereby govern nurses' learning and professional development.

This chapter thereby provides critical insight into the difficulties of critical nurse leadership at the local level and how the change programs paradoxically served to demonstrate the very lack of legitimacy of nurses' expertise and authority they were intended to remedy.

Chapter 5 examines the 'empowerment turn' in the reorganization of nursing work. Against the background of rising empowerment discourse and policy, it explores the practices, processes and outcomes of change programs that increasingly focused on shifting power transitions by repositioning nurses into new decision-making arenas and structures of hospitals.

Specifically, it offers a critical analysis of the complex and everyday political dynamics of empowerment, and of the multidimensional exercise of organizational power that mediate these change processes. This chapter shows that while new roles, resources and legislation have recently been introduced for nurses to enable participation in decision-making networks and platforms, the authority and agency to use them are often governed and constrained by vested power relations. As a result, change programs remain vulnerable to co-optation and top-down management.

These limitations illustrate the difficulties of empowerment, yet they also provide a backdrop for understanding how incremental change in power relations is achieved. Nurses' enhanced presence and political engagement in decision-making forums injected conflict into otherwise consensual and 'taken for granted' decision-making processes, rendering the underlying power dynamics increasingly visible and vulnerable. The findings show how this opened space for more reflexive and deliberate forms of

political entrepreneurship against constraint, while also cultivating broader support and more shared responsibility among stakeholders for emancipatory change — revealing the paradoxical and potentially emancipatory nature of organizational conflict.

The final chapter (6) answers the main research question by reflecting on the findings from the previous chapters and by tying together the different ways in which the politics of organizational change impact the reorganization of nursing work and the (re) positioning of nurses as an outcome of envisioned changes.

This includes, as mentioned, strong internal divisions and conflict within the nursing profession, epistemic politics, and the politics of empowerment. Together, these findings highlight that nurses are both agents and subjects in the political dynamics of change, challenging stereotypical and apolitical constructs of both organizational change processes and the nursing profession. Moreover, it reveals the laborious, incremental, and the uncertain, complex and political nature of reconfiguring nurses' position within healthcare organizations and systems.

In this concluding chapter, insights are used to reflect on and explicate moments of ethnographic struggle and the broader political narrative of 'failure' experienced during ethnographic fieldwork, along with the lessons learned for engaged ethnographers and research. First, it discusses how experiences of disconcertment, missteps, and friction can be productive in learning about the subtle (and sometimes not so subtle) dynamics and layers of organizational life and change processes. Second, it reflects on how field actors often have their own assumptions and expectations about the role of an engaged ethnographer, shaped by their own life worlds, agendas, and interests. It explores how this diversity brings into being the socio-political organizational research environment the ethnographer must navigate. The argument is made that this makes ethnography not only a social process, but also a political one, in which ongoing role negotiation and management becomes a central part of the ethnographer's daily research practice and analytical toolkit. In making this case, this dissertation advances a growing plea for reflexive awareness, acceptance and analytical value of politics and failure that accompany the everyday 'doings' of ethnography.

Finally, the chapter ends by outlining this dissertation's theoretical contributions and practical implications. Theoretically, it foregrounds the importance of bridging two bodies of literature that until now have remained largely separate — critical nursing studies and the politics of organizational change literature — to better examine and articulate the socio-political and lived realities of organizational change and its multifaceted outcomes in nursing and healthcare more broadly.

Practically, it draws implications for nurses, healthcare management and organizations, and policymakers. For nurses, a key implication is the need to develop and cultivate a

shared understanding and language around the profession's tacit epistemologies and organizational logics to engage with change, politics, and policy more effectively. In addition, it underscores the emancipatory importance of recognizing and leveraging the wide diversity of nursing roles, work, and expertise across different domains of healthcare, whether at the bedside, in research, management, or policy.

