The Multiple Middle: Managing in Healthcare

Lieke Oldenhof

The Multiple Middle: Managing in Healthcare

Lieke Oldenhof

Painting on the title page: Circles in a Circle
Artist: Vasily Kandinsky

According to Kandinsky the circle is the most elementary form which he described as ‘a single tension that carries countless tensions within it’. In this PhD thesis, the same could be said for the life world of middle managers who do not merely operate in the hierarchical middle, but in-between countless middles.

Further details:
Oil on canvas, 1923
38 7/8 x 37 5/8 inches (98.7 x 95.6 cm)
Philadelphia Museum of Art: The Louise and Walter Arensberg Collection, 1950

Oldenhof, L. E.
The Multiple Middle: Managing in Healthcare
Dissertation Erasmus University, The Netherlands

Designed by Helma Bovens en Matthijs Sluiter, Studio Het Mes
Printed by Optima Grafische Communicatie, Rotterdam

The Multiple Middle: Managing in Healthcare

Het meervoudige midden: managen in de gezondheidszorg

Proefschrift

ter verkrijging van de graad van doctor aan de
Erasmus Universiteit Rotterdam
op gezag van de
rector magnificus

prof.dr. H.A.P. Pols

en volgens besluit van het College voor Promoties.

De openbare verdediging zal plaatsvinden op

17 april 2015 om 9.30

door

Lieke Esselina Oldenhof

geboren te Enschede

Promotiecommissie

Promotor:	Prof.dr. K. Putters
Overige leden:	Prof.dr. R. Bal Prof.dr. P. L. Meurs Prof.dr. M. Noordegraaf
Copromotor:	Dr. A. M. V. Stoopendaal

Table of contents

Chapter 1	Introduction: opening up the middle in healthcare management	7
Chapter 2	Daily practices of operational healthcare managers: dealing with different values	30
Chapter 3	On justification work: how compromising enables public managers to deal with conflicting values	52
Chapter 4	Professional talk: how middle managers frame care workers as professionals	80
Chapter 5	Organized professionalism in healthcare: articulation work by neighbourhood nurses	108
Chapter 6	Middle managers distributing leadership in neighbourhood governance	134
Chapter 7	Changing boundaries: middle managers doing boundary work in neighbourhood care	156
Chapter 8	Reflections on the multiple and shifting middle in healthcare management	178
Summary		196
Samenvatting		202
Dankwoord		210
Curriculum Vitae		216

Chapter 1

Introduction: opening up the middle in healthcare management

The middle management debate: 'stuck in the middle'?

> 'A middle-management job in many organizations, especially in large ones, is a no-win deal. Middle managers feel themselves hemmed in by policies, procedures, and rules of someone else's making, and at the same time they feel themselves under pressure to innovate, communicate, and manage change. They feel pressure from the top and demands from the bottom. They typically have less latitude for action than onlookers seem to think they have.' (Albrecht 1990, p. 71)

> 'Middle-level managers are uniquely positioned between top management priorities and operating realities (...). Social interactions at this level have a high potential to influence strategy in both upward & downward directions.' (Floyd and Wooldrigde 2000, p. 37)

As these quotes of management scholars demonstrate, middle management is a heavily debated topic. Depending on whom one asks, the middle manager is either an immobile actor 'stuck in the middle' between organizational hierarchies — adding little value — or a strategic player who flexibly operates from the middle, thereby promoting necessary change in organizations. This presents us with an inconclusive and contradictory picture. To better understand the state of middle management, it's necessary to investigate what is happening to middle managers.

According to pessimistic accounts, middle managers are in trouble because of downsizing and the dismantling of organizational hierarchies (Peters 1992; Newell and Dopson 1996; Gratton 2011). In flattened organizations, there is less space for the middle manager in-between the organizational top and bottom. Moreover, as Thomas and Linstead remark (2002, p. 72), the intermediate position of the manager is now 'singled out as the root of many of the problems associated with the hierarchical organizational form'. Middle managers are associated with bureaucracy and inefficiency, which leaves middle management as 'an identity no-one wants' (Hyde et al. 2011, p. 9). Even middle managers disassociate themselves from the label of middle management, for example by saying that they are more senior than middle managers or are professionals who also manage on the side (ibid.). In literature, middle managers are furthermore portrayed as actors who are resistant to change. When strategic change is not in their self-interest, middle managers engage in 'footdragging', create 'roadblocks to implementation' or perform 'outright sabotage' (Guth and MacMillan 1986, p. 314). Other authors do not attribute bad intentions to middle managers, but simply describe them as immobile actors who are caught in the middle of hierarchy with little maneuvering room to make their own decisions (e.g. Albrecht 1990). As a result of being stuck-in-the-middle, middle managers can feel powerlessness (Goffee and Scase 1989), experience role ambiguity and vulnerability (Feldman 1999; Sims 2003; Thomas and Linstead 2002; Conway and Monks 2011) and become cynical towards organizational goals and executives (Osterman 2008). Given these difficulties and the discourse of post-bureaucratic organizing, the future of middle management is repeatedly called into question. In fact, some authors have proclaimed the end of middle management as we know it (Peters 1992; Gratton 2011).

We can contrast this gloomy vision with an optimistic view of middle management. In this view, organizational restructuring has created new opportunities for a strategic role of middle managers. Their intermediate position between top and bottom is not a hindrance, but an advantage when it comes to achieving strategic change, innovation and public outcome (Floyd and Wooldrigde 1994; Nonaka 1994; Dutton et al. 1997; Currie 2000; Balogun 2003; Rouleau 2005; Currie and Proctor 2005; De Vries and Van Tuijl 2006; Mantere 2008; Floyd and Wooldrigde 2008; Elshout 2009; Rouleau and Balogun 2011; Birken et al. 2013). Because of their intermediate position, middle managers have access to dispersed actors and a wide range of knowledge: both operational and strategic. This allows middle managers to fulfill roles as change intermediaries (Balogun 2003), implementers of healthcare innovations (Birken et al. 2012), boundary spanners (Currie 2006), knowledge brokers and engineers (Burgess and Currie 2013; Nonaka 1994), and strategic sensemakers and champions (Pappas et al. 2005; Wooldrigde et al. 2008; Rouleau and Balogun 2011). In these roles, middle managers flexibly mediate between junior staff and senior management (Harding 2014; Tengblad 2006), broker and integrate different sets of knowledge (Burgess and Currie 2013), and champion new initiatives upwards (Floyd and Wooldrigde 2008). Because of these advantages, middle management is not a superfluous management layer which can be 'cut out', but a valuable asset to the organization.

As becomes clear, the debate about middle management is deeply polarized and locked into dualisms of positive/negative, either/or, future/past, presence/non-presence (Linstead and Thomas 2002; Ainsworth et al. 2009). The middle manager is either a hero or a villain; crucial or absent; the heart of the organization or a marginal actor hovering in the periphery; a change promoter or change buffer; a dinosaur or a dynamo (Guth and MacMillan 1986; Floyd and Wooldridge 1994; Livian and Burgoyne ed. 1997; Balogun 2003; Embertson et al. 2006). These dichotomies urge researchers to take a stand: one is either 'for' or 'against' middle managers. Middle managers are the future or belong to the past. This thinking is exemplified by phrases such as 'in praise of middle managers' (Huy 2001) and 'the end of middle management' (Gratton 2011). The debate about middle management in fact has become 'stuck-in-the-middle' between oppositions. As a consequence, the term 'middle management' has become a monolithic subject that overshadows rather than enlightens the diversity of managerial practices.

I argue that it is unproductive to continue thinking in dichotomies. It is more interesting to investigate what these diverging views of middle management actually have in common. Shared assumptions that underlie current conceptualizations of middle management remain largely unrecognized, yet are important for the way we think about middle management. They determine how we view middle management and what elements of managerial work we find relevant (and which not). The main focus of this thesis is on middle management in healthcare. Nevertheless I will first unravel some general ontological questions about middle management, before zooming in on middle managers in the healthcare sector.

The ontological question: in the middle of what?

Despite very different appreciations of middle management, both pessimistic and optimistic views of middle management have very similar ontological assumptions about what constitutes 'the middle' in management. Across literatures, middle management is essentially viewed as a spatial construction of organizational hierarchy (Ainsworth et al. 2009). More specifically, the middle is constituted by an intermediate space in-between the *top* and the *bottom* of the organization. Middle managers thus inhabit a vast, vaguely defined *middle ground* in organizations, which can encompass basically anything except the top and bottom (ibid.). In order to get a grip on this unspecified middle ground, authors attempt to define middle management more specifically in relation to other organizational layers. For example Birken et al. (2012) and Elshout (2009), define middle managers as frontline supervisors who manage teams of professionals and operate in-between the work floor and higher management. Other authors, such as Mintzberg and Currie and Procter, exclude managers above the work floor and locate middle management in-between two management layers (Mintzberg 2009), with at least two levels of staff below them (Currie and Procter 2005). As such, middle managers report to managers *above* and supervise managers *below* (Mintzberg 2009).

Spatial conceptualizations of middle management like the ones above, have significantly influenced the way we talk, think and write about middle managers[1]. Not only their organizational position, but also their activities and relations to others are described in spatial metaphors. Some middle managers manage themselves 'out of the middle' by connecting (Mintzberg 2009), strategizing (Floyd and Wooldrigde 2000) or boundary spanning (Currie 2006), while others 'muddle in the middle' (Newell and Dopson 1996) or 'get stuck in the middle' (Sims 2003). The following quotes from middle management studies exemplify spatial thinking at its best: 'they feel pressure from the *top* and demands from the *bottom*' (Albrecht 1990, p. 71); 'are both targets of top-down changes and agents of change from the *bottom up*' (Conway and Monks 2011, p. 199); 'influence strategy in a *downward* manner, convergent with senior management plans, but also exert strategic influence *upwards* and divergent from senior management plans' (Burgess and Currie 2013, p. 134); function 'as *bridge* between visionary ideals of the top and the often chaotic reality on the *frontline* of business' (Nonaka 1994; p. 32). Moreover, in the doing of their work, middle managers are *geographically placed* in organizational fields. They manage concrete *places*, including organizational locations, units, divisions and departments. Middle managers are thus tied to and defined by place. As such, the *Gestalt* of the middle manager is deeply spatial and embedded in place.

However, the use of spatial language also has certain drawbacks, which need to be acknowledged. Up-down spatialization metaphors narrow our view of middle management. We describe the work of middle management mainly in vertical terms, e.g. managing upwards and downwards. Work that cannot be conceptualized in these spatial terms receives less attention. Also, the in-betweenness of middle managers is limited to the intermediate position in-between the top and bottom of the organization. Although organizational in-betweenness is an important reality of

1 To understand the influence of spatial metaphors in our daily life, see G. Lakeoff and M. Johnson (2003). *Metaphors we live by*. Chicago en London: The University of Chicago Press.

middle managers that significantly influences how they constitute and perceive their own work and identity (Harding et al. 2014), it is not the *only* reality. In order to open up the debate about middle management, I will explore the multiplicity of middle management in the next section, thereby shedding light on multiple co-existing middles.

The multiplicity of the middle

Building on Mol's idea of multiple ontologies (2002), I argue that middle management encompasses multiple realities and middles rather than just one. As Mol points out, '*ontology is not given in the order of things, but (...), instead, ontologies are brought into being, sustained, or allowed to wither away in common, day-to-day, sociomaterial practices.*' (ibid. p. 4) When we look at middle management, 'the middle' is not pregiven in an organizational structure or hierarchy, but is actively constituted, for example by creating an organizational chart, developing managerial positions, or framing managers as bridges between different organizational layers. Rather than 'being in the middle' of a hierarchy, it is the visual display of hierarchies that create 'middle' management. Moreover, middle management is not a singular reality, but encompasses multiple realities at the same time. For example, one and the same middle manager can experience multiple middle*s* simultaneously. This manager can find her/himself in the middle between conflicting values (e.g. efficient and good quality of care), in the middle of multiple identities (e.g. 'hybrid' managers with professional backgrounds) and in the middle between operational and strategic work (e.g. ad-hoc reality and abstract visions). Furthermore, these middles are not necessarily vertical in nature between top and bottom, but can be shaped in different directions, including lateral and horizontal. Finally, it is important to note that middles are locally shaped in daily practices. They are co-constructed by various actors, such as professionals, citizens, and policymakers, as well as specific objects such as buildings, organizational visions, policy documents, and laws. Moreover, they come into being in different places such as offices, meeting rooms, or at clients' homes and are spread across different time frames, for instance gradually over the years or during a short conversation. When attending to the multiple middle in management, it thus necessary to locally investigate how those 'middles' come into being, are enacted in daily work practices (more about that later) and to what kinds of effects.

To further develop the notion of multiplicity, I draw on various bodies of literature on values and justifications (Jacobs 1994; Pols 2004; Boltanksi and Thévenot 2006; Lamont 2012); connections between professionals, managers and organizations (Muzio and Kirkpatrick 2011; Evetts 2011; Thomas and Hewitt 2011; Noordegraaf 2011; Noordegraaf and De Wit 2012); inter-organizational collaboration of public service organizations in networks (Rhodes 1996; Ferlie et al. 2003; Osborn 2010); boundaries and boundary work (Hernes 2004; Lamont and Molnár 2002; Bal 1999; Star and Griesemer 1989; Gieryn 1983). These bodies of literature enable me to make visible alternative middles that so far have received little attention in

existing middle management literature. I specifically focus on public service provision when providing illustrations:

The middle in-between different justifications:
when in disagreement, middle managers justify their actions to significant others by drawing on different repertoires of justification (Boltanski and Thévenot 2006). They can for example justify a reform in public services by using market justifications (where efficiency and competition are central values) or use civic justifications (where good citizenship and solidarity are important values). When performing justification work, managers often invoke several justifications at once, thereby positioning themselves in the middle of justifications. Research that explores how middle managers use and add up different justifications is relevant especially in the light of legitimacy questions surrounding public service delivery in the middle of reforms.

The middle in-between different values:
when managing and organizing public services, middle managers are faced with different, sometimes conflicting values such as client-centeredness, transparency, accountability and efficiency. Middle managers operate right in the middle of values when managing value conflicts. The way middle managers deal with multiple values in their daily work is still an under-researched area (a notable exception is Hewison 2002).

The middle in-between managerial and professional worlds:
the worlds of professionals and managers are frequently depicted as analytically distinct and conflicting (see for a critique, Muzio and Kirkpatrick 2011 and Noordegraaf 2011). In the professional world, client-centered services and good quality are key for professionals, whereas in the managerial world efficiency gains and costs are the central focus of managers. It is unclear if and how middle managers actually experience this distinction between professional and managerial worlds: do they experience feelings of in-betweenness or not? And which discourses—professional and/or managerial—do middle managers draw on during their day-to-day interaction with professionals?

The middle in-between organizational boundaries:
public services are increasingly organized and managed in multi-actor networks and horizontal governance arrangements (Rhodes 1997; Osborn 2010). In these networks, various service providers (e.g. social support, healthcare, housing) are mutually dependent and collaborate to integrate fragmented and specialized services. Consequently, middle managers not only have to work *intra*-organizationally, but also *inter*-organizationally. When moving in-between various organizational realities, they may find themselves in various inter-organizational middles. How middle managers experience these middles and how they reconfigure composite boundaries (Hernes 2004) is a highly relevant topic.

By making this list, I attempt to foreground *other* middles in middle management. This does not imply a denial of the vertical middle in-between the top and bottom of the organization. This vertical middle remains an important constructed reality for

middle managers. Nevertheless, it is necessary to open up the middle by introducing the multiplicity of the middle. An important consequence of this alternative conceptualization is that middle management is no longer an exclusive category just belonging to middle managers with an intermediate position in the organization. The activity of middle managing can be enacted by various actors. Professionals may also manage in the (multiple) middle, for example, when they experience value conflicts or work in-between various organizations. Therefore I argue that it is necessary to broaden the scope of middle management: not only 'classic' middle managers with an intermediate organizational position should be researched, but also professionals who engage in some form of managing in (the) middle(s). In this thesis I attempt to do both. My main focus is on middle managers with an intermediate organizational position and how they experience multiple middles, but I also pay attention to professionals work in-between alternative middles.

Middle management in healthcare

So far, I have generally discussed middle management to tease out some of the underlying meanings of the middle. I now zoom in on middle management in the healthcare sector. This is a particularly interesting sector to research middle management for various reasons.

In healthcare, there is a growing body of literature about 'hybrid' middle managers (Llewellyn 2001; Hewison 2002; Iedema et al. 2003; Dopson and Fitzgerald 2006; Witman et al. 2010; Burgess and Currie 2013; Fitzgerald et al. 2013). 'Hybrid' refers to middle managers with a professional background in healthcare. A good example are doctors who take up management roles as clinical department heads or directors (Witman 2011 et al.; Iedema et al. 2003). Because of their professional background, they can mediate between professional and management expertise. Llewellyn has described this process of mediation with the metaphor of the 'two-way window' (2001): by moving between between the medical and managerial domain, hybrid management can improve interaction between these domains, thereby creating new bodies of integrated expertise (ibid.). As Burgess and Currie note (2013, p. 134), research almost exclusively focuses on doctors as hybrid managers, 'yet there is evidence that of a wide range of hybrids enacting strategic management roles in healthcare'. It is thus necessary to further study hybrid middle management by particularly focusing on other professional backgrounds such as nursing and social pedagogical work, as will be done in this thesis. In addition to filling this empirical gap, research on hybrid middle managers can contribute to new insights into 'the multiple middle' in management. Because of their professional background, hybrid middle managers may experience feelings of in-betweenness in more intense ways (Hewison 2002).

Healthcare management is furthermore relevant because of developments towards distributed leadership (Currie and Locket 2011; Martin and Learmonth 2012; Fitzgerald et al. 2013; Oborn et al. 2013). The notion of distributed leadership refers to more pluralized and shared forms of decision-making by a collective of

actors rather than one leader or figure with authority[2]. This form of leadership is currently being promoted in the healthcare sector as a way to reform service provision in multi-actor networks, stimulate innovations and to provide more agency to frontline professionals (Martin and Learmonth 2012). The popularity of distributed leadership is illustrated by new leadership roles for professionals and collective work forms such as self-steering teams and collaborative partnerships (Van Dalen 2012; De Blok and Pool 2010). The result could be a gradual replacement of 'traditional' top-middle-down management by 'new' forms of distributed leadership, yet it is still unclear how this supposed change affects the position of individual managers. Do managers still play an important, albeit different role or is 'management beyond-the-manager' increasingly a new reality (Mintzberg 2009, p. 147)? Since operational layers of middle management are responsible for managing teams of professionals on the work floor (Birken et al. 2012 and 2013), further research on the relation between middle management and professionals can shed light on these questions.

The Dutch care sector

This thesis is set in the Dutch care sector, which can be characterized as a hybrid sector with multiple logics at play, including market, public, professional and community logics (Putters 2009; Van der Pennen et al. 2014; Helderman 2007, Van de Bovenkamp et al. 2014). Because of these multiple logics, managers have to operate in a complex policy regime. The delivery and insurance of healthcare is organized by private care organizations and insurers that pursue public goals, i.e. affordability, accessibility and quality of care (Helderman 2007). Central government 'governs at a distance' via quality standards, benchmarks, inspections and regulations (Rose et al. 2006). In this complex regime, middle managers are not mere implementers of government policy, but active agents that attend to various logics, values, interests and actors. Managing is by definition a complex and ambiguous affair, even more so because there is no overarching norm to balance different values. Depending on transitions in the care sector, different values and priorities come to the fore in managerial work (Putters 2009).

Since the 1980's, the Dutch healthcare system has become more market-oriented (Helderman 2007; Van der Pennen et al. 2014; Grit and De Bont 2010). The introduction of regulated market competition in 2007 has led to a significant reordering of relations between patients/clients, insurers, care providers and the central government with more emphasis on competition and consumer choice. New financing systems such as Diagnoses Related Groups in curative care and client-linked budgets for long term care further aim to stimulate the making of (a) healthcare market(s). Even in the long-term care sector, which is not considered a 'real' market by economists, care providers are behaving more businesslike and competitively, especially since the introduction of client-linked budgets (Grit and De Bont).

2 Leaders and managers are often contrasted in terms of influence and position. Leaders are able influence other people without necessarily having a management position, whereas managers excert influence on the basis of their formal position. Yet, the notion of distributed leadership breaks down this artifical distinction between managers and leaders. Influence can be excerted by a collective of actors regardless of their background.

Similarly, managers, professionals and clients are triggered to behave more like actors in the market by adopting entrepreneurial and consumer roles (ibid.).

Alongside market reforms, developments of community-based care and participation have increasingly gained popularity. Long-term care providers that support people with disabilities and/or psychiatric problems have been forerunners in this development. Since the 1960's, 'total institutions' (Goffman 1991 reprint) have been gradually dismantled and replaced by small-scale care facilities in neighbourhoods. In these facilities, participation and integration of clients into society are central values. Building on these existing developments of community based care and participation, are the decentralizations in the social domain.Decentralizations such as The Social Support Act in 2007, have made local governments responsible for participation of citizens and the organization of care and support. Due to significant budget cuts, much is expected from citizen participation and the substitution of professional care services for informal help by volunteers, family members, neighbours and friends. Local governments emphasize that care professionals of public service providers should adopt new coordinating roles by supporting clients and involving the client's network/other public service providers (e.g. housing, social support), rather than directly providing care services themselves. There is still little knowledge about how professionals engage in these new coordinating roles and whether this instigates a new division of management responsibilities between managers, professionals and citizens.

The above transitions in the care sector effect managerial work while at the same time managerial work affectsthe shape and outcome of these transitions. Values like affordability, participation and quality of care are not pre-given qualities which can be defined outside practices (Broer 2012; Pols 2006; Mol 2008), but are being formed, enacted and (re) valued in daily work practices of middle managers. Moreover, in the doing of managerial work, new relations between managers, professionals and clients are being shaped. The outcome of current transitions is not so much determined by front stage politics and policy rhetoric, but backstage in managerial offices, in care homes, and during day-to-day negotiations between clients, professionals and managers.

In the public debate, public managers in general and healthcare managers in particular are being criticized for adding little value to public service provision and/or hindering professionals in doing their work (Plasterk 2007; Weggeman 2007; Van den Brink et al. 2005; Blok and Pool 2010; PVV 2010). Given public discontent about managers, it is relevant to investigate more closely the daily work of middle management in relation to significant others. This thesis specifically focuses on professionals and clients as significant others. Compared to executives, they have received relatively little attention in middle management research.

Research aim and questions

This thesis is about managerial work of middle management in the Dutch care sector. Within the care sector, I specifically focus on small-scale care facilities and neighborhood-based care for people with physical and/or mental disabilities (see paragraph 'research trajectory' for more details).

The aim of this thesis is to 1) describe and understand the day-to-day work of middle management in the Dutch care sector and 2) explore important shifts in middle management. The central research question is:

> *How is the daily work of middle management enacted and reconfigured in the Dutch care sector?*

In answering this question, I not only look at 'the vertical middle' in-between the top and the bottom of the organization, but also investigate alternative middles: i.e. middles in-between conflicting values and justifications, in-between organizational boundaries of different public service providers, and in-between professional and managerial worlds. My main focus is on middle managers that are responsible for managing several teams of professionals and different care locations. The majority of these middle managers can be described as 'hybrid managers': i.e. they have previously worked as professional themselves before becoming managers. In addition, I pay attention to organizing professionals who find themselves in the inter-organizational middle when coordinating efforts of different service providers, like neighbourhood nurses. In this thesis, middle management can therefore encompass both managerial and professional actors.

More specific research questions are:

1) *What daily work is being performed by middle management?*
Many abstract assumptions are made about what middle managers do in general, yet detailed studies of what middle managers actually do during their workday are still rare. An answer to this sub-question provides insights into mundane work of middle managers. Furthermore, different types of work are distinguished and described.

2) *How is this work being reconfigured and distributed to other actors, such as professionals and citizens?*
The nature of managerial work is changing due to transitions towards more citizen participation and self-steering, coordinating professionals. The answer to this sub-question provides insights into how managerial work itself is redefined and how managerial work is shared with relevant others, including clients and professionals.

3) *How does the daily work of middle management contribute to the (good) governance of care?*

Given the societal debate about managers in the public sector, it's important to investigate how work efforts of middle managers contribute to the organization of care and whether they contribute to 'good' care delivery.

Shadowing managerial work

> 'If you ***ask*** a manager what he does, he will most likely tell you that he plans, organizes, coordinates and controls. Then ***watch*** what he does. Don't be surprised if you can't relate what you see to these four words.' (Mintzberg 1975, p. 49)

This quote from management scholar Henry Mintzberg perfectly demonstrates why it is important to observe the work of managers. Managers themselves, as well as academic scholars, provide rather abstract and rational descriptions of managerial work (Barley and Kunda 2001). A good example of such an abstract, yet very influential management definition is Gulick's (1937) POSDCORB, which refers to planning, organizing, staffing, directing, coordinating, reporting and budgeting. According to this definition, management can be neatly subdivided into clearly demarcated and goal-oriented tasks.

This rational image of managerial work has been gradually debunked by scholars that observed the activities and behaviour of managers in their natural work environment (see for example Dalton 1959; Mintzberg 1973; Watson 1994; Noordegraaf 2000; Tengblad 2006; Stoopendaal 2008; Arman 2009; Mintzberg 2009; Tengblad 2012). Many of these observational studies used the technique of 'shadowing'. This is a specific observational technique which requires the researcher to follow the object of study—in this case the manager—during their workday. As Arman et al. note (2012, p. 301), 'shadowing means following people, wherever they are, whatever they are doing'. Studies based on shadowing, show that management is far from the orderly affair it's often made out to be in popular manuals on 'how to become a manager'. For most of the time, management consists of highly fragmented activities and ad-hoc decision-making (Mintzberg 1973; Arman 2009; Tengblad 2012) and requires continuous sensemaking of ambiguous situations in which multiple actors with conflicting perspectives are involved (Watson 1994; Noordegraaf 2000). These findings suggest that management is not so much about formulating strategic long-term plans on paper. Instead, management is more about emerging, informal sensemaking in interaction with others, thereby collectively shaping organizational outcomes (see Weick 1995; Rouleau 2005; Holmberg and Tyrstrup 2010; Rouleau and Balogun 2011).

By shadowing managers, management scholars have created a more realistic understanding of what managers do on a day-to-day basis. In this thesis I further build on this tradition by shadowing middle managers that are responsible for small-scale care facilities that are geographically dispersed across neighbourhoods. Shadowing allowed me to openly investigate the work of middle managers by deeply immersing myself in managerial practices. By doing so, I could develop a comprehensive

and holistic understanding of managerial work in all its facets. I opted for a practice-based approach of shadowing which focuses on managerial talk and behaviour, text, objects, spaces and interactions between various actors (Ciarniaswka 2007; Tengblad 2012; Noordegraaf 2014).

From a practice-based approach, the work of managers consists of embodied and spatialized experiences and actions. Managerial work is researched 'in action' and 'on the move'. I for example followed managers in cars when driving in-between care locations (while at the same time telephoning—hands free—with care workers who needed advice on ad-hoc problems), doing administration behind their desk, talking to other managers in the coffee corner about the weather or the organizational strategy, conducting meetings in offices with peer colleagues or client's family members, overseeing team meetings with professionals, eating dinner with clients and care workers in small-scale living facilitates, or calling up local business men to fix broken coffee machines. These shadowing experiences not only tell us something about individual managers, but also about how managerial work is collectively established in interaction (with objects and human actors) and how this work affects collective organizational outcomes and routines (Noordegraaf 2014).

During shadowing, I adopted a critical outlook at management. In line with critical management scholars, I view management as a normative phenomenon rather than a neutral function that consists of technical planning and coordinating (Alvesson and Willmott 1992; Grey and Willmott 2005). In everyday management, many normative choices are made about who should get what, which values are prioritized (e.g. public/private), and how work should be organized: democratically, bureaucratically or autocratically (Alvesson and Willmott 1992). Yet, managerial decisions are often objectified to the outer world as neutral outcomes by managers themselves and management scholars. To bring back normativity into managerial work studies, it is necessary to get behind objectified decision-making and investigate the underlying meaning of managerial talk and practices (Watson 1994; Alvesson 1994). Managers use words and streams of talk not just to describe situations as they are, but to organize and steer action of others (Czarniawska 2008; Oldenhof et al. 2014; Rouleau and Balogun 2011). Hence, words are not neutral signifiers, but the tools of managers to frame decisions in certain ways, sometimes consciously, sometimes unconsciously. What's more, talk can also be performative since the uttering of words can be an action in itself (Austin 1978). I have taken these insights into account during my research and investigated managerial talk in one-on-one situations (researcher/middle manager) as well as in collective situations in which middle managers interacted with clients, clients' relatives, professionals, peers, top managers and other actors outside the organization.

Shadowing required a subtle game of becoming more and less visible as a researcher. Sometimes I tried to fade into the background by positioning myself at the outskirts of a room, yet other times I actively participated, for example by doing trivial things like collecting and ordering chairs before meetings, making coffee or offering my perspective on an event/conflict when people explicitly asked my opinion. Not saying anything on the matter would not only be impolite, but would also deny myself a meaningful relation with people in the field. This meaningful relationship was also constructed during many informal conversations with middle managers

about their work. These conversations, which can be considered a form of real-time interviewing (Barley and Kunda 2001; Arman et al. 2012), provided rich information about how managers perceived concrete events or interactions (that had just taken place), but also gave insights into general views of middle managers about their work. Since it's difficult to talk about the specifics of what you do outside the context of actually doing it (ibid.), these real-time interviews were a valuable addition to the observations I conducted.

The research trajectory of this thesis

Important developments in Dutch healthcare, such as client-linked financing, small-scale care and neighbourhood based support, manifest themselves in 'small form' in the cases I researched over the years. My research started off in 2009 with a round of pilot-interviews to get a broad overview of middle management. I conducted interviews with middle managers working in various care organizations, ranging from home care, elderly care and care for people with disabilities to support facilities for homeless people with addictions (n= 23). Different levels of middle management were included: operational middle managers who supervised professionals on the work floor (n=18) and higher middle managers who supervised operational middle managers (n= 3). Additionally, two personnel managers were interviewed about their view on middle management (n=2). These interviews were used to explore the mundane work and daily dilemmas of operational middle managers across organizations. The interviews also explored developments that affected the work of middle managers, such as the introduction of client linked budgets. On the basis of this research, I wrote chapter 2. This chapter describes how operational middle managers since the introduction of client linked budgets deal with daily dilemmas, such as tensions between the values of affordability and good quality of care.

After the pilot-interviews, I decided to zoom in (Nicolini 2009) by shadowing 7 middle managers in one care organization (2011). This care organization provides small-scale care for people with mental and/or physical disabilities. Each middle manager was shadowed for 3 full workdays (total n= 21). In addition to this, I observed various organizational events, educational courses attended by middle managers, and meetings with executives, higher management and middle management (2011-2012). I also conducted document analysis of managerial texts, emails, minutes of meetings and the organizational vision. On the basis of this research, chapter 3 and 4 were written. Chapter 3 provides insights into how middle managers and executives deal with conflicting values in small-scale care facilities by means of compromises and justification work. This chapter was co-written with Jeroen Postma who collected data on healthcare executives. Chapter 4 describes how middle managers use the discourse of professionalism ('professional talk') to stimulate reflectivity of vocational care workers and promote the development of professional competencies.

Over the course of 2011 and 2012, I also researched the Neighbourhood Based Approach Program. This reform program was partially financed by the Ministry of Health, Welfare and Sports. Public service providers in care and welfare participated in this program. The goal of the program was to reform current care provision by integrating care with others services (welfare, housing) and by organizing care on a neighbourhood scale, thereby promoting citizen involvement and stimulating professionals to work more independently. I shadowed 3 middle managers in this program and additionally observed events, such as training sessions with project leaders and meetings of self-steering neighbourhood teams with various professionals (n= 15 days of observations). Chapter 6 and 7 were written on the basis of this research. Chapter 6 describes how middle managers play a key role in distributing leadership in neighbourhood governance to citizens and professionals. This chapter also goes into the bright and dark sights of distributing leadership. Chapter 7 describes the boundary work that middle managers perform when integrating services from different public service providers (housing, welfare, care) on a neighbourhood scale.

Finally, chapter 5 is based on semi-structured interviews (n=35) with neighbourhood nurses working at various home care organizations in 13 Dutch municipalities (2011-2012). The data were gathered by Jeroen Postma for the Visible Link Project, which was financed by the Netherlands Organization for Health Research and Development. The data were jointly analyzed by Jeroen Postma and myself and the article was co-written. Chapter 5 describes how neighbourhood nurses engage in organizing as intrinsic part of their professionalism. The chapter shows how neighbourhood nurses engage in different types of articulation work to link-up fragmented public services and to stimulate informal care by clients and their relatives.

Structure of the chapters

Chapter 2 describes how middle managers experience feelings of in-beweenness due to value conflicts. Since the recent introduction of client-based financing in the care sector, managers are expected to provide more client-centered and affordable care. In practice, managers experience ambiguity and tensions in the operationalization of these different values. By looking into local management practices, light is shed on the way managers actually deal with these tensions. On the basis of qualitative interviews with healthcare managers, four modes of dealing with tensions between different values are established: balancing values individually and collectively, prioritizing one value over the other, establishing compromises between values and making healthcare workers responsible for balancing different values. The findings demonstrate that managers increasingly feel pressure to more tightly manage their financial budget on location level. As a consequence, managers try to find solutions to keep care affordable, which they often feel ambivalent about. Nevertheless, managers also create flexibility in the new financing system by accomplishing compromises between values and reframing responsibilities for care. The results show that it is necessary to raise more awareness for the specific moral problems that operational healthcare managers experience when managing tensions between values.

Chapter 3 demonstrates how middle managers and executives in healthcare deal with value conflicts via compromises and justification work. In public administration, little attention has been paid to the possibility of constructive compromises that enable public managers to deal with conflicting values simultaneously rather than separately. We use Luc Boltanski and Laurent Thévenot's theory of justification to extend current conceptualizations of management of conflicting values. On the basis of a qualitative study of daily practices of Dutch health care managers it is shown how compromises are constructed and justified to significant others, such as clients and professionals. Because compromises are fragile and open to criticism, managers have to perform continuous 'justification work' that entails not only the use of rhetoric but also the adaption of behavior and material objects. By inscribing compromises into objects and behavior, managers are able to solidify compromises, thereby creating temporary stability in times of public sector change.

Chapter 4 examines how middle managers use the discourse of professionalism to create 'appropriate' work conduct of care workers at geographically dispersed small-scale care locations. Using Watson's concept of professional talk, we study how managers in their daily work talk about professionalism of vocationally skilled care workers. Based on observations and recordings of mundane conversations by middle managers, four different professional talks are found that co-exist in daily managerial practices: (1) appropriate looks and conduct, (2) reflectivity about personal values and 'good' care, (3) methodical work methods, (4) competencies. Jointly, these professional talks constitute an important discursive resource for middle managers to facilitate change on the work floor while governing from a geographical distance. Change involves the reconfiguration of care work and different managerial worker relations. Middle managers use professional talks in both enabling and disenabling ways vis-à-vis-care workers. Based on these findings, we suggest a more nuanced portrayal of the relationship between managers and professionals. Rather than being based on an intrinsic opposition, i.e. 'managers versus professionals', this relationship is flexibly reconstructed via professional talk.

Chapter 5 investigates how professionals manage in the middle of organizational boundaries and professional domains. Using the sociological concept of articulation work, we argue that organizational tasks are not always 'new', but can also be an inherent part of professional work, i.e. organizing at the heart of professionalism. Dutch neighbourhood nurses engage in different types of articulations work that professionals view as part of their daily work: i.e. intraprofessional, interprofessional and lay articulation work. Nurses use these types of articulation work to deal with fragmented and specialized home care services. Although articulation work results in more integration and improved coordination, it also leads to problems regarding competition between organizations and the limits of informal care and self-management. We conclude that articulation work traditionally lies at the heart of professionalism, but acquires new meaning due to changing organizational conditions and policy changes.

Chapter 6 addresses the key question of how leadership is being reconfigured in current neighbourhood governance. Building on theories of distributed leadership (DL), it is argued that neighbourhood leadership should not automatically be equated with the notion of an individual leader, but must be researched as a distributed activity enacted by a collective of local actors. A qualitative study of Dutch neighbourhood collaboratives by public service providers offers important insights into 'how' leadership is distributed and to what effect. Rather than a spontaneous bottom-up process, DL is steered by middle managers of public service providers. Middle managers not only distribute leadership to local actors, but also reshape responsibilities of citizens, professionals and themselves in the process. Three important consequences of distributing leadership are: 1) organizational responsibility for citizens and professionals to locally solve problems 2) the repositioning of middle managers as coach, 3) new maneuvering room for professionals. The findings also demonstrate that DL is a two-way street: parallel to distribution, new centralization occurs viaemerging coordinating roles. We conclude by describing both the bright and dark sight of DL: it provides opportunities for locally tailored services, but also carries the risk of overburdening citizens and professionals.

Chapter 7 describes how middle managers construct and reconfigure organizational boundaries between multiple service providers. In healthcare provision, organizational boundaries are often conceptualized as fixed barriers to service integration and change. However, this chapter demonstrates the constructed nature of boundaries and their change potential. On the basis of an ethnographic investigation of the Dutch reform program "The Neighbourhood Based Approach", we show how boundary work of middle managers encompasses both boundary (re) drawing and coordinating efforts of multiple service providers in new ways. By using boundary objects and new discourse, middle managers are able to reconfigure professional, sectoral, financial, accountability and geographical boundaries. As a result, alternative service arrangements and new work formats are developed, such as inter-professional neighbourhood teams. On the basis of our results, we reflect on the challenging nature of boundary work and outline some conditions for doing boundary work.

Chapter 8 provides a conclusion and outlines implications for theory and practice.

References

Albrecht, K. (1990). *Service within. Solving the middle management leadership crisis.* Homewood Illinois: Dow Jones-Irwin.

Ainsworth, S., D. Grant and R. Iedema (2009). 'Keeping things moving': space and the construction of middle management identity in a post-NPM organization. *Discourse & Communication* 3 (1): 5-25.

Alvesson, M. and H. Willmott ed. (1992). *Critical Management Studies*. London etc.: SAGE Publications.

Alvesson, M. (1994). Talking in organizations: Managing identity and impressions in an advertising agency. *Organization Studies* 15 (4): 535–563.

Arman, R., L. Dellve, E. Wikström and L. Törnström (2009). What healthcare managers do: applying Mintzberg's structured observation method. *Journal of Nursing Management* 17: 718-729.

Arman, R., O.E. Vie, H. Åsvoll (2012). Refining shadowing methods for studying managerial work. In *The work of managers. Towards a practice based theory of management,* Tengblad ed., 301-317. Oxford and New York: Oxford University Press.

Austin, J. L. (1978). *How to do things with words* (2nd ed.). Oxford: Oxford University Press.

Bal, R. (1999). *Grenzenwerk: Over de organisatie van normstelling voor de arbeidsplek*. Enschede: Twente University Press.

Balogun, J. (2003). From blaming the middle to harnessing its potential: creating change intermediaries. *British Journal of Management* 14: 69-83.

Barley, S.R. and G. Kunda (2001). Bringing work back in. *Organization Science* 12 (1): 76-95.

Birken, S. A., S.-Y. D. Lee and B.J. Weiner (2012). Uncovering middle managers' role in healthcare innovation implementation. *Implementation Science* 7 (28): 1-12.

Birken, S. A., S.-Y. D. Lee, B. J. Weiner, M. H. Chin and C.T. Schaefer (2013). Improving the effectiveness of health care innovation implementation: Middle managers as change agents. *Medical Care Research and Review* 70 (1): 29–45.

Boltanski, L. and L.Thévenot (2006). *On Justification: economies of worth.* Princeton NJ: Princeton University Press.

Broer, T. (2012). *Governing ideal of good care. Quality improvement in mental health care*. Rotterdam: dissertation Erasmus University.

Burgess, N. and G. Currie (2013). The knowledge brokering role of the hybrid middle level manager: the case of the NHS. *British Journal of Management* 24: 132-142.

Conway, E. and K. Monks (2011). Change from below: the role of middle managers in mediating paradoxical change. *Human Resource Management Journal* 21 (2): 190-203.

Currie, G. (2000). The role of middle managers in strategic change in the public sector. *Public Money & Management* 20 (1): 17-22.

Currie, G. and S.J. Procter (2005). The Antecedents of middle managers' strategic contribution: the case of a professional bureaucracy. *Journal of Management Studies* 42 (7): 1325-1356.

Currie, G. (2006). Reluctant but resourceful middle managers: the case of nurses in the NHS. *Journal of Nursing Management* 14 (1): 5-12.

Currie, G. and A. Lockett (2011). Distributing leadership in health and social care: concertive, conjoint or collective? *International Journal of Management Reviews* 13: 286-300.

Czarniawska, B. (2007). *Shadowing - and other techniques for doing fieldwork in modern societies*. Liber: Malmö.

Czarniawska, B. (2008). *A theory of organizing*. Cheltenham: Edward Elgar Publishing Ltd.

Dalton, M. (1959). *Men who manage*. New York: Wiley.

De Blok, J. and A. Pool (2010). *Buurtzorg: menselijkheid boven bureaucratie*. Den Haag: Boom Lemma.

De Vries, G. and H. van Tuijl ed. (2006). *Gezondheidszorg onder druk. Vitaliserende spanning in het middengebied van organisaties, een bedrijfskundige benadering.* Houten: Bohn Stafleu van Loghum.

Dopson, S. and L. Fitzgerald (2006). The role of the middle manager in the implementation of evidence-based healthcare. *Journal of Nursing Management* 14: 43-51.

Dutton, J. E., S. J. Ashford, E.E. Wierba, R. O'Neil and E. Hayes (1997). Reading the wind: how middle managers assess the context for issue selling to top managers. *Strategic Management Journal* 15: 407-25.

Elshout, Peer (2009). *Middenmanagement. Functie in ontwikkeling*. Tilburg: dissertation, Tilburg University Press.

Embertson, M. (2006). The importance of middle managers in healthcare organizations. *Journal of Healthcare Management* 51 (4): 223-232.

Evetts, J. (2011). A new professionalism? Challenges and opportunities. *Current Sociology* 59 (4): 406-422.

Feldman, S. (1999). In retrospect. The middle management muddle. *Administration and Policy in Mental Health* 26 (4): 281-290.

Ferlie, E., J. Hartley and S. Martin (2003). Changing public service organizations: current perspectives and future prospects. *British Journal of Management* 14: 1-14.

Fitzgerald, L., E. Ferlie, G. McGivern, D. Buchanan (2013). Distributed leadership patterns and service improvement: evidence and argument from English healthcare. *The Leadership Quarterly* 24: 227-239.

Floyd, S.W. and B. Wooldridge (1994). Dinosaurs or dynamos? Recognizing middle management's strategic role. *Academy of Management Perspectives* 8 (4): 47-57.

Floyd, S.W. and B. Wooldridge (2000). *Building strategy from the middle. Reconceptualizing strategy processes*. Thousand Oaks etc.: Sage Publications.

Goffman, E. (1991, reprint). *Asylums. Essays on the social situation of mental patients and other inmates*. London: Penguin Books (1961).

Gratton, L. (2011). Column. The end of middle management, *Harvard Business Review*, June 2011.

Grey, C. and H. Willmott ed. (2005). *Critical management studies. A reader*. Oxford and New York: Oxford University Press.

Grit, K. and A. de Bont (2010). Tailor-made finance care versus tailor-made care. Can the state strengthen consumer choice in healthcare by reforming the financial structure of long-term care? *Journal of Medical Ethics* 36 (2): 79-83.

Gronn, P. (2002). Distributed leadership as a unit of analysis. *The Leadership Quarterly* 13: 423-451.

Guth, W.D. and I.C. MacMillan (1986). Strategy implementation versus middle management self-interest. *Strategy Management Journal* 7: 313-327.

Gulick, L. (1937). Notes on the theory of organization. In *Papers on the Science of Administration,* Gulick, L. and L. Urwick. ed., 1-45. New York: Institute of Public Administration.

Gieryn, T.F. (1983). Boundary-work and the demarcation of science from non-science: strains and interests in professional ideologies of scientists, *American Sociological Review* 48 (6): 781-795.

Harding, N., H. Lee and J. Ford (2014). Who is 'the middle manager'? *Human Relations*, DOI: 10.1177/0018726713516654, 1-25.

Helderman, J.K. (2007). *Bringing the market back in? Institutional complementarity and hierarchy in Dutch housing and health care*. Rotterdam: dissertation Erasmus University.

Hewison, A. (2002). Managerial values and rationality in the UK National Health Service. *Public Management Review* 4 (4): 549-579.

Hernes, T. (2004). Studying composite boundaries: a framework of analysis. *Human Relations* 57 (1): 9-29.

Holmberg, I. and M. Tyrstrup (2010). Well then - What now? An everyday approach to managerial leadership. *Leadership* 6 (4): 353-372.

Huy, Q.N. (2001). In praise of middle managers. *Harvard Business Review* 79 (8): 72-79.

Hyde, P., E. Granter, L. McCann and J. Hassard (2011). The lost health service tribe: in search of middle managers. In *The reform of health care: shaping, adapting and resisting policy*, H. Dickenson and R. Mannion ed., 7-20. Basingstoke: Palgrave Macmillan.

Iedema, R., P. Degeling, J. Braithwaite and L. White (2003). 'It's an interesting conversation I'm hearing': The doctor as manager. *Organization Studies* 25 (1): 15-33.

Jacobs, J. (1994). *Systems of Survival: A Dialogue on the Moral Foundations of Commerce and Politics*. New York: Vintage.

Lakeoff, G. and M. Johnson (2003). *Metaphors we live by*. Chicago and London: The University of Chicago Press.

Lamont, M. (2012). Toward a Comparative Sociology of Valuation and Evaluation. *Annual Review of Sociology* 38: 201–21.

Livian, Y-F., J.G. Burgoyne (1997). *Middle managers in Europe*. London and New York: Routlegde.

Mantere, S. (2008). Role expectations and middle manager strategic agency. *Journal of Management Studies* 45 (5): 294-316.

Martin, G. and M. Learmonth (2012). A critical account of the rise and spread of 'leadership' the case of UK health care. *Social Science & Medicine* 74 (1): 281-288.

Martin, G.P., G. Currie and R. Finn (2009). Leadership, service reform, and public-service networks: the case of cancer-genetics pilots in the English NHS. *Journal of Public Administration Research* 19: 769-794.

Mintzberg, H. (1973). *The nature of managerial work*. New York: Harper & Row. Reprinted by Prentice-Hall (1980).

Mintzberg, H. (1975). *The manager's job. Folklore and fact.* Harvard Business Review, July-August, 49-61.

Mintzberg, H. (2009). *Managing*. Harlow etc.: Financial Times Prentice Hall.

Mol, A. (2002). *The body multiple: ontology in medical practice*. Durham and London: Duke University Press.

Mol, A. (2008). *The logic of care. Health and the problem of patient choice*. London and New York: Routledge.

Muzio, D. and I. Kirkpatrick (2011). Introduction: professions and organizations. A conceptual framework. *Current Sociology* 59 (4): 389–405.

Nonaka, I. (1994). A dynamic theory of knowledge creation. *Organization Science* 5: 14-37.

Newell, H. and S. Dopson (1996). Muddle in the middle: organizational restructuring and middle management careers. *Personnel Review* 25 (4): 4-20.

Nicolini, D. (2009). Zooming in and out: studying practices by switching theoretical lenses and trailing connections. *Organization Studies* 30 (12): 1391-1418.

Noordegraaf, M. (2000). *Attention! Work and behavior of public managers amidst ambiguity*. Delft: Eburon.

Noordegraaf, M. (2011). Risky business: how professionals and professional fields (must) deal with organizational issues. *Organization Studies* 32: 1349-1371.

Noordegraaf, M. and B. de Wit (2012). Responses to managerialism. *Public Administration* 90 (4): 957–973.

Noordegraaf, M. (2014). Shadowing managerial action instead of recording managerial text. *Qualitative Research in Organizations and Management: An International Journal* 9 (1):41-46.

Oborn, E., M. Barrett and S. Dawson (2013). Distributed leadership in policy formulation: a socio material perspective. *Organization Studies* 34 (2): 253-276.

Oldenhof, L., A. Stoopendaal and K. Putters (2013). Professional talk: how middle managers frame care workers as professionals. *Health Care Analysis* DOI 10.1007/s10728-013-0269-9

Osborn, S.P. (2010). The new public governance? *Emerging perspectives on the theory and practice of governance*. Abingdon etc.: Routlegde.

Osterman, Paul (2008). T*he truth about middle managers. Who they are, how they work, why they matter*. Boston: Harvard University Press.

Pappas, J. M., K. E. Flaherty, and B. Wooldridge (2004). Tapping into hospital champions: strategic middle managers. *Health Care Management Review* 29 (1): 8-16.

Partij voor de Vrijheid (2010). *Verkiezingsprogramma. De agenda van hoop & optimisme. Een tijd om te kiezen: PVV 2010-2015*, geraadpleegd 9 augustus 2014 op: http://www.parlement.com/9291000/d/2010pvvverkiezingsprogramma.pdf

Peters, T.J. (1992). *Liberation management: necessary disorganization for the nanosecond nineties*. London: Macmillan London.

Plasterk, R. (2007). 'Weg met de managers'. Interview met Roland Plasterk. *Vrij Nederland,* 30 juni 2007.

Pols, J. (2004). *Good care: enacting a complex ideal in long-term psychiatry*. Utrecht: Trimbos Instituut.

Putters, K. (2009). *Besturen met duivelselastiek* [Hybrid governance] (Inaugural lecture). Rotterdam: Institute of Health Policy and Management.

Rhodes, R.A.W. (1996). The new governance: governing without government. *Political Studies* XLIV: 652-667.

Rose, N., P. O'Malley and M. Valverde (2006). Governmentality. *Annual Review of Law and Social Science* 2: 83-104.

Rouleau L. (2005). Micro-practices of strategic sense-making and surviving. How middle managers interpret and sell change everyday. *Journal of Management Studies* 42 (7): 1414–1441.

Rouleau, L. and J. Balogun (2011). Middle managers, strategic sensemaking and discursive competence. *Journal of Management Studies* 48 (5): 953-983.