For healthcare organizations, recommendations include the importance of broadening the discursive, material and technical knowledge systems through which nurses' ideas, knowledge and experiences are engaged in change processes. Moreover, it calls for the implementation of robust training and learning infrastructures alongside change initiatives that offer nurses reflexive spaces to share experiences, develop (new) political literacy skills, and mobilize interests. For policymakers this dissertation invites a reconsideration of the prevailing tendency to 'projectify' nursing workforce problems. Meaningful and sustainable change requires recognition of the political and incremental nature of organizational and professional change, demanding long-term structural investment, support and attention.

Samenvatting

Verpleegkundige en verpleegkundige werk staan centraal in gezondheidsbeleid, professionele debatten, en in zorgorganisaties die worstelen met tekorten aan verpleegkundigen. Tegen deze achtergrond wordt de reorganisatie van verpleegkundig werk in toenemende mate — zowel politiek als discursief — aangemerkt als een urgente en internationale beleidsprioriteit. In Nederland — de empirische setting van dit proefschrift — heeft deze gevoelde urgentie afgelopen jaren geleid tot een sterke inzet op het reorganiseren van verpleegkundige werk middels innovatieve en experimentele benaderingen. Dit omvat zowel top-down wetswijzigingen als bottom-up en door verpleegkundigen aangestuurde organisatieverandering en empowerment. Centraal in dit proefschrift staat één van deze initiatieven: het participatief onderzoeksprogramma 'RN2Blend' — waaraan ik deelnam als een van de onderzoekers — in opdracht van het Ministerie van Volksgezondheid, Welzijn en Sport om veranderingen in het veld te onderzoeken en te ondersteunen.

Verandering is echter niet eenvoudig. Sterker nog, het is fundamenteel politiek van aard. Beoogde organisatieverandering in de verpleegkundige is doelbewust disruptief, complex en gelaagd, en vereist samenwerking en interactie tussen verschillende belanghebbenden met uiteenlopende belangen en prioriteiten. Daar komt bij dat de reorganisatie van verpleegkundig werk plaatsvindt in een sterk gepolitiseerde context, gevormd door de Covid-pandemie die langdurige uitdagingen in de beroepsgroep, de beperkte vertegenwoordiging en invloed van verpleegkundigen op organisatie en beleidsniveau, en systemische kwetsbaarheden in de gezondheidszorg blootlegde. Bovendien is er veel onenigheid en politiek debat binnen de (zeer diverse) verpleegkundige beroepsgroep over de betekenis en richting van professionalisering — iets waarmee ik tijdens mijn promotieonderzoek vaak werd geconfronteerd. De laatste jaren zijn deze debatten verder geïntensiveerd door een groeiende urgentie voor verandering tegen de achtergrond van toenemende tekorten en werkdruk, en door aanhoudend discussie en onenigheid over de richting en aanpak van de gewenste veranderingen. Dit alles maakt de verwachtingen en doelen voor de reorganisatie van verpleegkundig werk instabiel en omstreden.

De controverses en politiek van organisatieverandering wordt echter maar al te vaak terzijde geschoven door degenen die werken aan verandering of er onderzoek naar doen in de gezondheidspraktijk, -beleid en -onderzoek. Over verschillende velden heen is er een sterke neiging om organisatieverandering te benaderen als een apolitiek en technisch proces, met weinig aandacht voor conflict, competitie, en machtsverhoudingen in de organisatorische, institutionele en politieke arena's waarin verandering wordt onderhandeld, betwist en vormgegeven. Dit proefschrift kiest juist een ander perspectief en richt zich op het expliciet naar voren brengen – en kritisch beschouwen – van de politiek van het reorganiseren van verpleegkundig werk. Door de politieke dimensies van veranderprocessen op de voorgrond te plaatsen, beoogt dit onderzoek een meer

omvattend en ‘realistisch’ beeld te geven van de complexe en sociaal-politieke aard van het reorganiseren van verpleegkundige werk, met bredere lessen voor beleid en onderzoek.

Met dit doel bevindt dit proefschrift zich op het snijvlak van kritische verpleegkundige literatuur en literatuur over de politiek van organisatieverandering, waarbij deze laatste put uit drie academische disciplines: Sociology of Professions, Organization Studies, and Science and Technology Studies. Samen bieden deze literatuur stromingen een kritische lens om te analyseren hoe politieke dynamieken tot stand komen, verankerd raken, en de praktische en dubbelzinnige uitkomsten van verandering in de verpleegkunde vormgeven.

De centrale onderzoeksvraag luidt: hoe beïnvloedt de politiek van organisatieverandering de reorganisatie van verpleegkundig werk, en wat zijn de gevolgen voor het (her) positioneren van de verpleegkundige beroepsgroep?

Deze vraag heb ik mijn onderzoek onderzocht via kritisch betrokken en ‘multi-sited’ etnografisch onderzoek. Als onderdeel en onderzoeker van het onderzoeksconsortium ‘RN2Blend’ was ik in de positie om de politiek van het reorganiseren van verpleegkundige werk ‘van binnenuit’ te bestuderen. Gedurende vier jaar heb ik me ondergedompeld in verschillende ziekenhuizen en in de bredere veranderbeweging die actief ondersteund werd door RN2Blend. RN2Blend beoogde bij te dragen aan de veranderbeweging door een collaboratief onderzoeksproces met en voor verpleegkundigen te initiëren — met als doel om door middel van collectief gedreven en sociaal onderzoek professionele en organisatieverandering te stimuleren. Vanuit die insteek reisde ik naar en tussen verpleegkundige afdelingen en teams, nam ik deel aan dagelijkse (en pandemische) verpleegkundig en veranderwerk en initiatieven, reisde ik naar lokale conferentiezalen waar focusgroepen en workshops werden georganiseerd en verpleegkundigen en managers samenkwamen, verzamelde ik beleids- en organisatiedocumenten en observeerde en interviewde ik een breed scala aan belanghebbenden en betrokkenen. Daarnaast organiseerde en nam ik deel aan een verschillende lokale en nationale kennisuitwisselingsevenementen, conferenties en leerfestivals gericht op verandering, professionalisering en empowerment van verpleegkundigen.

Dit proefschrift benadrukt hoe het navigeren als onderzoeker vanuit een betrokken positie te midden van de politieke complexiteiten van organisatieverandering veeleisend en complex is, en kwetsbaar voor ‘etnografisch falen’. Toch zijn dergelijke ervaringen van ongemak en falen — zoals dit onderzoek laat zien — niet alleen ongemakkelijk, maar ook bijzonder leerzaam. In plaats van deze ervaringen terzijde te schuiven, gebruikt dit onderzoek onvolmaakte veldwerk en onderzoekservaringen als een kritisch startpunt voor het analyseren van veranderprocessen in de verpleegkunde vanuit een positie van gesitueerde kritiek.

Na de uiteenzetting van de theoretische en empirische benadering in het eerste hoofdstuk, reconstrueert **Hoofdstuk 2** hoe de Nederlandse verpleegkundige beroepsgroep reageerde op het wetvoorstel 'Wet BIG II', met als doel verpleegkundig werk te reorganiseren door nieuwe vormen van functiedifferentiatie naar opleidingsniveau wettelijk vast te leggen. Het hoofdstuk beschrijft hoe verpleegkundigen, tegen een achtergrond van (historisch gevormde en ervaren) gebrekkige vertegenwoordiging en inspraak, gebruik maakten van populistische strategieën om hun onvrede te uiten en verzet te organiseren tegen top-down veranderingen die zijn ervoeren als opgelegd door een (verpleegkundige) elite. Door deze strategieën te interpreteren als een vorm van 'politiek bedrijven', verkent het hoofdstuk op een kritische manier zowel de generatieve en destructieve implicaties van dergelijke partizaanse politieke actie voor organisatieverandering en, belangrijker nog, voor de (her)positionering van de verpleegkundige beroepsgroep.

De analyse laat zien hoe het gebruik van populistische strategieën verpleegkundige een specifieke manier bood om weerstand te bieden tegen top-down beleid. Het hoofdstuk onderzoekt hoe verpleegkundigen — op creatieve, zij het dubbelzinnige wijze — politiek ondernemerschap toonden in hun verzet tegen Wet BIG II, door alternatieve vormen van invloed en macht aan te wenden buiten de gebruikelijke institutionele en politieke infrastructuren voor professionele mobilisatie en belangenbehartiging.