Scase, R. and R. Goffee (1989). *Reluctant managers. Their work and lifestyles*. London etc.: Unwin Hyman Ltd.

Sims, D. (2003). Between the millstones: a narrative account of the vulnerability of middle managers' storying. *Human Relations* 56 (10): 1195-1211.

Star, S. L. and J. R. Griesemer (1989). Institutional ecology, 'translations' and boundary objects: amateurs and professionals in Berkeley's museum of vertebrate zoology, 1907-39. *Social Studies of Science* 19 (3): 387-420.

Stoopendaal, A (2008). *Zorg met afstand. Betrokken bestuur in grootschalige zorginstellingen*. Assen: Koninklijke van Gorcum.

Tengblad S. (2006). Is there a "New Managerial Work"? A comparison with Henry Mintzberg's classic study 30 years later. *Journal of Management Studies* 43 (7): 1438–1461.

Tengblad, S. ed. (2012). *The work of managers. Towards a practice theory of management.* Oxford and New York: Oxford University Press.

Thomas, P. and J. Hewitt (2011). Managerial organization and professional autonomy: A discourse-based conceptualization. *Organization Studies* 32(10): 1373–1393.

Thomas, R. and A. Linstead (2002). Losing the plot? Middle managers and identity. *Organization* 9(1): 71-93.

Van Dalen, A. (2012). *Zorgvernieuwing. Over anders besturen en organiseren*. Den Haag: Boom Lemma.

Van de Bovenkamp, H., M. de Mul, J. Quartz, A.M. Weggelaar-Jansen, R. Bal (2014). Institutional layering in governing quality. *Public Administration* 92(1): 208-223.

Van den Brink, G., T. Jansen en D. Pessers ed. (2005). *Beroepszeer. Waarom Nederland niet goed werkt*. Amsterdam: Uitgeverij Boom.

Van der Pennen, R., K. Putters and B. Berden (2014). Imperfect performance, a case study on the pay-for-performance instrument for physicians in Dutch Hospitals. *Administration & Society*: DOI: 10.1177/0095399714544944

Watson, T. J. (1994). *In search of management. Culture, chaos & control in managerial work*. London and New York: Routledge.

Weick, K. E. (1995). *Sensemaking in organizations*. Thousand Oaks etc.: SAGE Publications.

Witman, Y., G.A. Smid, P.L. Meurs and D.L. Willems (2011). Doctor in the lead: balancing between two worlds. *Organization* 18: 477-495.

Wooldridge, B. and S. Floyd (1990). The strategy process, middle management involvement, and organizational performance. S*trategic Management Journal* 11: 231–41.

Wooldridge, B., T. Schmid and S.W. Floyd (2008). The middle management perspective on strategy process: contributions, synthesis and future research. *Journal of Management* 34 (6): 1190–1221.

Chapter 2

Daily practices of operational healthcare managers: dealing with tensions between different values

Published in mildly edited form as:

Oldenhof, L. and K. Putters (2011). Daily practices of operational healthcare managers. Dealing with tensions between different values. *Medische Antropologie* 23 (1): 81-101.

Abstract

This article gives an empirical analysis of normative questions that come up in the daily practices of operational healthcare managers in the Netherlands. Since the recent introduction of client based financing in the care sector, managers are expected to provide more client-centered and affordable care. In practice, managers experience ambiguity and tensions in the operationalization of these different values. By looking into local management practices, light is shed on the way managers actually deal with these tensions. On the basis of qualitative interviews with healthcare managers, four modes of dealing with tensions between different values are established: balancing values individually and collectively, prioritizing one value over the other, establishing compromises between values and making healthcare workers responsible for balancing different values. Our findings show that managers increasingly feel pressure to more tightly manage their financial budget on location level. As a consequence, managers try to find solutions to keep care affordable, which they often feel ambivalent about. Nevertheless, managers also create flexibility in the new financing system by accomplishing compromises between values and reframing responsibilities for care. The authors conclude that it is necessary to raise awareness of moral distress that operational healthcare managers may experience when managing value conflicts.

Key words: operational healthcare managers, tensions between values, empirical ethics, client-based financing, care sector, the Netherlands.

Introduction

Healthcare managers increasingly play an important role in decision-making about the quality and distribution of care (Wall 1989; Dracapoulou 1998; Young 2003; Currie 2000 and 2006; Van Hout 2006; Darr 2007; Stoopendaal 2008; Putters 2009). As a consequence, daily normative decisions about which types of care should be provided and to whom, are no longer primarily the terrain of healthcare professionals such as doctors and nurses. Healthcare managers therefore have to find answers how to legitimately handle normative questions concerning a variety of issues, ranging from the allocation of scarce resources, cost containment and personnel management to overseeing quality and accountability initiatives and the protection of patients' rights (Wall 1989; Dracopoulou 1998; Weber 2000; Gallagher 2002; Van Dartel et al. 2002; Grit & Meurs 2005; Darr 2007).

Given these shifting responsibilities in healthcare, several authors plead for the development of universal ethical principles that healthcare managers should apply in their dealings with clients, care givers, society and other parties. It is argued that just like healthcare professionals, managers should have their own professional ethics to determine which values are important and how to balance different values (Wall 1989; Dracopoulou 1998; Weber 2000; Darr 2007).

Interestingly so, this appeal for an ethical framework for managers runs counter to the 'empirical turn' that has recently been taking place in medical ethics. Rather than considering care as a 'moral fill in' of universal principles and values, several authors argue that it makes more sense to consider the ethic of care as a practice, in which the provision of good care is not so much determined by ethical principles but is more a matter of doing, attentive experimentation and tinkering (Tronto 1994: 148; Mol et al. 2010). This shift away from applied ethics (the application of universal rules) towards everyday normative issues, has led to a recent appeal for more empirical studies of every day practices in healthcare (Willems & Pols 2010). Willems and Pols argue that by looking at local practices, a better insight is gained into how care givers and other actors conceptualize and deal with different values, ranging from efficiency and effectiveness to client-centeredness and justice. These different values can be seen as 'varieties of goodness' which sometimes clash and therefore require a lot of work to make them coexist in practice (Von Wright 1972; Mol et al. 2010; Willems & Pols 2010).

In this article we would like to contribute to the appeal for empirical studies of every day normative questions by looking at the various ways healthcare managers deal with tensions between different values in their daily practice. We will specifically focus on the recent introduction of client-linked budgets in the care sector. The so called 'weighted packages' (in Dutch: zorgzwaartepakketten) are seen by the Dutch Ministry of Healthcare as a policy instrument that enables the attainment of multiple values. This new system of output finance is expected to give healthcare providers the incentives to provide affordable care and at the same accomplish more client-centered care. Policy expectations concerning the attainment of (public) values however often play out differently in practice. The operationalization of values is not a technical activity of implementation, but a process that alters the form and shape of those values (Weick 1995; Stone 2002; Frederickson & Smith 2003; Pollitt & Bouckaert 2004; Zuiderent-Jerak et al. 2010; Bozeman 2007).

Healthcare managers play an important role operationalizing values in their work with client-linked budgets. Especially operational middle managers at location or unit level, who directly deal with healthcare workers, clients and client-linked budgets, have to weigh affordability and client-centeredness at the same time. They carry the dual responsibility for finances as well as the quality of care (Stoopendaal 2008). This dual responsibility, combined with the fact that most managers have a professional background as healthcare worker, makes them an interesting layer of management to research the enactment of different, possibly competing values (Damhuis et al. 2003; Young 2003; Currie 2006; Van Hout 2006; Elshout 2006; Stoopendaal 2008; Putters 2009; DeChurch et al. 2010). Furthermore, within the literature there appears to be a disagreement whether this layer of management feels comfortable or compromised managing different values in the context of a more businesslike approach to healthcare (Gallagher 2002; Bolton 2003; Young 2003; Pappas et al. 2004; Currie 2006; De Vries & Van Tuijl 2006; Van Hout 2006; Elshout 2006; Stoopendaal 2008; Actiz 2009; Cathcart et al. 2010; Mitton et al. 2011). By looking at the way operational middle managers deal with tensions between values in the context of client-linked budgets, further insights will be gained into this discussion.

On the basis of qualitative interviews with operational healthcare managers at location or unit level we would like to answer the following research question:

> *How do operational healthcare managers in the care sector deal with the values of affordability and client-centeredness in their daily management practices since the introduction of client-linked budgets?*

In this article we first briefly explore the question whether healthcare managers feel comfortable or compromised managing different values. We then explain in more detail why client-linked budgets represent an interesting case to research the management of different values in practice. In the method section we describe how we conducted the interviews and analyzed recurring themes. In the results, we describe four modes of dealing with tensions between values that managers employ in their daily work with client-linked budgets. In the discussion and conclusion we reflect on the question whether managers feel they can enact 'good' healthcare management.

Dealing with different values: feeling compromised or comfortable?

The responsibilities of operational healthcare managers at unit or location level have changed considerably since New Public Management (NPM) reforms in the healthcare sector. Due to the decentralization of managerial tasks and an increasing span of control, managers spend less time directly supervising healthcare workers and more time on managerial tasks such as budgeting, human resource management and the implementation of quality and accountability measures (Willmot 1998; Duffield & Franks 2001; Bolton 2003; Stoopendaal 2008; Actiz 2009).

This development has been described as shift from 'custodial management' to 'general management' (Bolton 2003; Young 2003). General managemententails responsibilities for a broad variety of values: not only client-centeredness but also more businesslike values such as effectiveness, efficiency and accountability (Young 2003; Damhuis et al. 2003; Currie 2006; Elshout 2006; Hutchinson & Purcell 2010; McCallin & Frankson 2010). Consequently, managers have to take deal with many different values. A result of this broadened work scope is that operational managers with a professional background as healthcare worker provide less or no direct care themselves anymore (Sambrook 2005; Stoopendaal 2008). Rather than doing physical work, they perform mental work that revolves around planning, coaching healthcare workers, attending meetings and implementing policy (Sambrook 2005).

Several authors notice that healthcare managers experience difficulties performing this new form of management. Firstly, managers with a professional background, especially nurse managers, can experience role conflicts when balancing the demands of the organization – such as efficiency and effectiveness – with those of individual patients (Hewison 1994). Moreover, they can dissociate themselves from the image of general manager by emphasizing their professional values about 'good care' (Bolton 2003; Wise 2007). Closely related to role conflict, is the concept of role ambiguity which refers to the lack of clarity about new management roles (McCallin & Frankson 2010).

Secondly, the broad responsibilities for sustaining quality, efficiency, safety and financial performance at unit level can cause anxiety and stress for several reasons. Managers experience a heavy workload and often lack the appropriate skills and competencies to perform a more business-like, administrative role (Terzioglu 2006; McCallin & Frankson 2010; Hutchinson & Purcell 2010). Insecurity and anxiety can also manifest themselves when managers experience tensions between competing values of 'good care' and don't know how to deal with these tensions (Van Hout 2006; Shirey et al. 2008; Cathcart et al. 2010). In its most extreme form, managers can experience moral distress when they are faced with conflicting values and demands. This means that managers feel constrained to do what they think is ethically right (Mitton et al. 2011).

While several authors stress the difficulties that operational healthcare managers experience, there are also signs of a more optimistic view. If operational healthcare managers feel supported within their organization, they can confidently function as boundary spanners that translate general policy ideas – about different values in healthcare – into context sensitive solutions and practices (Currie 2006). Furthermore, it is argued that by working collaboratively with healthcare workers, rivalry between the logic of business-like healthcare and professionalism can be managed successfully (Reay & Hinings 2009). An advantage of healthcare managers with a professional background is that can call on both caring and business rhetoric, which provides tactical maneuvering room and enhances their power to make their own value judgments (Young 2003).

Given these diverse views in literature on operational healthcare managers, it is necessary to gain a better understanding how they deal with concrete cases of different values in practice.

A case of different values: client-linked budgets in the care sector

As recently as January 2009, the Dutch government introduced client-linked budgets to finance the long term care. This means that care organizations no longer receive an average compensation for every client, but only get paid for the hours of care they provide to individual clients (Website Rijksoverheid). Despite initial statements that the new financing system would not be part of a policy of curtailment, the latest government proposals have stressed the need for budget cuts in order to keep the system of client-based financing affordable in the long run. Consequently, individual budgets for clients who receive intramural care ('weighted packages') are now being reformed which will have consequences for the financing of long term care facilities.

In this article we specifically focus on the so called 'weighted packages' for clients in intramural care, from now on referred to as client-linked budgets. The basic idea of this form of individual funding is that different budgets are assigned to clients on the basis of an assessment of their individual need of care. The allocated budget entitles clients to a certain amount of hours of care per week and compensates healthcare organizations accordingly. In the Dutch care sector there currently exist 52 different client-linked budgets, ranging from only a few hours of care per week to more than 30 hours per week (Website Rijksoverheid). Aside from the amount of hours, the different types of care that clients are entitled to are specified in the individual budgets, such as individual support or intensive care.

With the introduction of client-linked budgets the Dutch government intends to serve several goals. It is assumed that clients adopt a more active role as consumers. Within the boundaries of their individual budget, clients can make the choice how to spend their indicated hours of care. For example, they can decide to go on a daytrip with a supervisor, but can also use smaller chunks of supervision for weekly activities. Client-linked budgets are also seen as an instrument for clients to hold healthcare providers to account for the quality and quantity of care that is provided (Grit and Bont 2010). Healthcare organizations are obliged to draw up a 'care plan' for each client, which details the specific daily provision of care (for example how many minutes per day the clients receive assistance with showering or meals). This care plan can be seen as a contract which defines the care that clients are entitled to, but also makes clear the limits of the care that can be provided by healthcare organizations (Grit & Bont 2010; Zuiderent-Jerak et al. 2010).

Healthcare organizations are at the same time expected to make a better fit between the care they provide and the individual wishes of clients: not only because that is demanded of them in the new financial structure, but also because tailor made care can potentially attract new clients. The government also intends to make long term care affordable and economically sustainable in the long run. Client-linked budgets are seen as an instrument to manage the demand of care – and the costs that come with it – more explicitly. Care providers are discouraged to 'overcare', as in providing more can than is indicated.

All in all, the Dutch government considers client-linked budgets an important vehicle to attain multiple goals at the same time: it aims to attain more client-centered,

accountable and transparent care, while at the same time keeping costs in check. How does this policy work out in practice for operational healthcare managers?

Methods

Qualitative, semi-structured interviews were conducted with 16 operational healthcare managers that work in different healthcare organizations in the care sector in the Netherlands ranging from elderly care and care for the handicapped to care for homeless and addicted people. The working definition of healthcare manager that was adopted for the selection of interviewees was: managers that are hierarchically responsible supervising healthcare professionals and managing finances. All the managers that were interviewed had previously worked as a healthcare worker before becoming a manager. Their professional background varies, from nursing to social pedagogical work and care assistance. In addition to operational healthcare managers three higher managers, a personnel official and a team coordinator were interviewed as well to provide additional insights. Interviews lasted on average between an hour and 2 hours and a half. All interviews were fully transcribed. Interviewees were guar- anteed anonymity, so that they could talk freely about their work.

Rather than asking specific questions about different notions of 'good care', thereby priming the interviewees to talk about values, managers were asked to describe 1) their career path and professionals background, 2) how they spend their time on a typical working day, 3) their experiences of enjoyable and difficult aspects of their work, 3) their day-to-day decisions, 4) developments within healthcare that affected their day-to-day decisions. The semi-structured nature of the interviews allowed sufficient room for managers to engage in anecdotal stories about their daily work. Often these stories focused on the concrete tensions that they experienced when managing different values. By a process of inductive coding (Mortelmans 2007), key tensions and dilemmas between values were identified in the daily work of operational managers. In this article we have chosen to zoom in on the most persistent end recurring tension that managers struggle with: keeping care both affordable and client-centered care at the same time. The introduction of client-linked budgets was described by managers as an important development that influenced their day-to-day decisions concerning this tension. On the basis of further inductive coding, four modes of dealing with tensions between affordable and client-centered care were identified.

Results

In this section we first show that managers play an important role in operationalizing the values of affordable and client-centered care at unit or location level. We then describe the tensions that managers experience between affordability and

client-centeredness. Subsequently, four modes of dealing with tensions are established: balancing values individually and collectively, prioritizing one value over the other, establishing compromises between values and making healthcare workers responsible for balancing different values.

Operationalizing values at location level

Since the introduction of client-linked budgets, the notion of affordability of care is increasingly interpreted as an individual responsibility of location and units, and less as a collective organizational responsibility. Managers stressed that they feel more responsible for keeping to their location budget, because the new finance system has made it more clear which locations perform well financially and which location have budget deficits (see also Zuiderent-Jerak et al. 2010). The responsibility for stricter budget keeping – on the basis of client-linked budgets – is not perceived as an easy task. Managers often describe themselves as 'someone who is not interested in numbers and administration' and 'geared towards the human side'. Higher managers noticed that operational managers often lack the skills to make good business calculations on the basis of client-linked budgets. They also wondered whether operational managers are able to get a 'helicopter view' of all the interests at stake on location level. Several operational managers themselves mentioned that they struggle with getting a good overview, especially when it comes to matching flexible income (client-linked budgets) with expenditures (largely personnel costs, which are less flexible).

Due to client-linked budgets, most managers feel inclined to more strictly man- age personnel costs. Several managers mentioned that a shift is taking place towards flexibilizing the employment of healthcare workers on the basis individual budgets. They tell healthcare workers that they can no longer work regular shifts, which is not always appreciated. Often managers have to work hard to turn around initial feelings of resistance. In order to keep care affordable on location level, managers also try to get a better fit between the level of indications (heavy/light indications) and the educational qualifications of healthcare workers. Some managers indicated that it becomes necessary to turn around the culture of healthcare workers of 'doing things together', by making a more explicit distributions of tasks.

Managers experience 'mixed signals' about how they should keep care affordable. On the one hand they are encouraged within their organizations to become more entrepreneurial: 'good quality care' and 'a good reputation' in the community can attract new clients and extra income. At the same time, operational managers are warned by higher managers to not automatically accept new clients at location level. Because of annual arrangements between healthcare organizations and the local care administration office, organizations only get compensated for the production that is contracted in advance. Operational healthcare managers therefore sometimes feel unsure which role they should perform: as implementer of central policy or as entrepreneurial manager.

Managers also reshape notions of client-centeredness working with client-linked budgets. A rather common interpretation that managers made of client-centeredness was 'responding to the individual wishes of clients', which are written down in the care plan. Managers however were quick to point out that this way of envisaging client-centeredness can create false expectations: 'Care is not a matter of instant delivery' or 'it's not realistic to say: your wish is our command.' The impression can be created that every individual request can be met, whereas on location level it is not financially possible to provide fully individualized care. Managers therefore stated the importance of expectation management and the need for more explicit conversations between clients and healthcare workers about making choices:

> 'I think we need to engage more in conversation with our clients about his package and what he wants from us from that money (...). To lay down the options: "well, what do you want?" It's no longer the case that we can deliver everything; there we have to make choices.'

Paradoxically, providing client-centered care can also mean saying 'no' clients when they express their demands. Not because of financial limitations, but because it would not serve the best interest of the client given their particular care needs. Saying no to a 'customer' with an individual budget can give an uncomfortable feeling, as becomes clear from the following statement of a manager:

> 'It's an uncomfortable split. On the one hand someone is a customer and brings along a client-linked budget and so he has all kinds of desires and requests. And at the same time you are also the one that sometimes needs to say: "Well we can't deliver that (care, LO) taking into account the client's handicap." So you have a protecting role there too.'

For managers another way of providing client-centered care is to temporarily tone down the importance of the indication as a distribution mechanism of care. Generally, managers emphasized their task to guarantee the continuity of care in the long run by sticking to the financial scope set by the indication of clients. Yet managers also underscored the importance of not sticking too rigidly to the indication. Especially when clients need more care due to unexpected circumstances, the distribution of care can be based on the need of clients, rather than on economic demand (the indication):

> 'You have to also watch out that it's not becoming too business like. That client (...) had a rather tricky situation going on at his home in January and then he called more often and asked whether I could come around. Then we provide more hours of care than three to nine hours (indication, LO).'

Dealing with tensions between different values

According to the Ministry client-linked budgets will lead to more affordable as well as client-centered care. Client-centeredness and affordability are seen as values that rein- force each other positively. From the viewpoint of the interviewed healthcare managers, client-linked budgets are not always considered a 'win-win' situation. Generally speaking, managers feel a tension between attaining affordable and client-centered care at the same time. Several managers phrased this tension as a dilemma. From a pragmatic standpoint, dealing with dilemmas is seen as 'part of your job' or 'just something you have to get on with'. However, managers frequently mentioned feelings of unease and discomfort, especially in situations where managers feel they have to 'nibble away' at the quality of care. Being officially responsible for both the quality of care and finances, can feel particularly uncomfortable for less business minded managers who have difficulty getting a grip on the numbers. Which different dealing modes do managers develop in practice to solve the perceived tensions between affordability and client-centeredness?

Balancing values collectively and individually

Several managers pointed out that it is difficult to live up to the promise of providing more individualized care. In fact, managers notice an increase in the provision of group-based care at their locations since the introduction of client-linked budgets. They mentioned that individualized, tailor made care can only be realized when the bulk of care is provided collectively. One healthcare manager, who manages different living facilities for handicapped clients, elaborates on this paradoxical turn of the new financing system:

> 'With client based budgets you can really notice that you have to organize things collectively, what I just said. So you can focus less on the individual, whereas it was intended the other way around (...). Ok, so we are going to introduce client-linked budgets, but it has to be budget neutral. So, well guys, you know, with the same money that we have got we have to do it differently. Well, then you really can't provide more individual supervision (...). So, you have to somewhere organize things collectively, in order to be able to do the rest individually. So, in fact, for everybody collective meals, a few nights a week sitting together. Because otherwise you can't provide the other hours individually. So, is it often contradictory.'

It is often ambivalent for managers whether they provide care on the basis of demand (responding to individual wishes of clients) or supply (organizing collective care arrangement because it's necessary to make budget cuts on location level). The decision to provide collective care – be it shared meals or communal evening activities – is usually made because managers feel the pressure to keep care

affordable and 'stay out of the red numbers'. Generally speaking, keeping a healthy budget is not seen as a goal in itself, but is considered an important guarantee for the continuity of care in the long run. While the provision of collective care is often motivated by keeping a healthy budget, it can also be seen as a form of granting individual wishes, as clients sometimes do express the need for more social contact with other clients.

The balancing act between meeting individual wishes of clients and keeping care affordable through the means of group based care, gives managers a 'two faced' feeling, as becomes clear from the quote below:

> 'Now we have created two facilities where people can spend the evening with each other two nights a week. That means that they don't get individual supervision, but that it's group based, which of course is cheaper. I have to say, it all feels very two-faced. Luck was on our side that in the meantime people had asked: "We want to do something together." I felt good about that, because in general we try to do things very individually because we see that people respond to it very well (...). And sometimes, you create supply to see whether there is demand, but in principal it's on the basis of demand. So this is all very confusing, because we now open up these facilities because we have to cut back on hours. So we are going to make sure that those evenings are as much fun as possible.'

The provision of group-based care makes it possible to provide expensive types of care such as supervision during the night, which can't be delivered on the bases of one budget of an individual client. Collective sharing of these services is therefore necessary, but sometimes sits uncomfortably with the notions of individual rights and entitlements to care. Although not all clients are able to adopt the role of critical consumer, some family members insist on getting their 'due share' of care by referring to their individually assigned budget:

> 'Often clients aren't even that conscious of their rights and think: Well, it will be ok. Whereas parents and family more often say: "No, but that employee is on holiday, is there someone else coming? How do we handle that?" Or, when we aren't around for three weeks, "Can we get those hours back afterwards?"'

The provision of more group based also has important consequences for the scale of locations where clients live. In order to be able to provide group based care – and ensure the affordability of care within the setting of client-linked budgets – locations need to have a certain size. This however puts pressure on the ideal of small scale living facilities, which is seen as a form of client-centered care. Several managers mentioned that they felt a tension between realizing the strategic vision of their organization about small scale living arrangements and the practice of keeping small scale facilities profitable. This tension was especially felt by organizations that provided care for people with a handicap. Compared to healthcare providers in elderly care, these organizations usually have a longer history with small scale living

facilities that are based in residential areas. As becomes clear from the following quote of a troubled manager, it often feels like a dilemma to enact the ideal of small scale care arrangements and ensure affordability of care on location level:

> 'I have a couple of unprofitable locations. Once a choice was made to start up these locations. For example, a location where we have six clients who live there, the youngest is 16 en the oldest is 22. These are people who need constant supervision because they are very vulnerable and can be easily influenced. You can't leave them alone at that location. Maybe just for an hour or so, that you tell them: "I am going to do groceries and we will be back soon and you have a mobile so you can call me." But you can't leave them for a day, also not at night. But with six clients you can't provide night supervision. We used to be able to do that with ten clients. Now, they say, you need at least fifteen clients together. So you need fifteen clients to be able to provide supervision during the night. But we do have that location! So you can't just say: "Well guys, too bad, we can no longer provide night supervision." So, these are the strategic choices that I am very much struggling with at the moment, because I also find it a dilemma. I see a very big budget deficit and that deficit is only rising and it needs to be paid somehow. But on the other side I also see that those clients, well it can all be figured out that way, but you can't leave them alone.'

Different solutions were mentioned by managers to cope with this dilemma, ranging from scaling up locations by taking on extra clients, strategically choosing clients with a high indication of care, temporarily putting up with less quality of care (for example sharing a supervisor between several location in combination with the use of baby phones during the night), closing down unprofitable locations or – the opposite – running up a budget deficit. A strategic option that was mentioned more frequently than others was the selection of clients with 'high' indications, which guaranteed more income. Some managers realized however that this is not an uncomplicated strategy. So called 'difficult' clients, who need more care than others, can disturb the existing group dynamics. When this happens, extra supervision is needed, which defeats the original purpose of creating more financial leeway in the budget:

> 'You have to fill up (open spaces, LO) as quickly as possible. On the other side, you want there to be a good fit with other clients that you have. You can think: gosh, I want some- one who has a lot of behavioural problems, because that brings lot of money, a weighted package 7, or something like that. You think: yes, that is the one I need, that produces money. But well, that's also asking for trouble. Soon you need extra supervision because you can't do it with the money that you..., that it doesn't have a bad impact on the other clients.'

Prioritizing one value over the other

Several managers mentioned that they increasingly felt pressures to prioritize the value of affordable care to prevent budget deficits on location level. This need becomes apparent in several examples from practice. A recurring example of prioritizing affordable care is the provision of more group-based care such as communal evening activities. When managers need to 'cut back hours' because of budget deficits the option of group based care becomes more attractive. 'Scaling up' locations or units by taking on extra clients is also a strategy that is adopted more often. Managers are aware of the extra workload they put on the shoulders of healthcare workers and the danger of giving less personal attention to clients, but feel an even greater responsibility to guarantee the continuity of care in the long run by avoiding budget deficits. Another recurrent example of prioritizing affordable care is strategically taking on clients with a high indication. Managers are also forced to say 'no' to new clients who are expected to put a burden on the budget because they probably need more supervision than is indicated for in their individual budget. This gives managers an uncomfortable feeling:

> 'He has a weighted package 3. Well, in principle that could work for that location. But I would have to employ more hours, but I can't do that, because I don't have the money for it. So in the end, I have to turn him down (...). If he were to live there, it would all go terribly wrong. But I don't have any other places for him either.'

Despite increasing pressures to manage with a tight budget, managers try to create flexibility in the new financing system. This is the case when they temporarily tone down the importance of indications when clients unexpectedly need more care than their indication allows for. Examples that were mentioned during the interviews mostly concerned emergencies, such as extra supervision during hospital stays and sudden mental break downs of clients. On a more structural basis, some managers run up budget deficits because they choose to provide a certain quality of care they deem necessary for their clients (such as supervision during the night). On the one hand, a (large) budget deficit can be seen as a sign of financial mismanagement. On the other hand, it can also be interpreted as an attempt to sustain a certain level of good care.

From an organizational point of view, some allowances can be made when managers can properly account for these deficits on their location. Several managers mentioned that it is good practice to help out locations that are in financial need by reshuffling the central budget that is reserved for general investments. Some managers phrased this as 'solving things together, collectively' and 'practicing solidarity'. However, with the new financing system responsibilities for budgets are partly being decentralized to unit and location level. This means that locations more and more become their own 'independent shops', financed by the individual budgets of their own clients. Financially bad performing locations, who very well might be providing client-centered care to a complex group of clients, therefore need to negotiate more with other locations to take up part of their deficit.

Establishing compromises between values

Often managers try to establish compromises between affordability and client-centeredness. An example of such a compromise is the development of individual apartments under 'one roof' with communal living rooms, which facilitates the provision of individual as well as group-based care. This way, care can be affordable and client-centered by creating a balance between the clients need for privacy as well as their need for social contact with other clients:

> 'What we see with the construction of new houses it that we try to look for good 'in-between' forms. For example in X (name of place left out, LO), there we are busy with an initiative from parents. So people have their own apartments under one roof, but with two big communal living rooms. That is ideal really.'

Another recurrent compromise is the involvement of volunteers, interns and family members in the provision of care. Especially when there is a shortage of personnel, due to sick leave, managers try to sustain the quality of care by recruiting volunteers and interns. A manager who works with homeless people and clients with an addiction stresses the need to think outside the box in order to meet contradictory demands from 'the top' and 'the bottom':

> 'At the top you have a budget and a regional manager who just wants you to stay within the budget, that's that. And if there is no money left, there is no money. At the bottom they want...there is a high health related absenteeism at your unit. They don't want to work with considerably less people on the work floor and have to work twice as hard. They want you to get temporary workers (...). There is a tension there, because they cost a lot of money, which means that I can't keep to the budget (...). I always solve this by looking at it differently, so which solutions are there which meet both wishes? So I try to work with a lot of interns and volunteers.'

Increasingly managers point out to clients and their family members that client-linked budgets have very real consequences for the care that can or cannot be provided:

> 'Well yes, there are regulations from the top; we haven't chosen those weighted packages. And the financial picture that comes with it we haven't chosen either. Within our region, within the city, our regional manager has also organized an information meeting for family, so they can be taking along with the fact that this has consequences for the care that can be delivered.'

By framing care as a shared responsibility of the social network which surrounds the client, managers try to transfer some of the responsibilities of care to family members and friends of clients. When the client's social network is limited volunteers are actively recruited. By doing so, 'good caring' is being redefined. Healthcare workers should not automatically provide care themselves, but should 'take care' that other parties take up part of the responsibility of care:

> 'Look, we can provide bed, bath and bread. But if the client wants to cycle for an after- noon or evening, then it's very dependent on the client, but we will look for a volunteer. Is there someone in the network [of the client, LO]? Does that person have a network at all? Are we going to invest… is that supervisor 1 going to invest in cycling, then those hours (of care, LO) are depleted immediately. Or is this supervisor 1 going to invest in one hour of cycling and one hour of looking for someone, together with the client, that can structurally provide that. Look, that is the dynamic what it is supposed to be all about.'

Managers not only reframe what good caring by healthcare workers should be, but also demarcate what 'care' actually is. Due to client-linked budgets managers feel the need to explicitly demarcate boundaries between 'basic care' ('bed, bath and bread'), and 'extra care' which falls into the realm of 'well-being' and can be provided by volunteers and interns.

Making care givers responsible for balancing values

Managers increasingly frame the balancing act between affordable and client-centered care as a 'shared responsibility' between managers and care givers. They ask their team to come up with 'creative solutions' for keeping finances in check while at the same organizing care arrangements that meet the preferences of clients:

> 'When I am told "You need to cut back 36 hours at your location", I directly sit down with employees, inform them and take them along in the process. And I tell…let them think about how things can be done differently. And that they are going to think about their tasks, the way they supervise, how they do it and their time investment. In order they are directly involved in conversation with the costumer: "gosh, you know, I used to be there for you two hours a week, but from this moment I will be coming for one hour. How are going to use that hour? How are we going to do it? What do you really need? And what could you do yourself and what can you do together, for example, with your mother or your neighbor?" Do you get it? That there is continuous line. And that is fundamentally different. Previously supervisors had to do that less often and I to say that less often, because we had a lot more space and time.'

Making care givers responsible for balancing affordable care and client-centered care, is sometimes experienced as struggle by managers. The distribution of care on the basis of daily need can conflict with the distribution of care on the basis of an indication/client-linked budget:

> 'We struggle in our role as team leader with the fact that these girls that are on the work floor day in day out want to provide the best care,

> whether it fits the care package or not. As soon as that lady asks a question, they are going to answer that question or they are going to look for a solution and they are not going to think whether that lady has an indication for that.'

By emphasizing that a professional attitude not only entails 'caring for' clients in the physical sense, but also 'taking care of' financial and administrative matters concerning client-linked budgets, managers reframe what professional work should be about:

> 'Instead of just continuing giving care and doing your best, caring from your genes and your hart, now they also have to become more conscious that it costs money and that you need an indication and that the indication is perhaps too low at the moment. You have to look whether the means, the weighted package of the client, can be increased. And that second step I think is a logical one. That wasn't a logical step because you used to do your utmost best and there was money and you just had to make do.'

The inclusion of affordability criteria *within* professional notions of what good care should be, seems a logical step to more businesslike minded managers. Not all managers however feel comfortable with this trend. Some emphasize that they can relate to the inclination of healthcare workers to respond to the daily requests of care, whether or not that fits with the requirements of client-linked budgets. During the interviews managers frequently referred back to their own background as a care giver in terms of having a 'care-DNA,' being a 'people minded person,' 'having a strong sense of involvement.' Some managers, especially those that have worked in healthcare for a long time, wonder whether their personal sense of involvement doesn't stand in the way of a more businesslike approach towards care:

> 'Of course I am someone from the older generation, a high level of commitment, you know. At some point that's in your genes (...). Even if I become a hundred years old, I am not going to lose that. You can consider it a quality, but at the same time it's a trap as well. And, does it still suit the contemporary organization, you know? And, uh, but well, I am still here.'

Gradually you see unit leaders from the younger generation, that the younger generations are taking up management roles. They all have a heart which is geared towards the human side, but many managers are also much more businesslike. So, far more like cut to the chase.

Discussion

Our findings show that operational healthcare managers play an important role in operationalizing the generally framed policy goals of client-linked budgets into locally sensitive practices. They translate and reframe the meaning of affordability and client-centeredness at location and unit level and create modes of dealing with tensions between values in the context of the new financing system. Client-centeredness is reshaped by managers from a more *reactive* response of granting wishes of clients to a process of *active* negotiation between clients and care givers about what care can be provided within the limits of the location budget. Interestingly, operationalizing what affordable care actually means on location and unit level is less straightforward than the policy intentions of client-linked budgets imply. Managers receive mixed signals how to keep care affordable. While they are encouraged to act as entrepreneurs by managing their own budgets and attracting new clients and income, they are also advised to stick to collective production ceilings of their organization. Operational healthcare managers therefore seem unsure which role to perform, balancing between a more entrepreneurial role and the role of implementer of central policy. These findings seem to suggest that role ambiguity is not just a concept that applies to nurse managers in hospitals (Hewison 1994; McCallin & Frankson 2010), but can also be extended to operational healthcare managers in the care sector, who have a more varied professional background.

In the existing literature on operational healthcare managers, feelings of unease, anxiety and stress have been linked to an increased work load (Hutchinson & Purcell 2010), a lack of management training and business skills (Terzioglu 2006; McCallin & Frankson 2010) and difficulties handling tensions between competing values of good care (Van Hout 2006; Shirey et al. 2008; Cathcart et al. 2010; Mitton et al. 2010). In our study managers reported feelings of insecurity about managing their location budget on the basis of client-linked budgets. Especially matching flexible income (client-linked budgets) with costs (mainly personnel costs, which are only flexible to a certain extent) is not an easy task. They also described feelings of discomfort being responsible for a tight budget on the basis of client-linked budgets and the provision of good quality care. Within nurse management literature, several authors propose to so solve these difficulties and feelings of insecurity by stressing the need for courses on business skills and management development (Terzioglu 2006; Hutchinson & Purcell 2010; McCallin & Frankson 2010). Although we can imagine that courses on business skills can give useful insights, we question whether this solution can resolve the ambivalence and insecurities of managers about their own performance and their enactment of 'good' healthcare management.

Our four modes of dealing with tensions between values show that the daily practices of healthcare managers are full of inherent complexities, resulting from conflicting conceptions of good care. To suggest that feelings of insecurity and ambivalence are solely the result of lacking skills and competencies, would place too heavy a burden on the shoulders of individual healthcare managers. More importantly, a toolkit of budgeting techniques and business skills would obscure the fact that healthcare managers have to deal with 'varieties of goodness'

at the same time. A location budget that is efficiently managed on the basis of client-linked budgets, doesn't necessarily count as 'good' healthcare management. When other 'goods' are not taking into account, it might even be called 'bad' healthcare management.

We therefore stress the need for operational healthcare managers to become more reflexive and mindful about the ethical dimensions of every day decisions (Laroche 2009; Valentine et al. 2010). This is important because in the current financing system managers feel compromised in enacting what they think is 'good' healthcare management. When managers run up financial deficits at their location, they increasingly feel forced to say 'no' to clients with 'low indications', or the other way around, attract clients with 'high indications'. Several managers also feel 'two faced' about the development of scaling up locations and providing more group based care to keep care affordable for individual clients. As the practice of financial solidarity *between* locations is becoming less self-evident because of individual entitlements of clients to budgets, the above solutions can become more of a reality at location level. Managers do create flexibility in the financing system by making healthcare workers responsible for creative solutions and by reframing the responsibility for care as a broader responsibility of the network around clients, but these solutions in themselves also create new questions about how to appropriately balance between involving other parties and not burdening them too much.

Given the ambivalent, 'two-faced' feelings several operational healthcare managers experience when confronted with value tensions in their daily practices, we recommend further research that explores the relevance of the concept of moral distress in relation to healthcare management. This concept has been widely used to describe feelings of distress that healthcare professionals experience in their work when they are prevented from delivering the care that they deem necessary professionally or personally (Milton et al. 2010). Although this concept has recently been applied to hospital managers (Ibid.), it seems useful to further explore whether moral distress is also experienced by operational healthcare managers in less clinical settings, such as long term care and neighbourhood based care.

Conclusion

Our findings show that the world of operational healthcare managers is ambivalent and full of shifting tensions between different values. Rather than just leaving it at that, we wanted to understand how operational healthcare managers actually deal with tensions between affordable and client-centered care since the introduction of client-linked budgets. We identified four modes of dealing with these tensions in practice:
1) balancing values individually and collectively, 2) prioritizing one value over the other, 3) establishing compromises between values and 4) making healthcare workers responsible for balancing different values.

Managers find themselves balancing between the promise of individualized care and keeping care affordable in the long run by the provision of collective care in groups. In order to be able to give individual supervision to clients, which is an

important goal of client-linked budgets, managers need to provide more group based care. Only when clients share certain types of care together, it is possible to keep care affordable on location level. This sometimes sits uncomfortably with the idea of individual entitlements to care. It also puts pressure on the ideal of small scale living facilities. Managers therefore also balance between keeping care affordable through group-based care and not giving up ideals of small scale care. Increasingly managers feel pressured to prioritize affordability of care, when they run up budget deficits. Several solutions for keeping care affordable were mentioned such as scaling up locations, taking on new clients with high indications and flexibilizing shifts of healthcare workers. To lift some of this pressure, managers try to create flexibility within the new financing system by creating compromises such as living facilities that enable individualized as well as collective care. Recruiting volunteers and interns is another recurrent compromise between client-centered and affordable care. In addition, by framing care as a shared responsibility of the social network of the client, managers try to transfer some of the responsibilities of care to family members and friends of clients, thereby keeping care affordable in the long run. Last but not least, managers increasingly frame the balancing act between different values as a shared responsibility with healthcare workers. They ask care givers to come up with creative solutions themselves. The nature of the work of care givers is thereby changing too. Managers emphasize that a professional attitude not only entails 'caring for' clients in the physical sense, but also 'taking care of' financial and administrative matters.

This story about dealing modes is not a 'value free' story about technical managing in healthcare. We hope to have shown that the daily practices of operational healthcare managers entail different ways of dealing with every day normative issues which have a very real effect on the quality of care. It is therefore necessary to raise awareness of moral distress that operational healthcare managers may experience in their work.

Note

We would like to thank the participants of the conference 'Ethics, Health Care and Anthropology' and our colleagues of the section Healthcare Governance for comments on the first draft of this article. Special thanks go to Annemiek Stoopendaal, Rik Wehrens and Roland Bal for their suggestions to improve the article.

References

Actiz (2009). *Competentiewijzer. De leidinggevende als spelverdeler*. Bunnik: Libertas.

Bolton, S. C. (2003). Multiple roles? Nurses as managers in the NHS, *The International Journal of Public Sector Management* 16 (2): 122-30.

Bozeman, B. (2007). *Public values and public interest. Counterbalancing economic individualism.* Washington D.C.: Georgetown University Press.

Carney, M. (2006). Understanding organizational culture: The key to successful middle manager strategic involvement in health care delivery? *Journal of Nursing Management* 14: 23-33.

Cathcart, E. B. et al. (2010). The making of a nurse manager: the role of experiential learning in leadership development. *Journal of Nursing Management* 18 (4): 440-47.

Currie, G. (2000).The role of middle managers in strategic change in the public sector. *Public Money & Management* 20 (1): 17-22.

Currie, G. (2006). Reluctant but resourceful middle managers: The case of nurses in the NHS. *Journal of Nursing Management* 14 (1): 5-12.

Damhuis, G. et al. (2007). *Verbinden en loslaten. Organiseren vanuit het primaire proces*. Tilburg: University of Tilburg.

Darr, K. (2007). *Ethics in health services management*. Baltimore etc.: Health Professions Press.

DeChurch, L. A. et al. (2010). Leadership across levels: Levels of leaders and their impact. *The Leadership Quarterly* 21 (6): 1069-85.

De Vries, G. and H. van Tuijl (2006). *Gezondheidszorg onder druk. Vitaliserende spanning in het middenveld gebied van organisaties: Een bedrijfskundige benadering*. Houten: Bohn Stafleu van Loghum.

Dracapoulou, S. (ed.) (1998). *Ethics and values in health care management*. London and New York: Routledge.

Duffield, C. and H. Franks (2001). The role and preparation of first line nurse managers in Australia: where are we going and how do we get there? *Journal of Nursing Management* 9: 87-91.

Elshout, P. (2006). *Middenmanagement: Functie in ontwikkeling*. Tilburg: University of Tilburg.

Frederickson, G. H. and K. B. Smith (2003). *The public administration theory primer*. Boulder: Westview Press.

Gallagher, E. et al. (2002). Ethical dilemmas in home care case management. *Journal of Healthcare Management* 47 (2): 85-97.

Grit, K. and P. Meurs (2005). *Verschuivende verantwoordelijkheden. Dilemma's van zorgbestuurders.* Assen: Van Gorcum.

Grit, K. and A. Bont (2010). Tailor-made finance care versus tailor-made care. Can the state strengthen consumer choice in healthcare by reforming the financial structure of long-term care? *Journal of Medical Ethics* 36 (2): 79-83.

Hewison, A. (1994). Nurse management a case of competing rationalities. *Journal of Nursing Management* 1: 283-87.

Hutchinson, S. and J. Purcell (2010). Managing ward managers for roles in HRM in the NHS, overworked and under- resourced, *Human Resource Management Journal* 20 (4): 357-74.

Laroche, H. (2009).Overmanagement and the problem of moral consciousness. In *Ethical dilemmas in management,*C. Garsten and T. Hernes (eds), 132-47. London and New York: Routledge.

McCallin, A.M. and C.Frankson (2010). The role of the charge nurse manager: A descriptive exploratory study, *Journal of Nursing Management* 18: 319-25.

Mitton, C. et al. (2011). Moral distress among healthcare managers. Exploratory research in two British Columbia Health Authorities. *Health Care Analysis* 19: 107-21.

Mol, A., I. Moser and J. Pols (eds) (2010). *Care in practice. On tinkering in clinics, homes and farms*. Bielefeld: Transcript Verlag.

Mortelmans, D. (2007). *Handboek kwalitatieve onderzoeksmethoden*. Leuven and Voorburg: Acco.

Pappas, J. M. et al. (2004). Tapping into hospital champions-strategic middle managers. *Health Care Management Review* 29 (1): 8-16.

Pollitt, C. and G. Bouckaert (2004) *Public management reform. A comparative analysis.* Oxford: Oxford University Press.

Putters, K. (2009). *Besturen met duivelselastiek*. Rotterdam: Erasmus University.

Reay, T. and C.R. Hinings (2009). Managing the rivalry of competing institutional logics. *Organization Studies* 30:629-52.

Sambrook, S. (2006). Management development in the NHS: nurses and managers and identities, *Journal of European Industrial Training* 30 (10): 48-64.

Shirey, M.R. et al. (2008). Sleepless in America: nurse managers cope with stress and complexities. *Journal of Nursing Administration* 38 (3): 125-31.

Stone, D. (2002). *Policy paradox. The art of political decision making*. New York and London: W.W. Norton & Company.

Stoopendaal, A. (2008). *Zorg met afstand. Betrokken bestuur in grootschalige zorginstelling*. Assen: Van Gorcum.

Terzioglu, F. (2006). The perceived problem-solving ability of nurse managers. *Journal of Nursing Management* 14: 340-47.

Valentine, S. et al. (2010). Role conflict, mindfulness, and organizational ethics in an education-based healthcare institution. *Journal of Business Ethics* 94: 455-69.

Van Dartel, J.N. et al. (2002). *Ethiek bedrijven in de zorg. Een zaak van het management*. Assen: Van Gorcum.

Van Hout, E. (2007). *Zorg in spagaat. Management van hybride, maatschappelijke instellingen*. Den Haag: Lemma.

Von Wright, G. H. (1972). *The varieties of goodness*. New York & London: Routledge and The Humanities Press.

Wall, A. (1989). *Ethics and the health services manager.* London: King's fund published office.

Weber, L. J. (2000). Health care management ethics: Business ethics with a difference. *Business Ethics Quarterly* 10 (4): 975-82.

Weick, K. E. (1995). *Sensemaking in organizations*. London: Sage Publications.

Willems, D. and J. Pols (2010). Goodness! The empirical turn in health care ethics. *Medische Antropologie* 22 (1): 161-70.

Willmot, M. (1998). The new ward manager: An evaluation of the changing role of the charge nurse. *Journal of Advanced Nursing* 28 (2): 419-27.

Wise, S. (2007). Wanted: The next generation of nurse and midwifery managers. *International Journal of Public Sector Management* 20 (6): 473-83.

Wong, F. K. (1998). The nurse manager as a professional-managerial class: a case study. *Journal of Nursing Management* 6 (6): 343-50.

Young, A. (2003). Hardnosed or pink and fluffy? An examination of how middle managers in health care use competing metaphors of business and care to achieve desired outcomes. In *Gender and the public sector. Professionals and managerial change,* J. Barry, M. Dent and M. O'Neil (eds), 154-69. London and New York: Routledge.

Zuiderent-Jerak, T., K. Grit and T. van der Grinten (2011). *Markets and public values in healthcare*. Wetenschappelijke Raad voor het Regeringsbeleid: Webpublication 57.

Website links

http://www.rijksoverheid.nl/documenten-en-publicaties/vragen-en-antwoorden/wat-is-een-zorgzwaartepakket.html#anker-verschillende-zorgzwaartepakketten, last consulted on 15 January 2011.

Chapter 3

On justification work: how compromising enables public managers to deal with conflicting values

Published as:

Oldenhof, L., J. Postma and K. Putters (2014). On justification work: how compromising enables public managers to deal with conflicting values. *Public Administration Review* 74 (1): 52-63.

Abstract

In the public administration literature, a variety of responses to value conflicts have been described, such as trade-offs, decoupling values, and incrementalism. Yet little attention has been paid to the possibility of constructive compromises that enable public managers to deal with conflicting values simultaneously rather than separately. The authors use Luc Boltanski and Laurent Thévenot's theory of justification to extend current conceptualizations of management of conflicting values. On the basis of a qualitative study of daily practices of Dutch health care managers (executives and middle managers), they show how compromises are constructed and justified to significant others. Because compromises are fragile and open to criticism, managers have to perform continuous 'justification work' that entails not only the use of rhetoric but also the adaption of behavior and material objects. By inscribing compromises into objects and behavior, managers are able to solidify compromises, thereby creating temporary stability in times of public sector change.

Key words: public managers, value conflicts, justification work, compromises, healthcare.

Introduction

Policy issues in the public domain are often characterized by multiple conflicting values (Bozeman 2007; Koppenjan, Charles, and Ryan 2008; Loyens 2009; Spicer 2009; Steenhuisen, Dicke, and De Bruijn 2009; Van der Wal, De Graaf, and Lawton 2011). Recurring examples of value conflict include dilemmas between efficiency and equity (Le Grand 1990), efficiency and democratic legitimacy (Weihe 2008), and equity and liberty (Stone 2002). Public managers face these value conflicts in their daily work and have to find ways to manage the tensions between contradictory values.

Scholars have described various responses to value conflicts, ranging from trade-offs and decoupling values from one another, to incrementalism and case-by-case assessments of value conflicts (Steenhuisen 2009; Stewart 2009; Thacher and Rein 2004). Despite these valuable contributions, to date researchers have paid little attention to the possibility of producing constructive compromises that incorporate multiple, conflicting values. In day-to-day decision-making, public managers frequently make compromises, as they have to deal with conflicting values simultaneously, rather than separately or sequentially (Boltanski and Thévenot 2006; Brandsen, Van de Donk, and Putters 2005; Dunn and Jones 2010; Karré 2011; Oldenhof and Putters 2011). Yet these organizational actors are often portrayed as constrained agents that either have 'to conform with or deviate from abstract institutional logics' (Patriotta, Gond, and Schulz 2011, 1808). Patriotta, Gond and Schulz therefore call for studies that investigate the active role of organizational actors in constructing legitimate compromises, especially in environments where 'the harmonious arrangements of things and persons is always "up for grabs"' (2011, 1806).

Another gap in the literature concerns the question of how public managers *justify* compromises to themselves and the outer world (Jagd 2011; Patriotta, Gond, and Schulz 2011). Jagd recently observed that 'relatively few empirical studies explicitly focus on the complex processes involved in justification, critique, and attempts to produce compromises in organizations' (2011, 355). He asserts that 'empirical studies of "justification work" may be a potentially very promising focus for future empirical studies' (Jagd 2011, 343).