Tegelijkertijd laat het hoofdstuk zien hoe in een partizaanse missie de verpleegkundige identiteit steeds verder gepolitiseerd raakte. Binnen de beroepsgroep ontstond een scherpe verdeling tussen '(opr)echte' en 'elitaire' verpleegkundigen, met uiteenlopende en conflicterende visies op de voorgestelde en gewenste veranderingen. Deze verdeling bracht nieuwe vormen van moralisering, sociale onzekerheid en normatieve controle de veranderbeweging in, wat aanzienlijk invloed heeft op de steun, legitimiteit en verloop van (toekomstige) verander- projecten en trajecten.

Hoofdstuk 3 onderzoekt het onzichtbare en gelaagde reorganisatiewerk van verpleegkundigen terwijl zij navigeerden en inrichting gaven aan 'onontgonnen terrein' tijdens de Covid pandemie. Aan de hand van etnografische data en verzamelde dagboeken van verpleegkundigen uit de eerste periode van de pandemie laat het hoofdstuk zien hoe verpleegkundigen onder de druk van de pandemie zorg 'ter plekke en in het moment' reorganiseerden over verschillende zorglagen heen: in de dagelijkse patiëntenzorg, in de coördinatie van zorg binnen en tussen ziekenhuizen, en op systeemniveau.

Het hoofdstuk brengt specifiek de complexe assemblages van formele en informele kennis, vaardigheden en logica's — die veelal impliciet zijn en daarmee onzichtbaar — aan het licht die onderliggend zijn aan het experimenteerwerk van verpleegkundigen. Met experimenteer werk wordt gedoeld op improviserende en innovatieve handelingen die ter plekke worden ondernomen in reactie op onzekere, dynamische en voortdurend veranderende omstandigheden en eisen in organisaties. Door gericht aandacht te hebben

voor het gespecialiseerde en kennisintensieve karakter van dit experimenteerwerk– dat zich afspeelt binnen, tussen én aan de randen van zorgorganisaties en het zorgsysteem – biedt het hoofdstuk kritische inzichten in de processen van epistemische politiek en onrecht die etnografisch zijn waargenomen en onderzocht worden in dit en daaropvolgende hoofdstukken.

Het verkent verder het politieke karakter van het experimenteerwerk van verpleegkundigen, en belicht de normativiteit, politieke strategieën en machtsdynamieken die hiermee gepaard gaan. De bevindingen tonen hoe verpleegkundigen tijdens de pandemie vaak buitenspel werden gezet in formele besluitvorming, maar tegelijk hun veranderende organisatorische en institutionele positie – gekenmerkt door een plotselinge, zij het kortstondige, zichtbaarheid en waardering voor het beroep, hun centrale rol in de crisis en nieuwe afhankelijkheden binnen organisaties – wisten aan te grijpen om op politiek slimme wijze organisatieverandering te (her)onderhandelen en te sturen.

Hoofdstuk 4 richt zich op bottom-up veranderingsprogramma's die ontstonden als reactie op de mislukte wetshervorming 'Wet BIG II' en expliciet inzetten op door verpleegkundigen aangestuurd, praktijk gedreven en experimenteel leren. Binnen het beleidsdiscours werd deze beweging gezien en gepresenteerd als een manier om verantwoordelijkheid te decentraliseren, verandering te 'depolitiseren' en de diversiteit aan kennis, ervaring en ideeën van verpleegkundigen beter te benutten bij het reorganiseren van het beroep en werk.

Specifiek analyseert dit hoofdstuk deze veranderprogramma's vanuit een epistemologisch perspectief en legt de epistemische politiek bloot die hierin werkzaam is. Het onderzoekt kritisch hoe verschillende vormen van kennis worden gebruikt, gewaardeerd en gepolitiseerd in de dagelijkse veranderpraktijk. Daarbij wordt etnografisch zichtbaar hoe de impliciete epistemologieën die het experimentele leren van verpleegkundigen in de veranderingsprogramma's ondersteunen veelal onzichtbaar worden gemaakt door processen van epistemische politiek. Dit leidde er niet alleen toe dat het leren werd weggetrokken van de beoogde improviserende, experimenterende leerbenadering, maar creëerde ook ruimte voor andere belanghebbenden om via de culturele en discursieve autoriteit van evidence-based practice (EBP) sturend op te treden — waarbij EBP werd ingezet als een politiek instrument om leren te sturen, af te bakenen en te controleren, en daarmee het leren en de professionele ontwikkeling van verpleegkundigen te reguleren.

Dit hoofdstuk biedt daarmee kritisch inzicht in de moeilijkheden van kritisch verpleegkundig leiderschap op lokaal niveau en hoe de veranderingsprogramma's paradoxaal genoeg steeds meer diende om het gebrek aan legitimiteit van de kennis en autoriteit van verpleegkundigen aan te tonen – het probleem dat ze hadden moeten oplossen.

Hoofdstuk 5 onderzoekt de 'empowerment-wending' in de reorganisatie van verpleegkundig werk. Tegen de achtergrond van toenemend empowerment- discours en -beleid, verkent het de praktijken, processen en uitkomsten van veranderingsprogramma's die nadrukkelijk inzetten op een verschuiving van machtsrelaties door verpleegkundigen te herpositioneren in nieuwe besluitvormingsstructuren binnen ziekenhuizen.

Specifiek biedt het een kritische analyse van de complexe en alledaagse politieke dynamiek van empowerment, en van de multidimensionale uitoefening van macht in organisaties die deze veranderingsprocessen vormgeven. Hoewel er in recente jaren nieuwe rollen, middelen en wetgeving zijn geïntroduceerd om verpleegkundigen te betrekken bij besluitvorming, laat dit hoofdstuk zien dat de daadwerkelijke ruimte en autoriteit om hiervan gebruik te maken vaak wordt ingeperkt door bestaande en diepgewortelde machtsrelaties en -structuren. Hierdoor blijven veranderprogramma's vatbaar voor co-optatie en top-down management van empowerment.

Tegelijkertijd tonen deze beperkingen en uitdagingen ook hoe incrementele verandering in machtsrelaties kan plaatsvinden. De toegenomen aanwezigheid en politieke betrokkenheid van verpleegkundigen in besluitvormingsarena's bracht conflict in anderszins consensuele en 'vanzelfsprekende' besluitvormingsprocessen, en schudde deze processen daarmee op. Dit maakte diepgewortelde en van het zicht onttrokken machtsdynamieken zichtbaarder en daarmee ook kwetsbaarder. De bevindingen laten zien hoe dit ruimte maakte voor meer reflexieve en strategische vormen van politiek ondernemerschap van verpleegkundigen tegen beperkende macht, terwijl het ook bredere steun en meer gedeelde verantwoordelijkheid onder belanghebbenden voor emancipatoire verandering cultiveerde — waarmee de paradoxale en potentieel emanciperende aard van conflict binnen organisaties zichtbaar werd.

Het afsluitende hoofdstuk (6) beantwoordt de centrale onderzoeksvraag door te reflecteren op de bevindingen uit de voorgaande hoofdstukken en door de verschillende manieren samen te brengen waarop de politiek van organisatieverandering van invloed is op de reorganisatie van verpleegkundig werk en op de (her)positionering van verpleegkundigen als uitkomst van de beoogde veranderingen.

Daarbij gaat het, zoals eerder genoemd, om sterke interne verdeeldheid en conflict binnen de verpleegkundige beroepsgroep, epistemische politiek, en de politiek van empowerment. Gezamenlijk laten deze bevindingen zien dat verpleegkundigen zowel actief vormgeven aan als onderworpen zijn aan de politieke dynamiek van verandering — en daarmee dominante, apolitieke beelden van organisatieverandering én het verpleegkundig beroep ter discussie stellen. Bovendien benadrukt het hoe het herpositioneren van verpleegkundigen binnen zorgorganisaties en -systemen een moeizaam, arbeidsintensief, complex en politiek proces is.