In this article, we begin to fill in the gaps in public management research on conflicting values by focusing on compromises and justification work. We use Boltanski and Thévenot's theory of justification (Boltanski and Thévenot 1991; 1999; 2000; 2006) to analyze how managers reconcile justifications in order to deal with conflicting values. In line with Boltanski and Thévenot (2006), we define a justification as a logical and harmonious order of objects and people that entails a higher principle of justice. According to Boltanski and Thévenot, social order is fragile because people often use different justifications to legitimize their action. Especially in organizations with multiple imperatives, disagreements arise when people, knowingly or unknowingly, refer to different justifications. In those situations, competent actors need to solve conflicts by establishing compromises through justification work.

The empirical analysis is situated in the Dutch healthcare sector. This is an especially interesting setting for applying the justification framework due to recent public controversies on how to secure conflicting values of healthcare, namely, accessibility, affordability and efficiency (Van Egmond and Bal 2010). In the

Netherlands, healthcare is provided by private non-profit organizations serving public goals: the provision of good, affordable and accessible healthcare. The government regulates the system by law, incentives and inspection. Given the state regulation of healthcare and the public nature of the goals and value conflicts, the study of Dutch healthcare managers provides valuable insights into how public managers in general deal with value conflicts. By focusing on middle managers and executives, this article analyses the justification work involved in dealing with conflicting values and making compromises. In particular, the delivery of small-scale care for people with dementia or a disability in the Netherlands is studied in-depth. The research question is as follows*: how do middle managers and executives in the Dutch long-term care sector perform justification work in order to deal with conflicting values in the provision of small-scale care?*

This article is organized into five sections. The first section discusses research on conflicting values and presents the justification framework developed by Boltanski and Thévenot. Section two introduces small-scale care in the Netherlands. Section three describes the qualitative research methods. The fourth section presents the empirical analysis of the justification work managers perform when dealing with conflicting values in the provision of small-scale care. The final section discusses the results and conclusions.

Theoretical framework

Management of conflicting values

According to Kernaghan, value conflict 'is a pervasive feature of public administration' (2003, 712). Value conflicts can make decision-making exceedingly hard. As Van Wart notes, public decision makers 'want to do the right thing, but it is not always clear what that right thing is' (Van Wart 1998, 18). It is thus necessary to provide better insights into the way responses to value conflicts are constructed.

In public administration literature, responses to value conflicts are often portrayed as trade-offs between values (Bozeman 2008; Charles, Ryan, and Paredes 2008). An important underlying assumption of trade-offs is that public actors can 'balance the gains of one value against the costs of others,' resulting in 'less' of one value compared to 'more' of the other (Thacher and Rein 2004, 462). In this rational cost-benefit view, values are in essence commensurable and can be balanced according to a single overarching norm.

However, several authors have argued that the trade-off approach has limitations. Lukes (1989) and Spicer (2001, 2009) formulate a theoretical critique on trade-offs. Building on Berlin's ideas of incommensurability of values (Berlin 1982), they argue that it is impossible to calculate the costs and benefits of values because 'there is no single currency or scale on which conflicting values can be measured' (Lukes 1989, 135; Spicer 2009). Consequently, the incommensurability of values

limits the role that rational cost-benefit analysis can play in making moral choices (Spicer 2001). Additionally, Steenhuisen's study of infrastructure companies empirically shows that value decisions seldom take the form of explicit trade-offs. Instead, value conflicts are addressed implicitly by operational staff and middle management through one-sided priorities and single value-protocols (Steenhuisen 2009).

Despite the difficulties of systematic balancing and the lack of an overarching norm, it is believed that practitioners can still deal rationally with conflicting values (Steenhuisen 2009; Stewart 2009; Thacher and Rein 2004). Thacher and Rein (2004) describe three strategies practitioners use to manage value conflicts: 1) 'cycling': giving attention to each value sequentially 2) 'firewalls': establishing multiple institutions dedicated to different values, and 3) 'casuistry': a case-by-case judgment on how to respond to particular value conflicts. Building on Thacher and Rein (2004), Stewart (2006; 2009) recently extended this framework with additional strategies, namely 4) 'bias': excluding alternative values through the development of a dominant single value discourse, 5) 'hybridization': layering new policy on top of existing policy with a different value base, and 6) 'incrementalism': stepped change that avoids the further arousal of value conflicts, while signaling intentions to solve conflicts in the long run. Of the six, cycling, firewalls and bias can be considered examples of 'decoupled' responses, which separate conflicting values. This allows practitioners to circumvent conflicting values. In contrast, hybridization, incrementalism and casuistry allow for the possibility of multi-value responses: conflicting values can be addressed simultaneously.

Although the above strategies are frequently used in practice, it remains to be seen whether they are sustainable, long-term solutions to value conflicts (Steenhuisen 2009). Studies of policy change demonstrate that decoupling mechanisms can be corrosive to organizational morale (Sandholtz 2012), may inhibit policy learning (Stewart 2009), and are often undone in the long run by recoupling (Stewart 2009; Tilczik 2010). Consequently, Haack, Schoeneborn and Wickert (2012) argue that decoupling is not a permanent solution, but merely a transitory phenomenon.

Given the transitory nature of decoupling strategies and their potential negative side effects, it is necessary to investigate various strategies that incorporate rather than separate and bypass conflicting values. Although multi-value responses describe the co-existence of conflicting values, they do not sufficiently explain the dynamics of friction and productive (re) combinations of conflicting values. In other words, they do not provide insights into how competent actors actually deal with conflicting values. Work by economic sociologist Stark (2009) on heterarchies – that is, organizations with multiple evaluative principles – provides important insights into these dynamics. According to Stark, heterarchical organizations do not have to succumb to 'value cacophony,' but in fact can organize productive dissonance: disagreement over rivaling principles. This dissonance is said to enable opportunities for action and innovation (ibid.). For example, in an ethnographic account of a Wall Street trading room, Stark shows how innovation in quantitative finance can occur thanks to rivalry between specialized trading functions (i.e. arbitrage traders, momentum traders and value investors) and the use of different evaluative principles, metrics and instruments. Each trading function has its own desk in the trading room that is organized around one distinctive evaluative principle,

thereby building dissonance into the organizational structure. Through close contact on the trading floor, traders can recognize conflicting evaluative principles and generate new innovative forms of arbitrage (ibid.).

In Stark's perspective on heterarchy, disagreement is deemed more important than agreement and harmony. In fact, he pays little attention to how actors might incorporate multiple, conflicting values by means of compromises. In contrast, Boltanski and Thévenot (2006) show that compromises are at heart of the functioning of heterarchical organizations as they allow actors to deal with conflicting values in daily practice (Boltanski and Thévenot 2000; Lamont 2012). They describe modern organizations as 'composite assemblages that include arrangements deriving from different worlds' (Boltanski and Thévenot 2006, 18), and 'encompass resources that are heterogeneous in terms of their mode of coherence and the underlying principle of justice on which that coherence is based' (Boltanski and Thévenot 2006, 151). Because of the existence of multiple principles of justice, everyday clashes arise that can be suspended or remedied by constructing compromises. As an illustration of a compromise, Boltanski and Thévenot describe France's Economic and Social Council: a composite institution that merges civic and industrial values into mundane compromises such as the slogan 'we're all in this together: increased productivity is good for us all' (ibid. 279). Despite Boltanski and Thévenot's contribution, the construction of legitimate compromises is still an under-researched topic in public administration (Cloutier and Langley 2013; Patriotta, Gond and Schulz 2011). As Cloutier and Langley recently argued, the production of compromises remains 'largely invisible' in the institutional analysis of multiple logics (2013, 11). To remedy this blind spot, they recommend ethnographic research in situ that investigates micro-processes whereby various logics interact and merge into compromises. Boltanski and Thévenot's framework is especially suitable to study these micro-processes and the active role of competent actors in establishing compromises. For this reason, the framework of justification is applied to the Dutch healthcare sector and managerial practices in this sector.

On justification

According to Boltanski and Thévenot (2006), a neglected dimension of social interaction is the way people justify their actions in every day disputes. They consider the act of justification not as a cover up, but as an integral part of human interaction:

'Justifiable acts are our focus: we shall draw out all the possible consequences from the fact that people need to justify their actions. In other words, people do not ordinarily seek to invent false pretexts after the fact so as to cover up some secret motive, the way one comes up with an alibi; rather, they seek to carry out their actions in such a way that these can withstand the test of justification' (Boltanski and Thévenot 2006, 37).

Boltanski and Thévenot (2006) have developed six justifications[3], also called worlds, orders, repertoires or generalities of worth: 1) market, 2) industry, 3) civic, 4) domestic, 5) inspired, and 6) fame. These justifications are based on three bodies of data: empirical data gathered by asking people to create classification systems by sorting occupations into categories, a study of organization handbooks, and an analysis of political philosophical works by Rousseau (civic), Adam Smith (market), Saint-Simon (industrial), Bossuet (domestic), Augustine (inspiration), and Hobbes (fame). In their 2006 book 'On Justification' they extensively describe the six justifications summarized in Table 1. Each justification entails certain values[4], states of worthiness (shared ideas of what is good and just), and specific forms of evaluation (how the good and just is measured):

Table 1 Different justifications and values

Justification	Values	State of worth	Evaluation
1. Market	Competition, profit, consumer choice	Desirable, valuable, winner	Price
2. Industrial	Production efficiency, planning	Effective, functional, dependable	Functionality
3. Civic	Equality, welfare, social participation	Representative, free official, statutory	Votes, civic rights, law
4. Domestic	Household duties, tradition, trust, family honor	Benevolent, well-bred, wise, sensible	Responsibilities
5. Inspired	Inspiration, creativity, grace	Bizarre, different, original, spontaneous	Singularity, uniqueness
6. Fame	Public opinion	Celebrity, prestige	PR, public recognition

Based on: Boltanski and Thévenot (2006)

Boltanski and Thévenot (2006) argue that people explicitly or implicitly refer to one or more justifications when deciding what is just in ordinary situated disputes. In these situations, people realize that something is wrong and has to change. This

3 Boltanski and Thévenot argue that the six justifications are historical and social constructions 'and some of them are less and less able to ground people's justifications whereas other ones are emerging' (1999, 369). They identify a number of emerging justifications, including projective (Boltanski and Chiapello 2005), information, communicative and green (Thévenot et al. 2000). In this article, we use the six original justifications since they have a more solid empirical and theoretical foundation than the others (Boltanski and Thévenot 2006). Including other justifications would not provide additional insights into the study of conflicting values in small-scale care.

4 Please note that when broadly conceptualized, values can belong to different justifications. For example, the encompassing value of 'choice' can belong to both market (consumer choice) and civic (electing representatives in elections by casting a vote). For categorizations of values to be meaningful, it is necessary to operationalize values more specifically, as we do in Table 1.

realization has a dual meaning and refers to 'an inward reflexive move and to a performance in the outward world' (Boltanski and Thévenot 1999, 359). Therefore, people not only try to answer for their own interpretation of what is just but also to others with whom they interact.

As Table 1 makes clear, there is a plurality of justness. This means that justifications represent different types of common good (Boltanski and Thévenot 2000) or varieties of goodness (Wright 1972), and carry equal weight (Patriotta, Gond, and Schulz 2011). There is no overarching norm to balance different justifications. Each justification is a logical, harmonious order of objects and people that provides a general sense of justice. When justifying, people 'extract themselves from the immediate situation and rise to a level of generality' (Boltanski and Thévenot 2000, 213). In this process, people attach certain worth to persons and objects. For example, an object like a house can be endowed a different worth in each justification. The justification of the market sees a house as a good that can be traded for money, whereas the domestic justification sees it as a place where family life takes place. Similarly, people can be endowed with different values, such as consumers, citizens, or producers.

A distinguishing feature of the theory of justification is that it is based on the notion of equivalence. The theory therefore only applies to disputes in which people are equal and strive for agreement without exercising power. Acts of love, private arrangements, domination, force, routine, deceit, delusion, and self-deception fall outside the regime of justification (Boltanski and Thévenot 1999, 2000, 2006).

Conflicts, fragile compromises and justification work

According to Boltanski and Thévenot (2006), people are subjected to an imperative of justification when they experience different forms of disputes in everyday life, ranging from modest disagreements to full-blown clashes. Disagreements can arise in one justification over the distribution of worth, for example over the appropriate price of a certain good. In these situations, the judgment measure itself is not contested. However, disagreements can also extend to clashes (Boltanski and Thévenot 1999). This is the case when different justifications conflict and people disagree on the judgment measure, for example, whether it is appropriate to make a cost-benefit analysis of certain medical treatments. Then a 'clash between worlds' arises and people exchange criticism, blame, and grievances based on differing justifications (Boltanski and Thévenot 1999; 2006, 223 and 237). As Boltanski and Thévenot put it, 'The one who criticizes other persons must produce justifications in order to support their criticism just as the person who is the target of the criticisms must justify his or her actions in order to defend his or her own cause' (Boltanski and Thévenot 1999, 360).

Despite the plurality of justness and the lack of an overarching norm, Boltanski and Thévenot (2006) claim that compromises between justifications are possible. In fact, compromises are an integral part of social interaction. In the face of criticism, people try to make daily situations involving conflicting values workable by constructing a compromise between justifications (Lamont 2012). An important part of compromising consists of finding a formulation that is acceptable

to the people involved: the compromise needs to be justifiable to others. However, Boltanski and Thévenot (2000, 212) note that 'the competence to make an agreement is not a uniquely linguistic competence.' People also make compromises with the construction and arrangement of objects. Objects are important as 'every principle of justice is associated with a universe of objects that constitute a coherent world' (Boltanski and Thévenot 2000, 213). They have the potential to tie ill-suited elements together and solidify compromises. For example, Thévenot shows that compromises between market, civic, and domestic justifications can be incorporated in the design and construction of a new road (Thévenot 2002).

Compromises entail considerable work as they have to be created, solidified, and justified. In line with Jagd (2011), this is called justification work, which is not only about establishing compromises, but also about maintaining and re-crafting compromises. This is necessary because even when a compromise is solidified, it remains fragile, temporary and open to critique (Boltanski and Thévenot 2006; Patriotta, Gond, and Schulz 2011) because people make compromises between justifications 'without trying to clarify the principle upon which their agreement is founded' (Boltanski and Thévenot 1999, 347). Thus, the entities or beings combined in a compromise continue to belong to their justification of origin. People can reactivate the clash by bringing up one of the justifications again. A more complex situation then arises, as people cannot simply withstand the criticism and justify the compromise by referring to a higher common principle or overarching justification (Boltanski and Thévenot 2006). In these cases, actors must perform justification work by re-crafting existing compromises or creating new ones.

Conceptually, justification work aligns closely with the notion of discursive practices. A discursive practice not only entails language, but also action, objects and settings that have a constituting effect on each other (Fairclough and Wodak 1997; Potter 2004; Van Dijk 1997). In other words, language shapes and is shaped by situations, institutions, people, objects and social structures. Furthermore, Potter (2004) emphasizes that discursive practices are action-oriented, situated and constructed. This study further builds on this tradition by empirically showing how justification work is constituted in practice through objects, behavior and rhetoric.

Small-scale care

Traditionally, western countries modeled long-term care and housing for people with severe dementia and for people with a mental or physical disability on hospital care (Finnema et al. 2000). People deemed unable to care for themselves used to live in large-scale institutions, isolated from society, and restricted in opportunities and lifestyle (Ericsson 2002). In recent decades, care and housing have become de-institutionalized and community-based (Emerson 2004). The goal of de-institutionalization has been 'the complete replacement of institutions by services in the community' (Mansell 2006, 65). People with dementia or a disability increasingly live in small-scale domestic dwellings in residential neighborhoods (Braddock et al. 2001).

Consequently, the number of people that live in large-scale institutions has steadily declined in Europe and the US (Beadle-Brown, Mansell, and Kozma 2007).

Te Boekhorst et al. (2007, 18) define small-scale group living homes for people with dementia by seven characteristics, including 'residents are allowed to stay until death,' 'residents, family and staff together decide the daily course of events,' and 'care planning resembles a household routine.' The number of residents in small-scale homes typically ranges from five to nine (Verbeek et al. 2009). Van Hoof, Kort, and Van Waarde (2009, 387) define a small-scale home as 'a "normal" household' combined with '24-hr care and surveillance offered by one or two staff members.' Furthermore, 'there is room for one's own furniture and goods in a private living/bedroom. The kitchen unit, living room, and in most cases the sanitary units are shared.' In the shift to community care, the following values play an important role: self-determination, social integration, social relationships with relatives and friends, meaningful activity, health, engagement in domestic and personal activities, and general quality of life (Beadle-Brown, Mansell, and Kozma 2007; Emerson 2004; Kozma, Mansell, and Beadle-Brown 2009).

The case of small-scale care in the Netherlands is interesting for several reasons. De-institutionalization and tightening of budgets in long-term care could potentially lead to new value conflicts for managers. Previous research has already shown that small-scale living facilities can put a strain on the affordability of care (Oldenhof and Putters 2011). Furthermore, the scale of healthcare organizations and facilities is a heavily debated issue in the Netherlands, showing conflicting notions of professionalism, marketization, and quality of care (Postma, Van de Bovenkamp, and Putters forthcoming).

Methods

We used a qualitative research design to openly investigate how healthcare managers experience value conflicts and perform justification work. The qualitative analysis is based on 1) semi-structured interviews with middle managers and executives working in different organizations in long-term care, and 2) ethnographic observations of middle managers in one care organization. Appendix A contains details of the data sources.

In the period between November 2009 and June 2010 we conducted semi-structured interviews with healthcare middle managers and executives, including 16 interviews with middle managers in the long-term care sector who were responsible for managing healthcare professionals and the financial performance of residential facilities. The goal of the interviews was to investigate the daily dilemmas of middle managers. Middle managers were asked to describe a typical working day, their experiences with enjoyable/difficult aspects of their work and day-to-day decisions in the organization of care. Furthermore, 13 interviews were conducted with executives from 13 organizations for elderly care. The goal of these semi-structured interviews was to gain an overview of the different dilemmas executives face when dealing with scale in their healthcare organizations. All interviews were fully transcribed.

Additionally, ethnographic observations were conducted in an organization that provides local neighborhood small-scale care for people with a disability. In the period between February 2011 and December 2011, seven middle managers were shadowed for three days each, during the course of their regular working day. Field notes were taken during all the activities of middle managers, including team meetings, telephoning, coaching of professionals, and meetings with client councils and clients' relatives. These notes provided rich information about the daily management of small-scale homes.

The analysis of justification work not only focuses on how managers justify decisions regarding small-scale care to themselves and the researchers (see the interviews), but also emphasizes how managers justify their decisions vis-à-vis 'significant others' such as professionals, other managers, clients and their relatives (see the observations). The analysis is based on an initial phase of inductive exploration and a sequential phase of deductive coding based on Boltanski and Thévenot's framework of justification. The combination of inductive and deductive analysis on the one hand enabled an open exploration of value conflicts in managerial practices and on the other hand created opportunities to develop existing theory of justification further (e.g., justification work based on compromising and the elements of rhetoric, behavior, and objects).

First, by a process of inductive coding (Kvale and Brinkman 2009), we identified three value conflicts in the provision of small-scale care, (see the results section for descriptions). Signifiers of value conflicts were words like 'dilemma', 'tension', 'struggle', 'difficulty' and emotional utterances about 'what should be or should not be.' After identifying three main value conflicts, we linked them deductively to the six justifications. For example, with the help of Table 1, the value conflict between *freedom of choice* and *efficient organizing* of small-scale care was deductively coded as a conflict between market versus industry justifications. Please note that the coding evolved during the analytical process. The researchers' initial assumption was that value conflicts could only occur between different justifications, but this proved to be incorrect. The data showed that within one justification, value conflicts could also arise, such as the wish to integrate clients into society and receive legitimacy from local neighborhoods (both relating to the civic justification). This civic value conflict was included into the analysis, but we found no additional value conflicts within one justification in the data.

A second step in the analysis was to identify language, affiliated behavior and objects that managers use when dealing with value conflicts and using Table 1, to deductively ascribe these to the different justifications. For example, in the case of the third value conflict (integration of clients into society versus legitimacy from local neighborhoods), concrete objects like PR flyers were used to improve the 'public image' of clients with a disability in the neighborhood, which aligned with the fame justification (source: interviews). Additionally, baby phones and cameras were coded as objects stemming from the industry justification because these objects were used by managers to 'efficiently plan' and 'organize' 24-hour care in different locations (source: observations and interviews). Similarly, we linked managerial language and behavior to the justifications. For example, rhetoric on consumerism and client choice concerning spending client-linked budgets was linked to the market justification (source: observations and interviews).

Thirdly, we analyzed deductively the recurring combinations between justifications in order to identify compromises. This resulted in two central compromises concerning small-scale living facilities: civic/domestic and industry/market. These compromises were not only created rhetorically, but also were solidified over time in different work schedules, behavior of care workers and various buildings (i.e., the civic/domestic compromise materialized in domestic, family-sized houses, whereas the industry/market compromise was created in practice by individual apartments in communal buildings). The results section includes quotes that exemplify the identified value conflicts, (implicit) references to justifications and the two main compromises.

Results

This section shows how public middle managers and executives (called 'managers' from now on) deal with value conflicts in the provision of small-scale care for people with dementia or a disability. Firstly, we describe the current practice of small-scale care as a compromise between the domestic and the civic justification. Secondly, we define three emerging value conflicts, showing the fragility of the current compromise. Thirdly, we show how managerial justification work is performed by means of rhetoric, behavior, and material objects. Managers perform justification work to keep the current compromise together and create a new compromise between the industry and the market justification. Finally, we describe the cyclical nature of justification work.

Small-scale care as a compromise between the civic and domestic justification

As stated above, de-institutionalization in Dutch healthcare brought different values to the fore. This resulted in the practice of small-scale care that can be typified as a compromise between the civic and domestic justification. In their daily practices, managers justify this compromise in various ways. They argue that small-scale homes function like a regular (domestic) household, while simultaneously providing opportunities to integrate clients into society (civic). Clients are stimulated to engage in both household activities (domestic) and social activities in the neighborhood (civic). Managers encourage clients to have social relationships with relatives and friends (domestic) and be a good citizen and neighbor (civic). Elements from both justifications are reflected in the managers' language:

> 'These types of organizations belong to society; they (...) belong to local communities.' (executive) '(...) that people can live with pleasure in their home, and are able to continue living there and be themselves.' (middle manager)

The civic/domestic compromise is not just rhetorically justified: it is also solidified in materials and behavior. The most obvious material solidification of the compromise is that small-scale buildings are situated in regular neighborhoods. They have mostly replaced the large-scale institutions situated on secluded terrains. The compromise is further solidified in the behavior of managers as they work together with professionals and relatives to help clients live their lives as 'normally' as possible. Managers coach professionals to accept certain risks that come with treating clients as 'normal citizens' and 'family members.' When clients perform daily activities – like going to the supermarket independently, participating in neighborhood activities, or cooking for themselves – most of the attached risks are deemed acceptable because they are part of a 'normal life.' In addition, managers try to further solidify the compromise by involving relatives in the provision of small-scale care, for example by asking them to paint or decorate a client's room.

Critique on the fragile compromise: three value conflicts

While the current practice of small-scale care is a solidified compromise, it remains fragile and open to critique. Managers have to deal with two types of criticism. The civic/domestic compromise is first open to external critique from other justifications and corresponding values (outside the current compromise). It emanates from market and industry justifications, as some actors feel that they are not sufficiently reflected in the current practice of small-scale care. Secondly, because the civic-domestic compromise is a composite assemblage, it is open to internal critique from the 'pure' forms of the two justifications.

In managerial practices, critique manifests itself in value conflicts, which are expressions of the fragility of the current civic/domestic compromise. Although the value conflicts are not manifest in all practices and sometimes look differently in different contexts, there is a remarkable consensus in the conflicts that the managers in the study experienced. Interestingly, middle managers appear to experience value conflicts more intensely and more concretely than executives do. During interviews, they provided more detailed examples of value conflicts in the provision of small-scale care than executives did.

This section describes the three value conflicts that managers experience. The first two value conflicts are examples of external critique; the third value conflict is representative of internal critique.

Firstly, managers experience external critique as a value conflict between keeping small-scale homes *affordable* (market justification) and *planning 24-hour care* for clients (industry justification). Clients receive 24-hour care and supervision according to their client-linked budget (a legally defined individual budget that defines the amount and type of care a client is entitled to). However, managers struggle to realize 24-hour care in small-scale homes for a few clients with limited budgets. It is difficult to provide all the care clients are entitled to *and* stay within budget:

> 'We used to have six clients in one small-scale home (...). We just can't afford that any more. When you have clients that live in a small-scale home, and you have to arrange for supervision during the night, then it [the budget] is just too small.' (middle manager)

> 'With the new funding system, you cannot provide 24-hour care for a cluster of less than thirty clients.' (executive)

Secondly, managers experience external critique as a value conflict between guaranteeing *freedom of choice* for clients (market) and organizing small-scale care *efficiently* (industry). Managers stress the importance of clients with dementia or a disability having the freedom to choose how they want spend their client-linked budget. However, this freedom of choice is often at odds with the interest of the organization to provide care efficiently. For example, when some clients choose to go on holiday during the summer and other clients choose to stay at home, managers find it difficult to organize supervision for a small number of clients. The clients' daily choices, whether they would like to stay at home during the day or prefer to go out to activities, create conflicts:

> 'Can I say to a client that they are obliged to go to a social activity outside the home because I don't have the money to arrange for supervision of clients who want to stay at home? Can I do that?' (middle manager)

Thirdly, managers experience internal critique as a conflict between the wish to *integrate* clients into society and receive *legitimacy* from local neighborhoods (both civic). This value conflict manifests itself almost exclusively in small-scale care for people with a disability. Managers stress that people with a disability should live a normal life in the community; gaining acceptance and legitimacy from neighbors is central to this. However, they find it hard to realize this ideal in practice. Managers have to deal with conflicts between the wishes of neighbors (for peace and quiet) and the needs of clients to be who they are (often more noisy and expressive than quiet):

> 'Well, we've experienced lots of trouble with the neighbors in the past two years. (...) People who don't want it, don't like it, are bothered by the noise that clients make. People who get annoyed when a client undresses on the street. People who get upset because their children are scared of clients. Yes, things like that. Noise nuisance at night. They complain a lot about that. Houses have dropped in value.' (middle manager)

> 'You've got lots of neighbors who think, 'Go live in a cabin in the woods with your handicapped people.' (middle manager)

Dealing with value conflicts requires justification work

As the above has shown, the current practice of small-scale care is a fragile compromise between the civic and domestic justifications. This fragility manifests itself in three value conflicts. To deal with conflicts, managers perform justification work. The analysis identified two types of justification work: 1) maintaining the current compromise and 2) creating a new compromise. The analysis inductively shows that both types of justification work consist of rhetoric, human behavior and material objects. Rhetoric comprises the use of language; behavior largely manifests itself in the routines of professionals, clients and managers; and material objects include things like cameras and buildings. In the practice of justification work, these dimensions are often interwoven.

Justification work type 1: keeping the fragile compromise together

The first type of justification work is keeping the fragile civic/domestic compromise together. Managers include elements from different justifications into the current compromise in order to deal with conflicting values. However, they and other actors (like colleagues, clients and relatives of clients) sometimes perceived it as unjust as the current compromise becomes less 'pure'. Dealing with this injustice requires a lot of justification work to make language, behavior, and objects compatible.

Managers deal with the conflict between affordability and 24-hour care *(the first value conflict)* using civic, market and industry justifications. With regard to civic justification, managers emphasize that 24-hour care is not just the healthcare organization's professional responsibility. In the civic view, clients are portrayed as citizens with both the right and responsibility to participate in the provision of small-scale care, together with relatives and other actors from the community:

> 'The small-scale homes need to be connected to civil initiatives as far as possible. Citizens need to take far more responsibility. (...). So what we are going to do is arrange, together with social housing organizations to connect with citizens' initiatives. We want a community of professionals and citizens forming a small-scale home together.' (executive)

With regard to market justification, managers emphasize that clients are consumers too. As consumers, they are expected to use their client-linked budgets to make their own choices in the provision of 24-hour care. For example, people with a disability are asked what type of care they want most: assistance in the morning when getting up or supervision of social activities in the evening. Also, relatives are asked to assist in the choice of how to spend the client-linked budget, as demonstrated by these statements from a middle manager to parents of a client with a disability:

> 'Do we want all-night supervision? (...) It means that instead of three professionals in the evening, you only have two. Then you'd miss out on individual care in the evening. We always have to choose. Are you going to walk or ride the bike? Do you want to help clients prepare food or during the meal? It's a dilemma: how do you deal with it?' (middle manager)

> 'There is money, but you have to decide how to spend it.' (middle manager)

Aside from rhetorically emphasizing civic duties and consumer choice, managers work on material solutions that stem from the industry justification. Many small-scale residential homes use ICT devices to allow clients to be supervised from a distance. For example, baby phones and cameras are used to oversee clients at night. These devices alert professionals when clients need help. It permits one professional to be in attendance in one location who can supervise several homes.

Managers deal with conflicts between freedom of choice and efficient planning *(the second value conflict)* using the civic justification and stressing the importance of solidarity among clients. For example, they encourage clients to undertake the same activities or to go on holiday at the same time as other clients in their group. By calling on solidarity, managers try to achieve efficient care planning without restricting clients in their freedom of choice:

> 'In a group you have to agree on when, for example people can take a day off. Clients have to do more together, at the same moment. And clients sometimes fight about it because they cannot agree. As a manager you then have to take a step back.' (middle manager)

The conflict between the wish to integrate clients into society and receiving legitimacy from local neighborhoods *(the third value conflict)* is interesting as this is not a conflict between different justifications, but between interpretations of the civic justification. Neighbors define civic as a peaceful neighborhood where their children can play outside without noisy people next door and without being confronted by people acting strange. Managers define civic as the integration of clients into a pluralistic neighborhood where many kinds of people, both with and without disabilities, live and work together.

Managers use the justifications of fame and industry to deal with this value conflict. With regard to fame, managers try to improve the image of small-scale homes by investing in good will and PR. Through rhetoric (regular talks and meetings with neighbors), material objects (flyers), and behavior (recycling bottles), managers try to build local relationships:

> 'You try to work together with the neighborhood (...) We distribute flyers: we would like to collect your empty bottles for you. You want to show people that you are there for them. Be visible.' (middle manager)

With regard to industry, managers emphasize to neighbors that they have their safety in mind and have control over clients. Especially when complaints about clients seem hard to resolve, such as complaints about misconduct, managers stress the importance of rules:

> 'When neighbors address a client about his misconduct, for example, he [a client] (...) for example says "what the f***".We have made it very clear to this client that he lives in a home that is part of our organization and he has to respect certain rules.' (middle manager)

Justification work type 2: creating a new compromise

The second type of justification work is creating a new compromise between market and industry justifications. In creating a new compromise, managers try to resolve persistent criticism stemming from market and industry justifications (the first and second value conflicts). Managers take this rather radical step when they think that these value conflicts are unsolvable in the current civic/domestic compromise. Creating the new compromise requires more justification work than simply holding on to the current one. Managers not only have to rhetorically justify their decisions to actors that want to stick to the current practice of small-scale care, they have to change their own, and others' behavior and make fundamental rearrangements in objects (like buildings).

The first step of creating the new compromise involves critiquing the current one. Managers stress the undesirability of the civic/domestic compromise from the perspective of other justifications. For example, small-scale homes are criticized for limiting the clients' choice (market justification):

> 'Not every client benefits from a group of six people. They didn't choose this so-called family, but nonetheless they are locked up with six other people.' (executive)

Furthermore, the current compromise is attacked as a financial burden for society (civic) and an inefficient scale for planning (industry):

> 'You can only provide 24-hour care on a reasonable scale, (...) a unit of 20 clients. That's plain logic. You're just fooling people when you say that you can provide it in smaller units. That's irresponsible; you're bringing higher costs upon society.' (executive)

Next, managers create the new compromise that tries to resolve the value conflicts. In creating it, managers argue for up scaling small-scale homes. Up scaling is done by building homes consisting of multiple individual apartments (at least 20, with some 40–60 square meters per apartment) and shared communal living rooms. The scale of individual apartments is relatively small, whereas the size of the building is large

compared to the archetypical domestic house. The combination of private and communal rooms is regarded as a new way of providing small-scale care.

This new way can be seen as a compromise between the market and industry justifications. Managers justify the market/industry compromise by stressing the importance of affordable care (market) and more efficient planning in a larger building (industry). With regard to the market, they also argue that clients no longer have to share their lives with other clients in an artificial family household, but can choose whether they want to participate in daily activities in communal rooms or enjoy the privacy of their own apartment. Managers indicate that up scaling enables them to provide a broader range of services, thereby enhancing client choice:

> 'Matching is very important because we develop the support and care for clients from the group perspective. Shopping together, eating together, spending free time together, clients do everything together. On a larger scale I can make more combinations.' (middle manager)

With regard to the industry justification, managers claim that the new compromise enables more efficient planning. Expensive types of care, like night shift supervision, can be shared more easily over a larger number of clients in a larger building. Additionally, managers claim that they can organize the control over professionals better in larger buildings (industry):

> 'You've got some sort of social control over what happens. (...) A professional could make a mistake by intervening too physically. Or, well, you don't know what could happen. When it happens on the same team, you run the risk of professionals helping each other. Or keeping something like that quiet. That alone is reason enough to cluster more, because then we'd have more control over each other.' (middle manager)

Like the current civic/domestic compromise, the new market/industry compromise is solidified in a number of ways. The most visible aspect of the justification work of managers is material solidification in the stone of new buildings. With regard to rhetorical work, managers regularly talk to professionals, clients, and relatives to justify the new compromise. Particularly, managers stress the advantages of the new compromise for both clients and healthcare organizations. The market/industry compromise is also solidified in behavior. For example, managers make sure that professional work schedules permit efficient planning and keep the preferences and needs of clients in mind as far as possible. As a result, professionals are no longer responsible for providing care to one fixed group of clients in a single small-scale home. Instead, they often have to work at different sites in a larger building.

Managers and professionals try to change the clients' behavior, enhancing their independence and encouraging them to use their freedom of choice to live the life they prefer.

The cyclical nature of justification work

Justification work is highly cyclical, not a linear process leading to final outcomes. Even when compromises are solidified in objects and behavior, they remain subject to adaptation. Managers and care workers are constantly re-crafting individual compromises when their effect turns out to be undesirable in the critical eyes of relevant others. As the following quotes make clear, a good alignment between the provision of small-scale care and the needs of clients is not a given:

> 'Sometimes clients like to spend their time in a group [in a small-scale home], and want lots of support and other people around them. Then they really have to move against the current. We say (...) 'It's good that clients have lots of individual space, right? You need it, you'll get used to it'. But sometimes a client really doesn't want that.' (middle manager)

> 'Some clients didn't become happier [in individual apartments] (...). In a small-scale home, everything was arranged for them. Now they have to do it for themselves. Making a cup of coffee, turning on the lights in the evening, when it gets dark. We had a client who sat in the dark at night if you didn't help him. He didn't take any initiative.' (middle manager)

Mitigating undesired effects of compromises by means of redrafting is part of the ongoing justification work. For example, in the case of loneliness in individual apartments, managers encourage clients to visit the communal rooms and participate in social activities, such as cooking together. Or managers prepare fixed daily schedules for clients to make sure they do not stay in their apartments all day. By doing so, managers try to guarantee that compromises do not become ends in themselves and contribute to a good alignment between different needs. This alignment does not only take client's wishes into account, but also the broader interests of the organization and society with regards to affordability and accessibility of care.

Conclusion and discussion

Using the justification framework of Boltanski and Thévenot (1991; 1999; 2000; 2006), we studied how Dutch healthcare managers used compromises to deal with conflicting values in the practice of small-scale care. The results demonstrate that public managers play a crucial role in establishing, maintaining, and re-crafting justifiable compromises when faced with emerging value conflicts. This study describes two compromises that represent different ideals of small-scale care: a civic/domestic compromise (clients living in a domestic household in the neighborhood) and a market/industry compromise (clients living in a private apartment in a collective building). Because compromises are based on different justifications (civic, domestic, industry, market), they remain fragile and open to critique by clients, their relatives, professionals and neighbors. To deal with criticism and the emerging value conflicts,

public managers have to perform continuous justification work, which includes rebuilding existing compromises, creating new compromises and justifying these to significant others.

Although several scholars recently acknowledged the importance of justification processes and compromises (Jagd 2011; Patriotta et al. 2011; Cloutier and Langley 2013), this study provides a more detailed conceptualization of justification work *in situ*. The analysis demonstrates that justification work is not only *rhetorical* (justifying compromises to others), but also involves the use and adaptation of *material* objects (buildings) and the remodeling of professional *behavior* (working methods and schedules). Compromises can be solidified by inscribing them in material objects and behavior, thereby achieving temporary stability in times of public sector change. As Ramirez' analysis of the accountancy sector demonstrates (2013), when institutional change disrupts the underlying value systems of a professional sector 'compromising and legitimizing are all the more necessary' to realign conflicting values and restore a sense of worth in the professional community (ibid. 846). In the healthcare sector, compromising may in fact become more of a necessity due to New Public Management reforms that apply business models and market logics to public service provision (Simonet 2008; Grit and Dolfsma 2002), thereby challenging professional and public values. Although previous research has shown that value conflicts can be avoided by creating separations or 'firewalls' (Stewart 2006; Thacher and Rein 2004: Jacobs 1994), it is questionable whether decoupling mechanisms are sustainable in the long run (Sandholtz 2012; Steenhuisen 2009; Haack, Schoeneborn and Wickert 2012). The empirical analysis suggests that public managers can use compromises as a more durable strategy to cope with value conflicts, which broadens the scope of the strategies described so far in the literature, such as cycling, firewalls, and bias (Stewart 2006; Thacher and Rein 2004).

This study furthermore demonstrates that public managers are not cognitively bound to a cluster of like-minded, traditional management values, such as efficiency and effectiveness, but can engage with a plurality of values and justifications simultaneously (see also Patriotta et al. 2011). By incorporating multiple values into justifiable compromises, managers do not merely cope with value conflicts, but actively try to contribute to 'good' public service delivery. As the justification framework suggests, there is not just one good, but varieties of goodness that public managers need to take into account (Boltanski and Thévenot 1999; Von Wright 1972). Yet, managerial compromises do not have to lead to relativism ('anything goes'), as managerial actions are supported by justifiable arguments, materials and behavior. This research contributes to previous studies that show that public and private values often share a common core (Van der Wal, De Graaf, and Lasthuizen 2008) and need to be mixed in (semi-) public sectors, such as healthcare, social housing and waste management to provide good services (Brandsen, Van de Donk, and Putters 2005; Helderman 2007; Karré 2011; Putters 2009).

Compromising as a managerial and political strategy (Padgett and Ansell 1993) can enable productive solutions to value conflicts and provide temporary stability, but it does have important limitations. A 'justifiable' compromise does not necessarily contribute to 'good' public service delivery. Particularly when rhetorically skilled managers and politicians can advantageously 'sell' compromises to audiences with different worth, there is a risk of continuous legitimacy struggles

once compromises are criticized. These legitimacy struggles could lead to a gradual erosion or even complete lack of support for existing compromises. In that case, never-ending justification processes may do more harm than good, diverting attention away from the actual delivery of public services. Moreover, when public managers are unable to make compromises durable via solidification, the act of compromising is likely to yield only a temporal agreement to disagree (Cloutier and Langley 2013). While this loose agreement can permit necessary breathing space when actors are in conflict, it does not provide a structural basis for public service delivery and policymaking.

The empirical analysis also shows an interesting distinction between the way public middle managers and executives deal with value conflicts. Compared to executives, middle managers seem to experience a broader range of value conflicts in the provision of small- scale care. They also seem to experience value conflicts more concretely. Without going into all possible explanations for this variation, it can be concluded that middle managers experience value conflicts in a very direct, relational sense vis-à-vis significant others. Their close ties to clients, client's relatives, professionals, and neighbors constitute a web of morally 'thick relations' (De Graaf 2011; O'Kelly and Dubnick 2006). Due to these thick relations, middle managers can easily be torn between their individual allegiances and the attainment of public goals. Yet, despite being torn, they have to decide and act. They do not have the option to avoid or postpone morally difficult choices, as opposed to actors with thinner relations. Consequently, the justification work required from middle managers may be more challenging than that of executives in the case of small-scale care.

A limitation of this study is that the analysis is primarily based on *managerial* justification work by middle managers and executives. Future studies could pay more attention to interactions between a wider variety of actors, including policy makers, inspectorates, professionals, and clients. A multi-stakeholder approach could shed light on the reciprocal nature of justification work and the inner workings of legitimacy struggles that cut across different professional groups and organizational contexts (commercial businesses and public sector organizations).

While this study shows that justification work and managerial decision-making are closely connected (managers generally do what they say), it is conceivable that in more political or hierarchical environments, justification work can turn into a cover up. Therefore, an in-depth investigation of justification work is necessary to explore the underlying reasons why actors choose to justify compromises in decision-making processes as opposed to using other strategies (e.g. decoupling conflicting values). A related topic for future research could be the connection between compromises and 'good governance'. Relevant questions are for example: under what conditions do compromises lead to 'good' governance and when does it lead to 'bad' governance, (e.g. monstrous hybrids, Jacobs 1994)? Are these conditions different in public and private sectors? And how do deductive definitions of good governance (e.g. in guidelines and codes, see Aguilera and Cuervo-Cazurra 2004) reconcile with the inductive interpretations of good governance that are developed bottom-up in daily practices? A last fruitful direction for future research lies in the combined use of theories on justification and institutions. As Cloutier and Langley (2013) point out, institutional theory has several blind spots, such as a lack of attention for micro-processes and the active role of agents in establishing agreements,

which could be remedied by applying a justification framework. The conceptualization of justification work on the basis of rhetoric, behavior and objects, as developed in this paper, can be used to gain an in-depth material understanding of shifting institutional logics and the way micro-level compromises contribute to macro-level shifts.

Finally, there are some practical implications and recommendations for future studies. Justification work is 'emerging work' in situ, that is, based on discretionary decision-making in managerial practices and a 'situated sense of the just' (Boltanski and Thévenot 2000, 216). Given its emerging nature, top-down standardization and one-dimensional performance formats may inhibit the establishment of productive compromises. For that reason, policy makers should allow public managers sufficient discretionary space to negotiate, establish, and re-craft compromises in daily practices. When performing justification work, it is important that public managers not only look for vertical legitimization from their superiors and inspectorates, but also seek horizontal legitimization from clients, professionals and other service organization in their environment.

References

Aguilera, R. V. and A. Cuervo-Cazurra (2004). Codes of good governance worldwide: what is the trigger? *Organizations Studies* 25 (3): 415-443.

Beadle-Brown, J., J. Mansell and A. Kozma (2007). Deinstitutionalization in intellectual disabilities. *Current Opinion in Psychiatry* 20 (5): 437-42.

Berlin, I. (1982). *Against the current*. New York: Penguin Books.

Boltanski, L. and È. Chiapello (2005). *The new spirit of capitalism*. London and New York: Verso.

Boltanski, L. and L. Thévenot (1991). *De la justification: les économies de la grandeur*. Paris: Les Editions Gallimard.

Boltanski, L. and L. Thévenot (1999). The sociology of critical capacity. *European Journal of Social Theory* 2 (3): 359-377.

Boltanski, L. and L. Thévenot (2000). The reality of moral expectations: a sociology of situated judgement. *Philosophical Explorations* 3 (3): 208-231.

Boltanski, L. and L. Thévenot (2006). *On justification. Economies of worth*. Princeton and Oxford: Princeton University Press.

Bozeman, B. (2007). *Public values and public interest. Counterbalancing economic individualism*. Washington D.C.: Georgetown University Press.

Bozeman, B. (2008). Debate: public value trade-offs and methodological trade-offs. *Public Money & Management* 28 (3): 135-136.

Braddock, D., E. Emerson, D. Felce, and R. J. Stancliffe (2001). Living circumstances of children and adults with mental retardation or developmental disabilities in the United States, Canada, England and Wales, and Australia. *Mental Retardation and Developmental Disabilities Research Reviews* 7 (2): 115-21.

Brandsen, T., W. van de Donk, and K. Putters (2005). Griffins or chameleons? Hybridity as a permanent and inevitable characteristic of the third sector. *International Journal of Public Administration* 28 (9): 749-765.

Charles, M. B., R. Ryan, and C. Paredes (2008). Safe and sound? The public value trade-off in worker safety and public infrastructure procurement. *Public Money & Management* 28 (3): 159-166.

Cloutier, C. and A. Langley (2013). The logic of institutional logics: insights from French pragmatist sociology. *Journal of Management Inquiry*, published on line ahead of print; doi:10.1177/1056492612469057.

De Graaf, G. (2011). The loyalties of top public administrators. J*ournal of Public Administration Research and Theory* 21 (2): 285-306.

Dunn, M. B. and C. Jones (2010). Institutional logics and institutional pluralism: the contestation of care and science logics in medical education, 1967-2005. *Administrative Science Quarterly* 55: 114-149.

Emerson, E. (2004). Cluster housing for adults with intellectual disabilities. *Journal of Intellectual and Developmental Disability* 29 (3): 187-97.

Ericsson, K. (2002). *From institutional life to community participation: ideas and realities concerning support to people with intellectual disability.* Uppsala: Uppsala University.

Fairclough, N. and R. Wodak (1997). Critical discourse analysis. In *Discourse as social interaction*, edited by T. A. van Dijk, 258-284. London: Sage publication.

Finnema, E., R. M. Dröes, M. Ribbe, and W. van Tilburg (2000). A review of psychosocial models in psychogeriatrics: implications for care and research. *Alzheimer Disease and Associated Disorders* 14: 64-80.

Grit, K. and W. Dolfsma (2002). The dynamics of the Dutch health care system. A discourse analysis. *Review of Social Economy* 60 (3): 377-401.

Haack, P., D. Schöneborn, and C. Wickert (2012). Talking the talk, moral entrapment, creeping commitment? Exploring narrative dynamics in corporate responsibility standardization. *Organization Studies* 33 (5-6): 815-845.

Helderman, J. K. (2007). *Bringing the market back in? Institutional complementarity and hierarchy in Dutch housing and health care.* PhD diss.: Erasmus University Rotterdam.

Jacobs, J. (1994). *Systems of survival. A dialogue on the moral foundations of commerce and politics*. New York: Vintage Books.

Jagd, S. (2011). Pragmatic sociology and competing orders of worth in organizations. *European Journal of Social Theory* 14 (3): 343-359.

Karré, P. (2011). *Heads and tails: both sided of the coin.* PhD diss.: University of Amsterdam.

Kernaghan, K. (2003). Integrating values into public service: the values statement as centerpiece. *Public Administration Review* 63 (6): 711-719.

Koppenjan, J., M. B. Charles, and N. Ryan (2008). Editorial: managing competing public values in public infrastructure projects. *Public Money & Management* 28 (3): 131-134.

Kozma, A., J.Mansell, and J. Beadle-Brown (2009). Outcomes in different residential settings for people with intellectual disability: a systematic review. *American Journal on Intellectual and Developmental Disabilities* 114 (3): 193-222.

Kvale, S. and S. Brinkmann (2009). *Interviews: an introduction to qualitative research interviewing*. London etc.: SAGE Publications.

Lamont, M. (2012). Toward a comparative sociology of valuation and evaluation. *Annual Review of Sociology* 38: 201-221.

Le Grand, J. (1990). Equity versus efficiency: the elusive trade-off. *Ethics* 100 (3): 554-568.

Loyens, K. (2009). Occupational culture in policing reviewed: a comparison of values in the public and private police. *International Journal of Public Administration* 32 (6): 461-490.

Lukes, S. (1989). Making sense of moral conflict. In *Liberalism and the moral life*, edited by N. L. Rosenblum, 127-142. Cambridge: Harvard University Press.

Mansell, J. (2006). Deinstitutionalisation and community living: progress, problems and priorities. J*ournal of Intellectual and Developmental Disability* 31 (2): 65-76.

O'Kelly, C. and M. J. Dubnick (2006). Taking tough choices seriously: public administration and individual moral agency. *Journal of Public Administration Research and Theory* 16 (3): 393–415.

Oldenhof, L. and K. Putters (2011). The daily practices of operational healthcare managers: dealing with tensions between different values. *Medische Antropologie* 23 (1): 81-101.

Padgett, J. F. and C. K. Ansell (1993). Robust action and the rise of the Medici, 1400-1434. *The American Journal of Sociology* 98 (6): 1259-1319.

Patriotta, G., J. P. Gond and F. Schulz (2011). Maintaining legitimacy: controversies, orders of worth, and public justifications. *Journal of Management Studies* 48 (8): 1804-1836.

Postma, J., H. van de Bovenkamp, and K. Putters. *The social construction of organizational scale*. Forthcoming.

Potter, J. (2004). Discourse analysis. In *Handbook of data analysis*, edited by H. Melissa and A. Bryman, 607-624. London: Sage Publications.

Putters, K. (2009). *Besturen met duivelselastiek*. Rotterdam: Erasmus Universiteit.

Ramirez, C. (2013). 'We are being pilloried for something, we did not even know we had done wrong!' Quality control and orders of worth in the British audit profession. *Journal of Management Studies* 50 (5): 845-869.

Sandholtz, K. W. (2012). Making standards stick: a theory of coupled versus decoupled compliance. *Organization Studies* 33 (5-6): 655-679.

Simonet, D. (2008). The new public management theory and European health-care reforms, *Canadian Public Administration*, 51 (4): 617-635.

Spicer, M. W. (2001). Value pluralism and its implications for American public administration. *Administrative Theory & Praxis* 23 (4): 507-528.

Spicer, M. W. (2009). Value conflict and legal reasoning in public administration. *Administrative Theory & Praxis* 31 (4): 537-555.

Stark, D. (2009). *The sense of dissonance: accounts of worth in economic life*. Princeton and Oxford: Princeton University Press.

Steenhuisen, B. (2009). *Competing public values. Coping strategies in heavily regulated utility industries*. PhD diss.: Delft University of Technology.

Steenhuisen, B., W. Dicke and H. de Bruijn (2009). 'Soft' public values in jeopardy: reflecting on the institutionally fragmented situation in utility sectors. *International Journal of Public Administration* 32 (6): 491-507.

Stewart, J. (2006). Value conflict and policy change. *Review of Policy Research* 23 (1): 183-195.

Stewart, J. (2009). *Public policy values*. Basingstoke etc.: Palgrave MacMillan.

Stone, D. (2002). *Policy paradox. The art of political decision making*. New York and London: W.W. Norton and company.

Te Boekhorst, S., M. Depla, J. de Lange, A. M. Pot and J. Eefsting (2007). Kleinschalig wonen voor mensen met dementie: een begripsverheldering. Small-scale group living for elderly with dementia: a clarification. *Tijdschrift Voor Gerontologie En Geriatrie* 38 (1): 17-26.

Thacher, D. and M. Rein (2004). Managing value conflict in public policy. *Governance: An International Journal of Policy, Administration and Institutions* 17 (4): 457-486.

Thévenot, L. (2002). Which road to follow? The moral complexity of an 'equipped' humanity. In *Social studies of knowledge practices*, edited by J. Law and A. Mol, 53-87. Durham and London: Duke University Press.

Thévenot, L., M. Moody and C. Lafaye. (2000). Forms of valuing nature: arguments and modes of justification in French and American environmental disputes. In *Rethinking comparative cultural sociology: repertoires of evaluation in France and the United States*, edited by M. Lamont and L. Thévenot, 229-272. Cambridge: Cambridge University Press.

Tilcsik, A. (2010). From ritual to reality: demography, ideology, and decoupling in a post-communist government agency. *Academy of Management Journal* 53 (6): 1474-1498.

Van Dijk, T. A. (1997). Discourse as interaction in society. In *Discourse as social interaction*, edited by T. A. van Dijk, 1-37. London: Sage publications.

Van Egmond, S. and R. Bal (2010). Boundary configurations in science policy: modeling practices in health care. *Science, Technology & Human Values* 36 (1): 108-130.

Van Hoof, J., H. Kort and H. van Waarde (2009). Housing and care for older adults with dementia: a European perspective. *Journal of Housing and the Built Environment* 24 (3): 369-90.

Van der Wal, Z., G. de Graaf and K. Lasthuizen (2008). What's valued most? Similarities and differences between the organizational values of the public and private sector. *Public Administration* 86 (2): 465-482.

Van der Wal, Z., G. de Graaf and A. Lawton (2011). Editorial. Competing values in public management: an introduction to the symposium issue. *Public Management Review* 13 (3): 331-341.

Van Wart, M. (1998). *Changing public sector values*. New York and London: Garland Publishing Inc.

Verbeek, H., E. van Rossum, S. M. G. Zwakhalen, G. I. J. M. Kempen and J. P. H. Hamers (2009). Small, homelike care environments for older people with dementia: a literature review. *International Psychogeriatrics* 21 (2): 252-64.

Weihe, G. (2008). Public-private partnerships and public-private value trade-offs. *Public Money & Management* 28 (3): 153-158.

Von Wright, G. H. (1972). *The varieties of goodness*. New York and London: Routledge and The Humanities Press.

Appendix A: details of interviews and observations

Interviews with middle managers			Interviews with executives	
Gender	*Interview length*	*Organization*	*Gender*	*Interview length*
Female	1h 16m	A	Male	1h 22m
Female	1h 59m	A	Male	53m
Female	1h 1m	A	Male	56m
Female	1h 4m	A	Male	1h 16m
Female	1h 39m	A	Male	1h 13m
Female	1h 10m	A	Male	1h 35m
Male	1h 28m	B	Female	1h 9m
Female	1h 24m	B	Male	1h 2m
Female	1h 43m	C	Female	36m
Female	1h 24m	C	Male	52m
Female	1h 48m	C	Male	1h 1m
Female	2h 9m	C	Male	1h 17m
Male	51m	D	Male	1h 1m
Female	52m	D		
Male	1h 8m	E		
Female	2h 4m	F		

Location of observations	Activities
Small-scale homes and organizational offices	Observations of team meetings with care workers, client meetings; meetings with clients' relatives
Small-scale homes	Participation in daily activities of clients (e.g. drinking coffee and having dinner)
Headquarters of the organization	Observations of meetings with fellow middle managers; meetings with architects (to develop new living facilities)
Offices of middle managers	Observations of telephone calls and informal talks with colleagues and care workers
Cars of middle managers	Traveling to clients' living facilities

Chapter 4

Professional talk: how middle managers frame care workers as professionals

Published ahead of print as:

Oldenhof, L., A. Stoopendaal and K. Putters (2013). Professional talk: how middle managers frame care workers as professionals. *Health Care Analysis*
DOI 10.1007/s10728-013-0269-9

Abstract

This paper examines how middle managers in the long term care sector use the discourse of professionalism to create 'appropriate' work conduct of care workers. Using Watson's concept of *professional talk*, we study how managers in their daily work talk about professionalism of vocationally skilled care workers. Based on observations and recordings of mundane conversations by middle managers, we found 4 different professional talks that co-exist: 1) appropriate looks and conduct, 2) reflectivity about personal values and 'good' care, 3) methodical work methods, 4) competencies. Jointly, these professional talks constitute an important discursive resource for middle managers to facilitate change on the work floor. Change involves the reconfiguration of care work and different managerial-worker relations. Middle managers use professional talks in both enabling and disenabling ways vis-à-vis care workers. Based on these findings, we suggest a more nuanced portrayal of the relationship between managers and professionals. Rather than being based on an intrinsic opposition, i.e. 'managers versus professionals', this relationship is flexibly reconstructed via professional talk.

Key words: professional talk, middle managers, vocational care workers, long term care, professionalism.

Introduction

Conventionally, the notion of professionalism has been reserved for 'classic' occupations, such as medical doctors and judges (Evetts 2003). Increasingly however, professionalism is applied in a much more liberal sense (Wilenski 1964; Alvesson 1994; Fournier 1999; Lilleker and Negrine 2002; Watson 2003; Evetts 2003; Noordegraaf 2007). Already in 1964, Wilenski asked the question whether 'everyone was being professionalized?' (Wilensky 1964). He observed that even 'barbers, bellboys, bootblacks, and taxi-drivers' were 'easily professionalized', 'or so it appears' (ibid, p. 138). Nevertheless, Wilenski concluded that these new occupations were not professional in any objective sense. According to Wilenski, the 'professionalization of everyone' was -in the end- a 'bit of sociological romance', as 'many occupations which aspire to become professional are in organizational contexts that threaten autonomy and the service ideal' (ibid, p. 156). In this view, the label of professionalism was just reserved for a happy few.

Since Wilenski, less exclusive views on professionalism have been developed (Grey 1998; Fournier 1999; Watson 2003; Evetts 2003; Evetts 2006; Iedema et al. 2004; Thomas and Hewitt 2011). For example, Fournier (1999) and Watson (2003) no longer consider professionalism as an inherent and exclusive feature of classic occupations. They both argue that professionalism is a specific discourse that can be drawn upon by various occupations: both old (e.g. medicine and law) and new (e.g. healthcare management, social work, nursing, accountancy). As a discourse, professionalism can be instrumentally used to achieve occupational change and shape identities on the work floor (Watson 2003; Evetts 2003; Evetts 2006; Thomas and Hewitt 2011). While this discursive view on professionalism widens the scope of occupational groups that can be researched, Evetts nevertheless remarks that: 'The use of the discourse of professionalism in other occupational contexts is seldom addressed, however, yet it is this, which is providing a much more interesting challenge to social scientists.' (Evetts 2003: p. 22-23). In a similar vein, Noordegraaf notes that it is necessary to investigate new forms of professionalism in addition to the classic professions (Noordegraaf 2007; ibid 2011).

In this article, we aim to fill in the current gap about the discursive use of professionalism in other occupational domains. We use Watson's concept of 'professional talk' (2003) to investigate how managers *talk* about professionalism of vocationally skilled care workers who have received little formal education compared to classic professionals. Moreover, we research how managers use the discourse of professionalism to achieve change on the work floor. In literature, there is an increasing acknowledgement that managers utilize professional discourse to align the behaviour of practitioners to organizational targets and New Public Management reforms (Muzio and Kirkpatrick 2011; Evetts 2003; 2006; 2009). In this view, managers are often portrayed as the ones in control, imposing professional reform 'from above', whereas practitioners are seen as victims (Evetts 2006; see for a critique of this portrayal Noordegraaf 2011). Interestingly, the option that managers may use professional discourse in enabling and empowering ways remains unexplored. In this paper we openly investigate *how* middle managers actually engage in professional talk and to what effect. By adopting a linguistic approach to professionalism, we build on existing studies about professionalism as a discourse (Grey 1998; Fournier

1999; Watson 2003; Evetts 2003; 2006; 2009; 2011;Thomas and Hewitt 2011), but aim to take the debate forward. As Thomas and Hewitt have recently noted (2011, p. 1374): 'there is a need to get beyond the abstract Foucauldian notion of discourse (Fairclough, 1992; Foucault, 1972) and to investigate concrete instances of discursive practice in this context (Iedema et al., 2003)'. We claim that Watson's concept of 'professional talk' is particularly suitable to do so, since it focuses on mundane conversations about professionalism *in situ*.

Our empirical analysis is based on an ethnographic study of middle managers in a Dutch organization that provides care to people with mental and/or physical disabilities. Middle managers can be considered important framing actors with regards to professionalism, because they are positioned above the work floor and carry responsibilities for supervising and coaching care workers (Elshout 2006; Birken et al. 2012; Oldenhof 2012). Using the method of shadowing (Czarniawska 2007), we observed how middle managers in their daily work talked about professionalism of vocationally trained care workers and used professional discourse to reconfigure care work and managerial-worker relations. The care workers in our study have received little formal education compared to more classically trained doctors and nurses in hospital settings. The majority of care workers have received some form of vocational training: either internally within their own organization – via short training courses – or externally in vocational institutes that educate care assistant and support workers. Despite a relative short time span of educational training, care workers in long term care are expected to cope with complex demands on the work floor (RVZ 2009). In addition to performing daily care activities (e.g. assisting with bathing, dressing, eating), they are encouraged to enact new philosophies of care, such as client centered and demand based care, and are increasingly held responsible for administrative matters and prudential use of financial resources (Stone and Harahan 2009; RVZ 2009). This complex work has to be carried out in less than ideal circumstances due to increasing staff shortages (Hussein and Manthorpe 2005). The Dutch Healthcare Inspectorate has noted severe quantitative staff shortages in the disability sector that threaten the quality and continuity of care (IGZ 2007). In addition, the Inspectorate suggests that the quality of personnel often lags behind. Care organizations are urged by the Inspectorate to invest in the professionalization of their workers via means of further education and courses (ibid.).

We suggest in this paper that the performance of complex care work may not only be facilitated by formal means of education, but also by mundane professionalization projects that are instigated by middle managers. To guide our analysis, we have formulated two central research questions:

1. *How do middle managers talk about professionalism of care workers in their daily work?*

2. *How do commonly used notions of professionalism by middle managers reconfigure*
   1. *the content of daily care work?*
   2. *relations between middle managers and care workers?*

The article consists of five sections. First, we briefly discuss discursive studies on professionalism and outline some gaps in literature. Second, we explain Watson's concept of professional talk in more detail and demonstrate how a micro-analysis of discursive action can add to the existing debate on professionalism. Third, in the methods section we introduce the research site and explain how we used ethnographic methods to obtain and analyze data. Fourth, in the results section we describe four different 'professional talks' that middle managers frequently use vis-à-vis care workers. We also outline the main consequences of these talks for the content of care work and relations between middle managers and care workers. Fifth, we offer a discussion and conclusion in which we further reflect on the theoretical and societal relevance of our study.

Professionalism as a discourse

The discourse of professionalism is increasingly used in new occupational domains (see for example Grey's study 1998 for the accountancy sector; and Fournier's study 1999 for commercial business), in everyday speech (Watson 2003) and in policy debates between government and professional workers (Evetts 2006). In trying to account for the recent appeal of professionalism, authors provide several explanations. Evetts (2006), for example, argues that the discourse of professionalism provides means for governments and service organizations to achieve desired organizational change. According to Evetts (2006), the discourse of professionalism is often imposed 'from above' by managers of service organizations to make employees more budget-aware, target-driven, and entrepreneurial, in line with New Public Management ideology. She furthermore argues that professionalism can be a danger in disguise: it is initially welcomed by practitioners as a way to improve their status and autonomy, but in the end practitioners are controlled and limited in exercising discretion, judgment, and service ethic (Evetts 2011). So, despite its friendly appeal, professional discourse can have paradoxical effects (Muzio and Kirkpatrick 2011).

A different explanation for the popularity of professional discourse is given by Watson (2003), who argues that occupational groups are not necessarily victims, but in fact strategically use professionalism as a bandwagon idea to further their own interests (e.g. status enhancement, increased autonomy and pay raise). Similarly, several management studies show how managers conveniently copy the discourse of professionalism and its associated features -educational titles, regulatory bodies and codes- in order to shape their identity along the image of the classic professions and subsequently attain legitimacy (Mintzberg 2004; Davies 2006; Noordegraaf 2007;Noordegraaf en Van der Meulen 2008; Kipping 2011).

A yet alternative perspective on discursive use of professionalism is provided by Fournier (1999), who argues that the label of professionalism is not only useful internally – within occupational groups – but also externally, as a marketing device that attracts new business and customers. Using Foucault, she additionally demonstrates how the discourse of professionalism can be used as a disciplinary mechanism to create appropriate work conduct of employees. Rather than being imposed from

'above', professional discourse in the form of the self-actualizing employee and client centeredness are internalized by employees, who then steer themselves. This implies that it is no longer necessary for government and organizations to use direct control or domination to achieve 'desired' change. Instead, they can govern 'from a distance' (ibid.).

Interestingly, Thomas and Hewitt (2011) have noted that many studies on professionalism operationalize 'discourse' in a Foucauldian way (Grey 1998; Fournier 1999; Waring 2007; Evetts 2006 and 2011). Similar to Foucault, authors describe different *macro* discourses such 'professional' and 'managerial', 'medical' and 'client' (see for a good example Fournier 1999). These Foucauldian inspired studies offer valuable insights about changing attitudes towards public service provision and the influence of New Public Management, but according to Thomas and Hewitt (2011) there is a need to go beyond abstract Foucauldian discourse. They argue that little attention has been paid to more narrow conceptions of discourse, focusing on linguistic aspects, such as daily conversations *in situ*. A notable exception is the linguistically based discourse study by Iedema et al (2004). On the basis of daily conversations in an Australian hospital, Iedema et al show how one medical doctor with managerial responsibilities strategically tries to balance competing demands at the professional-organizational intersection (ibid). The doctor-manager sometimes mirrors the talk of more skeptical doctors regarding financial and regulatory limits to their medical work, but simultaneously aligns with managerial demands and policies (ibid.). As this study demonstrates, a textual analysis of talk can contribute to a better understanding of how practitioners engage in the intricate game of constructing professional discourse.

Professional talk by managers

In this article, we further build on a linguistic approach to discourse but take it a step forward by empirically researching the concept of 'professional talk', that was introduced by Watson in a critical review of studies on professionalism in 2003 (Watson 2003). As previous discursive studies have demonstrated, the notion of professionalism is far from neutral and has been strategically used by occupational groups, public service organizations and governments. Watson therefore argues that the concept of professionalism should not be carried over into the analytical work of scientists as they may inadvertently promote interests of certain occupations by calling them 'professional' (ibid.). Taking a more critical stand, researchers should instead make 'professional talk' a topic of scientific inquiry. By researching 'the way members of certain occupational groups utilize notions of professionalism to achieve certain purposes' (ibid. 2003, p. 94), it becomes possible to show *how* professionalism is used as a 'discursive resource' and to what effect. To our knowledge, the concept of professional talk has not been specifically investigated by other authors. Yet, we feel that an empirical investigation of professional talk could make a valuable contribution to existing discursive studies of professionalism for several reasons.

First, the focus on *talk* about professionalism in a specific organizational setting nicely ties in with a linguistic and contextual conception of discourse analysis

that Thomas and Hewitt have called for (2011). Second, a study of professional talk enables the analysis of *different discourses* of professionalism as opposed to assuming that there is just one unified professional discourse that is shared by everyone. By exploring the multiplicity of professional talks, we are able to investigate how different professional talks add up and come together (Mol and Law 2002). A micro-study of discourse can furthermore contribute to existing macro-oriented studies that compare Grand discourses (e.g. 'managerial', 'professional', 'medical', 'economic', and 'organizational'). Third, there is an increasing acknowledgement that managers instrumentally use professional discourse to normatively steer practitioners into adopting organizational goals (Muzio and Kirkpatrick 2011), but it seems that the role of managers in this is largely appreciated negatively, in terms of encroachment, manipulation and cajolement. For example, Evetts argues that 'professionalism is being used as an ideology and a discourse to convince, cajole and persuade employees, practitioners and other workers to perform and behave in ways which the organization or the institution deem to be appropriate, effective and efficient.' (Evetts 2003: p. 31). The possibility that managers use professional discourse in empowering and enabling ways remains unexplored. It is therefore fruitful to openly investigate how managers actually engage in professional talk and whether this enables and/or disenables practitioners in exercising their work. Fourth, we argue that current portrayals of management are often too generic and consequently provide little insights into managerial practices. For that reason, we zoom in on a particular layer of management, that is middle management. Due to its close position to both the work floor and higher management, middle management can be considered a centrifugal meeting point of different views on professionalisms: from the work floor, higher management, and HRM departments. Yet, middle managers also develop their own views about professionalism of care workers, which we will further investigate in this article.

Finally, it is necessary to provide a few explanatory remarks about the way we operationalize professional talk. When adopting a narrow conception of discourse, professional talk could be seen as a purely textual matter with no reach beyond the spoken language itself. In that case, there would be no connection between talk on the one hand and the framing of cognition and behaviour on the other hand. However, in line with Austin (1978, second edition), Watson (2003),Czarniawska (2008) and Mesman (2008), we argue that language not only concerns itself with sentences, but also embodies action, frames attitudes, and has certain performative effects. As Austin demonstrated, uttering sentences like 'I do (sc. take this woman to be my lawful wedded wife)' or 'I name this ship the Queen Elizabeth' are part of *performing* an action (1978; p. 5). Apart from instigating action, talk can serve other functions like providing information, expressing feelings and regulating professional identities (Alvesson 1994). In this article, we similarly assume that professional talk of middle managers is not just descriptive in nature, but has certain performative and regulative effects: it can potentially reconfigure the content of care work and change relations between middle managers and care workers. While assuming a coupling between talk and action, we are aware of the fact that talk is transient and doesn't alter attitudes in permanent ways (Iedema et al 2004). Nonetheless, we reason that a study of professional talk provides relevant insights into how managers at least *attempt* to change shop floor practices, sometimes achieving long-term change while in other times just making a small dent.

Methods

Methodology and context

In order to understand the mundane, day-to-day aspects of managing in the long term care sector, we opted for ethnographic methods. Our main data collection method was 'shadowing': a method that is particularly suitable for the in-depth study of organizational practices (Czarniawska 2007; Ybema et al. 2009). In our research, we followed middle managers in their regular work day. Middle managers are positioned between the work floor and higher management and carry first-line responsibilities for supervising care workers and managing finances and quality of care (Elshout 2006; Oldenhof and Putters 2011; Birken et al.2012; Birken et al. 2013). Due to their lynchpin position, middle managers are claimed to be key strategic players in organizations (Dopson and Fitzgerald 2006; Currie 2000; Floyd and Wooldridge 1997), but there is still little knowledge about the mundane aspects of managerial work that is performed 'in the middle'. In line with existing behavioural management studies (Mintzberg 1973; Kotter 1986; Noordegraaf 2000; Stoopendaal 2008; Arman et al. 2009), we did not predefine the work of middle managers in terms of what they *should do* according to their job description (e.g. coaching care workers), but observed what they actually *do* during their workday. Managerial behaviour not only included activities and bodily movements, but also daily talk of middle managers, which is the main focus in this article. We should mention that at the outset of our research we were not primarily focused on the professionalization of care workers via managerial talk. This theme gradually emerged during our observations and it was decided to develop this topic further in a separate article.

The research was conducted in a Dutch organization that provides care to clients with mental and/or physical disabilities. In order to guarantee the anonymity of the research subjects, this organization is from now on referred to as 'Zinta'(a fictional name). An important organizational aim of Zinta is to provide client-centered support and small-scale living facilities in residential neighbourhood. Underlying ideals behind this aim are the inclusion of clients into society and self-determination of clients. These ideals emanate from a broader deinstitutionalization process in the long term care sector that critiques large-scale 'total institutions' (see Goffman 1991, reprint) and favours philosophies of community based care (Van Loon and Van Hove 2001).

Due to the decentralized set-up of Zinta in different neighbourhoods, care workers are expected to work independently in teams. Most care workers at Zinta are vocationally trained: either by a regional education institute and/or internally at Zinta via short courses. A minority has received more extensive education at higher education institutes or universities, but this remains an exception. In care teams there are different functions, ranging from cleaners to personal supervisors 1, 2, 3 (going up in level), and care coordinators. The distribution of care work is primarily determined by function: for example, care coordinators usually perform coordinating work (e.g. personnel scheduling), whereas personal supervisors are responsible for supporting clients in their day-to-day routines. Generally, supervisors at level 3 are

expected to keep up client records and administration, whereas supervisors 1 are more involved in physical support and hands-on tasks. Middle managers have to manage several teams of care workers, ranging from approximately 20 to 70 care workers. Because teams are geographically dispersed in neighbourhoods, middle managers frequently have to travel and cannot be physically present on the work floor as much as they would like to be. Consequently, care coordinators perform part of the supervisory tasks of middle managers on location.

Data selection, collection and analysis

During the period November 2009 until May 2012, we shadowed 7 middle managers of Zinta in their workday. The initial contact with 3 middle managers was facilitated by the executive of Zinta and these managers subsequently agreed to be shadowed. In order to avoid bias towards managers that were 'in favour' with the executive, we selected 4 additional managers via the method of snowballing (Noy 2008). All 7 middle managers had worked previously as care workers themselves before becoming manager.

Daily conversations were recorded on tape recorderand extensive field notes were made both during and after observations (in total: 21 days of observation). Observations included various activities, ranging from formal team meetings, coaching sessions with care workers, job interviews, job evaluations, and training days for middle management to informal chats with clients and care workers. During observations, we conducted various informal interviews with middle managers and care workers. These interviews -varying from 5 minute chats to conversations of more than an hour- allowed us to explore the different meanings actors attributed to the observed events and more specifically the meaning of professionalism in situ. In addition to shadowing managers, we observed and made field notes of organizational meetings that related to professionalism in a broad sense, such as organizational vision days and middle management days.

During shadowing, middle managers frequently used the vocabulary of 'professionalism' and derivatives such as 'unprofessional' and 'professional'. They referred to professionalism generally, when mentioning professional work culture, but also in more specific sense, when talking about the attitude and conduct of specific employees. Furthermore, we noticed that the vocabulary of professionalism was not only used by middle managers, but also by care workers and higher management. For example, the executive of Zinta (who used to be a care giver himself), had published an educational book about 'professional' support. In this book, several requirements of professionalism were outlined, such as sufficient educational background, reflective behaviour of care workers, and methodical work methods.

Although the topic of professionalism was not our initial research focus, we were able to gather rich data on the use of professional discourse. These data primarily reflect the view of middle managers on professionalism of care workers, since they were our primary research subjects. A limitation of our study is that we could not fully explore the diverse opinions of care workers on professionalism. The presence

of managers may sometimes have inhibited care workers to express themselves freely when asked questions by the researcher. Furthermore, large team meetings did not always provide opportunities to separately question care workers about their function or views. Nevertheless, the managerial views on professionalism in the results section can to some extent be considered co-produced because managers interacted with care workers when expressing them and care workers provided reactions in response.

To increase the validity of our findings, we triangulated observational data with semi-structured interviews with managers that were included for observation as well as non-observed managers, among which one higher manager (in total: 5 transcribed interviews). These semi-structured interviews provided additional information about dilemmas of middle management with regards to professionalizing care workers, such as a lack of time to coach care workers face-to-face and the gap between the desired professional competencies of care workers and their actual competencies. To accomplish further triangulation, we analyzed organizational documents, such as the organizational vision on professional care and a document describing the desired functions and competencies in teams. These documents provided a 'formal view' on professionalism, which we contrasted with our observational data and interviews in order to understand how policies were translated to the work floor.

During the analysis of our data, all linguistic references to professionalism (spoken and written) were selected from the data, including 'professional', 'unprofessional' and 'profession'. We then inductively coded the references into overarching themes, which represent the different 'professional talks' that middle managers frequently used vis-à-vis care workers. Finally, we coded the main consequences of professional talks in terms of changing work content and relations between middle managers and care workers.

Results

On the basis of our analysis, 4 different professional talks can be identified: 1) appropriate looks and conduct, 2) reflectivity about personal values and 'good' care, 3) methodical work methods, 4) competencies. We then demonstrate that professional talks are not just rhetorical, but reconfigure care work and relations between care workers and middle managers.

Professional talk 1: appropriate looks and conduct

Middle managers strongly linked professionalism of care workers to outward appearance. Care workers were expected to 'look' professional when they interacted face-to-face with clients or their relatives. To phrase it in dramaturgical terms of Goffman (1990), a professional 'front stage performance' was required for 'audience'. Given

the fact that there were no organizational regulations regarding the use of uniforms, there was room for debate about what constituted 'proper' clothing. As becomes clear from the following quote of a middle manager (MM 1), skimpy and revealing clothing, such as shirts that showed belly buttons, were clearly considered unprofessional, but shorts and a vest in summer were a matter of debate:

> 'For example in summer: what clothes should employees wear? That's always….I have an employee who is rather sturdy. And if she wears shorts and a vest, it doesn't look very appetizing, to put it like that. Whereas if another employee wears a short and a vest, than I think: ok, that will do. So I sometimes say to this one employee, you know, you can't wear that (…). But you have to be careful not to hurt somebody's feelings. Because if someone is a bit fat, they can't really help it (…). So, one talks about these things, like what kind of clothing you can wear, and what kind of clothing you don't wear. With belly button shirts, I really think that is not appropriate. Well, now you don't see them that often (belly button shirts, LO), but there was a period when you saw a lot of belly button shirt. Yes! Those young supervisors who came to work with belly button shirts. Well, in the meantime those boys of 17, 18, 19, had a lot of hormones razing through their bodies, and when they also had a supervisor who was dressed like that, that didn't work.' (MM 1)

Due to the lack of official clothing rules, some middle managers developed general 'rules of thumb'. During a personnel meeting, which was attended by a group of middle managers, we observed that middle managers jokingly referred to skimpy clothing of care workers, but at the same time tried to develop rules of thumb, such as 'show no cracks' (MM2). Also, more concrete rules were proposed. One middle manager (MM3) suggested that temporary workers, who often worked at different locations, should wear red polo-shirts with the organizational logo and name tags. This way it could be made clear to clients, especially the ones with memory dysfunction, that they received assistance from 'professional' workers. Also, some middle managers strongly disapproved of the fact that care workers wore key-cords at work, with logos of well-known beer manufactures like Heineken. This was seen as unprofessional and it was argued that these accessories should not be allowed at work.

'Professional looks' are dependent on the setting and décor in which care workers perform their work. Because of the various services that were provided by care organization Zinta, care workers operated in different settings. Most worked in small scale care homes of Zinta, which were based in the neighbourhood, whereas others worked in private settings, at the client's home. Again others were hired on the basis of a client's individual budget to accompany the client to outdoor leisure activities. Especially in the last instance, it was not always a clear cut what care workers should wear.

During our observations, a particular case of 'proper clothing and conduct' was discussed extensively by a middle manager (MM3) and her colleagues. A female temporary worker of Zinta was asked by a male client to accompany him to a sauna visit, because he needed help with undressing due to his physical disabilities. The care worker was paid by client's individual budget (which the client can spend how

he sees fit). During the sauna visit, the care worker not only assisted the client in undressing, but also undressed herself and participated naked, like her client, in all sauna activities. Afterwards, the client bragged about the fact that he had seen this particular care worker naked to other clients and colleagues of the care worker. This caused considerable upset in the team, as most care workers were afraid that they would also have to accompany clients to sauna visits themselves. Due to the team gossip, a care coordinator and the middle manager were alerted about this event, but were initially unsure how to react. They then jointly discussed 'the sauna case' with an employee of the head office, who was known for her expertise about rule of conduct and the rights of handicapped people. During this discussion, it was agreed upon that the lack of clothing was 'unprofessional' and could elicit suspicions about sexually inappropriate conduct, despite the honest intentions of the care worker. In the following quote, the concerned middle manager describes how the sauna trajectory *should* have proceeded in a professional way:

> 'It's an interesting case. The client has a wish, which we are going to investigate: how are we going to realize that whish? So, we go to the sauna in Patersbos [fictional name], because that is around the corner. En then we can ask, well, is there someone who can assist him voluntarily? Or… a care worker accompanies the client to the sauna, and puts on a bathrobe, and assist the client with his undressing, and keeps on the bathrobe. And she can stay in the dressing room reading a book or sit at the bar drinking coffee. And she helps the client when she is called for. Those are the two options, but not going to the sauna all in the nude (…). And Y said [employee of the head office] that this doesn't fit with the professional framework, that there are risks involved in creating an uncomfortable situation with sexuality and all, you really have to avoid that, it's an undesirable situation. Interviewer: so what is the professional framework? MM3: The professional framework is that as a care provider you deliver professional assistance, and in my opinion it is not professional to sit next to your client stark naked enjoying a fun experience. Because the profession consists of the fact that you help your client realize his dream, in this case a sauna visit, and that you can do perfectly well with you bathrobe on.' (MM3)

As becomes clear from the quote, 'the professional framework', was not so much 'in place' already (e.g. an existent set of rules/protocols) but was an emerging set of opinions that was checked with peer colleagues and then externally presented as 'the professional framework' towards care workers and clients. Interestingly, this middle manager also made a distinction between different forms of professionalism: the client in question was in fact known for regularly using the 'professional' services of call girls, but this was to be clearly distinguished from the 'professional' services of care organization Zinta. This could furthermore explain why the 'sauna case' was perceived as a very sensitive matter and why considerable efforts were invested in (re) establishing the 'professional' image of Zinta as a care organization.

As the sauna case demonstrates, a professional front stage performance was not just restricted to looks, but also required the 'proper' conduct of care workers. Generally speaking, appropriate conduct involved the use of 'the right' language (how things are said). Middle managers concerned themselves repeatedly with the way care workers talked to clients. For example, they tried to sensitize care workers not to use the plural 'we' in their conversations, when actions only concerned the client. During a meeting of a client council, a middle manager promised to clients that care workers (who were also present at the meeting), were 'professional' enough not to say 'have we enjoyed showering?' (MM3). The use of negative words was also frowned upon, especially when these words didn't portray a truthful picture of the client. In an interview, a middle manager (MM1) described an incident with a care worker who had remarked during a team meeting that one particular client 'was manipulating things'. According to the middle manager, the client was simply unable to manipulate things: due to mental disabilities, the client had the intelligence of a 3 or 4 year old, despite being 18 years old. Consequently, by focusing on the abilities of the client, this middle manager claimed to have corrected and adjusted the language of care workers: 'When they say it here [in a team meeting], I can frame it in other ways, but when they call things like that (manipulate) on the street, or towards parents, then you have a different situation.' (MM1). Hence, 'backstage' settings like team meetings, provide important opportunities for middle managers to steer the conduct of care workers in certain ways, so that on the 'frontstage' care workers can behave 'professionally' (at least, in the eyes of middle managers).

Not only the use of words (*how* things are said), but also the content of conversations (*what* is said) was paid special attention to. Several middle managers remarked that care workers should be aware that conversations between colleagues could be overheard by clients (MM 2 and 3). Especially criticisms about the organization or the discussion of privacy sensitive information about clients, were deemed inappropriate in front of clients. Some managers remarked that, due to gossiping by care workers, clients picked up information and started repeating what they had heard, for example that at certain locations clients always receive 'too little food' (MM 3).

Middle managers also discouraged care workers to provide too much information about their personal life with clients. Care workers were advised to keep their professional distance. Sharing your personal life or troubles in detail with clients, was seen as unprofessional, even when client's asked explicit questions:

> 'You have an exemplary function. So, this one employee, who already has received a warning previously, she for example said to clients: "yes, I am going out in the weekend, dancing on bars". Well you know, even when you do that, you are not supposed to tell that to clients. And clients also ask supervisors: "have you smoked grass"? I always say [to care workers]: even if you have done so, you are not supposed to have a conversation about that. The only thing you are supposed to say is: "that's not the question, we are going to focus on you". (...). As a supervisor you have to be professional, you know: you have a different conservation with friends than with clients. With friends you discuss your relationship, but with clients you don't discuss your relationship (...). And sometimes it's a real

burden for clients, because they say: "I won't ask too much from my supervisor, because she already has so much trouble". Well, then you really have crossed the line of professional behaviour.' (MM1)

Professional talk 2: reflectivity about personal values and 'good care'

Being reflective about what constitutes 'good care' was viewed as an essential element of professionalism. Middle managers encouraged care workers not to judge 'good care' according to their own standards. Critical reflection about one's own values and norms, and how they implicitly influenced the provision of care, was seen as a professional thing to do. During team meetings, middle managers and care coordinators asked care workers to reflect about their own views and how these influenced the provision of care and the establishment of taken-for-granted rules. The following two descriptions of team meetings show how critical reflection is being enacted in practice:

> A middle manager has organized a Socratic dialogue for all care workers (a group of approximately 25 workers). The Socratic dialogue is meant to stimulate reflection about the meaning of 'good care' by asking open questions, without offering practical solutions. During the dialogue, a care coordinator discusses how care workers create a 'homely' feel at living locations for clients. She poses a question in order to generate discussion: 'which role do supervisors play at location de Berg (fictional name) in creating a homely feel?' A care worker responds: 'well, a big role actually. I always take my own norms and values as a starting point. I used to get a cookie and tea from my mother when I came home from school. So, when clients return home I do the same. It's a nice moment for them to relax'. The care coordinator responds by saying: 'but do clients always want a cookie? Also, you have to think about the fact that every care worker has his or her own norms and values, is that a good thing for clients?' (MM5)

> During a team meeting, a young male care worker, who wears an informal hoodie, indicates that he wants to discuss a client which he supervises. He describes the client: 'Peter (fictional client's name) always wants physical contact. He grabs my hand and presses it against his face. He likes to cuddle. Well, I don't mind, I like cuddling myself too'. The middle manager responds by slightly leaning forward and asking a critical question: 'so, just to capture your story, as a supervisor you make yourself available for physical contact. But you have to think carefully whether it is good to cuddle with the client all the time. The question is not so much whether you want to cuddle, but whether Peter likes that. Is that really the case?' Care worker: 'well, he wants to grab your hand. It gives him a

> sense of security. But sometimes I invite him to cuddle too (...)'. The middle manager stays quiet for a few seconds and seems to disapprove of the situation. Then he carefully formulates a response: 'look, we all have to watch out that Peter is not being cuddled all day long. Because cuddles make a really big impression on him, he is very vulnerable. It is not really professional to let your own needs for cuddling guide the care provision.' (MM6)

In these two conversations the middle manager and the care coordinator create an opposition between personal values and needs of care workers on the one hand and 'professionalism' on the other hand. Personal values and norms were seen as a 'stand-in-the-way' of professional care provision, especially when care workers did not critically reflect upon them.

Rather than letting personal values guide the care provision, middle managers encouraged care workers to prioritize client's needs and wishes. 'Good care' was often equated with 'client-centered care', in which the client was in the lead. This also fitted in with the organizational vision of Zinta, which promoted 'client-centered care' and 'client choice' as important organizational values. Yet in practice, care workers experienced difficulties in articulating and implementing client choice, especially when clients could not oversee the consequences of their own choices (e.g. pregnancy):

> 'It's difficult. I often want to send clients [who want to become pregnant] to the doctor, so that they can get anti-conception. I want to say: don't get pregnant! (...). With these things [pregnancy and drug use], client choice is a difficult principle' (care worker)

By jointly discussing the limits and possibilities of client choice, care workers and middle managers tried to grasp what good care is about. According to some middle managers, care workers were not always able to critically reflect on client choice:

> 'They often interpret the organizational vision literally. According to the vision, clients should have the freedom to choose. Then they just say to clients: "your wish is X, well we are going to do X". Your wish is our command. But that is not professional care. I would like care workers to engage in a conversation with clients, discussing the advantages and disadvantages of choices. For example, when a client from a Christian background wants a tattoo, care workers should not just say: "ok, we are going to do that, because that is your wish". No, they should, for example, point out that the client's parents might not appreciate it. The client can still make his own choice, but you have thought about the consequences of a choice together.' (MM5)

Enacting 'good care' not only entailed critical reflection about client choice in particular, but also included reflection in general about different forms of good care, so called 'varieties of goodness' (Wright 1972; Willems and Pols 2010; Mol, Moser and Pols ed. 2010). Good care can be based on client choice, but can also be 'safe', 'protocolized'

or 'affordable' (Willems and Pols 2010). Middle managers encouraged care workers to take into account these different forms of good care, rather than just focusing on one. We observed that managers and care workers alike were confronted with tensions between different forms of good care. For example, highly protocolized care could lead to more safety for clients, but sometimes excluded client choice. These tensions manifested themselves in daily care practices and required reflective behaviour of both care workers and middle managers.

During one team meeting, care workers and a middle manager discussed the use of protocols. Due to aggressive behaviour of a severely handicapped client during meals, a protocol had been drawn up by care workers. This protocol had to be followed by care workers during every meal. The protocol specified that the client could choose the amount of sandwiches he wanted to eat. It also specified that the client could only show three signs of aggressive behaviour. Throwing food and hitting a care worker counted as signs of aggression. After three signs of aggression, the meal of the client would be ended. When this protocol was discussed during a team meeting, care workers agreed that it had created more'structure' during meals, and had increased safety, not only of the client, but also of other clients and care workers. The middle manager agreed that the protocol had indeed increased safety, but questioned whether too strict an implementation of the protocol would exclude client choice:

> 'You want to create safety during lunch by standardizing, but what if Jan [fictional name client] wants to drink, and that option is not included in the protocol?' A care worker provides a solution: 'then we can include the option "drinking" in the protocol. The care coordinator starts laughing and remarks: 'but then we start working according to scripts, that is not really what we want'. The middle manager agrees: 'that's right, we want to create more structure and safety with the protocol, but now it's too strict, whereas our vision is that we want to be responsive to client's needs. In this specific situation, it [the protocol] may work and Jan can learn. But after a few weeks, we can maybe work more loosely.' (MM6)

Hence, reflective behavior about different forms of good care ('safe care'/ 'care that enables choice') and how they could be combined in daily care practices, was actively encouraged by middle managers and seen as part of professional behaviour.

Professional talk 3: methodical work methods

Another professional talk concerned the adoption of methodical work methods: i.e. working with individual Support Plans. In the Netherlands, care organizations are obliged to draw up a Support Plan for each client. Support Plans are organizational devices that are used to arrange support and care according to client's wishes (Van Loon and Zuiderent-Jerak 2012). Simultaneously, a Support Plan functions as a mechanism for managing demand (Grit & Bont 2010). It defines the type and amount

of support that clients are entitled to but also makes clear the limits of support that healthcare organizations can provide (ibid.). For example, a Support Plan can stipulate how many minutes per day clients receive assistance with showering or meals. Additionally, the Support Plan describes learning goals that client's want to achieve in different domains such as well-being and participation. Typical examples of learning goals for clients with disabilities are finding a part-time job, making friends, learning certain social skills, or doing groceries independently.

At Zinta, working 'methodically' with Support Plans was a 'hot issue' since the organization had received a warning by the Dutch Healthcare Inspectorate. As part of an improvement trajectory, Zinta had to guarantee that Support Plans were up-to-date and integrated in the daily work routines of care workers. Care workers were expected to formulate learning goals together with clients (e.g. participation in society via voluntary work, development of social skills, management of personal finances, etc.) and had to report on achievement of these goals or lack of progress. Middle managers frequently reminded care workers to update the Support Plan when changes occurred in the client's situation. This way, Zinta could be accountable to the Inspectorate. In the following quote, a middle manager contrasts a methodical work approach with unprofessional behaviour:

> 'When I started working at Zinta I was really surprised about the lack of methodical working, the way reports were written, that wasn't professional. For example, then you had a portfolio, with a few papers in it on which employees had written a story. I have really tried to change that. Also the way team meetings were conducted: 3 hours on end people were talking freely, without a red line, "madam X has problems with her elastic bands", etc, etc... I have tried to make employees work more methodically. That means to me that you know what questions for help a client has, his back-ground, that you jointly set up developmental goals, that you evaluate whether these goals have been achieved. You work towards something.' (MM6)

Given the focus on goals, care workers were expected to frequently evaluate with clients whether learning goals had been achieved. Middle managers argued that the evaluation of these goals was a crucial part of care work:

> 'Methodically working means that care workers have to supervise and assist the client on the basis of the Support Plan. So, you can't just go shopping with the client. You need to have conversations with clients about their learning goals: have we reached these goals?' (MM5)

Via Support Plans, tacit knowledge about client support was gradually being transferred to paper, as is illustrated in the following conversation between one middle manager and a care worker:

> 'With all due respect, what is in your head you have to put down on paper in the Support Plan.' (MM7)

The transfer of tacit knowledge by means of verbal evaluation and written reports, enabled middle managers to simultaneously *reconfigure* the content of care work, as we will illustrate in §5.6.

Professional talk 4: competencies

Via professional talk about competencies, care workers were encouraged to improve themselves, that is, work on the 'project of the self' (Grey 1994). During job evaluations, team meetings and coaching sessions, middle managers stimulated care workers to critically reflect about their strengths and weaknesses and develop professional competencies. Professional competencies were primarily operationalized in terms of *social* competencies required for good team work. For example, when a care worker asserted that she had difficulties with voicing critique about colleagues' work, she was encouraged to formulate learning goals (i.e. desired competencies), such as 'becoming more assertive' or 'giving direct feedback to colleagues' (MM6).

In addition to social competencies, middle managers increasingly stressed the importance of negotiating competencies. Care workers were expected to explicitly discuss the possibilities *and* financial limitations of care provision with clients and their family members. Client linked budgets and Support Plans were used to make choices about what type and amount of care could be provided. Conversations about these choices can be difficult ones, but middle managers believed that 'professional' care workers should have the ability to conduct these conversations, even when they were of a conflictual nature:

> 'They try to avoid difficult conversations and conflicts. Then they call me: "can you solve that?" I say to them "you have to be able to conduct difficult conversations too. You have to negotiate more with the client about which care can or can't be delivered. So, if a client wants assistance with his meals, what does that imply for the rest of his support?" Care workers have to demarcate boundaries.' (MM5)

While middle managers tried to steer workers towards active self-improvement, care workers were not always willing to take up this responsibility. For example, during job evaluations we observed that care workers had not prepared themselves and openly said so, signaling to middle managers that they did not attach particular importance to the managerial image of self-improvement. In these instances, middle managers were not taken aback, but continued asking reflective questions and discussing particular cases at work, thereby trying to engage care workers in reflection.

On the one hand, self-improvement via the development of professional competencies had a benevolent character. Care workers were offered the opportunity to learn new competencies which could benefit their career. They were also supported in this by coaching trajectories and additional courses. On the other hand, self-improvement also had a disciplining character. When care workers preferred not to work on their so called 'weaknesses' or did not achieve desired competencies, they

ran the risk of being transferred to other locations or being fired. As becomes clear from the following quote of a middle manager, this disciplining function of self-improvement was actually perceived as a useful steering mechanism:

> 'You can address workers about their goals and achieved results, it's open and methodical. Working methodically is relatively new here at Zinta. First, conversations with employees were less structured. We did not put things on paper that much, there were less rules and procedures. Now, we increasingly put things on paper. So with employees I build up a dossier on the basis of job evaluations. That is necessary because when care workers keep performing unsatisfactorily, then as a clustermanager I need sufficient evidence to transfer someone to another location of Zinta.' (MM4).

Despite the fact that middle managers invested considerable time in encouraging workers to develop professional competencies, some voiced skepticism about the achievability of the 'project of the self'. According to one middle manager, conservations about strengths and weaknesses had become routinized and, consequently, care workers just performed a 'trick' and were not engaged in real self-improvement (MM5). A higher manager also mentioned that many middle managers struggled with the fact that it was difficult to 'mold' the care worker to an ideal image of the professional worker:

> 'I see clustermanagers (middle managers, LO) struggling: you want to achieve results, you start working with competency based working, you use competencies at job evaluations conversations. En you do all this based on the assumption that the worker can improve, is moldable (...). But also after 4,5,7 years that worker still has the same weaknesses, the same pitfalls, and in some respects he doesn't fit the requirements for the competencies that are necessary, but in other areas this worker is so wonderful (...).' (Higher manager)

Professional talks: reconfiguring care work & relations

Professional talks are not just rhetorical plots but embody action. They were used by middle managers as a discursive resource to achieve change in daily care practices. To illustrate this, we zoom in on one specific professional talk, namely methodical work methods. The adoption of Support Plans as a methodical work method, *foregrounds* certain aspects of care work, while backgrounding other aspects. Support Plans foreground goal-centred approaches to care work that articulate client's wishes and goals. The articulation of client's goals requires shared decision-making (what are desirable goals according to clients and are they realizable according to care workers?), the joint evaluation of client's goals, and the reporting of results in administrative systems. Hence, via professional talk about methodical work methods the content of care work is becoming less tacit and more a business of talking,

articulating, and evaluating: face-to-face and on paper. Additionally, financial choices are being incorporated into care work because the type and amount of care are specified in Support Plans. Simultaneously, the focus on Support Plans *backgrounds* other aspects of care work that may be valuable to clients. Just being physically present for clients or accompanying clients to leisure activities become 'additional' to professional care work and are increasingly viewed as a societal responsibility of family members or volunteers. Especially when these activities are not incorporated in the Support Plan, it is difficult for care workers to legitimize their time-investment.

Professional talks also reconfigured relations between middle managers and care workers in both enabling and disenabling ways. By framing care workers as 'reflective', 'competent' and 'methodically working' professionals, middle managers enabled more *autonomous decision-making* by care workers. At decentralized locations of Zinta, care workers were encouraged to independently take care of the daily organization of care (e.g. personnel scheduling, updating Support Plans, the enlistment of volunteers, solving conflicts with clients and their relatives) and reflectively tinker with different demands of good care (efficient, client-centred, safe, etc.). Simultaneously, middle managers repositioned themselves differently vis-à-vis care workers: rather than instructional leaders, they presented themselves as *coaches* that stimulated care workers in making independent decisions. In the role of coach, middle managers tried to refrain from providing direct instructions or solutions to daily problems. This was not easy however. Middle managers were frequently contacted by care workers -either by phone, face-to-face, or email- and asked for concrete advise onhow to solve daily problems at locations, such as personnel shortages and conflicts between colleagues or with clients. Middle managers differed in their response: some tried to avoid giving instructions by asking reflective questions and placing responsibility back into the domain of the care worker, whereas others did provide solutions because they felt this was needed.

We observed that care workers had to walk a fine line in making autonomous decisions and enlisting the help of middle managers, especially when organizational risks were involved. For example, when an incident with an aggressive client had the potential to escalate further or result in reputation loss of the care organization, care workers *were* supposed to contact middle managers in time. In fact, speedily reporting to middle managers was seen as the professional thing to do. Care workers thus had to make their own risk assessment every time a conflict occurred and evaluate whether their middle manager should or should not be involved. When care workers involved a middle manager too quickly, it was seen as a sign of dependency and unprofessional behaviour, whereas when they reported an incident too late, it could also be classified as unprofessional behaviour.

While the use of professional talks generally enabled more autonomous decision-making and less dependency on instructions from middle managers, we also observed that professional talks could *disenable* care workers in performing their work independently. When managers were unsatisfied with the outcome of autonomous decision making, they could cast aside decisions on the basis of managerial authority, thereby creating *ambiguity* about the desirability of independent decision-making by care workers:

> 'Look, if a care worker wants to implement a wish of a client, but as a manager, I think it is a bad idea, then it is not going to happen. In the end, I am responsible and my signature is on Support Plan.' (MM6)

Furthermore, when middle managers did not sufficiently take into account individual needs and different educational background of care workers, expectations about reflective behaviour and autonomous decision-making could backfire. Some care workers with limited educational training or work experience (e.g. new interns) felt uncomfortable making complex decision on their own and subsequently postponed decisions. They seemed to benefit from direct guidance by middle managers. In contrast, care workers with many years of work experience and/or higher educational training, generally appreciated autonomy and only needed occasional feedback from managers. Professional talks thus seemed more effective when they were tailored to individual care workers rather than being generally applied as a blueprint.

Although professional talks changed work relations in important ways, as is shown above, a radical reordering of relations between middle managers and care workers did not occur. In fact, several middle managers remarked that they had too little time to enact the role of coach properly:

> 'The most important part of my function should be the coaching of care workers. Uuuhm,well... but aside from coaching, you have to meet many, many accountability demands. Thewhole finance has to be dealt with (...). I have to take care that my locations meet firesafety and labour technical criteria. Our organization also has to meet quality criteria in order to maintain the status of certified care organization. You just don't want to know howmany lists and check-ups I need to fill in, all the red tape (...) So, I really try to balance things, but it is not easy.' (MM7)

This also had consequences for the professional development of care workers. They were expected to act as autonomous professionals, but were not always supported in actually becoming professionals.

Discussion and conclusion

We investigated how middle managers in the Dutch long term care use professionalism as a discursive resource to change the daily conduct of vocationally skilled care workers. Using Watson's concept of 'professional talk' (Watson 2003), we described four different professional talks that middle managers use in mundane conversations on the work floor: 1) appropriate looks and conduct, 2) reflectivity about personal values and 'good care', 3) methodical work methods, 4) competencies.