In dit slothoofdstuk worden vergaarde inzichten gebruikt om te reflecteren op momenten van etnografische worstelingen en het bredere politieke narratief van 'falen' dat ik tijdens veldwerk ervaarde, evenals op de bredere lessen die dit opleverde voor kritisch betrokken etnografie en onderzoek. Ten eerste bespreekt het hoe ervaringen van ongemak, verwarring en wrijving productief kunnen zijn bij het leren over de subtiele (en soms niet zo subtiele) dynamieken en lagen van het leven in organisaties en veranderprocessen. Ten tweede wordt gereflecteerd op hoe actoren in het veld vaak hun eigen aannames en verwachtingen hebben over de rol van een betrokken etnograaf, gevormd door hun eigen leefwerelden, agenda's en belangen. Het verkent hoe deze diversiteit de sociaal-politieke onderzoeksetting mede vormgeeft waarin de etnograaf moet navigeren. Er wordt beargumenteerd dat dit etnografie niet alleen een sociaal, maar ook een politiek proces maakt, waarin voortdurende rolnavigatie- en onderhandeling een essentieel onderdeel vormen van de dagelijkse onderzoekspraktijk en het analytische instrumentarium van de etnograaf. Door dit punt te maken sluit het proefschrift aan bij een groende oproep tot reflexieve aandacht voor de rol van politiek en falen in de dagelijkse praktijk van etnografisch onderzoek — en de analytische waarde hiervan.

Tot slot sluit het hoofdstuk af met een uiteenzetting van de theoretische bijdragen en praktische implicaties van dit proefschrift. Theoretisch wordt het belang benadrukt van het overbruggen van twee wetenschapsgebieden die tot nu toe grotendeels gescheiden zijn gebleven — kritische verpleegkundige studies en de literatuur over de politiek van organisatieverandering — om de sociaal-politieke en geleefde realiteiten van organisatieverandering en de veelzijdige uitkomsten ervan in de verpleegkunde en de gezondheidszorg in bredere zin beter te onderzoeken en te duiden.

Praktisch werpt het proefschrift implicaties op voor verpleegkundigen, zorgorganisaties en beleidsmakers. Voor verpleegkundigen is een belangrijke les dat het essentieel is om een gezamenlijke taal, inzicht en eigenaarschap te ontwikkelen rondom de impliciete epistemologieën en organiserende logica's van het beroep, zodat verpleegkundigen beter kunnen deelnemen aan veranderingsprocessen, politiek en beleid. Daarnaast onderstreept het de emancipatoire waarde van het (h)erkennen en benutten van de brede diversiteit aan verpleegkundige rollen, werk en expertise in verschillende domeinen van de zorg — of die zich nu aan het bed bevinden, in onderzoek, management of beleid.

Voor zorgorganisaties zijn aanbevelingen onder meer het verbreden van de discursieve, materiële en technische kennissystemen waarmee verpleegkundigen betrokken worden bij veranderprocessen. Ook wordt gepleit voor het inbedden van stevige leer- en trainingsinfrastructuren bij veranderinitiatieven, waarin verpleegkundigen ruimte krijgen om ervaringen en kennis te delen, (nieuwe) politieke vaardigheden te ontwikkelen en belangen te mobiliseren. Voor beleidsmakers nodigt dit proefschrift uit tot een heroverweging van de heersende neiging om problemen in de verpleegkundige personeelsbezetting te 'projectiseren'. Betekenisvolle en duurzame verandering vereist

erkenning van de politieke en incrementele aard van organisatie en professionele verandering, en daarmee om structurele, langdurige investering, ondersteuning en aandacht.

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As so many have rightly said before me, doing — and especially finishing a PhD — is, above all, a collective effort. I am therefore happy to have the chance here to use the final pages to thank those who made this thesis possible — from the very beginning to the final word.

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I have had the luck of being part of another research community: the RN2Blend consortium. The consortium has been a rare but therefore very productive mix of researchers from a wide range of research institutions, roles and traditions but all – in one way or another – closely embedded in the nursing community. For me, someone who was initially somewhat unfamiliar with the field, your stories, experiences, connections and critical reflections on my work were highly valuable and appreciated! I want to thank you especially for our research meetings — a great place to triangulate the ideas and analysis presented in this thesis. Thank you Hester, Lisette, Pieterbas, Dewi, Jet, Catherina, Lucas, Liesbeth, Miriam, and Charlotte. And of course to my fellow PhD colleagues in the project — Hugo, Julia, Nienke, Marloes and Dieke. I enjoyed our time together and I learned a lot from our conversations and reading your work. Let's pick a date for drinks soon!

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My family and friends have also been of critical support. Without them, I guess this thesis would probably still be a scattered collection of notes. Throughout this thesis I argued that moments of ethnographic failure are inventible and of critical importance, but rarely make it into the final product. I think it is only fair to add that the same holds for the invisible work done by those 'at home' of the ethnographer. It certainly did for me. When deadlines loomed, field and office days were long, and the pressures mounted, I was offered places to work and write, and — most importantly — help with taking care of Zee and Manu. I especially want to thank Marlou and Christien. Your ongoing (and at times weekly) help made a real difference. But I also want to name Sophie, Ed, Baldo, Hans, Mette and Tess – thank you all! An extra note to my (extended) family is warranted. To Christien, thank you for always being there and checking in (yes, I bought a big pack of B12 pills), for your last-minutes spelling checks, and for generally getting me to where I am today. Thank you – love you. Dear Ed, you might be the only one who actually listens when I ramble about my research. I guess it is no surprise I became a sociologist. Thank you for all our conversations at your kitchen table. Dear Sophie, life — and this PhD — would have been a lot more boring without you. I don't think I can laugh like we do with anyone else. Thank you for being the person I tend to call when facing any small or big decision. To my oldest friends, Nena and Daan, thank you for our consistent dinners that were most welcome distractions. You're more siblings than friends. Thomas, thank you for the beers when they were most needed during my PhD journey. Our daughters being born on the same day feels fitting — our lives have unfolded pretty much in sync. Let's keep it that way. Thanks also to Timo, Appy, Errol and Jos – for all the good distractions and keeping close. Saskia and Sjoerd, thank you for being my paranimfen! We've been friends since our very first week as sociology students. To now close this academic chapter together seems like a very fitting full circle. A beer at Spinhuis next Thursday?

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The best is yet to come.

PhD Portfolio

Presentations

2024 *Modalities of Power: an ethnographic account of a nurse empowerment movement and its (non)performativity,* American Sociological Association (ASA), Toronto, Canada

2024 *The Power and Politics of Reorganizing Nursing Work,* Organisational Behaviour in Health Care (OBHC), Oslo, Norway

2023 *Epistemic Politics: nurses navigating pilot practice*, European Sociological Association (ESA) conference, Sociology of Professions: Dynamics of Professions and Professionalism: Work, Quality, and Expertise, Utrecht, the Netherlands

2022 *Organising Care in Times of Pandemic*, Organisational Behaviour in Health Care (OBHC), Birmingham, United Kingdom

2022 *Nursing Work in Times of Pandemic: an ethnographic account of nurses' organizational work in COVID-19 care*, Social Studies of Science (4S) conference, (Online), Toronto, Canada

2022 *Uncertain Futures: pandemic modelling and healthcare governance of COVID-19*, Social Studies of Science (4S) conference, (Online), Toronto, Canada

2021Frontline Professionals: nurses' valuation work in Covid care, Nordic Science and Technology Studies Conference 2021, (Online) Copenhagen, Denmark

Peer reviewed publications

Kuijper, S., Felder, M., Bal, R., Wallenburg, I., Clegg, S., (under review) Modalities of power: an ethnographic account of a nurse empowerment movement and its (non) performativity. *Journal of Political Power.*

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Awards

Top cited article 2022-2023 Sociology of Health and Illness: Assembling care: how nurses navigate uncharted territory in times of pandemic

Teaching

2024-2025 Advanced research methods (MSc Health Economics, Policy and Law; MSc Healthcare management), Erasmus School of Health Policy and Management – lecturer