Professional talks are not just rhetorical, but embody action (Austin 1978, second edition; Alvesson 1994; Watson 2003; Czarniawska 2008; Mesman 2008). With the help of words, alternative care practices and different relations between managers and care workers are being performed. By framing care workers as

'reflective', 'competent' and 'methodical' professionals, middle managers enabled care workers to make autonomous decisions about the daily organization of care at decentralized locations in the neighbourhood. Simultaneously, middle managers repositioned themselves as coaches that empowered rather than instructed care workers. This repositioning did not result in a fundamental /permanent reordering of relations, as middle managers had little time to fully enact their role as coach and some care workers still expressed the need for explicit instructions from middle managers. Consequently, professional talks resulted in a *hybrid constellation of relations*, in which new forms of managerial coaching and autonomous decision-making by care workers could co-exist with instructional leadership and the need for clear guidelines. Professional talk did not only reorder relations to some extent, but also reconfigured care work. Alternative aspects of care work were being foregrounded via professional talk, such as shared-decision-making with clients and the management of care, i.e. choices about the type and amount of care that can be provided according to client linked budgets and Support Plans.

Our findings demonstrate that here is not one unified professional discourse. Rather, middle managers operationalize professionalism in multiple ways, resulting in in the co-existence of different professional talks. The multiplicity of professional talks sheds light on the important question to what end healthcare managers, and public managers in general, actually use professional discourse vis-à-vis practitioners. Why do managers concern themselves with notions of professionalism in the first place? According to several scholars professional discourse is primarily used in the interests and priorities of employing organizations and their managers (Brint 1994; Evetts 2003; 2006; 2011). By imposing professional discourse 'from above', managers aim to make practitioners more budget aware, accountable, entrepreneurial, and target driven, thereby complying with New Public Management reforms in the public sector (Evetts 2003). This study only partially confirms these conclusions and provides a more nuanced picture. Indeed, *particular* versions of professional talk are used by middle managers to focus attention of care workers on financial and managerial issues. A good example is professional talk about negotiating competencies of care workers: according to middle managers these particular competencies are needed to conduct difficult conversations with clients and their relatives about financial limitations to the provision of care. Another example is professional talk about methodical work methods which is partially used to make care workers more 'accountable' to managers, the Health Care Inspectorate, and more importantly clients.

Yet, it could be argued that organizational changes in care work do not solely emanate from New Public Management ideology and reflect organizational/ managerial interests, but also represent broader societal ideas about transparency and financial sustainability of the care sector. Part of being a professional then entails dealing with organizational issues such as efficient use of scarce resources, accountability measures and multi-case coordination (Noordegraaf 2011; Actiz 2011). Interestingly, several of the professional talks that we found seem unrelated to New Public Management reforms. An important reason why middle managers used professional talk was to change very mundane matters of conduct (Grey 1998; Fournier 1999): i.e. how care workers dress themselves, keep an appropriate distance in their dealing with clients, critically reflect on personal values, and conduct conversations with colleagues and clients (professional talk 1, 2 and 4). These findings

suggest that managerial use of professional discourse is far more varied: it incorporates organizational and societal demands, aims to transform mundane conduct of care workers and advocates a more reflective approach to the provision of care. Given this potential for change, mundane professionalization projects of middle managers could be a valuable addition to formal education and accreditation schemes in the care sector. So far, The Dutch Healthcare Inspectorate has primarily focused on professionalization by means of formal education (IGZ 2007), but it may be useful to enlist the informal help of middle managers as change agents.

In line with recent critiques on dualisms (Gleeson and Knights 2006; Waring and Currie 2009; Noordegraaf 2011), we argue that it is unproductive to view relations between managers and care workers as intrinsically opposing ('managers *versus* professionals') or as a trade-off ('more managerialism leads to less professionalism'). Our linguistic study shows that relations on the work floor are flexibly constructed and shaped in everyday professional talk. This implies that relations can be reconfigured differently depending on *which* versions of professional talk are constructed and *how* they are applied by managers and reframed by care workers. Our findings demonstrate that middle managers use professional talk in both enabling and disenabling ways vis-à-vis care workers. For example, professional talk about reflection generally enables autonomous decision-making by care workers, but it can also disenable care workers when it is used ambiguously, remains disconnected to organizational support and decisions (Brunsson 1990), or insufficiently takes into account individual differences between care workers in terms of educational background and work experience (see also Van Loon and Zuiderent-Jerak 2012). Given the importance of professional talk for organizational relations, organizations could use professional talk as a potential connecting device. When used in the right way, professional talk can connect organizational and professional issues and establish effective work relations between managers and care workers. Moreover, the professional identity of middle managers themselves appeared to be based on their ability to connect professional knowledge from their previous background as care worker with more recently acquired managerial skills.

An important limitation of our study is that we conducted our observations in one Dutch care organization, which could limit the generalizability of the four professional talks to other organizational settings and sectors. Future studies could adopt a comparative approach by investigating professional talk in different sectors, such as hospital and elderly care. A comparative study of professional talk may shed light on the main differences and similarities in professionalization processes across sector boundaries. Furthermore, it could provide relevant insights into the role of formal education: to what extent does educational background of care workers (vocational/academic) influence the content of everyday professional talk? And do managers without a background in healthcare use professional talk differently than managers who have previously worked as care workers themselves? A last fruitful direction for research lies in the development of joined-up service provision (Bekkers 2011) and its consequences for redefining professional and managerial discourses. Given an increased emphasis on multi-disciplinary work and coordination, the potential hybridization of professional and managerial discourses seems a relevant topic for future research.

References

Actiz (2011). *Vakbekwaam mensenwerk. Anders werken in de langdurige zorg, nieuwe professionaliteit*. Utrecht: Actiz.

Alvesson, M. (1994). Talking in organizations: managing identity and impressions in an advertising agency. *Organization Studies* 15 (4): 535-563.

Alvesson, M. and D. Karreman (2000). Varieties of discourse: on the study of organizations through discourse analysis. *Human Relations* 53 (9): 1125-1149.

Arman, R., L. Dellve, E. Wikström & L. Törnström (2009). What health care managers do: applying Mintzberg's structured observation method, *Journal of Nursing Management* 17 (6): 718-729.

Austin, J.L. (1978, second edition). *How to do things with words*. Oxford etc.: Oxford University Press.

Bekkers, V. et al. (ed.) (2011). *Innovation in the public sector. Linking capacity and leadership*. Basingstoke etc.: Palgrave McMillan.

Birken, S. A., S-Y. D. Lee and B.J. Weiner (2012). Uncovering middle managers' role in healthcare innovation implementation. *Implementation Science* 7 (28): DOI 10.1186/1748-5908-7-28

Birken, S.A., S-Y. D. Lee, B. J. Weiner, M. H. Chin and C. T. Schaefer (2013). Improving the effectiveness of health care innovation implementation: middle managers as change agents *Medical Care Research and Review* 70 (1): 29-45.

Brint, S.G. (1994). *In an age of experts: the changing role of professionals in politics and public life*. Princeton, NJ: Princeton University Press.

Brunsson, N. (1990). Deciding for responsibility and legitimation: alternative interpretations of organizational decision-making *Accounting, Organizations and Society* 15 (1/2): 47-59.

Currie, G. (2000). The role of middle managers in strategic change in the public sector. *Public Money & Management* 20 (1): 17-22.

Czarniawska, B. (2007), *Shadowing and other techniques for doing fieldwork in modern societies*, Malmö/ Copenhagen: Liber and Copenhagen Business School Press.

Czarniawska, B (2008). *A theory of organizing*. Cheltenham UK and Northampton MA: Edward Elgar.

Davies, S. (2006). Health services management education: why and what? *Journal of Health, Organization and Management* 20 (4): 325 -34.

Dopson, S. and L. Fitzgerald (2006). The role of the middle manager in the implementation of evidence-based health care *Journal of Nursing Management* 14: 43-51.

Elshout, P. (2006). *Middenmanagement: Functie in ontwikkeling*. Tilburg: University of Tilburg.

Evetts, J. (2003). The construction of professionalism in new and existing occupational contexts: promoting and facilitating occupational change. *International Journal of Sociology and Social Policy* 23 (4): 22-35.

Evetts, J. (2006). Short note: the sociology of professional groups. *Current Sociology* 54: 133-143.

Evetts, J. (2009). New professionalism and new public management: changes, continuities and consequences *Comparative Sociology* 8: 247-266.

Evetts, J. (2011). A new professionalism? Challenges and opportunities. *Current Sociology* 59 (4): 406-422.

Floyd, S. W. and B. Wooldridge (1997). Middle management's strategic influence and organizational performance. *Journal of Management Studies* 34 (3): 465-85.

Fournier, V. (1999). The appeal to 'professionalism' as a disciplinary mechanism. *Social Review* 47 (2): 280-307.

Gleeson, D. and D. Knights (2006). Challenging dualism: public professionalism in 'troubled' times. *Sociology* 40 (2): 277–295.

Goffman, E. (1990, reprint). *The presentation of self in everyday life*. London etc.: Penguin Books (1959).

Goffman, E. (1991, reprint). *Asylums. Essays on the social situation of mental patients and other inmates*. London etc.: Penguin Books (1961).

Grey, C. (1998). On being a professional in a 'big six' firm. A*ccounting, Organizations and Society* 23 (5/6): 569-587.

Grey, C. (1994). Career as a project of the self and labour process discipline, *Sociology* 28 (2): 479-497.

Grit, K. & A. Bont (2010). Tailor-made finance care versus tailor-made care. Can the state strengthen consumer choice in healthcare by reforming the financial structure of long-term care? *Journal of Medical Ethics* 36 (2): 79-83.

Hussein, S. and J. Manthorpe (2005). An international review of the long-term care workforce. J*ournal of Aging & Social Policy* 17 (4): 75-94.

Iedema, R., P. Degeling, J. Braithwaite and L. White (2003). 'It's an interesting conversation I'm hearing': the doctor as manager. *Organization Studies* 25 (1): 15–33.

Inspectie voor de Gezondheidszorg, IGZ (2007). *Verantwoorde zorg voor gehandicapten onder druk*. Den Haag: IGZ.

Kipping, M. (2011). Hollow from the start? Image professionalism in management consulting. *Current Sociology* 59 (4): 530-550.

Kotter, J.P. (1986). *The general managers*. New York etc.: The Free Press.

Lilleker, D.G. and R. Negrine (2002). Professionalization: of what? Since when? By whom? *The Harvard International Journal of Press/Politics* 7 (4): 98-103.

Mesman, J. (2008). *Uncertainty in medical innovation: experienced pioneers in neonatal care*. Basingstoke: Palgrave MacMillan.

Mintzberg, H. (1973). *The nature of managerial work*. New York: Harper & Row. Reprinted by Prentice-Hall (1980).

Mintzberg, H. (2004). *Managers not MBA's. A hard look at the soft practice of managing and management development.* London: Financial Times Prentice Hall.

Mol, A., I. Moser and J. Pols ed. (2010). *Care in practice. On tinkering in clinics, homes and farms*. Bielefeld: Transcript Verlag.

Mol, A. and J. Law (2002). Complexities: an introduction. In *Complexities: social studies of knowledge practices*, J. Law and A. Mol ed., 1-22. Durham and London: Duke University Press.

Muzio, D. and I. Kirkpatrick (2011). Introduction: professions and organizations – a conceptual framework. *Current Sociology* 59 (4): 389-405.

Noordegraaf, M. (2000). *Attention! Work and behavior of public managers amidst ambiguity*. Delft: Eburon.

Noordegraaf, M. (2007). From 'pure' to 'hybrid' professionalism: present-day professionalism in ambiguous public domains. *Administration and Society* 39, 761-785.

Noordegraaf M. and M.Van der Meulen (2008). Professional power play: Organizing management in health care. *Public Administration* 86 (4): 1055–1069.

Noordegraaf, M. (2011). Risky business: how professionals and professional fields (must) deal with organizational issues. *Organization Studies* 32 (10): 1349-1371.

Noy, C. (2008). Sampling knowledge: the hermeneutics of snowball sampling in qualitative research. *International Journal of Social Research Methodology* 11 (4): 327-344.

Oldenhof, L. and K. Putters (2011). Daily practices of operational healthcare managers: dealing with tensions between different values *Medische Antropologie* 23 (1): 81-101.

Oldenhof, L. (2012). *De middenmanager: sleutelfiguur bij transities in de langdurige zorg*. Studie voor de Raad voor de Volksgezondheid en Zorg. Den Haag: RVZ.

Raad voor de Volksgezondheid en Zorg, RVZ (2009). *Dilemma's van verpleegkundigen en verzorgenden*. Den Haag: Centrum voor Ethiek en Gezondheid.

Stoopendaal, A. (2008). *Zorg met afstand*. B*etrokken bestuur in grootschalige zorginstellingen*. Rotterdam: Van Gorcum.

Stone, R. and M.F. Harahan (2009). Improving the long term care workforce serving older adults. *Health Affairs* 29 (1): 109-115.

Thomas, P. and J. Hewitt (2011). Managerial organization and professional autonomy: a discourse-based conceptualization. *Organization Studies* 32 (10): 1373-1393.

Van Loon, E. and T. Zuiderent-Jerak (2012). Framing reflexivity in quality improvement devices in the care for older people. *Health Care Analysis* 20 (2): 119-138.

Van Loon, J. and G. van Hove (2001). Emancipation and self-determination of people with learning disabilities and down-sizing institutional care, *Disability & Society* 16 (2): 233-254.

Waring, J. and G. Currie (2009). Managing expert knowledge: organizational challenges and managerial futures for the UK medical profession *Organization Studies* 30 (07): 755-778.

Waring, J. (2007). Adaptive regulation or governmentality: patient safety and changing regulation of medicine, *Sociology of Health & Illness* 29 (2): 163-179.

Watson, T.J.(1994). *In search of management*. London: Routledge.

Watson, T. (2003). Professions and professionalism. Should we jump off the bandwagon, better to study where it is going? *International Studies of Management and Organization* 32 (2): 93-105.

Wilensky, H.L. (1964). The professionalization of everyone? *American Journal of Sociology* 70 (2): 137-158.

Ybema, S., D. Yanow, H. Wels and F. Kamsteeg ed. (2009). *Organizational ethnography. Studying the complexities of everyday life*. London etc.: SAGE.

Chapter 5

Organized professionalism in healthcare: articulation work by neighbourhood nurses

Published as:

Postma, J., L. Oldenhof and K. Putters (2015). Organized professionalism in healthcare: articulation work by neighbourhood nurses. *Journal of Professions and Organization* 2 (1): 61-77.

Abstract

Organizational and professional logics are often viewed as intrinsically conflicting. Organizational influences either encroach on professional work or professionals resist change and evade organizational rules. Increasingly however, this dualistic view is supplemented with the perspective of organized professionalism, which focuses on the negotiated and reciprocal relationship between organizational and professional logics. In this perspective, professionals increasingly engage in new organizational issues and incorporate those into their professional work. We build on these insights, but take the debate on organized professionalism one step further. Using the sociological concept of articulation work, we show that organizational tasks are not always 'new', but can be inherent to professionalism. In a study of Dutch neighbourhood nurses (NNs), we find three types of articulation work: intra-professional, interprofessional, and lay articulation work. NNs perform articulation work to provide and organize care at the same time. They integrate taylorized home care services, coordinate the work of different professionals, and stimulate informal care. We conclude that articulation work traditionally lies at the heart of professionalism, but is not static and acquires new meaning because of changing organizational conditions and policy reforms.

Keywords: organized professionalism; articulation work; Taylorization; neighbourhood nurse; home care; division of labor.

Introduction

> 'Home care has become an impersonal, ice-cold form of service delivery. If you need care, you should not be surprised to see three different care workers at your bedside on a single morning: a health assistant washes you, a nurse administers an injection and a home help prepares your breakfast. Home care is provided with a stopwatch in hand: one minute for putting on compression stockings, two minutes for applying a bandage.' (Editor of Dutch newspaper *Telegraaf*, 14 February 2004)

The above quote exemplifies unease in society about the organization of home care. Not only newspaper editors, but also professionals, managers and politicians argue that division of labour, treatment of healthcare professionals as 'production workers', and the rise of a powerful management caste has led to fragmentation and deprofessionalization of care (Tonkens 2003; De Blok and Pool 2010; Van Dalen 2012). In this article, we however show the possibility of reprofessionalization and integration of fragmented public services. We do so by studying a case of organized professionalism in which neighbourhood nurses perform articulation work. By performing articulation work, they undo 'tayloristic' notions of labour division and managerial control that were introduced in public service provision in the last decades (Pollitt 1990; Bolton 2004). These notions originate from the work of engineer Frederick Winslow Taylor more than 100 years ago. Taylorization entails the replacement of professional judgment and personal experience by science-like rules, managerial planning, and division of labour:

> 'The development of a science (...) involves the establishment of many rules, laws, formulae which replace the judgement of the individual workman and which can be effectively used only after having been systematically recorded, indexed etc. (...). Thus all the planning which under the old system was done by the workman, as a result of his personal experience, must of necessity under the new system be done by the management in accordance with the laws of science (...). The man in the planning room, whose speciality under scientific management is planning ahead, invariably finds that the work can be done better and more economically by a subdivision of labour.' (Taylor 1911, reprint 1998: p.16)

Unrest about managerial dominance and taylorization of professional work is not merely a Dutch phenomenon (Pollitt 1990; Bolton 2004), but mirrors an international debate about professional and organizational logics. In this debate, the two logics are depicted as intrinsically conflicting (Muzio and Kirkpatrick 2011; Noordegraaf 2011). On the one hand, increased organizational control is said to infringe on the professional domain. Under pressure of production targets, quality indicators and increased regulation and standardization, professionals reluctantly give in to managerial power, supposedly leading to 'deprofessionalization' and 'proletarization' (Gleeson and Knights 2006; Noordegraaf 2007; Evetts 2011; Muzio and Kirkpatrick 2011). On the other hand, autonomous professions are frequently depicted as resistant to change and difficult to control, both by markets and organizations. Professionals fight back

organizational pressure by means of specialization, protection of jurisdictions and conservation of occupational values (Evetts 2011; Muzio and Kirkpatrick 2011). Hence, organizations and professions are framed in this literature as opposing logics. The interplay of these logics is seen as a zero-sum game: an increase in the one, leads to a decrease in the other.

recent stream of research on 'organized professionalism' (Noordegraaf 2011; Muzio and Kirkpatrick 2011; Evetts 2009) challenges this dualism. This research shows that organizational and professional logics are increasingly intertwining in work practices where professionals have to respond to new expectations of public service delivery from clients, organizations and the state (e.g. Cohen et al 2002; Evetts 2009; 2011; Gleeson and Knights 2006, Noordegraaf 2007, 2011; Waring and Curie 2009). As Noordegraaf (2011: p. 1358) argues, 'increasingly, organizing and managing must be seen as professional issues'. Tasks such as quality management, cross-sector coordination and risk evaluation are not only managerial or organizational, but also part and parcel of professional work (Noordegraaf 2011). In this view, professional and organizational logics co-exist in practice (Faulconbridge and Muzio 2008), and in fact should be mixed in order to deliver high-quality public services (Noordegraaf 2011). Despite increasing attention for the entanglement of logics, our knowledge of the changing relationship between organizations and professions still remains rather limited (Muzio and Kirkpatrick 2011). Especially the question *how and to what extent* professional work is getting more or less organizational remains unaddressed.

In this article, we contribute to the literature on organized professionalism by showing that 'organizational' tasks, like coordinating and planning, do not necessarily come 'on top of' professional work but can be *an intrinsic part* of professionalism. We do so by using the concept of articulation work by sociologist Anselm Strauss and colleagues (1985). Articulation work can be described as a 'supra type of work' that connects and integrates tasks, responsibilities, and types of work, thereby establishing a 'total arc of work' (Strauss et al. 1985; Eschenfelder 2003; Hampson and Junor 2005). Importantly, articulation work questions the dichotomy between organizational and professional logics that is still (implicitly) present in organized professionalism literature and provides an alternative perspective on how the delivery and the organization of public services are intertwined in daily practices.

We use the concept of articulation work to study a new initiative in Dutch home care, called the 'Visible link' (in Dutch: 'Zichtbare schakel'), that reintroduces neighbourhood nurses after they were gradually organized out of home care during the last decades. The initiative aims to stimulate both professional autonomy of neighbourhood nurses and to enhance the integration of different services (e.g. care, welfare, and housing). Neighbourhood nurses are viewed as an alternative to the current taylorized organization of home care: they are responsible for providing a broad range of services themselves as well as organizing and coordinating services that are delivered by other professionals. Our research addresses the following question: how do Dutch neighbourhood nurses engage in articulation work and what are the consequences for the delivery and organization of home care? The empirical analysis is based on semi-structured interviews with 35 neighbourhood nurses, resulting in 84 detailed client reports. By studying the articulation work of neighbourhood nurses in the setting of Dutch home care, we aim to offer new insights into 'organizational work' that is inherent to professionalism and thereby contribute to the academic debate about professions and organizations.

Organized professionalism

Theories that portray organizational and professional logics as separate and conflicting forces are increasingly criticized (e.g. Cohen et al. 2002; Gleeson and Knights 2006; Noordegraaf 2007, 2011; Evetts 2009, 2011; Waring and Curie 2009). A first critique is that these theories overstate the analytical distinction between *pure* 'professional' and 'organizational' logics, thereby foregrounding differences and conflicts and backgrounding common ground, interaction and hybridization processes. As Noordegraaf (2007) points out, professional groups, market actors, and the state have historically influenced each other; professionals have never been 'free' from outside logics. A second criticism relates to the claim that professional and organizational logics are intrinsically conflicting. Authors have recently countered this assumption by empirically showing that the way professional and organizational logics coexist in practice is the result of daily negotiations and interactions between managers, professionals and clients as well as organizational procedures and macro policies. The outcome of these negotiations can differ from conflicts and clashes to hybridization and compromises (Wallenburg et al. 2012; Oldenhof et al. 2014).

Building on these criticisms, less dualistic views on professional and organizational logics have been developed, which are grouped under the overarching term of 'organized professionalism' (Evetts 2009; Noordegraaf 2011; Muzio and Kirkpatrick 2011). Broadly defined, organized professionalism denotes the mediation and hybridization between organizational and professional logics in daily work practices. Organized professionalism assumes that the relationship between organizations and professions is dynamic, negotiated, and reciprocal in nature rather than pre-determined and fixed (Cohen et al. 2002; Noordegraaf 2011). Although authors in this body of literature still assume that professional and organizational logics are analytically distinct, they no longer expect logics to exist in their pure form and *a priori* lead to conflict. To underline the interdependency of professional and organizational logics, authors describe forms of 'entanglement' and 'hybridization' (e.g. Noordegraaf 2011; Wallenburg et al. 2012). However, the debate on organized professionalism sometimes becomes fuzzy because authors (implicitly) use different interpretations of the term. Before discussing our contribution to this literature, we therefore provide a short overview of the current debate. On the basis of existing studies, we identify three main interpretations of organized professionalism: (1) organizations as sites for professional development, (2) organizational influences on professional work, and (3) new organizational roles for professionals.

First, several authors interpret organized professionalism in terms of *organizational sites that facilitate professionalization* (Muzio and Kirkpatrick 2011). Professionals increasingly work in large-scale, global organizations that play an important role in the professionalization of workers, for example by providing educational courses and infrastructure that aid further specialization (Faulconbridge and Muzio 2008; Evetts 2011; Muzio and Kirkpatrick 2011; Oldenhof et al. 2013). As a result, employing organizations (Evetts 2011) and managers (Oldenhof et al. 2013) have become key actors in the development of professions in addition to states and universities.

Second, organized professionalism can refer to broad *societal and organizational influences that change the nature of professional work.* Trends such as increasing specialization and work division, technological advancement, changing working conditions and the rise of multi-problem cases, call for new forms of organization, coordination, and integration of professional services (Noordegraaf 2007, 2011; Evetts 2011). Moreover, trends like outsourcing, privatization and commercialization urge professionals to rethink their work and develop 'organizational' responses to deal with more competitive environments (Gleeson and Knights 2006; Waring and Currie 2009; Evetts 2011; Waring and Bishop 2013). For example, Waring and Bishop's (2013) study of private providers of public healthcare in the UK, illustrates how global bureaucratic reforms and market logics transform the organization of medical work, leading to more rationalized and standardized medical practices, which they dub as 'McMedicine'. Medical expertise is still important, but is increasingly aligned with organizational and commercial needs (ibid). Doctors can adopt different strategies to cope with organizational influences. They can acquiesce or resist organizational changes, but also mediate, co-opt, and co-create organizational reforms (Waring and Currie 2009). Gleeson and Knights (2006) call the latter strategies 'creative mediation', which can be viewed as an alternative to top-down compliance or bottom-up resistance to organizational reforms (Waring and Currie 2009).

Third, organized professionalism can be understood in terms of *new organizational roles that professionals adopt to deal with societal and organizational influences such as outlined above*. This stream of literature does not focus on the mediation of outside pressures in professional work, but on the tasks and responsibilities that come 'on top' of their work. For example in healthcare, doctors are increasingly becoming 'organized professionals' who combine their medical work with new organizational responsibilities such as the implementation of management appraisal instruments and information systems (Waring and Currie 2009; Witman et al. 2011).

The above forms of organized professionalism all describe the changing relation between organizations and professions. What conclusions can be drawn from this? First, studies on organized professionalism show that organizations can no longer be ignored in the study of professionals 'if we accept the fundamentally dialectic and negotiated nature of this relationship [between organizations and professions] at the micro-level' (Cohen et al. 2002: p. 8). Second, professionals are not necessarily victims of managerial pressure or rebels against organizational control, but actively reconfigure their professional work and reshape organizational policies. As a result, professional and organizational logics co-exist in work floor practices. Third, despite the identification of creative mediation strategies, studies on organized professionalism still assume that organizational and professional logics do not necessarily merge or integrate but remain analytically distinct. Both logics encompass different worlds, values and repertoires. As a result, in the current debate on organized professionalism, much emphasis is put on 'new' organizational roles and organizational work that comes 'on top of' professional work. The possibility that professionals may not perceive 'organizational tasks', such as coordinating and planning, as a separate organizational logic but as an inherent part of their work, is left relatively unexplored.

By introducing the concept of 'articulation work' (Strauss et al. 1985) in the following section, we aim to take the debate on organized professionalism one step

forward *by going one step backward*: what organizing work is an intrinsic part of professional work? We use articulation work to provide a better understanding of 'classic' organizing work that is performed by professionals. At the same time, we investigate how classic organizing acquires new meaning in response to changes in policies, organizational strategies and societal trends. We show how certain elements of professional articulation work stay the same, while other elements change in reaction to outside pressures. We thereby contribute to the second stream of literature on organized professionalism that we identified before.

Articulation work

The concept of articulation work was originally developed by sociologists Strauss, Fagerhausen, Suczek and Wiener, who were interested in the organization of medical work. They conducted extensive observations in American hospitals to study the work involved in treating dying patients (Strauss et al. 1985, reprint 1997). An important finding of their ethnographic study was that there are different types of work that actors combine to provide good patient care: machine work (the use of technical equipment), comfort work (relieving patients from physical discomforts), sentimental work (supporting patients in coping with anxiety and depression), safety work (reducing medical risks that endanger patients' health) and articulation work (coordination and integration). In this article, we focus on *articulation work* to investigate how professionals engage in coordination and integration as part of their professional work.

Over the course of a disease, or the so-called 'illness trajectory' (Strauss et al. 1985), healthcare professionals not only have to deal with the physiological unfolding of the disease itself, but also with the organization of work. Strauss et al. (1985) coined the term articulation work to refer to this 'supra-type of work'. Articulation work occurs in any situation where labour is divided and in some way needs to be integrated or coordinated. It involves 'the meshing of (1) numerous tasks and, clusters of tasks and segments of the total arc, (2) the meshing of efforts of various unit-workers (individuals, departments, etc.), (3) the meshing of actors with their various types of work and implicated tasks' (Strauss 1985: p. 8). As a result of articulation work, the 'total arc of work' can be maintained. The arc of work constitutes all the work that is necessary to deliver and organize professional services. Articulation work reduces fragmentation and contributes to a proper flow of work (Strauss 1988). An example of articulation work can be found in the daily work of hospital nurses. When a patient refuses treatment or wants to go home despite deteriorating conditions, nurses have to make articulations to avoid that medical trajectories get fragmented, or in other words, get 'disarticulated'. They alert doctors and other nurses or organize a multidisciplinary team meeting about the patient's new situation, thereby making articulations between medical disciplines. At the same time, they make articulations between tasks by reassuring and convincing the patient to stay in the hospital, emotion work, while performing other types of care work, e.g. machine and safety work.

The example of hospital nursing shows that activities like planning, organizing and coordinating are not necessarily extra organizational tasks on top of professional work or stem from a separate organizational logic, but can be *at the heart* of professional work. The concept of articulation work therefore allows us to go beyond the dichotomy between organizational and professional logics that is still – implicitly – assumed in studies about organized professionalism. Furthermore, Straus et al. (1985) show the possibility of professionals operating on a continuum from articulation to *dis*articulation. Depending on their work environment, they may be enabled or inhibited in making articulations. For example, disarticulation can occur in taylorized and standardized work settings in which specialized professionals are assigned separate tasks and need to make production on tight time schedules. In these organizational settings, professionals may not have the opportunity to articulate and integrate different types of work (Hampson and Junor 2005).

Several authors stress that articulation work is more than 'mere coordination' (Hampson and Junor 2005: p. 167, emphasis in original) or 'cooperative work' (Schmidt and Simone 1996: p. 158). Articulation work reduces the distributed and specialized nature of work by *integrating* and *meshing* different types of professional work (e.g. emotion, safety, machine and comfort work), professional disciplines (medical or otherwise), resources (e.g. finances, personnel, time) and work arrangements (e.g. multidisciplinary team meetings or interdepartmental projects) (Strauss 1988; Schmidt and Simone 1996). Integration and meshing can be attained via formal planning and scheduling, but also requires implicit and intangible efforts, such as the bringing together of social worlds (Gerson and Star 1986; Hampson and Junor 2005). The latter is necessary as increasing professionalization and specialization lead to a multitude of occupational communities and specialties, resulting in different ideas about what constitutes good work. When different social worlds intersect, they can either mix harmoniously or create tensions (Strauss 1985). Managing these tensions is an important part of articulation work (Strauss 1985; Hampson and Junor 2005).

The concept of articulation work is not just applicable to work in hospitals. Several authors have investigated articulation work in other settings, like informal care giving at home (Corbin and Strauss 1985; Timmermans and Freidin 2007), social care (Allen et al. 2004), customer service work in call centres (Hampson and Junor 2005), traffic control at airports (Suchman 1996), and computer system design and maintenance (Grinter 1996; Schmidt and Simone 1996; Berg 1999; Schmidt 1999; Star and Strauss 1999; Ferreira et al. 2011). These studies show that articulation work often remains in the background and is seldom part of standard job descriptions (Suchman 1996). Timmermans and Freidin (2007: p. 1351) remark that articulation work usually is done by 'invisible armies of nameless secretaries, support staff, technicians, administrative and other help, editors, and other backstage workers'. In a similar vein, Hampson and Junor (2005: p. 178) note that articulation work involves 'invisible skills'. Although it is generally thought that call centre agents perform completely standardized work, they frequently have to depart from standard scripts and need to skilfully deal with competing values of customer responsiveness and business efficiency. This work is not expressed in job descriptions and invisible to managers and others in the outside world. Articulation work is thus more likely than other types of work to be made invisible, even though it is crucially important for the smooth operation of organizations.

To our knowledge, the concept of articulation work has not been used in the current debate on organized professionalism. Yet, we feel that the theoretical implications of articulation work, combined with an empirical investigation of articulation work in Dutch home care, could contribute to this debate. The concept allows us to explore how professionals engage in organizing as an intrinsic part of their work. By empirically investigating articulation work of neighbourhood nurses in Dutch home care, we examine both articulations and disarticulations in public service delivery. Our study contributes to the literature on articulation work by investigating articulation work in an interorganizational neighbourhood setting where service providers in care, welfare and housing collaborate. Articulation work in this interorganizational setting may have its own dynamics compared to articulation work that so far has been researched within the boundaries of one organization (e.g. one hospital, call centre, or airport).

Home care in the Netherlands: articulation and disarticulation

This study about articulation work is situated in the Dutch home care sector. We focus on the work of neighbourhood nurses who participate in a project called 'the Visible link'. In this project, neighbourhood nurses have a large degree of autonomy to perform activities they deem necessary to achieve the goals of the project: improving the coherence ('the link') between housing, healthcare, and social services on the scale of the neighbourhood; increasing accessibility of services for citizens; matching supply of services with demand; and increasing the autonomy and quality of life of vulnerable citizens (ZonMw 2009). Moreover, neighbourhood nurses are also free to find and select citizens that need their support the most, thereby determining who are eligible for the project. Local project leaders were appointed to facilitate the neighbourhood nurses in their work, like providing office spaces and organizing meetings. In the following, we provide a short overview of the history of Dutch home care, including the introduction of the Visible link project. We illustrate how the work of neighbourhood nurses provides a suitable case to study articulation and disarticulation of professional work.

Until the 1970s, home care in the Netherlands was provided by local, private nonprofit associations with different denominations: Roman Catholic, protestant and general. During the 1970s, these organizations merged into the National Cross Association, resulting in one organization providing home care (Van der Zee et al. 1994). Neighbourhood nurses were employed by the National Cross Association and together with general practitioners were responsible for organizing public healthcare on a local level. Nursing work included a variety of activities: health education (e.g. in schools), preventive health home-visits to citizens with potential problems, supporting informal care and stimulating self-care, domestic activities in clients' homes (e.g. preparing food and drinks), providing psychosocial care, hygienic care and technical nursing care (e.g. dressing wounds, preventing decubitus, applying

catheters, and administering injections), and coordinating care and administrative activities (Van der Zee et al. 1994). Due to task variety and a large degree of autonomy, nurses were able to make articulations between types of work (e.g. medical, education, self-care) and actors (e.g. general practitioners, schools, client's family). The work of the Dutch neighbourhood nurse in this period resembles the work of the 'community nurse' (e.g. Chalmers and Bramadat 1996) or the 'district nurse' (e.g. McGarry 2003) in other Western countries.

Between the 1980s and 2000s, home care was reformed in response to various developments: an ageing population, technological changes that enabled the provision of complex care at home, the need for cost-effective use of resources, the urgency to reduce waiting lists, and a call for better quality of care and more freedom of choice for clients (Jansen et al. 1996a; Meurs and Van der Grinten 2005). Policy reforms introduced business-like incentives and competition in home care (Dekker 2004; Helderman et al. 2005). The reimbursement system changed from budget- and input-financing to product- and output-financing (Jansen et al. 1996a), introducing incentives for home care organizations to increase production in order to collect more revenues. Furthermore, legislative changes allowed for new home care organizations to enter 'the market'. In most areas, patients could now choose between several home care organizations. In order to achieve economies of scale and strengthen their market position, local home care organizations started to merge with other home care organizations (Noordegraaf et al. 2005; De Blok and Pool 2010).

Building on these market-oriented reforms, home care organizations restructured the work of neighbourhood nurses along tayloristic principles of work division and specialization in order to increase efficiency and quality (Jansen et al. 1996a, 1996b, 1997; De Blok and Pool 2010). It was believed that the different elements of nursing work had to be 'carried out by the most appropriate nurse in the most appropriate way' (Jansen et al. 1997: p. 220). Consequently, nursing work was being 'disarticulated' by subdividing tasks, the so-called 'products'. These products were to be executed by different care workers, depending on required professional capabilities. Neighbourhood nurses became involved in assessment, diagnostics, and care in unstructured situations, including the arrangement of care prior to hospital admission and after discharge. They also increasingly specialized in certain types of care (e.g. in diabetes, dementia or incontinence). Second level auxiliary nurses concerned themselves with personal hygiene of clients and well-defined, uncomplicated technical nursing activities. Health assistants focused on problems in housekeeping and supported clients in case informal caregivers could no longer provide necessary care. Finally, home helps were introduced to deliver domestic services, especially cleaning (Jansen et al. 1997; De Blok and Pool 2010).

During the 2000s, public discontent arose about the tayloristic organization and provision of home care. Patients, especially those with multiple conditions, complained about the fragmentation of care: for every task, a new care worker was assigned, resulting in a multitude of professionals going in and out of clients' homes. Coordination was lacking as professionals were primarily responsible for their own work. Furthermore, professionals complained that new layers of management introduced undesirable commercialization of home care, restricted their autonomy, and continued to narrow the scope of their work to specific medical-technical interventions and coaching of other care workers (Tonkens 2003; De Blok and Pool 2010;

Van Dalen 2012). Tasks such as brokerage, contracting, budget-holding, service development, assessment and care planning now belonged exclusively to the domain of care managers. As such, almost all articulation work was organized out of the work of the neighbourhood nurse and transferred to managers and central planning departments.

In response to increasing societal concerns about home care, Dutch parliament accepted a motion in 2008 that called for more integrated home care and reinforcement of the position of the neighbourhood nurse, i.e. more autonomy and a broader range of responsibilities. The motion adopted by the Dutch Ministers of Health and Internal Affairs. They asked the Netherlands Organization for Health Research and Development (ZonMw) to set up the Visible link project. After 2 years, there were 95 projects in 50 municipalities nationwide, especially in so-called 'vulnerable neighbourhoods', comprising between 300 and 350 neighbourhood nurses (ZonMw 2011).

The work of neighbourhood nurses in the Visible link project provides an interesting case to study articulation work. Until the 1980s, articulation work was an integral part of neighbourhood nursing. During the 1980s and 1990s, a major part of articulation work was organized out of the work of neighbourhood nurses. In the Visible link project, neighbourhood nurses are given new opportunities to perform articulation work against the backdrop of a taylorized home care system. This fragmented public service environment, combined with increasing budget cuts and the need for informal care, differs notably from the environment in previous decades and provides new organizing challenges. It is still unknown how articulation work in this changed context takes shape and what the consequences are for clients, other professionals and organizations in neighbourhoods.

Methodology: interviews with neighbourhood nurses

On the basis of interviews with neighbourhood nurses, we analyse how they perform articulation work and thereby enact organized professionalism. The neighbourhood nurses were part of the Visible link project. In September 2011, the Netherlands Organization for Health Research and Development (ZonMw) requested BMC - a Dutch research and consultancy firm - to perform a 'social cost-benefit analysis' of the Visible link project (for the report, see Van der Meer and Postma 2012). The researchers from BMC had no prior involvement in the project. In this article, we use data that were initially gathered for the cost-benefit analysis, in which one of the authors was involved, for an analysis of articulation work. At the start of the analysis, the researchers selected projects in 13 municipalities. The selection was based on the size of the projects in terms of budget and the geographical dispersion of the projects over the Netherlands, making the sample representative for the Visible link project (Van der Meer and Postma 2012). The sample included the four largest projects in major Dutch cities (Rotterdam, Amsterdam, Utrecht, and The Hague), five medium-sized projects, and five small projects. The researchers then randomly selected neighbourhood nurses from each project, leading to a total of 35

respondents. A team of two researchers conducted semi-structured interviews with the nurses about clients in the project. The researchers selected clients randomly from digital registration systems in which neighbourhood nurses register their clients. In the large projects, 5-17 clients were discussed; in the small and medium-sized projects 5 clients were discussed. A discussion about a client lasted approximately 45 minutes. In total, the researchers included 84 clients in the study.

The aim of the interviews was to gain insight in the daily work of neighbourhood nurses. During the interviews, each client was discussed along four main questions: (1) Could you describe the (problems of the) client and his or her social, economic and health status?; (2) What activities did you undertake in this situation?; (3) What do you see as the result of these actions?; and (4) What do you think would have happened to the client if there would not have been an intervention by you? With regard to the fourth question, the neighbourhood nurses were asked to describe the hypothetical situation in which there would not have been a Visible link project and the client would have received care from regular service providers or would not have received care at all. Notably, the majority of neighbourhood nurses in the Visible link project also work part-time as a nurse in regular home care organizations, so they were expected to come up with reliable judgements about the hypothetical situation.

During the interviews, the two researchers took notes separately. After the interviews, they also wrote reports separately and subsequently discussed and combined the reports. They then sent the reports to the neighbourhood nurses themselves, other professionals that were involved in the case(s) and an independent group of experts that did not know the neighbourhood nurses and clients, including a general practitioner, a social worker and two geriatricians. The other involved professionals provided first-hand feedback on the clients and the outcomes of the actions of the neighbourhood nurses. Based on their experience with similar clients, the group of experts assessed whether the judgements of the neighbourhood nurses with regard to the hypothetical situation (what would have happened without an intervention from the neighbourhood nurse?) was reliable. The peer checks improved the validity of the reports, which was necessary because neighbourhood nurses may have been inclined to emphasize their own accomplishments and paint a negative picture of the hypothetical situation (i.e. services from regular providers or no aid at all). The peer checks resulted in some minor corrections in the reports, sometimes leading to more positive and other times to more negative outcomes. These minor corrections indicate that the neighbourhood nurses were fairly accurate in their assessment of cases. Table 1 shows a typical report.

Table 1. Typical report of a client of a neighbourhood nurse.

Client description	83 year old woman; lives alone; has two sons and a daughter. The client's daughter takes care of the paper work and performs minor household tasks. The general practitioner (GP) and the daughter notice memory loss of the client: the client often forgets to take her medication and gets lost when she goes somewhere by car. The GP and the daughter sign the client up for a dementia test at a mental care organization. The client does not want to be 'nurtured' and cancels the test. The GP and the daughter are worried and do not know what to do next. Especially the daughter has difficulties in dealing with the situation.
First contact	
Real	The GP calls the neighbourhood nurse (NN).
Hypothetical	The GP would have called a regular home care organization.
Activities	
Real	NN wants to bring in a health assistant to support the client in taking her medication, but the client refuses. NN also tries to convince the client to go to the mental care organization for the test, but she refuses this as well. After a meeting between the GP, the daughter and NN, they decide to replace part of the medication with another type that NN can administer periodically through a syringe. Together they also decide that the daughter will support the client in taking in the other medication.
	NN talks to the daughter several times. She supports her and gives her tips on how to deal with her mother. As a consequence, the daughter does not need to contact the GP any more. NN stimulates the daughter to call on her two brothers to also take part in caring for their mother. Finally, NN arranges with the daughter that NN will continue to visit the client every month to keep an eye on the situation.
Hypothetical	A nurse from a regular home care organization would perform an intake with the client. The client would not accept care after which the nurse would conclude that the client does not want and need home care services. There would be no further actions.
Results	
Real	The client gets the medication that she needs.
	The GP has to invest less time in talking to the client and her daughter than before.
	The daughter feels supported and can handle the situation better.
	NN has diagnosed the client and can bring in additional care quickly if the situation deteriorates.
Hypothetical	The client runs (minor) health risks because she would not, or only partly, get the medication she needs.
	The GP would have to invest more time in talking to the client and her daughter. Additional home care could not be brought in quickly in an emergency situation because regular healthcare organizations would have to diagnose the situation first.
	There is a chance that after some time the daughter would be burdened too heavily and not be able to support her mother any more. Additional professional services would have to be brought in or the client would have to be admitted in a nursing home.

The interviews provided rich data on the daily work of neighbourhood nurses. Neighbourhood nurses described in detail the background of their clients, the activities they perform and the perceived results. The answer to the fourth question (what do you think would have happened to the client if you would not have intervened?) illustrates how neighbourhood nurses compare their own work to that of other professionals in healthcare and social services. This allows us to contrast the perception of professional work that is narrowly defined under the influence of taylorization with professional work that includes a broader range of articulation work.

An empirical analysis of articulation work contributes to a better understanding of organized professionalism. In order to explore in depth the articulation work that neighbourhood nurses perform, we analysed the differences between the work of neighbourhood nurses in the Visible link project and their perception of the hypothetical situation. As a first analytical step, we read back each report and compared the real and hypothetical situation. We noted that neighbourhood nurses spend much more time with clients, their relatives, and other professionals (e.g. GPs, youth care workers, and employees of housing associations) than they would have done in their capacity as nurse at a regular home care organization. This is not surprising since the Visible link project enables neighbourhood nurses to independently decide what type of support is most needed for clients and how much time is invested in providing this support. Neighbourhood nurses thus are not constrained by the taylorized financial system in regular home care that is based on fixed products. As a second analytical step, we closely investigated reports to find out how neighbourhood nurses use this 'extra' time. During this second step, we used the concept of articulation work from Strauss et al. (1985) as a sensitizing concept to interpret data theoretically while still keeping an open mind to new, emerging types of articulation work in the neighbourhood setting.

First, we looked at articulation work that Strauss (1985: p. 8) calls 'the meshing of numerous tasks, clusters of tasks, and segments'. In the interviews, neighbourhood nurses indicated that they perform and combine a wider variety of tasks than professionals at regular home care organizations. They are not only involved in specialized medical treatments, but also perform 'easier' tasks like washing and administering medication. Furthermore, neighbourhood nurses combine, extend or shorten the execution of tasks in order to establish a 'total arc of work'. They do not feel obliged to fit their work in predefined time slots, as professionals in regular home care organizations are required to do. We call the integration of tasks in one professional domain 'intra-professional articulation work'. Second, we looked at the meshing of 'efforts of various unit-workers (individuals, departments, etc.)' and 'actors with their various types of work and implicated tasks' (Strauss 1985: p. 8). In our analysis, we noticed that neighbourhood nurses meet up and talk on the phone with other professionals in order to coordinate care and support between service providers, ranging from GP's and hospitals to elderly care institutions. In the regular home care system, they are hardly allowed to do this because this activity cannot be captured in a 'product'. We labelled these activities as 'inter-professional articulation work'. Finally, we found that neighbourhood nurses regularly engage with clients and relatives in order to stimulate self-management of clients and active involvement of the social network. We identified these activities as 'lay articulation work.

Three types of articulation work

In our analysis, we identified three types or articulation work: intra-professional, inter-professional, and lay articulation work. *Intraprofessional* articulation work comprises alignments of tasks that neighbourhood nurses individually perform when dealing with clients. *Interprofessional* articulation work entails the work of a neighbourhood nurse that is aimed at improving cooperation and coordination between professionals from different organizations and sectors. *Lay* articulation work refers to the efforts of the neighbourhood nurse to organize and stimulate informal care and self-management. According to neighbourhood nurses, the three types of articulation work distinguish the work in the Visible link project from the work of regular home care workers. It should be noted that the three types of articulation work vary between neighbourhood nurses. For example, some neighbourhood nurses invest more time involving relatives in the support of clients than others. Despite these individual differences, all neighbourhood nurses engage in the three types of articulation work during their daily activities. Jointly, these types of articulation work form an important basis of their professionalism. In our analysis, we also pay attention to the tensions and dilemmas that come with articulation work. Articulation work is not always a smooth process because it entails conflicting perspectives, interests and values.

Intraprofessional articulation work

Our analysis of the reports shows that the daily work of neighbourhood nurses varies widely: from health education and preventive home visits to psychosocial care and medical-technical interventions. Neighbourhood nurses perform articulation work in order to align those tasks to each client's specific needs. They do so from the first moment they get into contact with a client and set a diagnosis. Setting a diagnosis can be quite complicated because nurses encounter clients with complex, multiple problems who distrust professionals and try to avoid professional care. Usually, clients of neighbourhood nurses have a long history of social, physical, and mental problems, including long-term unemployment, addictions to drugs and alcohol, physical and mental disabilities, problematic family situations, psychoses, anxiety disorders, and paranoia. These clients have little family or friends to fall back on.

In order to get insight into clients' needs and convince them to accept help, neighbourhood nurses use unconventional approaches and invest a significant amount of time 'just talking' to gain clients' trust. By phoning up clients, visiting them at their homes - multiple times if necessary- or contacting clients indirectly via others - like neighbours or a GP -, neighbourhood nurses try to build a relationship with clients and convince them to accept care. During home visits, the neighbourhood nurse assesses a client's needs and tries to provide care without evoking resistance. In this process, they perform articulation work by mixing, extending, or sometimes shortening tasks that cannot always by captured in separate 'products', as is shown in a case of an 80-year-old couple that displays signs of dementia:

> NN visits the couple. The conversation is difficult and the atmosphere is grim. The man is verbally aggressive when NN asks the couple questions about their well-being. NN ends the conversation and comes back a week later. After that, NN visits the couple once a week to administer medication through a syringe to the woman and to stay in touch with the couple. Slowly the relation between NN and the couple improves. NN notices that the woman takes too much pain medication because she forgets she already has taken a dose. This causes abdominal pain. NN arranges another system for administering medication to make sure the woman does not use too much of it. NN checks the use of medication weekly and asks the GP to subscribe additional medication for the abdominal pain.

The example shows how a neighbourhood nurse articulates different aspects of her work, including talking to clients and gaining trust, adjusting the medication system, and monitoring the situation, in order to prevent the illness trajectory to go off track. In other cases, neighbourhood nurses take time to talk to clients and gradually start to assist them with washing, while simultaneously convincing clients to accept other forms of home support.

Although intraprofessional articulation work encompasses various tasks, some things are left out. Our analysis of the reports shows that neighbourhood nurses in the Visible link project are not involved in making financial decisions about the allocation of scarce resources, such as personnel and client budgets. Neighbourhood nurses can determine who receives support and what type of support is provided without concern for budget. They are not being held accountable for the effectiveness and efficiency of their choices. Financial decisions regarding the Visible link project are made on a macro level by the Ministers of Health and Internal Affairs and thereby are kept out of articulation work of neighbourhood nurses.

Interprofessional articulation work

Although neighbourhood nurses deliver care themselves, they often enlist formal services from regular service organizations after some time. They introduce professionals from regular service organizations to clients, subsequently deliver care together, and after some time delegate care to regular professionals altogether. By doing so, they try to make the client 'fit' (again) in the regular public service system, giving themselves time to focus on the next difficult case in the neighbourhood. Neighbourhood nurses not only bring in professionals from other organizations, they also coach other professionals -especially lower educated auxiliary nurses, health assistants, and home helps- and coordinate different services that clients receive. Coordination encompasses 'new' professionals who are brought in and 'old' professionals that were already engaged in service provision. Inter-organizational articulation work thereby entails the coordination of different professionals that are involved with a client. Exemplary is a case where professionals from a home care organization call the neighbourhood nurse because they feel treated disrespectfully

by the 19-year-old son of a 46- year-old woman with multiple sclerosis. They also fail to reach an agreement about the type and amount of care the client should receive, especially with regard to lifting the client in and out of bed as the client refuses the use of a mechanical lift:

> NN organizes a meeting with the client, the client's son, a former partner of the client and the home care professionals who are involved. The outcome of the meeting is that the son helps the professionals to lift his mother in and out of bed. In case he is not at home, professionals use the mechanical lift. The meeting also results in an agreement about what services are provided by the professionals from the home care organizations. NN coaches the other professionals how to deal with the client and her son, among other things by organizing another meeting with the involved parties. NN also organizes a course for professionals on how to use the mechanical lift. After a while, NN organizes a meeting with the GP and the former partner of the client and discusses if it is still possible for the client to live at home. They conclude that the client has lost a lot of weight, faces several other problems, and has to be admitted to a hospital. The client is reluctant to go at first, but finally agrees.