2023-2024 Advanced research methods (MSc Health Economics, Policy and Law; MSc Healthcare management), Erasmus School of Health Policy and Management – lecturer and tutor

2023-2024 Quality and Safety (MSc Healthcare management), Erasmus School of Health Policy and Management) – Lecturer and tutor

2023-2024 Management van Zorgorganisaties (BSc Gezondheidswetenschappen), Erasmus School of Health Policy and Management) – Lecturer

2023-2024 Academische Vorming & Vaardigheden (BSc Gezondheidswetenschappen), Erasmus School of Health Policy and Management), Tutor

2022-2023 Quality and Safety (MSc Healthcare management), Erasmus School of Health Policy and Management) – Tutor

2022-2023 Kritische Studies Management en Innovatie (Pre-Master Zorgmanagement), Erasmus School of Health Policy and Management - Tutor

2022-2023 Academische Vorming & Vaardigheden (BSc Gezondheidswetenschappen), Erasmus School of Health Policy and Management) - Tutor

2021-2022 Advanced research methods (MSc Health Economics, Policy and Law; MSc Healthcare management), Erasmus School of Health Policy and Management – Lecturer and tutor

2021-2022 Kritische Studies Management en Innovatie (Pre-Master Zorgmanagement), Erasmus School of Health Policy and Management - Tutor

2019-2020 Kritische Studies Management en Innovatie (Pre-Master Zorgmanagement), Erasmus School of Health Policy and Management - Tutor

Training

Currently – Basiskwalificatie Onderwijs (BKO)

2024 - Organisational Behaviour in Health Care (OBHC) Pre-Conference graduate Workshop, academic writing

2022 - The View from Somewhere: Geographies of Knowledge and STS, Netherlands Graduate School of Science, Technology, and Modern Culture (WTMC), workshop

2022 - Trust and Truth, Netherlands Graduate School of Science, Technology, and Modern Culture (WTMC), workshop

2022 - Organisational Behaviour in Health Care (OBHC) Pre-Conference graduate Workshop, academic writing

2021- Datafying Non-humans, Netherlands Graduate School of Science, Technology, and Modern Culture (WTMC), workshop

2021 - A new Political Sociology of Science, Netherlands Graduate School of Science, Technology, and Modern Culture (WTMC), summerschool

2020 - Participatief Actieonderzoek, Evers Research & Training, workshop

2020 - Naturalistisch onderzoek: inleiding kwalitatief onderzoek, Evers Research & Training, workshop

2020 - Searching, finding and managing your literature, Erasmus Graduate School of Social Sciences and the Humanities, workshop

Other activities

2023 - Visiting fellow School of Project Management, Faculty of Engineering, University of Sydney, Australia

Nurses and nursing practice are key in health policy and professional debate, and in healthcare organizations struggling with nurse shortages. In this context, the reorganization of nursing work is increasingly framed – politically and discursively – as an urgent global policy priority, sparking a wave of change initiatives in recent years.

Too often, however, the political nature of change is pushed aside by those working on and studying change in healthcare practice, policy, and research. Across fields, there is a strong tendency to treat change as technical and apolitical processes; detached from the organizational, institutional and political arenas in which envisioned changes are negotiated, contested and ultimately decided. This research challenges this deficit by zooming in on the politics of organizational change that inform and shape the reorganization of nursing work. In doing so, it seeks to offer a more comprehensive – and realist – account of how organizational change unfolds 'on the ground' in (Dutch) hospital practice and its multifaceted outcomes for the profession.

Drawing on extensive and engaged ethnographic research within 'RN2Blend' – a nationwide participatory research program tasked with studying and facilitating change in nursing – this research analyzes the politics of reorganizing nursing work 'from within'. It shows how the reform of nursing work and the professionalization of nurses runs the risk of becoming stuck in politicized debates about identity, epistemic knowledge and organizational impact, arguing for the recognition of nurses' practical and experimenting knowledge for organizational and policy change. The insights will be of interest to nurses, healthcare managers, professional nursing associations, policymakers, and anyone concerned practically or conceptually with power, politics, and organizational change – in nursing and beyond.