Another example is a young couple, who both have a mental disability: a woman, 26-years- old with a chronic muscle disease and a man, 32-years-old with a history of drug addiction. They live in an unclean home, partly caused by domestic animals that are not properly cared for. After neighbours file complaints at the housing association, the neighbourhood nurse visits the couple:

> NN talks to the couple and analyses their problems: an unclean home, a deteriorating relation with the professionals that support them in managing their household, reluctance towards other types of support or care, bad eating habits, and obesity. After the first visit, NN calls a home care organization and applies for domestic services for the couple. The home care organization states that the house needs to be cleaned thoroughly and professionally before domestic services can be granted. NN also contacts the GP and organizes a multidisciplinary meeting with the GP and professionals from the housing association and the home care organization. Together, they draw up a plan of action that includes an upgrade of the support the couple receives and a thorough cleaning of the house. NN talks several times to the couple and convinces them to accept the help that is offered. Furthermore, NN advices the woman to go to a dietician and stimulates her to go to a centre for daytime activities that is aimed at people with a mental disability. NN urges the man to seek help from a psychiatrist. NN will monitor the situation closely and coordinate the support the couple receives in the period to come.

Coordination is particularly important in cases of clients with multiple problems who have to deal with multiple professionals. According to neighbourhood nurses, these professionals often do not effectively work together. Especially when professionals

are specialized, have different backgrounds and work for different organizations, there is a risk of miscommunication, overlap and insufficient care. By articulating the activities of these professionals, neighbourhood nurses contribute to the integration of public services.

However, neighbourhood nurses sometimes struggle with other professionals, e.g. social workers, who also profile themselves as 'general professionals' that coordinate the efforts of different professionals. Other 'general professionals' do not automatically accept the authority of the neighbourhood nurse as the primary link between services. In some cases, this results in conflicts between neighbourhood nurses and other professionals over who should provide and organize care. Furthermore, neighbourhood nurses are sometimes pressured by organizations to refer clients to them and not to other organizations. In several cases, neighbourhood nurses feel that this pressure, emanating from competition between home care organizations, endangers their autonomy to decide together with a client what the best choice of care is.

Lay articulation work

Neighbourhood nurses are not only involved in delivering and organizing care by professionals, but also stimulate 'informal' care and self-management of clients. Stimulating informal care and self-management of clients involves subtle articulation work that is aimed at minimizing the amount of professional care by organizing and supporting social networks and by educating clients how to best take care of themselves. This third type of articulation work primarily entails interactions with clients, their relatives (mostly a partner or children), neighbours and volunteers. Most of the interactions are casual and take place during other activities (e.g. while delivering care).

The activities informal care givers perform often have a social or practical function, like going shopping with a client, accompanying a client to a hospital, walking the dog together, or going to a community centre for social activities. Especially when a partner or children are involved, informal care also constitutes activities like helping clients with washing, dressing, or administering medication. In processes of lay articulation work, neighbourhood nurses investigate whether informal care is possible by talking to friends, neighbours, and relatives. If they are willing and able to help, neighbourhood nurses coach them how to best support clients. Also, they bring in people from voluntary organizations, as the case of a 71-year-old woman illustrates. In this situation, a GP signals that the woman has feelings of grief and guilt, but is unsure how to deal with these feelings. He calls the neighbourhood nurse who visits the client at home.

> NN visits the client and notices that her house is packed with lots of plants and several domestic animals. The garden is neglected and full of trees and bushes. The woman is sad and tells about her loneliness and feelings of guilt after her husband passed away. Recently her dog died

too. NN urges the client to go to social activities in a neighbourhood centre and proposes to apply for support with household activities and enlist a volunteer service that can do some work in her garden. NN also signs up the client at an organization for social services, after which a social worker pays a visit. The social worker aims to find a volunteer to undertake social activities with the client.

In addition to stimulating informal care, neighbourhood nurses try to strengthen self-management of clients. In one case, a GP suspects that a 58-year-old woman with a mild mental disability has thrombosis in a leg. However, the client is afraid of hospitals and does not want to go there for tests. After calling a professional from a home care organization, who also fails to convince the client, the GP calls the neighbourhood nurse:

> NN visits the client several times, provides information and advice and offers to accompany the client to the hospital for tests. After some time, the client agrees. The tests show that the woman does not have thrombosis; she does however need treatment from a dermatologist. NN regularly accompanies the client to the hospital. It turns out that the client needs to be admitted to the hospital after all. NN regularly talks to the woman a lot and finally convinces her to get admitted. After coming home from the treatment, NN brings in home care to help the client putting on compression stockings she now needs. Next NN teaches the woman how to put on the stockings herself. NN also arranges for a medication system through which the client can administer medication herself, a transportation pass that she uses to go to the hospital independently and brings in social and healthcare workers to support the client in household activities, administration and personal hygiene.

Neighbourhood nurses stimulate self-management of clients by talking to them and explaining how they can manage their physical, mental or social problems, but also by doing things together. Activities include providing clients information about social and healthcare services in the neighbourhood; helping them to apply for those services; advising clients on how to deal with other healthcare professionals, family and friends; encouraging clients to undertake social activities; and learning clients about personal hygiene and the use of medication. By articulating different elements of professional work, and gradually transferring tasks to informal care givers and clients, neighbourhood nurses substitute professional home care for informal care.

Nevertheless, lay articulation work is not easy. Frequently neighbourhood nurses experience difficulties in stimulating self-management when clients do not have the motivation or competences to care for themselves. Also informal care is not always the answer, especially when clients do not have a strong social network or the social network is part of the problem. In these situations, bringing in people from voluntary organizations only provides a partial and temporary solution since volunteers often are not equipped to deal with those difficult clients who tend to avoid care and social contacts.

Discussion

Our study illuminates the classic organizing work that is an inherent part of today's organized professionalism. The analysis of articulation work contributes to the literature on organized professionalism in three ways. First, articulation work redirects current attention for 'new forms of organizing' to 'existing forms of organizing' within professional work. In the debate on organized professionalism, much emphasis is put on the increasing need for professionals to organize their work and adopt new organizational roles in response to changing expectations of service delivery. This is exemplified by Noordegraaf's remark that 'organizing and managing have become important for professionals and for the work settings in which they operate. Both professional work and work settings need to be structured, steered, financed and facilitated, in order to render services amidst challenging circumstances' (2007: p. 1362). This line of reasoning suggests that managing and organizing are traditionally not (so much) part of professional work. Yet, our empirical study and earlier sociological studies of articulation work demonstrate that professionals in healthcare and other domains, such as social work, airport traffic control, and IT, always have engaged in organizing and coordinating as part of their professional work (Strauss et al. 1985; Grinter 1996; Schmidt and Simone 1996; Suchman 1996; Berg 1999; Schmidt 1999; Star and Strauss 1999; Allen et al. 2004; Timmermans and Freidin 2007; Ferreira et al. 2011). Hence, a focus on articulation work introduces classic forms of professional organizing into the debate on organized professionalism, thereby broadening its analytical scope.

Second, the empirical analysis demonstrates that even though articulation work could be considered a case of 'classic' and 'inherent' organizing of professionals, it does acquire *new meaning* due to changing organizational conditions, policies and societal demands. Our empirical analysis and historical description of home care demonstrate that contemporary neighbourhood nurses perform articulation work differently than neighbourhood nurses in the 1970s. Articulation work of today's neighbourhood nurses is performed in a highly specialized and fragmented field of public services. This organizational setting requires 'interorganizational articulation work' of nurses who join-up specialized services in care, housing, and welfare on the scale of neighbourhoods (Lowndes and Sullivan 2008). Moreover, 'lay articulation work' of neighbourhood nurses closely aligns with societal and policy demands to transform the traditional welfare state of 'entitlements' into a society where 'every citizen participates' (see also Liljegren et al. 2014). Professionals increasingly attempt to substitute formal for informal care by stimulating self-management and enlisting the social network of clients. Both 'interorganizational articulation work' and 'lay-articulation work' are contemporary forms of articulation work which are combined with more traditional 'intraprofessional articulation work', i.e. the meshing of professional tasks such as medical interventions, prevention, and health education.

Third, our study builds on the conceptual shift from conflicting logics to organized professionalism, but takes it one step further. When organizing is an inherent part of professionalism, the question 'who' organizes or 'should' organize becomes less relevant. Instead, the question in the debate on organized professionalism becomes *what kind of organizing* is done and who benefits from this. To answer this, more detailed empirical accounts of daily professional work in different domains are

required. As our empirical account of the daily work in the nursing domain demonstrates, different types of organizing work are necessary. For example, interorganizational articulation work between care, welfare, and housing seems particularly suitable for multiproblem cases. Clients with several problems -e.g. ill health, debts, and depression- usually do not fit into the specific client categories and specialized services of regular providers. In these cases, articulation work by neighbourhood nurses seems to get them right back on track. Yet, it could be argued that clients with less complex and varied problems still could benefit from a certain extent of task division and specialization in home care. For example, if someone has one specific problem regarding diabetes, he or she benefits more from the help of a nurse who is specialized in diabetes than from the help of a neighbourhood nurse. Also division of labour can contribute to an efficient delivery of services as neighbourhood nurses spend much more time with clients than other professionals. It therefore seems necessary to differentiate between types of articulation work and extent of specialization, depending on the specific needs of clients and the necessity of efficiency gains.

A limitation of our study is that we have not conducted a systematic comparison between neighbourhood nurses and other home care workers. Instead, we relied on the experiences of neighbourhood nurses in assessing hypothetical situations. Furthermore, the project of the neighbourhood nurse is still not systematically embedded in Dutch healthcare system due to its pilot phase and temporary funding. Therefore, the transitions that we describe in this article may not be of a structural kind, although international studies on organized professionalism (e.g. Cohen et al. 2002; Gleeson and Knights 2006; Noordegraaf 2011; Waring and Curie 2009; Witman et al. 2011) indicate that 'organizing professionals' are here to stay. With regard to future studies on organized professionalism, we recommend that scholars do not only study new organizational roles and responsibilities of professionals, but also focus on (the relation with) traditional articulation work in different professional domains. This might generate new insights in professional-organizational dynamics in addition to mediation, co-optation, co-creation and other types of creative mediation (Gleeson and Knights 2006; Waring and Currie 2009).

Conclusion

Our research aim was to investigate how Dutch neighbourhood nurses engage in articulation work and what the consequences are for the delivery and organization of home care. Articulation work is at the heart of professional work and encompasses coordination between actors, e.g. professionals, clients and managers, and meshing of professional work, organizational tasks and social worlds (Gerson and Star 1986; Strauss et al. 1985). Our empirical study demonstrates how, due a tayloristic work division, articulation work was removed from neighbourhood nursing and transferred to central planning departments from the 1980s onwards. The recent introduction of the Visible link project brought articulation work back into the professional domain. In this project, neighbourhood nurses still provide medical

and emotional care to clients, but are also responsible for managing their own work, establishing organizational and professional connections between care, welfare and housing and stimulating informal care and self-management of clients. By doing so, they establish a total arc of work and contribute to more integrated public service provision.

Nevertheless, our analysis also demonstrates that articulation work is not the silver bullet for resolving all tensions in the organization and delivery of public services. Although articulation work solves certain problems, like fragmentation of services, it creates and enhances other ones, like competition between organizations about client's referrals, struggles with other professionals over the question who coordinates, and difficulties when encountering the limits to informal care and self-management. Furthermore, the study demonstrates what is currently 'left out' of articulation work. In the Visible link project, neighbourhood nurses do not concern themselves with financial decisions about the allocation of scarce resources such as personnel and client budgets. Consequently, potential value conflicts about this allocation are kept away from neighbourhood nurses. It could therefore be argued that articulation work of the Dutch neighbourhood nurse is an example of 'partial' organized professionalism: some elements of work are being articulated, whereas other elements stay disarticulated. Partial organizing then is not necessarily the result of a taylorized system, as the Visible link project demonstrates. It can also be a conscious policy choice to keep different types of organizing apart, thereby 'unburdening' professionals with difficult value conflicts (e.g. Thacher and Rein 2004), such as the conflict between ensuring financial sustainability on a macro level and accessibility of care for individual clients.

References

Allen, D., L. Griffiths and P. Lyne (2004). Understanding complex trajectories in health and social care provision. *Sociology of Health & Illness* 26: 1008-1030.

Berg, M. (1999). Patient care information systems and health care work: a sociotechnical approach. *International Journal of Medical Informatics* 55: 87-101.

Bolton, C. (2004). A simple matter of control? NHS hospital nurses and new management. *Journal of Management Studies* 41: 317-333.

Chalmers, K.I. and I.J. Bramadat (1996). Community development: theoretical and practical issues for community health nursing in Canada. *Journal of Advanced Nursing* 24: 719-726.

Cohen, L., R. Finn, A. Wilkinson and J. Arnold (2002). Preface: professional work and management. *International Studies of Management and Organization* 32: 3-24.

Corbin, J.M. and A.L. Strauss (1993). The articulation of work through interaction. *The Sociological Quarterly* 34: 71-83.

De Blok, D. and A. Pool (2010). *Buurtzorg: menselijkheid boven bureaucratie (Neighbourhood care: humanity over bureaucracy).* The Hague: Boom Lemma Uitgevers.

Dekker, P. (2004). The Netherlands: from private initiatives to non-profit hybrids and back? In *The third sector in Europe*, A. Evers and J. Laville (eds), 144-165. Cheltenham: Edward Elgar Publishing Limited.

Eschenfelder, K.R. (2003). The importance of articulation work to agency content management: balancing publication and control. *Proceedings of the 36th Annual Hawaii International Conference on System Sciences*.

Evetts, J. (2009). New professionalism and new public management: changes, continuities and consequences. *Comparative Sociology* 8: 247-266.

Evetts, J. (2011). A new professionalism? Challenges and opportunities. *Current Sociology* 59: 406-422.

Faulconbridge, J. and D. Muzio (2008). Organizational professionalism in globalizing law firms. *Work, Employment & Society* 22: 7-25.

Ferreira, J., H. Sharp and H. Robinson (2011). User experience design and agile development: managing cooperation through articulation work. *Software: Practice and Experience* 41: 963-974.

Gerson, E.M. and S.L. Star (1986). Analyzing due process in the workplace. *ACM Transactions on Information Systems (TOIS)* 4: 257-270.

Gleeson, D. and D. Knights (2006). Challenging dualism: public professionalism in 'troubled' times'. *Sociology* 40: 277-295.

Grinter, R.E. (1996). Supporting articulation work using software configuration management systems. *Computer Supported Cooperative Work (CSCW)* 5: 447-465.

Hampson, I. and A. Junor (2005). Invisible work, invisible skills: interactive customer service as articulation work. *New Technology, Work and Employment* 20: 166-181.

Helderman, J., F.T. Schut, T.E.D. van der Grinten and W.P.M.M. van de Ven (2005). Market-oriented health care reforms and policy learning in the Netherlands. *Journal of Health Politics, Policy and Law* 30: 189-210.

Jansen, P.G., A. Kerkstra, H.H. Abu-Saad and J. van der Zee (1996). The effects of job characteristics and individual characteristics on job satisfaction and burnout in community nursing. *International Journal of Nursing Studies* 33: 407-421.

Jansen, P.G., A. Kerkstra, H.H. Abu-Saad and J. van der Zee (1996). Models of differentiated practice and specialization in community nursing: a review of the literature. *Journal of Advanced Nursing* 24: 968-980.

Jansen, P.G., A. Kerkstra, H.H. Abu-Saad and J. van der Zee (1997). Differentiated practice and specialization in community nursing: a descriptive study in the Netherlands. *Health & Social Care in the Community* 5: 219-226.

Liljegren, A., S. Höjer and T. Forkby (2014). Laypersons, professions, and governance in the welfare state: the Swedish child protection system. *Journal of Professions and Organizations* 1: 161-175.

Lowndes, V. and H. Sullivan (2008). How low can you go? Rationales and challenges for neighbourhood governance. *Public Administration* 86: 53-74.

McGarry, J. (2003). The essence of 'community' within community nursing: a district nursing perspective. *Health & Social Care in the Community* 11: 423-430.

Meurs, P. and T.E.D. van de Grinten (2005). *Gemengd besturen.* The Hague: Academic Service.

Muzio, D. and I. Kirkpatrick (2011). Introduction. Professions and organizations: a conceptual framework. *Current Sociology* 59: 389-405.

Noordegraaf, M., P. Meurs and A. Stoopendaal (2005). Pushed organizational pulls. *Public Management Review* 7: 25-43.

Noordegraaf, M. (2007). From 'pure' to 'hybrid' professionalism present-day professionalism in ambiguous public domains. *Administration & Society* 39: 761-785.

Noordegraaf, M. (2011). Risky business: how professionals and professional fields (must) deal with organizational issues. *Organization Studies* 32: 1349-1371.

Oldenhof, L., A. Stoopendaal and K. Putters (2013). Professional talk: how middle managers frame care workers as professionals. *Health Care Analysis* DOI 10.1007/s10728-013-0269-9

Oldenhof, L., J. Postma and K. Putters (2014). On justification work: how compromising enables public managers to deal with conflicting values. *Public Administration Review* 74: 52-63.

Pollitt, C. (1990). *Managerialism and the public services*, second edition. Oxford: Basil Blackwell.

Schmidt, K. (1999). Of maps and scripts: the status of formal constructs in cooperative work. *Information and Software Technology* 41: 319-329.

Schmidt, K. and C. Simonee (1996). Coordination mechanisms: Towards a conceptual foundation of CSCW systems design. *Computer Supported Cooperative Work (CSCW)* 5: 155-200.

Star, S.L. and A.L. Strauss (1999). Layers of silence, arenas of voice: the ecology of visible and invisible work. *Computer Supported Cooperative Work (CSCW)* 8: 9-30.

Strauss, A.L. (1985). Work and the division of labor. *The Sociological Quarterly* 26: 1-19.

Strauss, A.L. (1988). The articulation of project work: an organizational process. *The Sociological Quarterly* 29: 163-178.

Strauss, A.L., S. Fagerhaugh, B. Suczek and C. Wiener (1985, reprint 1997). *The social organization of medical work.* New Brunswick and London: Transaction Publishers.

Suchman, L. (1996). Supporting articulation work. In *Computerization and controversy: value conflicts and social choices*, R. Kling (ed), 407-423. San Diego, CA: Academic Press.

Taylor, F.W. (1911, reprint 1997). *The principles of scientific management*. Mineola NY: Dover Publications Inc.

Telegraaf (Dutch newspaper) (2004). *Dertig jaar grootheids(waanzin) afgestraft (Thirty years of up-scaling megalomania is being punished)* pp. 4.

Thacher, D. and M. Rein (2004). Managing value conflict in public policy. *Governance* 17: 457-486.

Timmermans, S. and B. Freidin (2007). Caretaking as articulation work: the effects of taking up responsibility for a child with asthma on labor force participation. S*ocial Science & Medicine* 65: 1351-1363.

Tonkens, E. (2003). *Mondige burgers, getemde professionals (Articulate citizens, tamed professionals)*. Amsterdam: Uitgeverij Van Gennep B.V.

Van Dalen, A. (2012). *Zorgvernieuwing (Healthcare innovation)*. The Hague: Boom Lemma Uitgevers.

Van der Meer, E. and J. Postma (2012). *De 'Zichtbare schakel' wijkverpleegkundige (The 'Visible link' neighbourhood nurse)*. Amersfoort: BMC.

Van der Zee, J., K. Kramer, A. Derksen, A. Kerkstra and F.C.J. Stevens (1994). Community nursing in Belgium, Germany and the Netherlands. *Journal of Advanced Nursing* 20: 791-801.

Wallenburg, I., J. K. Helderman, A. de Bont, F. Scheele and P.L. Meurs (2012). Negotiating authority: a comparative study of reform in medical training regimes. *Journal of Health Politics, Policy and Law* 37: 439-467.

Waring, J. and S. Bishop (2013). McDonaldization or commercial re-stratification: corporatization and the multimodal organisation of English doctors. *Social Science & Medicine* 82: 147-155.

Waring, J. and G. Currie (2009). Managing expert knowledge: organizational challenges and managerial futures for the UK medical profession. *Organization Studies* 30: 755-778.

Witman, Y., G.A. Smid, P.L. Meurs and D.L. Willems (2011). Doctor in the lead: balancing between two worlds. *Organization* 18: 477-495.

ZonMw (Netherlands Organization for Health Research and Development) (2009). *Uitvoeringsprogramma Zichtbare schakel (Visible link program)*. The Hague: ZonMw.

ZonMw (Netherlands Organization for Health Research and Development) (2011). *2 jaar Zichtbare schakel (2 years of Visible link)*. The Hague: ZonMw.

Chapter 6

Middle managers distributing leadership in neighbourhood governance

Co-authors: A. Stoopendaal and K. Putters
Under review in: *Local Government Studies*

Abstract

This paper addresses the key question of how leadership is being reconfigured in current neighbourhood governance. Building on theories of distributed leadership (DL), we argue that neighbourhood leadership should not automatically be equated with the notion of an individual leader, but must be researched as a distributed activity enacted by a collective of local actors. Our qualitative study of Dutch neighbourhood collaboratives by public service providers offers important insights into 'how' leadership is distributed and to what effect. Rather than a spontaneous bottom-up process, DL is steered by middle managers of public service providers. Middle managers not only distribute leadership to local actors, but also *reshape* responsibilities of citizens, professionals and themselves in the process. Three important consequences of distributing leadership are: 1) organizational responsibilities for citizens and professionals to locally solve problems 2) the repositioning of middle managers as coach, 3) new maneuvering room for professionals. The findings also demonstrate that DL is a two-way street: parallel to distribution, new centralization occurs via emerging coordinating roles. We conclude that DL has both a bright and dark sight. It provides opportunities for locally tailored services, but also carries the risk of overburdening citizens and professionals.

Keywords: distributed leadership, neighbourhood governance,
middle managers, professionals, citizens, public service providers.

Introduction

Across Europe, policymakers increasingly view neighbourhoods as appropriate governance sites due to their local scale (Lowndes and Sullivan 2008). On the scale of the neighbourhood, various public reform goals are addressed, such as integration of fragmented public services, local entrepreneurship and the empowerment of self-reliant citizens (Chaskin 1998; Purdue 2001; Lowndes and Sullivan 2008; Davies and Pill 2012). Arguably, policy attention for neighbourhoods is not new. Neighbourhoods have featured in classical discussions about decentralization and the effectiveness of small-scale governance (Lowndes and Sullivan 2008). Current neighbourhood-based reforms often build on these classical arguments, but are also rooted in the contemporary transformation of the welfare state and the transition from 'government to governance' (Rhodes 2007, p. 1254). Rather than top-down steering and provision of public services by central government, local parties are expected jointly organize the provision of public services, such as welfare, care, and housing. Governance on the scale of the neighbourhood is defined by different scholars with the term *neighbourhood governance* (Purdue 2001; Lowndes and Sullivan 2008; Durose and Lowndes 2010; Davies and Pill 2012; Griggs and Roberts 2012), which signifies 'arrangements for collective decision making and/or public service delivery at the sub-local level' (Lowndes and Sullivan 2008, p. 62).

As Lowndes and Sullivan note, a central implication of neighbourhood governance is the 'transfer of political and/or managerial authority from 'higher' to 'lower' level actors (ibid: p.62)'. This transfer potentially puts a wider variety of local actors 'in the lead', including individual citizens, neighbourhood groups, professionals of public service providers, local politicians and entrepreneurs. Collectively, these local actors are considered to be 'in the lead' with regards to joining-up public services in neighbourhoods, finding new ways to organize informal support, and developing community initiatives (ibid).

So far, little attention has been paid to the actual process that underpins this transfer of political and/or managerial power. Existing studies of neighbourhood governance have primarily focused on the results of this transfer in terms of community empowerment, citizen participation, and democratic dialogue (Pill and Bailey 2012; Durose and Lowndes 2010; Farrelly 2009; Kokx and van Kempen 2009). For example, Pill and Bailey's study of neighbourhood governance in Westminster (2012) demonstrates that commitment of central government to neighbourhood governance, does not necessarily result in more local empowerment and co-production due to continuing dependency on central funding and policy targets.

In this paper we adopt a different approach by zooming in on *the process* that underpins the transfer of managerial power to lower level actors. Building on theories of distributed leadership (Gronn 2002; 2008; Martin et al. 2009; Oborn et al. 2013; Currie and Lockett 2011), we investigate 'how' leadership is distributed to local actors and to what effect. Our study is based on a qualitative investigation of a Dutch reform program, called the Neighbourhood Based Approach (NBA, 2010-2011). This program was partially financed by the Dutch Ministry of Health, Welfare and Sports and was executed by public service providers from the care & welfare sector. The goal of the program was threefold: 1) to create integration between fragmented public services in the care, welfare and housing sector, 2) to empower citizens and

professionals to organize neighbourhood based support and identify opportunities for service improvement, 3) and to reduce societal costs via the prevention of health related problems. The implementation of the NBA-program was delegated to 10 project leaders, who mainly had a function as middle manager in their 'home organization': i.e. they were responsible for the supervision of several teams of frontline professionals and were supervised by higher management (Birken et al. 2011). As 'NBA-project leader', they were also responsible for orchestrating collaboration 'outside' their own organization (care/welfare). This meant spanning boundaries between different service organizations in the neighbourhood (i.e. welfare, care and housing) and supervising multi-disciplinary neighbourhood teams. By observing middle managers in the NBA-program, we were able to investigate how managers were involved in the local distribution of leadership. The research question we address is: how do middle managers of public service providers distribute leadership in the space of neighbourhood and what are the main consequences of this distribution for citizens, professionals and managers?

The outline of the paper is as follows. We briefly discuss the Dutch context of neighbourhood governance. We then outline existing studies on neighbourhood leadership and argue that the current focus on individual leaders (e.g. community leaders and local leaders) needs to be supplemented with attention for distributed leadership. After describing our case study and methods, we present our main findings. The results section demonstrates that middle managers not only *distribute* leadership to a wider variety of local actors, but also *reshape* responsibilities of those local actors in the process. Finally, we provide a conclusion and reflect on the 'bright' and 'dark' sights of distributed leadership.

The Dutch context of neighbourhood governance

Similar to the United Kingdom (Lowndes and Sullivan 2008; Durose and Lowndes 2010; Pill and Bailey 2012), the Netherlands has a long history of area-based interventions, which facilitate the regeneration of neighbourhoods and promote citizen participation (RMO 2008). Recently though, neighbourhoods have moved prominently into the mainstream policy agenda (Van Hulst et al. 2011). In 2007, the Dutch government labeled 40 deprived neighbourhoods as 'problem neighbourhoods'. These deprived neighbourhoods have been focal points for cross-sector interventions and have received considerable resources to empower citizens and to reform physical and social structures (ibid.). A recent policy evaluation by a governmental planning agency (SCP 2013), provided mixed conclusions about the effectiveness of regeneration policies in deprived neighbourhoods. Although neighbourhoods residents were generally more satisfied, no significant improvements were measured in terms of safety, livability, and social-economic status of the residents (ibid.).

In addition to these area-based initiatives, the Dutch government has introduced new legislation that promotes citizen participation and alternative governance arrangements on a local level. The implemented Dutch Social Support Act (2007), symbolizes a major welfare state reform (Putters et al. 2010). The central

government not only decentralizes responsibilities for social care and support to local governments, but also advocates 'a broader paradigm shift that should change the way in which clients, citizens, governments and providers act and think' (Putters el al 2010: p. 3). The core of this paradigm shift is constituted by the replacement of citizen's entitlements to care and support for a compensation principle by local governments (ibid.). As a consequence, local governments have to compensate citizens who are unable to participate in society with 'locally tailored' solutions. These solutions can still include 'individual' arrangements for support/care provided by professional service organizations, but increasingly a shift is taking place towards more 'collective' solutions, such as neighbourhood facilities and social support structures by neighbours, family and friends (Van Dijk et al. 2013).

The latest Dutch government coalition, further builds on this local paradigm shift. In a recent declaration, the government argues that care and support should preferably be organized 'close by' in neighbourhoods rather than in large-scale institutions (*Dutch Government* 2012). Neighbourhood-based care and support entails the geographical reordering and joining-up of specialized public services and the (partial) substitution of 'formal' services, provided by public service organizations, for 'informal' self-help by citizens and neighbourhood networks. It is assumed that neighbourhood-based care and support is more effective and efficient because of its appeal to self-reliance and new opportunities for professionals to locally create 'tailored' services if citizens are unable to solve problems themselves (ibid).

These developments towards neighbourhood governance are rooted in Dutch legislation and policy reform, but resemble many underlying rationales of neighbourhood governance that Lowndes and Sullivan previously identified in the UK (Lowndes and Sullivan 2008). In the Dutch context, the civic (active citizenship), social (citizen well-being) and economic rational (efficient en effective service delivery) seem particularly prevalent as drivers of change. A Dutch case of neighbourhood governance can provide further insights into the working of these rationales beyond the UK context.

Neighbourhood governance: from individual to distributed leadership

As Pill and Baily assert (2012), new institutional arrangements in neighbourhoods are not just dependent on regulations, but also on leadership of key players. When broadly defined, leadership denotes the ability to influence key objectives, strategies and commitment (Yukl 1989; Alvesson and Sveningsson 2003). According to Gronn, leadership involves different units of analysis, as it can be ascribed to 'one individual, an aggregate of separate individuals, sets of small numbers of individuals acting in concert or larger plural-member organizational units' (Gronn 2002: p. 428).

Interestingly, existing studies on neighbourhood and local leadership, pay much attention to *individual leaders* who have the ability to successfully collaborate with a broad variety of stakeholders and broker trust (Purdue 2001; Bergström et al.

2008; Durose and Lowndes 2010). In literature, different types of leaders are mentioned such as 'community leaders' (Purdue 2001; Purdue et al. 2000), 'local leaders' (Grint 2011), 'catalyst leaders' (Luke 1997), 'political and administrative leaders' (Bergström et al. 2008), 'entrepreneurial leaders', 'business leaders' and 'city leaders' (Purdue 2001; Durose and Lowndes 2010). The background of these leaders differs, but a common denominator is that individual leaders have the capacities to advance local collaboration in such ways that stakeholders, despite competing interests, collectively deal with wicked problems and achieve public outcome.

Although individual leaders can be important for creating 'good' neighbourhood governance, we argue that it is necessary decenter leadership and pay more attention to *distributed forms of leadership.* A distributed approach to leadership no longer automatically equates leadership with an individual leader, but is built on the assumption that leadership functions -i.e. making key decisions, influencing organizational culture, steering outcomes- can also be enacted by a collective of people (Gronn 2002). As Oborn et al. (2013) note, distributed leadership 'includes activities that are 'stretched out' over multiple people in diverse stakeholder groups and across numerous tools and situations' (ibid. p. 254). By considering leadership as a distributed activity, it becomes possible to move beyond the notion of leadership as solely determined by individuals and special characteristics (Gronn 2002). This seems especially necessary in the case of neighbourhood governance since power is distributed across various local actors and decision-making is negotiated in nature (Lowndes and Sullivan 2008).

The idea of distributed leadership is not new, as Mayrowetz notes (2008). Yet, there is still insufficient understanding of *the distribution process*: 'how' is leadership actually distributed and 'by whom' (Oborn et al. 2013; Currie and Lockett 2011; Martin et al. 2009)? In a recent literature review, Currie and Lockett conclude that there are no definite answers to these questions. On the one hand, there are authors who argue that DL 'does not mean the absence of leadership hierarchy' and in fact requires top-down involvement of managers (2011, p. 290). In this view, managers are facilitators of leadership: empowering others to lead themselves (Raelin 2013; Buljac-Samardžić 2012). On the other hand, there are authors who believe that in essence 'nobody is in charge' and distributed leadership is a spontaneous bottom-up process (Buchanan et al. 2007, cited in Currie and Lockett 2011, p. 290). By investigating the Dutch Neighbourhood Based Approach Program, we aim to shed light on this still underresearched distribution process.

Methods

Our qualitative study is based on the Dutch reform program, called 'The Neighbourhood Based Approach' (January-December 2011). Ten public service providers of care and welfare were allowed to participate in the program on the condition that they would contribute to inter-organizational collaboration (care, welfare and housing), holistic client support, and develop neighbourhood initiatives that empowered citizens and preferably substituted 'formal' services for 'informal' support. A consultancy firm was

appointed by the Ministry of Health, Welfare and Sports to evaluate the program and to organize collective project days for learning exchange.

We used the technique of 'zooming out' (Nicolini 2009) by investigating the broader dynamics of the reform program. To attain an overview, we observed collective project days (n=6). During these days, middle managers discussed experiences with peers and attended presentations by external consultants about local network collaboration. Additionally, we 'zoomed in' on the daily work of middle managers *on site*: working on their individual project. We observed middle managers (n=4) from August 2011 until May 2012 (most projects continued after funding had ended). The first middle manager carried responsibility for a multi-functional neighbourhood accommodation (MFA), which provided support to elderly people, clients with a handicap and young children. The second middle manager coordinated collaboration between two care organizations that provided sheltered housing to young adults who were homeless and had psychiatric/mental problems. To cope with multi-problems, expert knowledge of two care organizations was combined and a housing association provided small-scale accommodation that allowed for the integration of clients into the neighbourhood. The third and fourth middle manager were jointly responsible for a cross-sector collaborative between a housing association, a home care organization and a welfare organization. The aim of the project was to strengthen the social structure of two deprived neighbourhoods in a mid-large Dutch city. The neighbourhoods were selected because they supposedly lacked 'social cohesion'. All three projects made use of integrated neighbourhood teams, which included professionals from different backgrounds (housing, care and welfare). Neighbourhood teams were expected to develop holistic, integrated approaches to service provision while at the same time empowering citizens to take care of their own life as much as possible.

Multiple data collecting methods were used including: informal interviews with middle managers and professionals; observations of daily work of middle managers, including coaching sessions, team meetings with care workers and consultations with citizens; document analysis of minutes and strategic visions; and a survey with middle managers who evaluated the outcome of their projects and daily dilemmas. In total, we conducted 15 days of observations in the three projects (n=15). A voice recorder was used during all observation days and elaborate field notes were made.

During observations and interviews, we did not search for a common definition of leadership that is generalizable to a broad variety of settings (Alvesson and Sveningsson 2003b). Instead, we investigated mundane constructions of leadership in the specific setting of the NBA-Program. By focusing on middle managers – in interaction with peers, professionals and sometimes citizens – we were able to show that leadership and its distribution is a 'co-constructed reality, in particular, the processes and outcomes of interaction between and among social actors' (Fairhurst and Grant 2010: p. 175). This transforms leadership from a pre-determined hypothesis of the researcher to a contextual phenomenon that is constructed by organizational actors themselves. Moreover, we particularly focused on leadership talk and its performative effects on mundane work practices (Martin and Learmonth 2012; Alvesson and Sveningsson 2003b).

When analyzing the data, we specifically looked for language references to leadership. Because we did not want to limit ourselves to references to the single word 'leadership', we investigated a broad variety of language references –so to say proxies of leadership- including terms like 'being in the lead', 'taking the initiative', 'leading', and 'project leadership'. These language references were usually made by middle managers in interaction with peers, professionals and sometimes citizens. We were therefore able to investigate how leadership was co-constructed and distributed in practice.

Results

We first describe how middle managers in the NBA-program attempt to distribute leadership by rhetorically framing citizens and professionals as being 'jointly in the lead' in organizing neighbourhood based support, redesigning services and reviving deprived neighbourhoods. We then outline three consequences of distributing leadership: 1) organizational responsibilities for citizens and professionals to locally solve problems, 2) the repositioning middle managers as coach, 3) new maneuvering room for professionals. Leadership is not only distributed in a numerical sense (more actors in the lead), but also qualitatively, i.e. responsibilities of local actors are being reshaped in the process of distribution. Finally, we demonstrate that attempts to distribute leadership are simultaneously accompanied with efforts to 'recenter' leadership via new coordinating roles.

Distributing leadership: professionals and citizens 'in the lead'

In the NBA-program, middle managers frequently referred to professionals and citizens as being the ones 'in the lead', 'taking charge' and 'leading the initiative' in the neighbourhood. This pro-active image of citizens and professionals was contrasted with a passive portrayal of managers as the ones who had to 'give up control' and 'trust' in people rather than centrally steer local processes on the basis of organizational production targets. Hence, leadership – here defined as 'being in the lead' – was rhetorically decoupled from a managerial position and collectivized to a broader group of actors, as becomes clear from the following two conversations:

> A middle manager gives a presentation to other project leaders of the NBA-program: 'We have to collaborate in care and in other services. It is the professional who has to take the lead, together with citizens. But the professional is steered by a management layer that wants to control and confine. So the executives of different service organizations (names omitted) have now signed a declaration of intent which states

that managers need to give room to professionals to develop things, not to control them.' (25-11-2011)

A middle manager in the NBA-program addresses a newly formed integrated neighbourhood team, which includes professionals from different service providers: 'Management shouldn't tell you anymore what you should do. That's the old way of doing things. They have to support you in doing your job well'. A team-coordinator responds by saying: 'it would be quite nice if a professional could say to the manager. I want to determine myself how I use my hours' (referring to organizational production targets of service providers and accountability for time-use). Frontline worker: 'We are not used to this. Usually, managers say how we should do it. But now we should tell managers how things should be run?' Team-coordinator: 'Now the roles have changed, managers should be accountable to you!' (17-10-2011)

Generally speaking, citizens and professionals were expected to jointly take the lead because they both possessed local, specific knowledge about problems in neighbourhoods, such as loneliness of elderly or a lack of physical infrastructure (e.g. communal buildings). Although middle managers projected an image of shared knowledge use by professionals and citizens in 'neighbourhood networks', it appeared that these networks were not necessarily already in place, but were more an object 'in the making'. The development of neighbourhood networks was facilitated in one of the NBA-projects by organizing meetings in certain deprived neighbourhoods. During these meetings, professionals (including neighbourhood nurses, welfare workers and employees of housing associations), citizens and a middle manager discussed jointly how to transform a socially deprived neighbourhood into a 'caring' neighbourhood. However, during these meetings it became clear that citizens had very different interpretations of a caring neighbourhood than professionals. Whereas citizens referred to 'caring' as a professional activity that should be carried about by service providers (i.e. professionals 'in the lead'), professionals discussed 'caring' as form of informal neighbourhood help that could potentially replace or postpone professional services (i.e. citizens 'in the lead').

The different interpretations of a 'caring' neighbourhood demonstrate that *joint* leadership in networks was a highly negotiated co-construction. In this co-construction, the question 'who' is supposed to be 'in the lead' was passed back and forth between citizens, professionals and managers, as becomes clear from the following discussion during a neighbourhood meeting:

An owner of a Do-It-Yourself shop directs his attention towards a member of the residential committee: 'You have a function as a residential committee. You have to look beyond the dog pooh. Your neighbourhood newsletter only contains moaning and groaning. Why don't you use your newsletter for announcing that you are going to organize social activities in the neighbourhood, for example doing groceries together with lonely people?'. The member of the residential committee does not immediately warm to this suggestion: yeah.... but why can't we use professionals for

> doing that? A neighbourhood nurse is quick to react: 'no, we have to stay with you for a while. Why can't you do it yourself?' A manager joins the plea of the neighbourhood nurse: 'do you for example know any widowers in the neighbourhood? You can visit them at home and pay them attention.' The member of the residential committee replies: 'Yes I know one, his loneliness is driving him crazy, but I think we need to enlist the help of professionals.' The neighbourhood nurse seems unwilling to adopt this suggestion: 'Not everything can be done by professionals. The problem seems to be that there is a lack of organizational capacity in the neighbourhood.' The DIY owner joins the conversation again: 'It is difficult. I think residents of the neighbourhood are all individualists. The biggest problem is: how do you get them away from their tv's? How do you get them out of their hut? And I think professionals should be the ones to do that. When I knock on the door of someone who is lonely and I introduce myself by saying "I am Peter (different name), the local entrepreneur, do you want to have a cup of coffee with me?", then they will think I am nuts! People do not want to admit that they are lonely. They have a certain proud and they are afraid.' (9-11-2011)

As this conversation illustrates, managerial talk about collaboratively 'being in the lead' in neighbourhoods, did not automatically translate into joint leadership *practices*. Citizens that were present at the neighbourhood meeting seemed to feel uncomfortable to involve themselves in the private life of other neighbourhood residents, as the quote of the DIY owner suggests.

Middle managers not only talked about 'being in the lead' in a collaborative sense (citizens and professionals working together in neighbourhood networks), but also in oppositional ways. Middle managers argued that clients and their individual choices should be put 'in the lead' *vis-à-vis* 'professionals'. This resonates with New Public Management discourse about consumer-driven services and the call for professionals to redesign services according to individual choice rather than existing supply. This consumer driven discourse was supplemented in the NBA-program with a new emerging discourse of active citizenship. People who needed care or support were not just portrayed as consumers/clients, but also as active citizens who had to take care of themselves and their own network (family, friends, neighbours). Care workers were portrayed as the ones who were inclined to *take over* responsibilities of clients by providing too much care. By projecting this image of care workers, middle managers simultaneously conveyed the message that care workers should not invest all their time in 'caring for' clients by providing physical care themselves, but should 'organize' that clients could function as independently as possible. This could for example be achieved by a joint-up approach to service delivery. For example, when a client expressed the wish to live independently at home despite deteriorating health, care workers were encouraged to enlist the help of employees from a housing association to make physical adjustments in the client's home. This joint-up approach could prevent an early transferal of this client to a nursing home, thereby saving costs.

Consequences of distributing leadership

On the basis of our data we describe three main consequences of distributing leadership.

Organizational responsibilities for citizens and professionals to locally solve problems

An important consequence of distributing leadership, is that both citizens and professionals were being made responsible for local 'organizing', albeit in a different sense. Citizens who were immobile or ill were expected to organize informal assistance themselves, such as finding someone (a friend, neighbour of family-member) to do groceries or clean their house:

> 'We want that the neighbourhood provides a first shelter when you run into questions and problems, before you go to professionals. For example, when it snows, and you are no longer mobile, who is going to get you a loaf of bread?'(8-03-2012)

Being 'in the lead' was accompanied with increased expectations of self-reliance, as a middle manager stressed:

> 'We have a large group of people who think they still live in the social welfare state, that everything is taken care of by the state and professionals. But this group of people has to realize that they are independently responsible for their own lives.' (7-12-2011)

The transition of a social welfare state into a participation society entailed shifting responsibilities. Individual responsibilities of citizens were being 'foregrounded', while responsibilities of central government and public service providers were being 'backgrounded'. Middle managers argued that only when citizens were unable to solve problems themselves, it was appropriate to enlist professional help by service providers.

Citizens were also expected to concern themselves with broader issues in their environment, such as a lack of social cohesion in their own neighbourhood or loneliness of neighbours. So clients of service providers were increasingly viewed as 'active citizens' with organizational responsibilities for their own well-being and that of the broader community. This appeal to active citizenship and its accompanying responsibilities was not immediately embraced by citizens (see previous section). Consequently, middle managers and professionals alike mentioned that it was notoriously difficult to motivate people to fulfill their supposedly 'civic duties'. Due to a short time-span of the NBA-program (1 year), it may be the case that more emphasis is given to difficulties with citizen participation, whereas a longer time-span may have generated more positive experiences.

With regards to professionals, their 'being in the lead' also implied certain organizational responsibilities and obligations, yet different ones than that of citizens. Professionals in integrated neighbourhood teams were expected to come-up with locally tailored solutions: by supporting clients in becoming more self-reliant, enlisting volunteers/neighbours, and joining-up different services (care, welfare, housing) when clients had multiple problems. To that end, organizational responsibilities for team budgets and collective decision-making were delegated to neighbourhood teams. It was assumed that professional teams on the scale of the neighbourhood, could more easily join-up different services, determine local investments, and support citizens. In the following conversation between a manager and a newly set-up integrated neighbourhood team, it is shown how financial decision-making and budget keeping are being incorporated into professional work:

> Professional X of an integrated neighbourhood team: 'If we disagree and can't make a decision, then I think everything falls back on management'. Middle manager A of the NBA-program: 'No, because the executives of the service providers have declared that the integrated teams are self-steering. You (with emphasis) have to make the decisions'. Middle manager B of the NBA-program: 'Look, you know, employees are often scared to decide how they spend their budget. In Brazil, residents of neighbourhoods already make budgetary decisions themselves. They decide whether they spend money on trees or on parking spaces. That is exactly what you are going to do!' Professional X seems uncomfortable with the attribution of budgetary responsibility: 'But if we can't come to an agreement in the integrated team, then management should decide.' Middle manager B, in a decisive but comforting tone: 'no, you are going to do it yourselves, but there will always be management, that won't disappear.' (17-10-2011)

Professionals initially seemed reluctant to adopt these financial responsibilities. Nevertheless, later in the program we observed team meetings in which professionals made decisions about spending budget and financing new neighbourhood initiatives such as cooking nights for lonely people.

New organizational responsibilities implied that professionals were also 'in charge' when problems needed to be solved, such as insufficient budget or difficulties in cross-sector collaboration. These problems were still viewed by professionals as managerial responsibilities, but were now gradually incorporated into professional work. This incorporation of responsibilities made it more difficult for professionals to utter critique during team meetings about the feasibility of projects, as they were the ones who had initiated them. By framing professionals as self-steering actors, they were also made *accountable* for organizational outcomes, such as integration of service delivery and the reduction of costs via the substitution of professional services for informal help. During team meetings, middle managers emphasized that professionals should therefore be able to narratively account for their actions.

Repositioning middle managers as coach

As professionals adopt organizational responsibilities (i.e. budgetary tasks and intra-organizational collaboration) that are classically viewed as management tasks, one may expect a reduction in managerial workload. Nonetheless, middle managers complained that they had little time on their hands. Apparently, attempts to 'decentre' middle managers by distributing leadership, did not result in a disappearance of middle management. Rather, middle managers performed different roles, which did not lessen workload but changed its content. So, middle managers remained very much 'centred', but in which way?

Middle managers described a gradual, albeit significant transition in managerial roles from 'hierarchical steering and control' on the basis of organizational production targets towards 'coaching' of frontline staff:

> 'The way managers and executives think has to turn around: not wanting to control and dominate, but to let go and give space to the consumer to seek solutions together with professionals (...). While the current system requires managers that dominate ("control freaks"), the new system requires managers that are not afraid to let go ("coaches").' (survey answer by one of the middle manager in the NBA Program)

On first sight, 'letting go' may give the impression of management doing less. Yet, we observed that middle managers invested much time in 'coaching' workers to make independent decisions in integrated neighbourhood teams. They tried to avoid direct instructions and asked open questions that stimulated reflective thinking and independent decision-making. Examples of these questions were 'Why do you think this is good care?/ 'How do you want to proceed?' As one middle manager explained, it is not about the quickest solution, but about reaching a deliberative solution:

> 'I often have to balance with frontline staff, like Anna (different name). I want to get her to do things, but I do not want to offend her with instructive commands or expectations that are too high. Often I know the answers myself, but do not tell them. So I ask open questions and we talk about the client case together.' (18-08-2011)

Middle managers had to balance their emerging role as coach with their role as external boundary spanners, which they were also expected to perform in the NBA-program. To be able to span boundaries between different service providers and other local actors, middle managers were geographically mobile and often 'on the road'. They attended many meetings with local politicians, civil servants, managers of other service providers, neighbourhood committees, and local entrepreneurs in order to explore and negotiate the meaning of neighbourhood based support as an alternative to 'regular' care provision. Consequently, managers were not always visible for professionals on the work floor.

New maneuvering room for professionals

With the assignment of organizational responsibilities for collaboration in neighbourhoods, professionals appeared to gain new maneuvering room. They initiated cross-sector arrangements between service providers and citizens, which transcended their own disciplinary background and work domain. Concrete examples of these new arrangements are consulting hours for frail elderly with integrated teams (i.e. including professionals from the welfare, housing and care sector) and collaborations between care organizations and schools with regards to work experience for clients with disabilities and 'regular' vocational students.

Skeptics could argue that maneuvering room only exists in managerial rhetoric about entrepeneurship and leadership. Yet we observed that professionals indeed strengthened cross-sector relations and tried to create tailored services. In the following quote, a neighborhood nurse describes how her work has changed since the assignment of her role as lynchpin in the neighbourhood:

> 'I used to have less freedom. I had to make production: do the same route every time. Quickly helping people with their elasticated stockings. I noticed that people had different problems, such as loneliness or an unsuitable housing situation, but I didn't have the time to address these problems (...). Now I work as a neighbourhood nurse and I have to switch between care, welfare and housing. When I started as a neighbourhood nurse, I didn't know all the organizations in the neighbourhood. So I quickly went to a lot of network meetings (...). I was really surprised by all the different professionals who work in the neighbourhood! When you get to know each other, it reduces the threshold when you want to transfer clients. So now I say to a client: I know this person from organization X, why don't you contact her?' (16-05-2012)

This example shows that professionals like the neighbourhood nurse increasingly occupy 'in-between organizational spaces' on the scale of neighbourhood. These spaces provided maneuvering room to build cross-sector relations and strengthen ties with neighbourhood actors, but were also perceived as confusing spaces. Professionals noted that it was difficult to keep oversight of all the neighbourhood initiatives organized by different service providers, local government and citizens themselves. Many professionals felt the need for more oversight and 'linkage':

> Professional A: 'Look, there are so many initiatives. The local government already has a project called "Dreams about Helmerbuurt" (fictional name of neighbourhood). For this project residents had to describe their dreams for the neighbourhood.' Professional B: 'I have the feeling that our neighbourhood meetings strongly resemble "Dreams about Helmerbuurt", we more or less do the same thing all over again.' Professional A: 'I notice that I have lost oversight. You have the workers lunch, the workers meetings, "Dreams about Helmerbuurt", the neighbourhood meetings... if I wanted to I could do something every night.' Professional B: 'I miss a link between all these initiatives.' (9-11-2011)

The occupation of in-between spaces thus required a good deal of sensemaking by professionals: what is the scope of this space, how does it relate to the neighbourhood, and does it make sense to join-up different neighbourhood initiatives? It appeared that professionals appreciated the active involvement of middle management in these sensemaking processes.

Recentering leadership: just a few 'in the lead'

Attempts to distribute leadership were simultaneously accompanied with efforts to 'recenter' leadership. Professionals questioned the feasibility of collective decision-making in integrated neighbourhood teams and wondered whether it would not be a better idea to informally assign a few people as coordinators or team captains:

> Professional A: 'To whom am I accountable in an integrated team? That is not really clear to me'. Middle manager: 'well, you have to consider how decisions are made, on the basis of consensus? Or democracy?(...).' Professional B: 'I think we need a team captain who can decide.' (17-10-2011)

Middle managers also encouraged team-members to assign coordinating roles to individuals. In the end most integrated teams in the NBA program functioned with a team-coordinator, who was either assigned by a middle manager or was informally promoted by peers.

Team members were often relieved that a team-coordinator was responsible for coordinating work:

> Team-coordinator of an integrated neighbourhood team: 'We have to coordinate more, especially between our team and the structure committee. I think it's a difficult one. How should we go about?' A team member of the housing association argues that they should not invest too much effort in coordinating: 'We can read each others minutes, we already have enough meetings as it is.' The team-coordinator seems to think this is not enough and half humorously, half grudgingly offers to do it herself: 'As a coordinator of this team, I can once in a while join meetings of the structure committee. After all, I have been bombarded as a coordinator of this team, haha!' All team members seem relieved and laugh. A team worker then comments: 'Well I am really glad that you are the coordinator.' (16-05-2012)

Coordinating work was perceived by some professionals as 'additional work', which distracted them from their 'real' work, namely providing client care and face-to-face contact. Nevertheless, middle managers emphasized that inter-organizational coordination and 'being in the know' about developments outside one's own organization, was an essential part of professional work. Without inter-organizational knowledge,

holistic service provision would be unattainable in the first place. Professionals were therefore encouraged to attend meetings outside the remit of their work territories.

Another way to recenter leadership, was to delegate responsibilities for coordination to new 'lynchpin' functions, such as neighbourhood nurses. As lynchpin, they were expected to 'take the lead' in coordinating services in care, welfare and housing that were provided by different organizations (see previous section, p. 11). When clients needed assistance, neighbourhood nurses could ensure a referral to the appropriate service provider(s) or link-up services by making integrated care arrangements. Middle managers also tried to recenter leadership by framing residents as the focal point of their neighbourhood. For example, during a neighbourhood meeting, citizens known for their active social role in the neighbourhood were framed as the 'the social heart of the neighbourhood' who could signal problems (e.g. loneliness) and connect neighbours. These organizational attempts to put active citizens 'in the lead' did not always materialize in practice, as citizens reframed the organizational lead in terms of a 'professional responsibility' (see previous results, p. 9).

Discussion and conclusion

This article has addressed the key question of how leadership is distributed and reconfigured in current neighbourhood governance. As Lowndes and Sullivan noted (2008), an important implication of neighbourhood governance is the transfer of managerial authority to lower level actors, which potentially puts a wider collective of local actors 'in the lead'. Yet still little is known about the underlying process that supports this transfer. Our Dutch study of neighbourhood collaboratives reveals that middle managers of public service providers play a crucial role in distributing leadership to professionals and citizens. The distribution of leadership is not only numerical in nature (i.e. more local actors in the lead), but also entails the *reshaping* of responsibilities of citizens, professionals and managers themselves. Three consequences of distributing leadership are: 1) organizational responsibilities for professionals and citizens, 2) the repositioning of middle managers as coach, and 3) new maneuvering room for professionals.

We contribute to existing theory on neighbourhood governance by arguing that the current focus on individual leaders (Luke 1997; Purdue 2001; Purdue et al. 2000; Bergström et al. 2008; Grint 2011; Durose and Lowndes 2010), should be supplemented by attention for leadership as a distributed activity that is 'stretched out' over a collective of local actors (Currie and Locket 2011; Oborn et al. 2013). Our study offers important insights about the process of distributing leadership and its consequences. First, contrary to expectations (Gronn 2002), the distribution of leadership is not a spontaneous, bottom-up process but is steered 'from the middle' by management. In the NBA-program, middle managers rhetorically decoupled 'the lead' from their own managerial position and framed citizens and professionals as being 'jointly in the lead' in neighbourhoods. Second, our study suggests that managerial rhetoric about leadership is not 'just talk', but also has certain performative

effects (Austin 1978; Oldenhof et al. 2013): i.e. in the process of distribution the nature of organizing and social relations is being reconfigured. Clients of public service providers are increasingly portrayed as 'active citizens' who need to 'organize' their own support or enlist informal help by neighbours, friends and family. Middle managers emphasized that professionals should also engage in 'organizing' rather than merely 'caring for' clients in a physical sense. This organizing included arranging a social network that supported clients, substituting 'expensive care' for less costly interventions, and integrating different services (e.g. housing adjustments and social support) that enable clients to live independently at home. To that end, middle managers coached professionals to take 'the organizational lead' in self-steering neighbourhood teams by allocating budgets, networking and coordinating cross-sector collaboration (i.e. welfare, care, housing). These forms of professional organizing demonstrate that organizing is not just a managerial responsibility, as suggested by the classic management acronym POSCORB (planning, organizing, staffing, directing, coordinating, reporting and budgeting). Hence, new forms of organizing are developed which provide an alternative to managerial organizing (Parker 2002; Noordegraaf 2011). Paradoxically, distribution of leadership to professionals and citizens did not result in the disappearance or 'decentering' of managers (Anderson 2008). Although middle managers frequently discussed a reduced role for management and the necessity of 'letting go', they still remained 'centred' in alternative ways due to their emerging role as coach of self-steering neighbourhood teams and their external role as boundary spanner on a management/policy level between different service providers.

Despite common associations with participatory decisionmaking (Mayrowetz 2008), the distribution of leadership has not resulted in a democratic utopia in which everyone is equally 'in the lead'. We observed that the distribution of leadership involved a complex game of passing back and forth leadership between management, professionals and citizens. Professionals attempted to *recenter* leadership by developing new coordinating roles. For example, they informally appointed fellow team members as captain. Additionally, citizens were not always willing to 'take the lead' and *re*framed leadership in terms of a professional responsibility of service providers. Hence, rather than leadership being evenly distributed (i.e. everyone 'in the lead'), leadership is in fact enacted by a more select group of actors (i.e. a few 'in the lead'), including professionals with coordinating tasks, middle managers with coaching roles, and 'willing' citizens.

Confirming previous studies on distributed leadership (Spillane and Orlina 2005; Gronn 2002, 2008; Grint 2010, Currie and Lockett 2011; Martin and Learmonth 2012), we conclude that distributed leadership has both bright and dark sights. On the bright sight, maneuvering room and organizational responsibilities enable professionals to 'take the lead' by creating tailored solutions on a small-scale, joining-up fragmented professional work and disciplines, and engaging with local communities. On the dark sight, we also see some disadvantages. When talk about active citizenship becomes too politicized, it may burden people with duties, like self-reliance and neighbourliness, which they may be unwilling or unable to fulfill (Davies and Pill 2012; Kokx and Kempen 2009; Van de Bovenkamp 2010). Another potential dark sight of distributed leadership, is that it may create the false impression that professionals are always able to 'creatively solve' problems (e.g. rising healthcare

costs) on the scale of the neighbourhood. Yet, as Durose and Lowndes have argued, policy problems cannot solely be addressed on a neighbourhoods scale because neighbourhoods are 'shaped by policy shifts and resource dependencies at the city, regional, national and European levels' (Durose and Lowndes 2010: p. 356). Consequently, neighbourhood approaches always need to be embedded in a multi-level governance environment in order to be effective (ibid.).

An important limitation of our research is the limited generalizability of our findings due to the specific Dutch setting of our study. Future research could therefore adopt a comparative approach by systematically investigating neighbourhood governance and leadership trends across different countries.

References

Alvesson, M. and S. Sveningsson (2003a). Managers doing leadership: the extra-ordinarization of the mundane. *Human Relations* 56: 1435-1459.

Alvesson, M. and S. Sveningsson (2003b). The great disappearing act: difficulties in doing 'leadership'. *The Leadership Quarterly* 14: 359-381.

Anderson, K.D. (2008). Transformational teacher leadership: decentering the search for transformational leadership. *International Journal of Management in Education* 2 (2): 109-123.

Austin, J. L. (1978). *How to do things with words* (2nd ed.). Oxford: Oxford University Press.

Bergström, T., H. Magnusson and U. Ramberg (2008). Through a glass darkly: leadership complexity in Swedish Local Government. *Local Government Studies* 34 (2): 203-220.

Birken, S. A., S-Y. D. Lee and B.J. Weiner (2012). Uncovering middle managers' role in healthcare innovation implementation. *Implementation Science* 7 (28) doi: 10.1186/1748-5908-7-28

Buljac-Samardžić, M. (2012). *Healthy teams. Analyzing and improving team performance in long-term care*. Rotterdam: Erasmus University.

Chaskin, R.J. (1998). Neighborhood as a unit of planning and action: a heuristic approach. *Journal of Planning Literature* 13: 11-30.

Currie, G. and A. Lockett (2011). Distributing leadership in health and social care: concertive, conjoint or collective? *International Journal of Management Reviews* 13: 286-300.

Davies, J.S. and M. Pill (2012). Hollowing out neighbourhood governance? Rescaling revitalization in Baltimore and Bristol. *Urban Studies* 49 (10): 2199-2217.

Dijk, H.M. van, Cramm, J.M., Nieboer, A.P. (2013). The experiences of neighbour, volunteer and professional support-givers in supporting community dwelling older people. *Health and Social Care in the Community* 21 (2): 150-158.

Dutch Government (2012). *Bruggen slaan. Regeerakkoord VVD en PvdA* 29-10-2012, see website link: [http://www.rijksoverheid.nl/regering/documenten-en-publicaties/rapporten/2012/10/29/regeerakkoord.html].

Durose, C. and V. Lowndes (2010). Neighbourhood governance: contested rationales within a multi-level setting – a study of Manchester. *Local Government Studies* 36 (3): 341-359.

Fairhurst, G.T. and D. Grant (2010). The social construction of leadership. A sailing guide. *Management Communication Quarterly* 24 (2): 171-210.

Farrelly, M. (2009). Citizen participation and neighbourhood governance: analysing democratic practice. *Local Government Studies* 35 (4): 387-400.

Griggs, S. and M. Roberts (2012). From neighbourhood governance to neighbourhood management: a 'roll-out' neo-liberal design for devolved governance in the united kingdom? *Local Government Studies* 38 (2): 183-210.

Grint, K. and C. Holt (2011). Leading questions: if 'Total Place', 'Big Society' and local leadership are the answers: what is the question? *Leadership* 7 (1): 85-98.

Grint, K. (2010). The sacred in leadership: separation, sacrifice and silence. *Organization Studies* 31 (1): 89-107.

Gronn, P. (2002). Distributed leadership as a unit of analysis. *The Leadership Quarterly* 13: 423-451.

Gronn, P. (2008). The future of distributed leadership. *Journal of Educational Administration* 46: 141–158.

Hulst, M. van, L. de Graaf and G. van den Brink (2011). Exemplary practitioners. A review of actors who make a difference in governing. *Administrative Theory and Practice* 3 (1): 120-142.

Kokx, A. and R. van Kempen (2009). Joining forces in urban restructuring: dealing with collaborative ideals and role conflicts in Breda, The Netherlands. *Environment and Plannning A* 41 (5): 1234-1250.

Lowndes, V. and H. Sullivan (2008). How low can you go? Rationales and challenges for neighbourhood governance. *Public Administration* 86 (1): 53-74.

Luke, J.S. (1997). *Catalytic leadership: strategies for an interconnected world*. New York: Jossey-Bass.

Martin, G., G. Currie and R. Finn (2009). Leadership, service reform, and public-service networks, the case of cancer-genetics pilots in the English NHS. *Journal of Public Administration Research and Theory* 19 (4): 769-794.

Martin, G. and M. Learmonth (2012). A critical account of the rise and spread of 'leadership' the case of UK health care. *Social Science & Medicine* 74 (1): 281-288.

Maxcy, B. D. and T.S.T. Nguyen (2006). The politics of distributing leadership: Reconsidering leadership distribution in two Texas elementary schools. *Educational Policy* 20: 163–196.

Mayrowetz, D. (2008). Making sense of distributed leadership: exploring the multiple usages of the concept in the field. *Educational Administration Quarterly* 44 (3): 424-435.

Nicolini, D. (2011). Zooming in and zooming out. Studying practices by switching theoretical lenses and trailing connections. *Organization Studies* 30: (12) 1391-1418.

Noordegraaf, M. (2011). Risky business. How professionals and professional fields (must) deal with organizational issues. *Organization Studies* 32 (10): 1349-1371.

Oborn, E., M. Barrett and S. Dawson (2013). Distributed leadership in policy formulation: a socio material perspective. *Organization Studies* 34 (2): 253-276.

Oldenhof, L., A. Stoopendaal and K. Putters (2013). Professional talk: how middle managers frame care workers as professionals. *Health Care Analysis*, published ahead of print: DOI 10.1007/s10728-013-0269-9.

Parker, M. (2002). *Against management*. Cambridge etc.: Polity Press.

Pill, M. and N. Bailey (2012). Community empowerment or a strategy of containment? Evaluating neighbourhood governance in the city of Westminster. *Local Government Studies* 38 (6): 731-751.

Purdue, D. K. Razzaque, R. Hambleton, M. Stewart, C. Huxham and S. Vangen (2000). *Community leadership in area regeneration*. Bristol: The Policy Press.

Purdue, D. (2001). Neighbourhood governance: leadership, trust and social capital. *Urban Studies* 38 (12): 2211-2224.

Putters, K., K. Grit, M. Janssen, D. Schmidt and P. Meurs (2010). *Governance of local care & social service. An evaluation of the implementation of the WMO in the Netherlands*. Rotterdam: Erasmus University.

Raad voor Maatschappelijke Ontwikkeling (2009). *De wijk nemen. Een subtiel samenspel van burgers, maatschappelijke organisaties en overheid*. Amsterdam: Uitgeverij SWP.

Raelin, J.A. (2013). The manager as facilitator of dialogue. *Organization* 20 (6): 818-839.

Rhodes, R.A.W. (2007). Understanding governance: ten years on. *Organization Studies* 28 (8): 1243-1264.

Sociaal Cultureel Planbureau (2013). *Werk aan de wijk. Een quasi-experimentele evaluatie van het krachtwijkenbeleid*. Den Haag: SCP.

Spillane, J.P. and E.C. Orlina (2005). Investigating leadership practice: exploring the entailments of taking a distributed perspective. *Leadership and Policy in Schools* 4 (3): 157-176.

Van de Bovenkamp, H. (2010). *The limits of patient power. Examining active citizenship in Dutch healthcare*. Rotterdam: dissertation Erasmus University.

Yukl, G. (1989). Managerial leadership: a review of theory and research. *Journal of Management* 15 (2): 251–289.

Chapter 7

Changing boundaries: middle managers doing boundary work in neighbourhood care

Co-authors: A. Stoopendaal and K. Putters
Submitted to: *Social Science & Medicine*

Abstract

In healthcare provision, organizational boundaries are often conceptualized as fixed barriers to service integration and change. However, this paper demonstrates the constructed nature of boundaries and their change potential. On the basis of an ethnographic investigation of the Dutch reform program 'The Neighbourhood Based Approach', we show how boundary work of middle managers encompasses both boundary (re) drawing and coordinating efforts of multiple service providers in new ways. By using boundary objects and new discourse, middle managers are able to reconfigure professional, sectoral, financial, accountability and geographical boundaries. As a result, alternative service arrangements and work formats are developed, such as inter-professional neighbourhood teams. On the basis of our results, we reflect on the challenging nature of boundary work and outline some conditions for doing boundary work.

Keywords: middle managers, boundary work, healthcare, inter-organizational collaboration, neighbourhoods.

Introduction

Boundaries have come to play a key role in studies on healthcare provision, collaborative partnerships, inter-organizational cooperation and service integration (Braithwaite et al. 1994; Callister and Wall 2001; Nancarrow and Borthwick 2005; Stern and Green 2005; Rugkåsa et al.; Allen 2009; Martin et al. 2009; Walker et al. 2009; Fitzpatrick and Ellingsen 2013; Arman et al. 2012; Sullivan and Williams 2012). In these studies, opposing views of boundaries co-exist. On the one side, boundaries are portrayed as roadblocks to reform and join-up fragmented services in health, social care and other sectors (Callister and Wall 2001; Stern and Green 2005; Martin et al. 2009). When explaining slow reform or difficulties in collaboration, authors frequently refer to the obduracy of professional, jurisdictional, statutory and organizational boundaries (Callister and Wall 2001; Stern and Green 2005; Hall 2005; Martin et al. 2009). These boundaries appear difficult to overcome, despite attempts of boundary spanning. On the other side, the importance of boundaries is downplayed with the notion of the 'boundaryless' organization (Braithwaite et al. 1994; Ashkenas et al. 2002; Rusu et al. 2010). According to several authors (Braithwaite et al. 1994; Rusu et al. 2010), the rise of network-based collaboration and e-health lead to boundary blurring and the disappearance of organizational boundaries altogether. In this view, boundaries are rapidly becoming a relict of the past.

We argue that both views don't do sufficient justice to boundaries as an analytical concept. The image of a 'boundary less health organization' may indeed capture recent developments like network-based partnerships and distributed leadership, yet it does not automatically imply that boundaries no longer exist (Barley and Kunda 2001). On the contrary, old boundaries may disappear, yet new boundaries come into being. Therefore, as Barley and Kunda note (ibid.; p. 78), 'the issue is not whether boundaries do or do not exist, but how and where people draw boundaries'. Additionally, the conceptualization of boundaries as roadblocks has limitations too. By portraying boundaries as barriers to change, one easily overlooks the possibility that boundaries can enable action, change and organizational learning (Giddens 1984; Douglas 2002; Hernes 2003 and 2004b; Balogun et al. 2005; Akkerman and Bakker 2011). For example, Hernes demonstrates how the construction of mental, social, physical boundaries is central to process of organizing and organizational change. According to Hernes (2004a), we are therefore well advised to study boundary-related activities if we want to study change.

We aim to contribute to the debate on boundaries by investigating how the activity of boundary drawing enables inter-organizational change in healthcare provision. Building on previous work of Science and Technology scholars (Gieryn 1983; Jasanoff 1987; Halffman 2003; Bijker et al. 2009; Star 2010), we use the concept of *boundary work* to guide our investigation. Conceptually, boundary work refers to activities that organizational actors perform when 1) drawing boundaries, and 2) coordinating work in new ways (Halffman 2003). The concept of boundary work was originally coined to explain the constructed demarcation between the world of science and non-science (e.g. policy and religion). Yet we feel that an application of boundary work in a healthcare setting has much to offer. It allows for a more flexible understanding of boundaries: not as a priori barriers, but as distinctions made by people to achieve certain goals in the organization of healthcare (e.g. improved

service provision). Additionally, a focus on boundary work enables us to foreground concrete activities that organizational actors perform when drawing and redrawing boundaries. By making this work visible, we are able to show 'how' boundaries are drawn and embodied.

Our study is based on a qualitative investigation of a Dutch transition program for care providers called 'The Neighbourhood Based Approach' (NBA). This program was co-financed by the Ministry of Health, Welfare and Sports. The main goals of the program were to join-up services by public service providers in health, social care, and housing, 2) develop new professional work formats on a neighbourhood scale. Our focus is on middle managers that participated in the NBA-program and were attributed the responsibility of project leader of cross-sector projects. As project leader, they were expected to not just 'manage across organizational boundaries', but to change those very boundaries. To be able to describe boundary work 'in action', we used ethnographic methods. The first author shadowed middle managers *in situ* and observed collective meetings of the NBA program (2011-2012).

This paper proceeds as follows. We first explain how boundary work contributes to an alternative understanding of boundaries. Next, we describe our ethnographic methods and the NBA-program. We then present our findings that show how middle managers conduct boundary work by means of language and objects. We conclude with theoretical implications of our research and recommendations for further research.

From boundaries to boundary work

Before zooming in on boundary work, it's necessary to briefly zoom out and explore the overarching concept of boundaries. As Lamont and Molnár note in their extensive literature review (2002), boundaries are more than barriers and roadblocks. In fact, boundaries are associated with a wide variety of phenomena, ranging from class differences, race/gender inequality and professional jurisdictions to scientific controversies, nation building and deterritorialization. In a broad sense, boundaries can be defined as distinctions that categorize people, objects, practices, time and space (ibid. 2002; Akkerman and Bakker 2011). According to Lamont and Molnar boundaries can refer to objectified forms of social differences and unequal access to resources. Yet they also observe a more symbolic use of boundaries as 'tools by which individuals and groups struggle over and come to agree upon definitions of reality' (2002; p. 168). In this last sense, boundaries are not the starting point of analysis (e.g. given inequalities that need be solved), but the outcome of struggles over whose classification of reality is deemed most legitimate (ibid 2002; Gieryn 1983; Wehrens et al. 2011). That is, boundaries are the result ofboundary work conducted by people rather than a-priori entities (Gieryn 1983; Halffman 2003).

This shift from boundaries to boundary work is a crucial one if we want to improve our understanding of organizational boundaries and organizing. An investigation of boundary work allows us to see how organizational classifications, such as 'top/bottom' and 'internal/external', are produced, renegotiated and accepted

as status quo in and between organizations. This status quo is far from permanent however. As Hernes notes (2004a), boundaries are constantly drawn and redrawn. Hernes considers this continuous process of boundary drawing intrinsic to organizing: 'Boundaries are not by-products of organization, but rather organization (defined broadly, ranging from informal groups to formal organizations) evolves through the process of boundary setting. Like any social system, an organization emerges through the process of drawing distinctions.' (Hernes 2004a: p. 10). This implies that organizational survival and maintenance is not automatically given, but the result of boundaries being reproduced and institutionalized into routines. Oppositely, organizational change can be understood as unsettling and opening up existing boundaries (Balogun et al. 2005; Chreim et al. 2013) or the drawing of new boundaries.

The concept of boundary work aligns with the symbolic use of boundaries as described by Lamont and Molnár (2002), but provides important additional insights. Boundary work does not merely focus on boundaries, but also on the work that needs to be done to accomplish those boundaries (Halffman 2003). It thereby answers the 'how' question: how are boundaries produced and what are they made of? Early studies on boundary work by Gieryn (1983) and Jasanoff (1987) demonstrate the importance of language use for creating boundaries. For example Gieryn demonstrates how scientists employ rhetorical strategies that exclude rivals (e.g. technicians, people in business and government) from the scientific domain by using words like 'pseudo' and 'amateur' (1983, p. 792). According to Gieryn boundary work can be defined as a rhetorical style and boundaries as discursive constructions. Building on Gieryn's insights, Halffman (2003) also emphasizes the importance of language: not just for constructing boundaries, but also for changing them.

Nonetheless, Halffman warns us too: boundary work should not be reduced to language only. In addition to language, he identifies people and objects as important *boundary devices* that embody the results of boundary work (ibid.). Boundary people function on the boundary of multiple social worlds (Star and Griesemer 1989), make connections between worlds, but also safeguard access to these worlds by deciding who belongs and who doesn't belong (Halffman 2003). Illustrations of boundary people are gatekeepers, such as journal editors who decide which articles are deemed scientific enough to be accepted to the journal (ibid.; Jasanoff 1987) or knowledge brokers that mediate and translate expertise (Kimble et al. 2010). In addition to boundary people, objects also play a crucial role in boundary work. Boundary objects can be used to connect social worlds and coordinate dispersed work (Star and Griesemer 1989; Carlile 2002; Bechky 2003; Levina and Vaast 2005; Allen 2009; Ootes et al. 2010; Star 2010; Sullivan and Williams 2012). According to Griesemer and Star (1989, p. 393) boundary objects are particularly suitable for translation and connecting worlds, given that they 'are both plastic enough to adapt to local needs and the constraints of several parties employing them, yet robust enough to maintain a common identity across sites'. Precisely because boundary objects are loosely defined, they facilitate collaboration between different communities that adapt boundary objects to fit their own identity (Allen 2009). Examples of boundary objects are standardized work forms (Star and Griesemer 1989), clinical pathways (Allen 2009) and multi-disciplinary teams (Sullivan and Williams 2012).

As becomes clear from the description of boundary devices (i.e. language, people and objects), boundary work is not just about making demarcations, but also

about coordination and integration. Boundary objects and boundary people are particularly suitable for integrating and smoothening conflicting efforts of different organizations, professions and communities of practice (Williams and Sullivan 2012). According to Halffman (2003) and Bijker et al. (2009), the definition of boundary work should therefore include the dual processes of division and coordination. By drawing boundaries, divisions are created that simultaneously specify conditions for future exchange and collaboration (Halffman 2003). Boundary drawing is thus always followed by coordination work in which actors rearrange activities in new ways (Bijker et al. 2009). This coordination concerns practical and political questions about a different work division (who does what) and distribution of resources (who gets what).

The dual definition of boundary work, as a means for creating (new) divisions and coordination, is especially useful when we want to get a better grip on inter-organizational dynamics in healthcare.

Boundary work in healthcare

In healthcare, fragmentation of service provision by multiple organizations is a recurring theme (Sullivan and Williams 2012). Frequently, boundaries in finance, professional expertise and regulations are conceptualized as roadblocks and barriers to seamless service delivery (Callister and Wall 2001; Hall 2005; Stern and Green 2005). Yet, there is a small but growing body of literature that views boundaries in a less deterministic light: i.e. as the negotiated result of boundary work. Various authors have used the notion of boundary work to understand such diverse topics as leadership and collaboration in inter-professional teams (Hall 2005; Chreim et al. 2013), the organization of egg and sperm donation (Johnson 2013), ethical decision-making in human genetics (Ehrich et al. 2006; Wainwright et al. 2006), the introduction of new professionals and the protection of old professionals (Bosley and Dale 2008; Burri 2008; Kilpatrick et al. 2012). Much attention is given to boundary work in terms of division and defense of professional domains. A good example is Bosley and Dales' study about the introduction of healthcare assistants in a general practice. This study reveals how nurses feel threatened by the presence of new professionals and conduct boundary work to regain territory. Moreover, the studies of Chreim et al. (2013) and Hall (2005) reveal the centrality of boundary drawing in the setting of inter-professional teams. Chreim's study (2013) demonstrates how leadership in teams involves the drawing of multiple boundaries: between team members, between personal life and professional work and between managerial leadership and clinical roles.

Compared to boundary drawing, coordination between multiple organizations has received considerably less attention in studies of boundary work. A notable exception is Johnson's study about organizational boundary work between different parties involved with egg and sperm donation. Multiple organizations construct family boundaries by creating identity categories (e.g. 'donor' and 'recipient'), managing disclosure of personal information (e.g. donor identity) and controlling multi-party

interactions (e.g. by expectation management). Johnson also describes the limits to inter-organizational collaboration: in the end individual organizations want to keep control over donation arrangements by developing bounded, exclusive relationships with consumers (ibid). Although Johnson's study gives valuable insights into coordination between multiple organizations, inter-organizational boundaries themselves are still viewed as fixed realities. We however argue that 'inter-organizational boundaries' are not always that clear-cut. From the perspective of boundary work, actors first have to draw boundaries between organizations before they are able to coordinate 'inter-organizational' work and relations. By researching the NBA-program in this article, we are able to investigate how 'inter-organizational collaboration' and 'the joining-up of services' are instantiations of boundary work.

Boundary work can be conducted by a wide range of actors. We choose to focus on middle managers of public service providers. Middle managers are an interesting group to research because their position is often spatially defined in-between the boundaries of the work floor and higher management. In addition, they are spatially positioned in-between internal and external organizational environments. Due to these spatial conceptualizations, middle managers are described as important boundary spanners that span both intra- and interorganizational boundaries (Noble and Jones 2006; Pappas and Wooldrigde 2007). An important underlying assumption of boundary spanning is that boundaries and the position of the middle manager are relatively stable. That is boundaries can be 'bridged' and middle managers operate from a clear position in the organization. An investigation of boundary work can provide an alternative understanding of boundaries and the work of middle management. Rather than treating organizational boundaries (intra/inter) and the position of middle managers as given, we research how they are constructed in daily action. To our knowledge, a middle management perspective of boundary work is absent from literature, yet we feel it could provide relevant insights to existing literature.

Methods

For this study, we investigated middle managers that participated as project leader in a Dutch public service program called 'The Neighbourhood Based Approach' (NBA). Ten long-term care providers were allowed to participate in the program on the condition that their project would contribute to the joining-up of service provision in health, social support and housing on a neighbourhood scale. The overarching goal of the program was to 'de-velop, de-regulate, and de-institutionalize'. These concepts referred to different levels at which project leaders (n=10) could initiate organizational change. De-velop' referred to the development of competencies of professionals and clients to become more independent and empowered. 'De-regulate' was an appeal to eliminate different rules and protocols of separate organizations, so that integrated service provision could be enhanced in inter-professional teams and networks. 'De-institutionalize' referred to macro level institutions, such as different financing systems between sectors and national regulations.

The NBA-program was supported and evaluated by a Dutch consultancy firm called Viatore and a cross-sector committee with representatives from various sectors (i.e. housing, elderly care, home care, care for people with disabilities). Together with this cross-sector committee, Viatore organized a support infrastructure for project leaders. 'On site' tours were organized to various NBA-projects to promote knowledge exchange between project leaders. Training sessions were given by external consultants to teach project leaders negotiating tactics and principles of horizontal collaboration. Additionally, a website was developed to show the change stories of project leaders and describe their most important learning experiences (http://wijkenbuurtgerichtwerken.nl).

To determine how middle managers in their capacity as project leader draw organizational boundaries, it's necessary to gather data about their daily work, with whom they work, and how they conceptualized relations between different service providers (Barley and Kunda 2001). Ethnographic methods are particularly suitable to understand everyday work and the intricacies of organizational life (Ybema et al. 2009). This requires hanging out, shadowing people, attending (uneventful) meetings and monitoring 'up close and in person' (ibid., p. 1). For this study we did just that. We observed both collective meetings of the NBA-program and individual work of middle managers 'on site' in the period January 2011-April 2012. With regards to the collective NBA-program, we attended meetings, social drinks, conferences and training sessions to get an in-depth understanding of interactions between managers, members of the cross sector committee and consultants. The primary focus of these collective gatherings was knowledge exchange, learning and reflection of project leaders.

Additionally, we shadowed four middle managers *on site* managing their NBA-project (n=14 days). As middle managers, they carried responsibility in their own home organization for the supervision of professional teams and finances. In addition, as project leader for the NBA-program they were responsible for 'linking-up services' and 'inter-organizational collaboration'. This required a more external focus towards other service providers, local politicians and civil servants. There were differences between middle managers in terms of projects. The first middle manager was responsible for a multi-functional accommodation (MFA) that provided services to elderly people, clients with a handicap and children. As part of this MFA, a restaurant was built to mix-up different groups. Clients with disabilities were encouraged to work in this restaurant and elderly people/neighbours visited the restaurant as customers. The second middle manager supervised collaboration between two care organizations that provided sheltered housing in neighbourhoods to young adults who were homeless and had psychiatric problems. To cope with the multi-problems of these clients, separate specialties of the two care organizations were combined and a housing association delivered accommodation. The third and fourth middle manager jointly managed a cross-sector partnership between a housing association, a home care organization and a welfare organization that provided advice to elderly people. The aim of the project was to strengthen the social structure of two deprived neighbourhoods. All three projects set-up inter-professional neighbourhood teams, which included professionals from various organizational background such as home care, social care and housing.

During the shadowing of middle managers, we used a voice recorder and made elaborate field notes of daily interactions between project leaders and a wide variety of actors, including professionals, clients, executives and local politicians. To further increase the trustworthiness of our research, we combined our observations with informal interviews with project leaders and professionals; document analysis of minutes and strategic visions; and a survey with all project leaders of the NBA-program evaluating the outcome of their project and describing daily dilemmas.

To guide our data analysis, we made use of sensitizing concepts. In contrast to definitive concepts, sensitizing concepts point the researcher where to look and give a general direction to make sense of the data (Blumer 1954). From existing literature, we derived the sensitizing concepts 'boundaries', 'boundary work', 'boundary object', and 'boundary people' (Star and Griesemer 1989; Hernes 2004a; Gieryn 1983). These concepts enabled us to investigate how middle managers reconfigured organizational boundaries in the NBA-program. Although boundaries appear to be intangible and difficult to research (Hernes 2004a), they can be investigated by means of language, people and materials (Halffman 2003). We therefore specifically paid attention to how middle managers used boundary defining language (e.g. 'us'/'them') or boundary transcending language (e.g. 'we'). Moreover, we investigated how middle managers used objects to connect professionals and organizations. Examples of boundary objects that we found were graphic models of network collaboration and tools for making a societal cost-benefit analysis. The analysis resulted in the identification of multiple boundaries (i.e. sectoral, professional, financial, accountability and georgraphical), reconfigurations of boundaries, and conditions for boundary work.

To verify our findings, we used a member check. We presented our analysis of boundary work at three occasions: a meeting for all participants of the NBA-program and two conferences that were attended by some project leaders and a wider audience of executives and umbrella organizations. These audiences informed us that our findings sounded very familiar and plausible to them. Moreover, various middle managers remarked that the analysis enabled them to explain the indescribable aspects of their own work. This feedback assured us that our analysis was sufficiently valid and that no additional data collection was necessary.

Result section

In this section we first describe how middle managers draw multiple boundaries to create a sense of urgency for inter-organizational change. We then show how middle managers employ boundary objects and invent new language to reshape collaboration between multiple service providers. After that, we zoom-in on one example of boundary work 'in action'. Finally, we reflect on the legitimacy of middle managers as boundary people and the importance of boundary spaces.

Drawing boundaries: creating a sense of urgency for organizational change

In the NBA-program, middle managers frequently talked about the entrenched nature of organizational boundaries that hindered collaboration between different service providers, such as differences in finance, regulations and professional work methods. On first glance, middle managers appeared to view these boundaries as structural in nature and therefore difficult to change. Yet, a closer look revealed that middle managers strategically used the notion of boundaries vis-à-vis various publics to enact change. By emphasizing the existence of multiple boundaries towards executives, professionals, civil servants and local politicians, they created as a sense of urgency for unsettling organizational routines and establishing new forms of collaboration, as we will show below.

First, middle managers frequently discussed sectoral boundaries at individual project sites and during collective NBA-meetings. Sectoral boundaries were discursively framed as *differences between the domains of health, social care and housing*. Middle managers described health, social care, and housing as separate 'silos', with diverging interests, identities and goals. For example, during a network training in the NBA-program, middle managers of care providers used boundary defining language to distinguish 'themselves' from 'other' sectors. The housing sector was portrayed as a sector that was primarily interested in 'stones' and 'inning rent', whereas the care and welfare sectors were portrayed as domains that were more focused on 'citizen empowerment' and 'the regeneration of deprived neighbourhoods'. Middle managers furthermore stressed sectoral boundaries by identifying *with* and placing themselves *within* sectors, as the following quote illustrates:

> 'I work at an organization that provides home care, so I talk about "care", whereas people who work in welfare do not like to talk about care, they emphasize "wellbeing".' (middle manager, 16- 05-2011)

After having defined boundaries between different sectors, middle managers then stressed the need to transform or even dissolve sectoral boundaries. Especially in case of 'wicked' social problems, such as disintegrating neighbourhoods or multi-problem cases, middle managers pleaded for a cross-sector approach and the joining-up of service.

Second, middle managers stressed the obduracy of *financial and accountability boundaries*. These boundaries were primarily discussed in the context of inter-professional neighbourhood teams. In these teams, professionals from different organizational backgrounds were expected to work together to integrate services in health, social care, and housing. Despite these expectations, professionals and middle managers often felt they were still held accountable for financial output criteria belonging to their home organization (such as 'client visits'), rather than the overarching, ambiguous goal of 'integrated service provision'. Team members and managers argued that they faced dual accountabilit*ies* – towards their home organization and towards the integrated team – which increased their workload. By drawing financial and accountability boundaries between various organizations, team members and

middle managers created urgency for inter-organizational changes, such as a shared budget for integrated teams in order to work more independently and become less bounded to intra-organizational 'production' demands.

Furthermore, middle managers portrayed *financial and accountability boundaries* as barriers to cost containment on a macro societal level. For example, when professionals and managers from a home care provider encouraged the use of social interventions for clients (in order to reduce more 'expensive' healthcare treatments and the use of medicine), this was allegedly discouraged by the executive of their own home organization. Especially middle managers who were responsible for setting-up integrated neighbourhood teams, claimed they were critiqued for dwindling organizational 'production' or 'leaking' financial resources to other organizations. An illustration of leaking was the use of client-linked budgets (i.e. the main financial resource for care providers) to non-care related activities. Middle managers strategically used critique from their own home organization to create a sense of urgency for change and justify deinstitutionalization towards other service providers. In the following quote, financial boundaries between organizations are presented as a justification for institutional change:

> 'It is contra intuitive when a care organization says: welfare interventions are preferable and can prevent care. Then you just shoot yourself in your own foot financially. Your own production is jeopardized, your own organizational future. And yet this is precisely what we have to. It is what is requested when we look at the future and the need to contain rising societal costs. So we can no longer work institutionally bound. We have to deregulate our own systems.' (middle manager, 22-09-2011)

More concretely, some middle managers in the NBA program pleaded for the abandonment of separate organizational output criteria:

> 'Managers should no longer judge professionals on the basis of output criteria stemming from the professional's own organization. We have to become free from the mother organization. This implies that an individual member from organization X is no longer held accountable for output criteria of organization X.' (middle manager, 17-10-2011)

This plead was not unanimously viewed as an appropriate solution. Some professionals stressed the advantages of keeping separate output criteria. Their own output criteria seemed to represent a familiar way to judge their performance as professionals, whereas newly negotiated performance criteria in integrated teams seemed more ambiguous and insecure.

Third, middle managers framed *professional boundaries* as a mixed blessing for inter-organizational collaboration. In integrated neighbourhood teams, professionals from various backgrounds encountered professional boundaries between different working methods. For example, some professionals were used to proactively approach clients via house visits, whereas other professionals thought it was more appropriate to let clients take the initiative. On the one hand, professional differences were framed as an advantage to analyze complex problems and multi-faceted

client cases. On the other hand, these differences were also portrayed as a barrier to developing holistic service provision. Tensions between different work methods were acknowledged by project leaders as part and parcel of integrated teams. Yet, at the same time, they also encouraged professionals to reconfigure work methods to overcome disadvantages of specialization. The shape and form of this integrated working method was not given, but was developed along the way in these projects.

Fourth, middle managers drew *geographical boundaries* around the entity of the neighbourhood. In contrast to other boundaries, neighbourhood boundaries were primarily perceived in a positive light. In the NBA program, 'the neighbourhood' was viewed as an important locus for citizen empowerment, co-production, and the integration of public services. Middle managers agreed that the neighbourhood was a 'good scale' for achieving a variety of policy goals (see also Lowndes and Sullivan 2008). Despite the apparent attraction of 'the neighbourhood', it was unclear to middle managers what actually constituted a neighbourhood. So, geographical boundaries were constructed in different ways and imbued with different meanings. Whereas some middle managers talked about 'the neighbourhood' in quite a literal fashion, referring to city districts as defined by municipalities, other projectleaders referred to the neighbourhood as local communities. Again, others operationalized the idea of the neighbourhood as a cluster of buildings, shopping facilities, and community centers. This implies that neighbourhoods are negotiated constructions rather than stable entities.

Inter-organizational collaboration: new vocabulary and boundary objects

To be able to reconfigure multiple boundaries (i.e. sectoral, professional, financial, accountability, geographical) and shape inter-organizational collaboration in the NBA-program, middle managers gradually developed a new boundary transcending vocabulary and metric system. The use of various boundary concepts and objects proofed crucial for this development.

Middle managers expressed a need for a new vocabulary and metric that could adequately put into words and numbers the societal gains of inter-organizational collaboration on a neighbourhood scale. It was felt that inter-organizational collaboration reduced societal costs by preventing duplication of services and promoting citizen participation and holistic treatment of multi-problem cases. Yet, these societal gains were difficult to capture in the language of intra-organizational goals/targets or monetary value. Especially at intersections of organizational worlds (e.g. inter-organizational steer groups, integrated teams, and policy meetings with local municipalities), middle managers experienced the limits of their conventional vocabulary. During the course of the NBA-program, they therefore searched for news words. Particularly the discursive phrase 'social-return-on-investment' turned out to be crucial for communicating the advantages of a neighbourhood-based approach to various parties. This catchy phrase was initially

picked up by a middle manager who wanted to describe the societal benefits of a multi-functional accommodation vis-à-vis important stakeholders including the local government:

> 'One of the challenges is that we have to make visible the societal gains that the neighbourhood approach is producing. It is very difficult to explain to other parties, such as the local municipality, what we are doing. That's why I am now busy with the concept of social-return-on-investment. In the Netherlands, there is a whole network of advisors who have developed this concept. And I am talking to them. So hopefully, I can use the concept of 'social-return-on-investment' for developing a tool, a societal cost-benefit analysis. Next week I am going the present this concept at the platform of care, welfare and housing, so the local municipality can see what we are doing here.' (middle manager, 8-11-2011)

As it turned out, the discursive term 'social-return-on-investment' and the tool 'societal cost-benefit analysis' emerged respectively as an important boundary concept and boundary object during the following meetings with aldermen and executives of different service providers (housing, social care and homecare). During these meetings, fundamental questions were discussed such as: what is a societal benefit, how can it be quantified, and should parties that invest in the creation of societal gains also financially reap the benefits? This last question was fiercely debated as some care organizations felt their investments were insufficiently rewarded financially. Home care organizations claimed to make efforts to decrease societal costs, for example by stimulating self-sufficiency of clients and the use of social interventions (e.g. drinking coffee and doing social activities in a multi-functional accommodation) rather than home care services (which were considered more expensive), and as a consequence, reduced their own production and profit margins. This argument of home care organizations can be viewed as a discursive move in the renegotiation of existing financial boundaries between service providers in care, welfare and housing. The concept of 'social return on investment' provided an opportunity to openly discuss differences in interpretation (what is a societal benefit) and connect diverging financial interests of different service providers. In the following months, other middle managers in the NBA-program adopted the concept of 'social-return-on-investment' too. With the help of a large Dutch consultancy firm (BMC), a societal cost-benefit analysis was jointly developed with project leaders, thereby translating the boundary *concept* of 'social-return-on-investment' into a concrete boundary *object*, which could be used in diverse collaborative settings.

Furthermore, graphic models functioned as important boundary objects to shape inter-organizational collaboration. At the start of the NBA-program, a Dutch consultancy firm ('A&O Advies') introduced graphic models of network collaboration to middle managers. These models presented an abstract overview of the different stages of network collaboration, such as agenda-setting and multi-party decision-making. In these models, an 'ideal curve' was drawn for assessing the development of network collaboration in cross-sector projects. This curve was a useful tool for project leaders to reflect about progress in their projects and to communicate with external parties about the results of their projects. At another training session, half a

year later, several project leaders mentioned that they had frequently used the model of the ideal curve for negotiating how progress of their projects should be evaluated by significant others. When progress was perceived slow by executives in their home organization or partner organizations, project leaders were able to explain that cooperation in networks adhered to other principles than intra-organizational collaboration. By linking abstract models of network governance to concrete issues of time-management in their own projects, these models functioned as useful boundary objects.

However, not all boundary objects adopted by middle managers were successful in practice. 'Boundary objects in-theory' did not always become 'boundary objects in-use' (see also Levina and Vaast 2005). In theory, boundary objects like standardized work forms and protocols (Star and Griesemer 1989) are said to be useful for reconfiguring professional boundaries and coordinating work in inter-professional teams. In the NBA-program, one particular project leader aimed to standardize work methods of professionals from different organizational backgrounds by using a protocol for client contact. He claimed that this protocol was necessary to restrict 'the proliferation of different work methods' and develop a unified approach for client contact (middle manager, 5-12-2011). Yet, professionals in the integrated team hardly used the form and assured the project leader they were still able to good service provision. This implies that protocols and standardized work forms, do not possess inherent qualities as boundary objects, but can only *become* boundary objects when they are used in a connective way by practitioners.

Zooming in: examples of boundary work 'in action'

In order to illuminate how middle managers performed boundary work 'in action', we focus on one particular cross-sector meeting about the improvement of deprived neighbourhoods in a mid-large Dutch city. At this meeting, representatives of public service providers (housing, health, social care), two middle managers from the NBA-program, and civil servants of the local government discussed the development of 'integrated neighbourhood teams'. During the meeting, two middle managers gradually noticed that different perceptions of scale were causing confusion. Civil servants assumed that the future 'social neighbourhood team' of the local government, would operate at the same scale as the already existing 'caring neighbourhood teams' that were managed by the two middle managers. However, the civil servants' perception of scale proofed to be a very different one from than that of the service providers. Civil servants talked about a much larger scale (a city district) than middle managers of service providers that referred to a specific cluster of buildings for elderly people. By pinpointing and discussing different meanings of scale explicitly, the middle managers were not only able to avoid further confusion, but also negotiated alternative scales and geographical boundaries for organizing neighbourhood based services. They argued that a smaller scale of the neighbourhood was more appropriate for close contact with citizens. In their opinion, a neighbourhood team at city district scale would become a mini government office. These comments were taken on board by

civil servants. A few months after this meeting, the 'social neighbourhood teams' of the local government operated at a smaller scale and professionals from service providers were hired as team members, thereby interconnecting work activities to a certain extent. Despite these interconnections however, neighbourhood teams of public service providers mostly operated parallel to neighbourhood teams of local government.

Reconfigurations of geographical boundaries were not an isolated phenomenon: they were closely connected to reconfigurations of professional and financial boundaries. For example, task divisions between professionals from various organizational backgrounds were reshuffled due to a neighbourhood based approach of work. Employees of housing associations conventionally performed tasks such as material improvements of buildings, but in neighbourhood teams were expected to answer questions of elderly people about all kinds of aspects of life (not just questions about physical aspects of living arrangements). More in general, professionals were encouraged to focus on empowerment of citizens rather than merely providing services. This also required making connections between formal and informal care. The set-up of neighbourhood teams also sparked debate about financial boundaries. Neighbourhood teams were allocated independent budgets, but team members still worked part-time for their respective home organizations. These dual memberships created questions about potential client' referrals to home organizations and the need to make 'financial production'. These examples demonstrate that boundary work of middle managers concerns multiple boundaries (e.g. geographical, professional, financial) rather than singular ones. Moreover, boundary work is not just about boundary drawing, but also includes boundary reconfiguration and boundary coordination. As a result, providers and local governments reconfigured service provision into neighbourhood based formats.

Conditions for boundary work: boundary spaces and legitimate boundary people

On the basis of our ethnographic research, we identified two important conditions for doing boundary work: 1) the existence of boundary spaces and 2) legitimacy of boundary people.

Boundary work was challenging for middle managers as they encountered organizational struggles. Blowing of steam and venting frustration was not always possible in one's own organization. An important boundary space for middle managers to share experiences was the NBA 'community of practice' that was developed as part of the NBA-program. Consultancy firm Viatore and a cross-sector committee with representatives of umbrella organizations (e.g. home care, housing, social care) facilitated the infrastructure for this community of practice. They organized collective training days and visits at individual project sites to exchange knowledge between middle managers, enlisted consultancy firms to provide courses about negotiation tactics, developed a collective website with learning principles for neighbourhood

based ways of working, made films of individual projects that were circulated to all participants of the NBA-program, and organized conferences and social drinks. Jointly, these activities gradually created a community of practice, which middle managers referred to as a safe heaven and community.

In this community of practice, middle managers compared their own experiences with other managers, gave emotional support and encouragement to each other, and formulated overarching learning principles for neighbourhood based care. At one particular training session we observed, a middle manager whose project was doomed to fail, broke down in tears. Others comforted him and this moment of emotional catharsis was transformed into a collective learning experience (what to do when encountering intra-organizational resistance). In addition, the community of practice was important for the exchange of boundary objects. Due to the presence of consultancy firms, useful boundary objects were brought in, such as the 'ideal curve' that helped middle managers to reconfigure organizational boundaries. As such, the community of practice functioned as an important boundary space that enabled boundary reshuffling.

Another important condition for boundary work was the legitimacy of middle managers as boundary people. Despite the crucial contribution of middle managers to collaboration, some middle managers noticed that they were not always successful in renegotiating boundaries. They particularly struggled with their dual memberships: being representative of their 'home organization' and project leader of a 'cross sector project'. As a consequence, they were not always perceived by other parties as neutral lynchpins. An illustration is the case of a project leader who was perceived by other service providers as a typical representative of his home organization due to his appointment as project leader by his own executive. The project leader's appointment thus was viewed as biased, as he himself noticed: 'My appointment as project leader was seen as a sewn up case' (middle manager, 17-05-2011). As a consequence, his credibility towards other public service providers was jeopardized. Other project leaders also acknowledged these difficulties of dual membership, but tried to manage legitimacy issues by switching identities. They sometimes used their function as project manager to introduce themselves to external audiences and in other settings presented themselves as middle manager. This implies that legitimacy of boundary people is fragile, yet to a certain extent manageable by shifting identities.

Conclusion and discussion

This study investigated how boundary work enables new forms of collaboration between service providers in health, social support and housing. The use of ethnographic methods allowed us to capture complexities of boundary work performed by middle managers in the Dutch reform program 'The Neighbourhood Based Approach' (NBA-program). An important part of boundary work was creating a sense of urgency for inter-organizational change and joining-up service provision on a neighbourhood scale. Middle managers did so by discursively emphasizing the

hindering existence of boundaries between public service providers, such as different professional work methods, regulations and financial systems. This form of boundary drawing paved the way for boundary reshuffling and new collaboration in inter-professional neighbourhood teams. To reshape collaboration, middle managers used both language and objects. They acted as important rhetorical change agents (see also Rouleau and Balogun 2011) by using new boundarytranscending vocabulary such as 'social-return-on-investment' to describe the societal gains of neighbourhood teams and a cross-sector approach. This new vocabulary was linked to boundary objects, such as a 'societal cost-benefit analysis' that renegotiated the meaning of profit and organizational production targets. Also in inter-professional neighbourhood teams, middle managers reconfigured professional boundaries by creating new work divisions that required professionals to step out of their comfort zone. This professional reconfiguration went beyond the notion of 'joining-up service provision' because new professional roles and skills were developed. The results revealed that boundary work was challenging work and at times frustrating. To support middle managers in this work, a NBA-community of practice functioned as an important boundary space for sensemaking, moral support and learning.

Although the change motto of the NBA-program 'de-velop, de-regulate, de-institutionalize' suggested that it was desirable to eradicate organizational boundaries, daily work practices of middle managers showed otherwise. In fact, boundaries were crucial for organizing change in service provision. For example, by drawing geographical boundaries around the entity of the neighbourhood, new work territories, inter-professional teams and work methods could be established. Because the scale of the neighbourhood was highly contested and drawn in different ways (from a city district to a cluster of service apartments), multiple neighbourhood teams were created by public service providers and local governments. This shows that the rhetoric of deinstitutionalization did not lead to fewer institutions and boundaries, but to different institutions and different boundaries. Rather than pleading for 'boundaryless' organizations (Braithwaite et al. 1994; Ashkenas et al. 2002; Rusu et al. 2010), it thus makes more sense to investigate which types of boundaries are enabling and hindering good service provision (Hernes 2003). Our research reveals that neighbourhood boundaries and work formats hold a new promise of societal benefits that go beyond mere organizational production targets, but it is still too early to tell whether that promise is met. What our results do show however is the necessity of a more flexible attitude towards boundaries. Current boundary spanning approaches still assume that boundaries stay in place and subsequently can be bridged or crossed (Williams 2002; Noble and Jones 2006; Pappas and Wooldridge 2007). Yet, the analysis of boundary work indicates that boundaries are mobile and constantly change in shape and form. Therefore perspectives of boundary work (Gieryn 1983; Halffman 2003), boundaryshaking (Balogun et al. 2005) and boundary mediation (Sullivan and Williams 2012), seem better suited to address processes of unsettling, altering, tinkering and institutionalizing of boundaries.

Our research also contributes to a more fine-grained understanding of organizational boundaries. As Hernes noted (2004a, p. 12) 'the general label of organizational boundaries' says little because it can encompass many things. It is therefore necessary to differentiate between various types of boundaries.

Our results demonstrate that middle managers deal with composite boundaries: i.e. professional, financial, accountability, geographical and sectoral boundaries. In the daily work of middle managers these composite boundaries are not neatly differentiated, but entangled in complex nodes. Reconfiguring just one type of boundary is nearly impossible since this reconfiguration will likely prompt the redrawing of other types of boundaries. As our research illustrated, the redrawing of neighbourhood boundaries also had consequences for how professional boundaries were reconfigured and conceptualizations of good service provision were reshaped. Due to this interconnected nature of boundaries, managerial boundary work is complex work that takes time. Change through boundary work is therefore likely to be incremental rather than radical in outlook. The incremental nature of change can furthermore be explained by institutional layering in healthcare (Van de Bovenkamp et al. 2014). Because new institutional arrangements are layered on top of existing ones (e.g. state, market, civil society, professional self-regulation), boundary work is institutional work *par excellence*: it is conducted in an institutionally layered environment that at the same is the primary object of change and deinstitutionalization. In the NBA-program, deinstitutionalization was not just directed at the healthcare sector, but at multiple sectors simultaneously (i.e. healthcare, social care and housing). This inter-sectoral focus could explain why boundary work in the NBA-program was particularly challenging.

Despite the challenging nature of boundary work, middle managers proofed to be important boundary people that connected and reconfigured organizational and professional worlds. Because of multiple memberships to their 'home' organization and cross-sector projects, middle managers could broker knowledge and connect multiple audiences (see also Star and Griesemer 1989).Yet, they also had to walk a fine line between representing the interests of their own organization and promoting inter-organizational collaboration. Especially when their identity was perceived as biased towards financial interests of the home organization, middle managers could lose face in inter-organizational collaboration. An important strategy to manage credibility towards various publics was to switch identities by using different functions as project leader and middle manager. This shows that middle managers are not successful boundary workers by definition. They need to actively shape legitimacy to be able to perform boundary work effectively.

A limitation of this study is that we could not investigate the long term career of boundary workers as we only followed middle managers for the official duration of the NBA-program. Since boundary workers are creating incremental change, it is necessary to follow their work for a longer period of time to be able to assess whether boundary work contributes to broader paradigm changes in healthcare provision. A fruitful avenue for further research would be historical studies of boundary work that pay attention to change over time and more specifically changing status of boundary people, objects and language.

References

Akkerman, S. F. and A. Bakker (2011). Boundary crossing and boundary objects. *Review of Educational Research* 81 (2): 132-169.

Allen, D. (2009). From boundary concept to boundary object: the practice and politics of care pathway development. *Social Science & Medicine* 69: 354-361.

Arman, R., E. Wikström, E. Tengelin and L. Dellve (2012). Work activities and stress among managers in health care. In *The work of managers. Towards a practice theory of management*, S. Tengblad ed., 105-130. Oxford and New York: Oxford University Press

Ashkenas, R., D. Ulrich, T. Jick and K. Steve (2002). *The boundaryless organization. Breaking the chains of organizational structure*. San Francisco: Jossey-Bass Wiley.

Balogun, J., P. Gleadle, V.H. Hailey and H. Willmott (2005). Managing change across boundaries: boundary-shaking practices. *British Journal of Management* 16: 261-278.

Barley, S.R. and G. Kunda (2001). Bringing work back in. *Organization Science* 12 (1): 76-95.

Bechky, B. A. (2003). Sharing meaning across occupational communities: the transformation of understanding on a production floor. *Organization Science* 14 (3): 312-330.

Blumer, H. (1954). What is wrong with social theory? *American Sociological Review* 19 (1): 3-10.

Bosley, S. and J. Dale (2008). Healthcare assistants in general practice: practical and conceptual issues of skill-mix change. *British Journal of General Practice* 58: 118-224.

Braithwaite, J., R.F. Vining, L. Lazarus (1994). The boundaryless hospital. *Australian and New Zealand Journal of Medicine* 24 (5): 565-571.

Burri, R.V. (2008). Doing distinctions: boundary work and symbolic capital in radiology. *Social Studies of Science* 38 (1): 35-62.

Bijker, W.E., R. Bal and R. Hendriks (2009). *The paradox of scientific authority. The role of scientific advice in democracies*. Cambridge MA and London: MIT Press.

Callister, R. R. and J. A. Wall Jr. (2001). Conflict across organizational boundaries: managed care organizations versus health care providers. *Journal of Applied Psychology* 86 (4): 754-763.

Carlile, P. R. (2002). A pragmatic view of knowledge and boundaries: boundary objects in new product development. *Organization Science* 13 (4): 442-455.

Chreim, S., A. Langley, M. Comeau-Vallée, J.L. Huq and T. Reay (2013). Leadership as boundary work in healthcare teams. *Leadership* 9 (2): 201-228.

Douglas, M. (2002, first published 1966). *Purity and danger.* Routledge: London and New York.

Ehrich, K., C. Williams, R. Scott, J. Sandall and B. Farsides (2006). Social welfare, genetic warfare? Boundary-work in the IVF/PGD clinic. *Social Science & Medicine* 63 (5): 1213-1224.

Fitzpatrick, G. and G. Ellingsen (2013). A review of 25 years of CSCW research in healthcare: contributions, challenges and future agendas. *Computer Supported Cooperative Work* 22: 609-665.

Giddens, A. (1984). *The constitution of society: outline of the theory of structuration.* Berkeley and Los Angeles: University of California Press.

Gieryn, T. F. (1983). Boundary-work and the demarcation of science from non-science: strains and interests in professional ideologies of scientists. *American Sociological Review* 48 (6): 781-795.

Jasanoff, S.S. (1987). Contested boundaries in policy-relevant science. *Social Studies of Science* 17: 195-230.

Halffman, W. (2003). *Boundaries of regulatory science*. Amsterdam: University of Amsterdam.

Hall, P. (2005). Interprofessional teamwork, professional cultures as barriers. *Journal of Interprofessional Care* supplement 1: 188-196.

Hernes, T. (2003). Enabling and constraining properties of boundaries. In *Managing boundaries in organizations. Multiple perspectives*, N. Paulsen and T. Hernes (ed). Basingstoke: Palgrave McMillan.

Hernes, T. (2004a). Studying composite boundaries: a framework of analysis. *Human Relations* 57 (1): 9-29.

Hernes, T. (2004b). *The spatial construction of organization*. Amsterdam and Philadelphia: John Benjamins Publishing Company.

Johnson, K.M. (2013). Making families: organizational boundary work in US egg and sperm donation. *Social Science & Medicine* 99: 64-71.

Kilpatrick, K., M. Lavoie-Tremblay, J.A. Ritchie, L. Lamothe and D. Doran (2012). Boundary work and the introduction of acute care nurse practitioners in healthcare teams. *Journal of Advanced Nursing* 68 (7): 1504-1515.

Kimble, C., C. Grenier and K. Goglio-Primard (2010). Innovation and knowledge sharing across professional boundaries: political interplay between boundary objects and brokers. *International Journal of Information Management* 30: 437-444.

Lamont, M. and V. Molnár (2002). The study of boundaries in the social sciences. *Annual Review of Sociology* 28: 167-195.

Levina, N. and E. Vaast (2005). The emergence of boundary spanning competence in practice: implications for implementation and use of information systems. *MIS Quarterly* 29 (2): 335-363.

Lowndes, V. and H. Sullivan (2008). How low can you go? Rationales and challenges for neighbourhood governance. *Public Administration* 86 (1): 53-74.

Martin, G.P., G. Currie and R. Finn (2009). Reconfiguring or reproducing intra-professional boundaries? Specialist expertise, generalist knowledge and the 'modernization' of the medical workforce. *Social Science & Medicine* 68: 1191-1198.

Nancarrow, S.A. and A.M. Borthwick (2005). Dynamic professional boundaries in the healthcare workforce. *Sociology of Health &Illness* 27 (7): 897-919.

Noble, G. and R. Jones (2006). The role of boundary-spanning managers in the establishment of public-private partnerships. *Public Administration* 84 (4): 891-917.

Ootes, S., J. Pols, E. Tonkens and D. Willems (2010). Bridging boundaries: the concept of 'citizenship' as a boundary concept in mental healthcare. *Medische Antropologie* 22 (2): 375-388.

Pappas, M. and B. Wooldridge (2007). Middle managers' divergent strategic activity: an investigation of multiple measures of network centrality. *Journal of Management Studies* 44 (3): 323-341.

Rouleau, L. and J. Balogun (2011). Middle managers strategic sensemaking and discursive competence. *Journal of Management Studies* 48 (5): 953-983.

Rugkåsa, J., N. K. Shortt and L. Boydell (2007). The right tool for the right task: boundary spanners in a partnership approach to tackle fuel poverty in rural Northern Ireland. *Health and Social Care in the Community* 15 (3): 221-230.

Rusu, M. G. Saplacan, G. Sebestyen, N. Todor, L. Krucz and C. Lelutin (2010). E-health: towards a healthcare service-oriented boundary-less infrastructure. *Applied Medical Informatics* 27 (3): 1-14.

Star, S. L. and J. R. Griesemer (1989). Institutional ecology, 'translations' and boundary objects: amateurs and professionals in Berkeley's museum of vertebrate zoology, 1907-39. *Social Studies of Science* 19 (3): 387-420.

Star, S. L. (2010). This is not a boundary object: reflections on the origin of a concept. *Science, Technology & Human Values* 35 (5): 601-617.

Stern, R. and J. Green (2005). Boundary workers and the management of frustration: a case study of two Healthy City partnerships. *Health Promotion International* 20 (3): 269-276.

Sullivan, H. and P. Williams (2012). Whose kettle? Exploring the role of objects in managing and mediating the boundaries of integration in health and social care. *Journal of Health Organization and Management* 26 (2): 697-712.

Van de Bovenkamp, H., M. de Mul, J. Quartz, A.M. Weggelaar-Jansen, R. Bal (2014). Institutional layering in governing quality. *Public Administration* 92 (1): 208-223.

Walker, R., P. Smith and J. Adams (2009). Making partnerships work: issues of risk, trust and control for managers and service providers. *Health Care Analysis* 17: 47-67.

Wainwright, S.P., C. Williams, M. Michael, B. Farsides and A. Cribb (2006). Ethical boundary-work in the embryonic stem cell laboratory. *Sociology of Health & Illness* 28 (6): 732-748.

Wehrens, R., M. Bekker and R. Bal (2011). Coordination of research, policy and practice: a case study of collaboration in the field of public health. *Science and Public Policy* 38 (10): 755-766.

Williams, P. (2002). The competent boundary spanner. *Public Administration* 80 (1): 103-124.

Ybema, S., D. Yanow, H. Wels and F. Kamsteeg ed. (2009). *Organizational ethnography. Studying the complexities of everyday life*. Los Angeles etc.: SAGE.

Chapter 8

Reflections on the multiple and shifting middle in healthcare management

Reflections: looking back and looking forward

> 'What does a manager do? Ask a simple question and you get a simple answer. He manages. In this age of organization in which most of us spend some time in business, educational, philantropic, or governmental organizations, it is assumed that their management is not only crucial, but well understood. It is taken for granted, like the job description of a doctor; he helps the ill, and the manager manages (...). Yet, once past simple definitions such as "a manager is someone who gets work done through other people", there is a mounting evidence that the job of manager in any type of organization is not understood or is badly understood.' (Sayles 1964, p. 1)

Things can change. The taken-for-grantedness of management, which management scholar Sayles described in the 1960's, seems to have largely disappeared in today's society. Public managers in healthcare and other sectors have come under increasing societal scrutiny and critique. It is argued that they add little value to public service provision. Professionals, such as doctors and nurses, and citizens can 'organize' their own work and care in a post-bureaucratic society. They do not need management (De Blok and Pool 2010). Yet, some things stay the same. Despite critique, management still exists and is still little understood. What does a manager do? This is an old but relevant question which this thesis aims to provide an answer to.

I specifically focused on the daily work of middle management in healthcare: a management layer which is known to be *either* 'stuck-in-the-middle' between the organizational top and bottom *or* strategically operating from this same middle as change agents. According to pessimistic accounts, the intermediate position between top and bottom, is precisely the reason why middle management gets stuck and can add little value to the organization. In optimistic accounts, the vertical middle allows managers to connect various actors and strategize 'upwards' and 'downwards'. In both accounts, middle management is essentially defined by its spatial position in the organizational hierarchy.

In this thesis I have contributed to the debate by showing that the middle does not necessarily have to be a vertical middle: i.e. in-between the top and the bottom of the care organization. I have foregrounded other middles in middle management, thereby demonstrating how the middle in healthcare management can be multiple rather than singular. For instance, middle managers in the care sector move in the middle of conflicting values (e.g. guaranteeing efficiency and good quality of care with declining resources) and in the middle of various justifications (e.g. civic, market, industry) when justifying public service reform to significant others, such as clients and professionals. Also, middle managers with professional care backgrounds (i.e. hybrid middle managers) can operate in the middle of managerial and professional worlds. Furthermore, middle managers are increasingly placed in the middle of various inter-organizational boundaries because of organizational collaboration between different public-service providers and across sectors. These middles are not fixed realities, but are flexibly (re) constructed in daily action and shift over time.

I also broadened the scope of middle management by shifting the focus from middle management as a specific group to middle management as an activity.

Various actors are engaged in the activity of middle managing. Not only classic middle managers with an intermediate position in the organization manage in the (multiple) middle, but also organizing professionals. Given developments towards self-governance of professionals (Van Dalen 2012; De Blok and Pool 2010) and organized professionalism (Noordegraaf 2011), professionals increasingly engage in management activities as part of their care work. Therefore, this research included both managerial and professional actors. The main focus is on hybrid middle managers that are positioned above the work floor and supervise teams of care professionals. In addition, I have paid attention to neighbourhood nurses and other organizing professionals who increasingly manage inter-organizational boundaries and financial resources.

The main research question which I addressed in this thesis is:

> *How is the daily work of middle management enacted and reconfigured in Dutch healthcare?*

Sub-questions are:

> *What daily work is being performed by middle management?*
>
> *How is this work being reconfigured and distributed to others actors, such as professionals and citizens?*
>
> *How does the daily work of middle management contribute to (good) governance of care?*

These questions were answered by means of qualitative, ethnographic research. At the start of my research, I conducted pilot interviews with middle managers in different care organizations, ranging from home- and elderlycare to care for the homeless. These pilot interviews allowed me to gain a broad overview of the work of middle management in the care sector. I then 'zoomed in' on daily managerial work by extensively shadowing middle managers in one care organization that supports people with disabilities. In this organization, middle managers were responsible for supervising professionals and managing small-scale care facilities in the neighbourhood. Shadowing allowed me to develop a comprehensive picture of managerial work 'in action'. During shadowing, I focused on managerial talk, interaction between managers, professionals and clients, and objects (e.g. houses and living rooms of clients; managerial offices). I also investigated a public sector reform program, called the Neighbourhood Based Approach (NBA). In this program, different public sector organizations (care, housing, welfare) worked together to organize neighbourhood-based support and care. I shadowed middle managers and observed professionals who worked in neighbourhood-based teams. Finally, interviews with neighbourhood nurses in the Visible Link Project, conducted by Jeroen Postma, supplement my own data selection.

In this concluding chapter, I first describe different types of managerial work which are performed in the (multiple) middle. Moreover, I demonstrate how

this managerial work — in itself a dynamic concept — is being reconfigured and distributed to other actors. Subsequently I describe the contribution of managerial work of middle management to (good) governance of care. Finally, I reflect on the implications of this research for both theory, methodology and practice.

Managerial work conducted in the (multiple) middle

Managerial work is used as a common denominator to refer to overarching activities such as coordinating and organizing. When looking closely at (managerial) work however, it encompasses a myriad of activities and different kinds of work (Strauss et al. 1997). In this thesis, I have distinguished different types of managerial work in the multiple middle: 1) valuation work, 2) justification work, 3) professionalization work, 4) articulation work and 5) boundary work. What's more, when zooming in on one type of work, for example valuation work, one sees that there are also different ways of doing this type of work. Further zooming in thus allows one to see greater detail and more nuances in work. Yet, when adding up these different ways of doing and types of work, it also becomes possible to view the greater picture, that is, how managerial work as a whole comes into being.

The first important type of work that middle managers perform is **valuation work**, that is, dealing with tensions and conflicts between values in the organization and provision of care. In chapter 2 I have investigated how operational middle managers deal with conflicting values since the introduction of the new financing system of client-linked budgets. From a policy perspective, individual client linked-budgets are an important tool to ensure both client-centred and affordable care in long term care. Yet, middle managers experience tensions in the joint operationalization of affordable and client care in practice. Based on interviews with middle managers, we identified four modes of dealing with value tensions between affordable and client-centred care: 1) balancing values individually and collectively (i.e. at client and group level), 2) prioritizing one value over the other (i.e. temporarily focusing on the realization of one particular value), 3) establishing compromises between values (i.e. new settlements, like the involvement of volunteers) and 4) making healthcare workers responsible for balancing different values (i.e. delegating value tensions to the work floor). These modes show that there are different ways of doing valuation work and that managers use various modes simultaneously to manage care locations and deal with value tensions.

Closely related to valuation work is **justification work**: the construction and recrafting of compromises and the justification of these compromises vis-à-vis significant others by means of rhetoric, objects and behaviour (see also Boltanski and Thévenot 2006; Jagd 2011). Chapter 3 explored how middle managers and executives of small-scale care facilities create compromises that represent different ideals of small-scale care: a civic/domestic compromise (i.e. clients that live in a domestic household with other clients and perform civic duties in the neighbourhood) and market/industry compromise (i.e. market consumers that live in a private apartment complex that allows for an industrial/efficient organization of care). Because

compromises are based on different justifications (civic, domestic, industry, market), they remain fragile and open to critique by clients, their relatives, professionals, and neighbours. For example, the civic/domestic compromise of small-scale care, is critiqued by neighbours who experience noise by clients. To deal with this critique and emerging value conflicts, managers have to perform continuous 'justification work' that entails not only the use of rhetoric (e.g. framing), but also the adaption of behaviour of professionals (e.g. work methods and schedules) and the recrafting of objects (e.g. reordering buildings and living rooms). By inscribing compromises into objects and behaviour, managers are able to solidify compromises, thereby creating temporary stability in the provision of small-scale care.

Another type of work that is conducted by middle management is **professionalization work**: professionalizing care workers via reflection, the use of methodical work methods and the coaching of competencies. Especially middle managers that are responsible for supervising teams on the work floor engage in this type of work during day-to-day interactions with care workers. Chapter 4 investigated how middle managers play a role in professionalizing vocationally trained care workers in long term care. They do so by frequently using the discourse of professionalism — i.e. 'professional talk' (Watson 2003) — to frame care workers as 'professionals'. The professional frame encompasses diverging notions, ranging from 'presentable looks' when interacting with clients (e.g. no cleavages or short skirts) and 'methodical work methods' (e.g. working with Care Living Plans) to 'reflectivity' about what constitutes good care and 'competencies' to give constructive feedback to colleagues. By framing care workers as professionals, middle managers tried to achieve different care practices and more autonomous decisions by care workers at decentralized locations in the neighbourhood. This chapter thus showed the importance of professional talk as a discursive resource to achieve change on the work floor. Interestingly, middle managers frequently drew on their own background as professional when using professional discourse, thereby gaining legitimacy and credibility in the eyes of care workers. Hence, being 'hybrid' middle managers helped considerably in professionalization efforts.

Not only middle managers, but also professionals can engage in managerial work in the middle, for example when dealing with different service providers and organizational boundaries. In chapter 5, we investigated how neighbourhood nurses in the Visible Link Project (in Dutch: Zichtbare Schakels) engaged in organizing work – that is, **articulation work** – as part of their professionalism (Strauss et al. 1997). A historical analysis of home care demonstrated how part of this organizing work gradually had been removed from care work of nurses since the 1980's. Due to scale enlargements, the emergence of central planning departments and sub specialization in home care, a taylorized separation between the excecution and planning of professional work was established. As a consequence, the work of nurses became increasingly fragmented and specialized. By bringing back organizing into professional work, the Visible Link project allowed neighbourhood nurses to organize a more encompassing arc of work: not only by organizing their own care work, but also by linking-up different services, such as care, housing, GP and social support. Chapter 5 also revealed that neighbourhood nurses perform different types of articulation work: a) intra-professional articulation work (i.e. meshing up different care tasks, such as giving medication and showering), b) inter-professional (i.e.

coordinating and integrating efforts of various professionals from different organizations) and c) lay-articulation work (i.e. organizing the involvement of the client's informal network and stimulating self-management of clients). Together, these different types of articulation work make up an important part of the professional work of neighbourhood nurses.

Finally, **boundary work** is an important type of work that is performed by middle management. Chapter 7 explored how middle managers conducted boundary work in the reform program 'The Neighbourhood Based Approach' by (re)constructing organizational boundaries and coordinating service provision in new ways. To create a sense of urgency for inter-organizational collaboration on a neighbourhood scale, middle managers emphasized the existence of hindering boundaries between service providers, such as different financial systems and professional work methods. After having drawn boundaries, middle managers reconfigured these boundaries by means of language and boundary objects. Middle managers acted as important rhetorical change agents by using new vocabulary such as 'social-return-on-investment' to describe the societal gains of a cross-sector approach and inter-professional neighbourhood teams. This new vocabulary was linked to boundary objects, such as a 'societal cost-benefit analysis' that renegotiated the meaning of profit and organizational production targets. As a result of boundary work, new arrangements of neighbourhood based support were developed. Although the change motto of the NBA-program 'de-velop, de-regulate, de-institutionalize' suggested that it was desirable to eradicate organizational boundaries, daily work practices of middle managers showed otherwise. In fact, boundary drawing was crucial for organizing change in service provision. This chapter also demonstrated that middle managers had to carefully manage their legitimacy as boundary people by switching identities between project leader in the NBA-program and middle manager in their home organization.

Together, these types of work tell us something about managerial work that is conducted in the multiple middle: between different values, justifications, organizational, professional and managerial worlds. The multiple middle is not pre-given and static, but is enacted, reconfigured and reshaped in the doing of daily work. New middles are created depending on the work that middle managers do, the policies that are implemented and broader societal trends at play. Therefore, the middles in management do not only tell us something about the idiosyncratic work of middle managers, but also about the broader dynamics in the society. Unresolved tensions in society, such as frictions between societal and market based reforms, manifest themselves in small form in the daily work of middle management. Middle managers shape and partially resolve these tensions by performing different types of work. At the end of this chapter, I reflect on the consequences of this work for the governance of good care.

Shifting middles in healthcare management

This thesis also explored how some functions of middle management, such as budget keeping and organizational coordination, are reconfigured and distributed to actors such as professionals and clients. As Watson already noted, 'no organization can survive

without management. But whether that function is carried out by a single person, by a team, or by the democratic involvement of every member of the organization is a matter of choice.' (Watson 1994: p. 39). Similarly in the healthcare sector, care organization make choices about how management tasks are divided, which managerial functions are created and how professionals organized and organizing (e.g. in self-steering teams). In this thesis, I primarily investigated organizations that had chosen to embed some managerial functions at mid-level management. On the basis of their job description, middle managers were responsible for managing professionals, quality of care and budgets on locations. In passing, however, I discovered that an important part of what middle managers do is distributing some of these responsibilities to the work floor and to clients. So, paradoxically, part of managing is distributing management. In this distribution, managerial and professional responsibilities also get reshaped and remade, thereby adopting a different form.

Distribution of managerial responsibilities can take place in various ways, as is shown in chapters 2, 4 and 7. For instance, middle managers try to 'responsibilize' care workers to deal with financial and organizational issues in the new financing system in long term care (Newman 2013). As is revealed in chapter 2, middle managers urge care workers to make explicit choices about which type of care and how much care can be provided to individual clients according to client-linked budgets. By doing so, professional work is being reconfigured and remade. 'Caring for' is not only about providing physical and mental support to clients, but is increasingly about negotiating with clients and family members about choices in care delivery and the financing of these choices. The introduction of client-linked budgets in long term care have made these choices more explicit, individual and part of care work. Although middle managers in many care organizations still carry final responsibility for the financial management of locations, mundane financial choices are increasingly made by care workers on the work floor.

Distribution of managerial and organizational responsibilities to professionals and clients also occurred via 'place-shaping' of the neighbourhood (Grant and Dollery 2011: Lowndes and Sullivan 2008). In chapter 7, I investigated how middle managers of care providers distributed leadership to professionals and citizens in the Neighbourhood Based Approach Program. 'The neighbourhood' is framed and shaped by middle managers in the NBA-program as the ideal place for professionals and citizens to co-create and reorganize services, organize informal care networks, and join-up and coordinate fragmented services in care, welfare and housing. This implies that the neighbourhood is not merely a neutral territory which can be located on a map, but an important symbol that can be mobilized to legitimize a reconfiguration of responsibilities. For instance in the NBA-program, middle managers delegated financial responsibilities to professionals in self-steering neighbourhood teams. These teams were made responsible for budget keeping, local coordination and joining-up welfare, care and housing services in order to establish more integrated support to clients. Middle managers also framed clients of service providers as 'citizens in the lead' who could provide feedback to reorganize existing care services, self-organize their own informal care networks, and support neighbours in need. As such, both professionals and clients were being shaped as self-organizing subjects, while managers reconfigured their role from instruction-based managers to facilitators and coaches of self-governance (see also Raelin 2013). In these roles, middle managers

still very much steered behaviour, but in more 'subtle' ways via facilitating reflection and dialogue.

With regards to care workers, middle managers not only used the mechanism of placeshaping, but also invoked the discourse of professionalism to reshape manager-worker relations and organizational responsibilities. By framing care workers as 'reflective', 'competent' and 'methodically working' *professionals*, middle managers enabled more autonomous decision-making by care workers (chapter 4). For instance, at decentralized locations care workers were encouraged to independently deal with the daily organization of care by scheduling personnel, administering 'near incidents', updating and rewriting Support Plans of clients, enlisting volunteers and solving conflicts with clients and their relatives. In addition, they were expected to reflectively tinker with different demands of good care, such as 'efficient', 'client-centred' and 'safe' care. In this constellation, care workers had to walk a fine line when making decisions, especially when organizational risks were involved. In principle, autonomous decision-making and organizing were encouraged, but when incidents had the potential to escalate and cause reputational loss (e.g. conflicts between aggressive clients), care workers were expected to immediately contact their middle manager who could then asses the broader consequences for the organization.

As a result of these distributions and reconfigurations, some middles in management are also shifting to professionals and clients. For instance, value tensions about budgets and quality of care are not just managerial dilemmas, but have become part and parcel of professional work and the life worlds of clients and/or their relatives (chapter 2). Shifting middles in management can have bright and dark sights (chapter 7). On the bright sight, maneuvering room is created for professionals and clients to create new combinations between formal and informal care. Moreover, in self-steering neighbourhood teams professionals can decide how they want to allocate team budgets to solve local problems. On the dark sight, new middles can also burden professionals and clients. Clients may be unwilling or unable to fulfill duties like self-reliance, self-organization and neighbourliness. Furthermore, not all care workers are interested in taking up managerial and organizational responsibilities. Differences exist between professionals. Neighbourhood nurses, who are highly educated, benefited from self-governance (chapter 5), whereas some vocationally trained care workers also appreciated clear guidance and instructions from team managers in certain situations (chapter 4). Hence, differences in background and capabilities also set limits to the distribution of responsibilities.

The contribution of middle management to the governance of 'good' care

Since the contribution of managers is increasingly questioned in the societal debate, it was relevant to investigate how middle management contributed to the governance of 'good' care. This is a difficult question to answer because 1) there is no agreement on

what this good should look like, 2) there is not one good, but several 'goods' to consider, 3) good is a relative term (good in the eyes of whom?). As Willems and Pols argued (2010), good care can be conceptualized in different, sometimes conflicting ways: 'Care can be good when it is just, effective, or ethically legitimated. It can be good when it is "managed well", and uses public money sparingly. Care may be called "good" when the patient is leading, and more than once a combination of goods is asked for.' (Pols and Willems 2010, p. 162). Rather than deductively determining what is good care and good governance by researching good governance codes and ethical guidelines, I inductively investigated how middle management conceptualized good care and how this should be organized. This approach aligns with an empirical shift in ethics, which focuses on daily practices and mundane ethics rather than 'big' ethical issues about life and death (Pols and Willems 2010). In this thesis, middle managers did not provide 'good' care themselves, although they may have done so in the past in their previous capacity as care worker. The contribution of middle management thus focuses how 'good' care is organized, managed and justified: i.e. the governance of 'good' care.

The research demonstrated that middle managers are not cognitively bound to a cluster of like-minded, traditional management values, such as efficiency and effectiveness, but engaged with a plurality of values and justifications (Patriotta et al. 2011). In the daily organization of care, middle managers concerned themselves with multiple values like client-centered care, safe care, 24-hour care, affordable care and accountable care. They also dealt with tensions between these values. Chapter 4 revealed that middle managers tinkered together with care workers to align different notions of good care, such as safe care and care that enables client choice. Safety protocols, intended to structure daily rituals like dinner and lunch at small-scale living facilities for severely handicapped clients, seemed to exclude client choice as this was not scripted into the protocol. By exploring how choice (e.g. what to drink) could be included in daily rituals and to what extent the protocol could be flexibly interpreted, choice and safe care could be aligned in the organization of good care (Stoopendaal and Bal 2013). Hence, taking into account varieties of goodness and managing tensions between different forms of good, was an essential part of the governance of 'good care'. Middle managers did not do this alone, but together with care workers, clients and their relatives and sometimes neighbours. This was also demonstrated in chapter 2, where middle managers argued that the balancing act between affordable and client-centred care in the new financing system was a shared responsibility between managers and care workers.

In addition to taking into account varieties of goodness and managing value tensions, middle managers actively built compromises and *justified* these compromises to significant others, thereby trying to contribute to *legitimate* governance (chapter 3). At small-scale living facilities, compromises were created to ensure 24-hour supervision for a small number of clients, while also ensuring affordability and continuity of care in the long run. During meetings with client's relatives, middle managers discussed various options, for example the involvement of volunteers and family members or the use of new monitoring devices that could be combined with supervision by one professional who covered several locations. Compromises like these were viewed as necessary in order to maintain the ideal of small-scale care. Compromises were however fragile and required continuous justification work

of middle managers. Whether compromises were deemed legitimate in the eyes of clients, their relatives and care workers, depended on how middle managers justified these compromises. Compromises could for example be justified from a market perspective by arguing that clients and their relatives had to make consumer choices how to spend their individual budget (e.g. supervision during the night or support with day-time activities) or from a civic perspective (e.g. a greater need for an active civil society/substitution of formal for informal care). By referring to multiple justifications and building compromises into buildings (e.g. small-scale living facilities) and work methods (e.g. domestic routines), middle managers could create legitimacy in the eyes of various actors. This legitimacy was not permanent however and could erode when feelings of injustice arose. Middle managers therefore had to recraft existing compromises, create new ones and perform continuous justification work. It can therefore be concluded that the governance of 'good' care is a highly cyclical process without final or definite outcomes. Nevertheless, managerial compromises did not have to lead to relativism ('anything goes'), as managerial actions always had to be supported by justifiable arguments, materials, and behaviour (chapter 3).

Governance of 'good' but also 'bad' care is highly situated. Some compromises worked well for clients with minor physical disabilities but not for clients with severe mental disabilities. A good compromise could turn into a bad compromise when used as a 'best practice' across different sites and clients. Middle managers therefore had to tune into to the local, specific and individual, while simultaneously achieving collective outcomes and organizing group-based care for several clients. As a consequence, middle managers experienced feelings of unease, ambiguity and even distress when they for example prioritized the interest of the group over that of the individual or prioritized one value over the other (chapter 2). This makes clear that governance of 'good' care is anything but easy: it's ambiguous and encompasses varieties of goodness, value tensions and paradoxes. The contribution of middle management to the governance of good care is to manage these tensions well, allow for and actively establish varieties of goodness and justify compromises to significant others like clients, their relatives and care workers. This work cannot be captured in abstract good governance codes that outline general principles, but only becomes visible and tangible in and through practices.

It goes without saying that individual differences existed between middle managers and their contribution to governance of good care. Some middle managers were notably more effective than their counterparts. Especially middle managers that created maneuvering room to move in-between multiple middles and made an active effort to engage stakeholders in mediating these middles, were more likely to make a difference. In contrast, managers that considered their environment as status quo and simplified value choices as either/or decisions were considerably less effective and remained on the sideline.

Overall conclusion and theoretical implications

My ethnographic research revealed that *middle* management in healthcare is multiple and does not confine itself to a vertical middle position in-between the 'top' and 'bottom' of the organizational hierarchy. There are non-positional middles which are equally important to middle management, such as middles in-between conflicting values and justifications, inter-organizational middles and the professional-managerial hybrid middles. By multiplying the middle, different types of managerial work become visible: i.e. valuation work, justification work, professionalization work, articulation work and boundary work. Together, these types of work contribute to the governance of good care. This thesis also showed that the middle is not only multiple, but also shifting in healthcare management. Part of the organizing work of middle management is distributed and reconfigured to professionals and citizens, thereby shifting middles from 'classic' middle managers to professionals and citizens.

Ethnographic research is particularly suitable to capture locally embedded knowledge and unravel situated routines. Indeed, by shadowing middle managers I familiarized myself with their personal routines (e.g. how they conduct team meetings, drink coffee and talk to their employees) and the idiosyncratic nature of their work in the long term care setting (e.g. management of small-scale homes). Yet, ethnographic research simultaneously allows me to make inferential and theoretical generalizations (Mortelmans 2007) that go beyond the long-term care context and capture a 'welfare state in transition'. I would argue that theoretical concepts such as boundary work are not merely applicable to boundary negotiations conducted by middle managers in the healthcare sector, but also have explanatory power for other settings and phenomena, such as the participation society in the Netherlands or the big society in the UK. Shifting responsibilities between 'formal' and 'informal' caregivers are a case in point. Via boundary work, conventional task divisions between laypersons and professionals are currently being reshaped and new answers are given to old questions such as 'what belongs to the core of what professionals do and what tasks can be delegated to other actors, such as family, friends and neighbours'? Likewise, professionalization work can encompass both 'managerial efforts' of middle managers to professionalize care workers with limited training as well as 'professional efforts' by for example social workers to educate volunteers in carrying out professional tasks. What's more, concepts such as distributed leadership are not merely revealing new work divisions between middle managers and self-steering teams of professionals, but also explain how professionals involve citizen collectives in public service provision (e.g. running libraries or multi-functional accommodations) and the management of wicked problems in socially deprived neighbourhoods. Given the broader explanatory power of these concepts, the constructed typology of work in this thesis could therefore serve as a useful tool kit to analyze changing configurations between citizens, professionals and managers in the newly emerging participation society.

With specific regards to management literature, this thesis also has theoretical implications. One important implication of the multiple and shifting middle is that research about middle management can no longer confine itself exclusively to the boundaries of a well-defined managerial position in a functional bureaucracy.

Increasingly, middle management research may be dispersed across space, time and place. Consequently, research may be conducted outside the formal entity of the organization, encompass material practices and processes and involve managerial, professional and civic actors alike. This dispersed focus of the research also has important implications for the methods that researchers apply. The object of shadowing is likely to shift from individuals (i.e. middle managers: their work, position, identity and roles) to processes and activities (i.e. different actors that manage middles in public service delivery and civil society). Compared to shadowing individuals, shadowing *processes* requires a more flexible approach since the focus may shift from one practice to the other. Moreover, different actors, but also objects come on and get off the stage (Czarniawska 2007, 2008). In future research, scholars that shadow processes could use Actor Network Theory as a basis, since ANT pays equal attention to humans and non-humans and foregrounds ongoing processes of negotiations and translations instead of assuming fixed positions and organizational structures (Latour 2002).

Moreover, this thesis sheds light on the post-bureaucratic question whether 'management beyond the manager' is possible (Mintzberg 2009). As Mintzberg recently noted 'always of some importance and now increasingly so, is the managing that happens beyond what is done by the people designated as managers. The job, or at least parts of it, gets diffused to other people, who carry out certain managerial roles.' (Mintzberg 2009, p.147-148). This suggests that management first has to be dispersed in other to be carried out by non-managers. As chapter 5 on neighbourhood nurses demonstrates, this is not necessarily the case. Managing and organizing can be an inherent part of professional work. From a historical perspective, Dutch neighbourhood nurses used to organize their own work, plan client routes and coordinate efforts of different professionals and service providers. During the 1990's and 2000's organizing was taken out of professional work and delegated to central planning departments. Due to a neo-Taylorist separation between planning and execution of work, neighbourhood nurses experienced a fragmented sense of self and occupation. This changed when organizing and managing were brought back in the work of neighbourhood nurses with the Visible Link project and the rise of new organizing principles such as developed in the *Buurtzorg* network. The case of neighbourhood nurses shows that 'who' organizes and manages is highly negotiated and determined by dominant views about good management, e.g. Taylor's scientific management, New Public Management and professional management.

In the Neighbourhood Based Approach Program (NBA), the question 'who' manages and organizes was also a matter of fierce debate. Middle managers tried to distribute responsibilities for managing and organizing to professionals in self-steering teams (e.g. budget-keeping and inter-organizational coordination) and citizens (e.g. self-organizing informal and formal care; the organization of neighbourhood community). Yet, professionals and citizens did not always embrace self-governance and tried to recenter responsibilities for management to either middle managers or professionals with coordinating roles. Moreover, the distribution and reconfiguration of management did not lead to the disappearance or breakdown of middle management. The middle manager stayed very much centred, albeit in a different role as coach that empowered professionals to organize, innovate and manage budgets. As such, management did not take place 'beyond' the manager (Mintzberg

2009), but was 'co-produced' with and facilitated by the manager (Raelin 2013). Yet, coaching did not replace formal authority of managers altogether. Middle managers were still officially and personally held accountable for the performance of teams and units (see also Hales 2002). Post-bureaucratic claims about empowered and decentralized organizations without hierarchical management should therefore be nuanced (for a critique of these claims see Hales 2002; Parker 2002). Instead, it's more accurate to talk about hybrid entanglements between hierarchical management and empowerment discourses.

Finally, this research provides insights into the normativity of management, thereby contributing to managerial work studies (Tengblad 2012). While some managerial work studies categorize and depict management in neutral activities, such as desk work and meetings (Mintzberg 1973; Arman et al. 2009), other managerial work studies uncover the normativity that goes behind these seemingly neutral activities. Scholars like Jackall and Watson have emphasized the normative, moral and political dimensions of managerial work (Jackall 1988; Watson 1994). This research ties into this tradition by revealing how middle managers deal with different, sometimes conflicting, values of good care and how they justify compromises to significant others. The analysis of justification and evaluation work in chapters 2 and 3 are good examples of normative management 'in action'. In the doing of work, middle managers take along their personal values (Hewison 2002), but also deal with values of clients and professionals, as well as different values of good care. This makes healthcare management a priori a normative affair. This does not have to lessen the legitimacy of management. On the contrary, when managers openly acknowledge that they deal with (difficult) value choices and co-construct these choices with relevant others, the legitimacy of management may increase rather than wither away.

Practical implications

Politicians, opinion makers and professionals increasingly question the need for managers in healthcare and other sectors. Appeals are made to 'cut out' or reduce management in numbers, especially middle management. The popularity of self-steering teams in homecare (e.g. *Buurtzorg*) is proof of successful non-managerial organizing. Care organizations in other sectors have quickly embraced self-steering teams of *Buurtzorg* as best practice. Who needs middle management anymore? Yet, cutting out middle management will not solve all problems of healthcare organizations. What's more, it may burden care workers who do not wish to be involved in organizing and managing. Although highly trained (neighbourhood) nurses seemed to benefit from self-governance (chapter 5), vocationally trained care workers often appreciated the presence of middle managers who supported and coached them in the daily organization and provision of care (chapter 4). Also, hybrid middle managers played a crucial role in professionalizing vocationally trained care workers. They used their own background as professional to trigger reflection of care workers and to connect managerial and professional worlds (chapter 4). Cutting out middle

management in healthcare thus implies cutting out professional-managerial bridges. Politicians, policymakers, and healthcare executives should therefore carefully consider the situated contributions of middle managers in specific organizations. They should also take into account the different needs of care workers with various educational backgrounds and capacities. Top-down implementing a blueprint of self-governance across the care sector (a paradox in itself) will probably do more harm than good since it ignores situated differences between professionals and care organizations.

This research has also implications for the work and education of middle managers in healthcare. Because middle managers have to deal with multiple values of good care in their daily work (e.g. client-centered, accountable, efficient, affordable, safe), it is important that educational institutes teach middle managers to be guardians of varieties of goodness. This means that managers are able to make good compromises between multiple values and allow different ideals of good care to coexist. When educational curricula break down management in seperate topics (e.g. financial management, quality of care, project management), value tensions and compromises become invisible, thereby simplifying management as a tool box of techniques. Integrated courses that show the difficulties of doing valuation and justification work, give middle managers a real chance to learn about the complexities of multiple value management in practice. With regards to the daily work of middle managers, it is important that executives pay attention to potential moral distress of middle managers (chapter 2). They may sometimes feel prevented in organizing the care they deem necessary according to their own moral standards, which can lead to feelings of distress. If middle managers develop moral distress, this should be picked-up by higher levels of management so middle managers can be sufficiently supported.

Finally, is also essential to realize that neighbourhood governance of care and support is not the magic bullet. Middle managers themselves, but also policymakers and politicians have exceedingly high expectations about neighbourhood governance. They argue that on the scale of the neighbourhood, citizens are more inclined to help others and engage in community initiatives. Moreover, professionals are expected to transform themselves from specialists to generalists who work across disciplinary boundaries while also empowering citizens to take care of themselves. Although neighbourhood governance does offer new opportunities for joining-up care, social work and housing services and promoting citizen participation (chapter 5 and 7), it has limitations. Neighbourhoods are not always safe heavens of community spirited people who are happy and able to help (chapter 7). They can be dangerous and vulnerable places that bundle together people who have difficulty coping with their own life as it is. In vulnerable neighbourhoods, it is therefore important to create good combinations between formal and informal care rather than breakdown professional service provision and infrastructures. For local politicians it is also important to embed neighbourhood policies in multi-level governance since neighbourhoods are shaped by policies and resource dependencies at the level of the city, region and country. Lastly, with current decentralizations of care and support to local governments, local politicians and civil servants should balance the benefits and disadvantages of generalist professionals with specialized professionals. Generalists may be able to work with various clients groups and provide integrated

support in different life domains, yet they may lack much needed specialist expertise to recognize complex conditions. Vice versa, specialized professional have developed expertise about certain client groups and conditions, but may not see the overall picture. Replacing 'old' specialists with 'new' generalists, which seems to be the current trend, is not the solution. Rather, specialist expertise and a general/holistic approach to life can strengthen each other in the organization of neighbourhood-based care and support.

Concluding remarks

The daily work of middle management provides insights into local compromises between different values of good care, but also illuminates unresolved tensions in the current reconfiguration of the welfare state. Unresolved questions at the national level manifest themselves in the mundane work of middle managers. Due to their close relations with clients, their relatives, professionals and higher managers, middle managers cannot procrastinate difficult decisions or indulge in abstract theorizing: they need to act and make concrete decisions. This makes middle management par excellence 'management in action'. Because the middle is shifting and multiple in nature, it is necessary to develop new understandings of middle management that go beyond well-defined managerial positions in the organizational hierarchy. Considering middle management as a collective endeavour of various actors that deal with multiple middles, is an important step towards developing new understandings of management.

References

Arman, R., L. Dellve, E. Wikström and L. Törnström (2009). What healthcare managers do: applying Mintzberg's structured observation method. *Journal of Nursing Management* 17: 718-729.

Arman, R., O.E. Vie and H. Åsvoll (2012). Refining shadowing methods for studying managerial work. In *The work of managers. Towards a practice based theory of management*, Tengblad ed., 301-317. Oxford and New York: Oxford University Press.

Czarniawska, B. (2007). *Shadowing - and other techniques for doing fieldwork in modern societies*. Liber: Malmö.

Czarniawska, B. (2008). *A theory of organizing.* Cheltenham: Edward Elgar Publishing Ltd.

Boltanski, L. and L. Thévenot (2006). *On justification: economies of worth.* Princeton, NJ: Princeton University Press.

De Blok, J. and A. Pool (2010). *Buurtzorg: menselijkheid boven bureaucratie*. Den Haag: Boom Lemma.

Durose, C. and V. Lowndes (2010). Neighbourhood governance: contested rationales within a multi-level setting – a study of Manchester. *Local Government Studies* 36 (3): 341-359.

Jackal, R. (1988). *Moral mazes. The world of corporate managers*. New York: Oxford University Press.

Jagd, S. (2011). Pragmatic sociology and competing orders of worth in organizations. *European Journal of Social Theory* 14 (3): 343-59.

Grant, B. and B. Dollery (2011). Political geography as public policy. 'Place-shaping' as a mode of local government reform. *Ethics, Policy & Environment* 14 (2): 193-209.

Hales, C. (2002). 'Buraucracy-lite' and continuities in managerial work. *British Journal of Management* 13: 51-66.

Hewison, A. (2002). Managerial values and rationality in the UK National Health Service. *Public Management Review* 4 (4): 549-579.

Holmberg, I. and M. Tyrstrup (2010). Well then – What now? An everyday approach to managerial leadership. *Leadership* 6 (4): 353-372.

Latour, B. (2002). *Aramis or the love of technology*. Cambridge MA and London: Harvard University Press.

Lowndes, V. and H. Sullivan (2008). How low can you go? Rationales and challenges for neighbourhood governance. *Public Administration* 86 (1): 53-74.

Mintzberg, H. (1973). *The nature of managerial work*. New York: Harper & Row. Reprinted by Prentice-Hall (1980).

Mortelmans, D. (2007). *Handboek kwalitatieve onderzoeksmethoden*. Leuven and Den Haag: Acco.

Newman, J. (2013). Professionals, power and the reform of public services. In *Professionals under pressure. The reconfiguration of professional work in changing public services*, M. Noordegraaf and B. Steijn ed., 41-53. Amsterdam: Amsterdam University Press.

Parker, T. (2002). *Against management*. Cambrigde etc.: Polity Press.

Patriotta, G., J-P. Gond and F. Schulz (2011). Maintaining legitimacy: controversies, orders of worth, and public justifications. *Journal of Management Studies* 48(8): 1804-36.

Raelin, J.A. (2013). The manager as facilitator of dialogue *Organization* 20 (6): 818-839.

Sayles, L.R. (1964). *Managerial behaviour. Administration in complex organizations.* New York etc.: McGraw-Hill Book Company.

Strauss, A.L., S. Fagerhaugh, B. Suczek and C. Wiener (1997). *Social organization of medical work*. New Brunswick and London: Transaction Publishers.

Stoopendaal, A. and R. Bal (2013). Conferences, tablecloths and cupboards: how to understand the situatedness of quality improvements in long-term-care. *Social Science & Medicine* 78: 78-85.

Van Dalen, A. (2012). *Zorgvernieuwing. Over anders besturen en organiseren*. Den Haag: Boom Lemma.

Watson, T. (1994). *In search of management. Culture, chaos & control in managerial work.* London and New York: Routlegde.

Watson, T. (2003). Professions and professionalism. Should we jump off the bandwagon, better to study where it is going? *International Studies of Management and Organization* 32 (2): 93-105.

Summary

The future of the middle manager is a much debated topic; not only in healthcare but also in other sectors. The middle manager is either viewed as an important change agent or as a relict of the past. Despite these opposing views, the underlying definition of middle management is one and the same: middle management is defined as a place somewhere 'in the middle' of the work floor and higher management. This spatial definition of middle management is foregrounding management activities in 'upward' (higher management) and 'downward' directions (work floor), while backgrounding other management activities. As a consequence, we only have a partial and limited view of what middle management entails.

The central aim of this thesis is to open up the middle by researching the multiplicity of the middle in healthcare, thereby gaining new insights in day-to-day work of middle management and important transitions in this work. This thesis foregrounds alternative middles that so far have received little attention in literature: the middle in-between 1) conflicting values of good care; 2) different justifications used towards stakeholders; 3) professional and managerial discourses; and 4) organizational boundaries between care, welfare and housing. The empirical analysis does not only sheds light on the type of work that is conducted in these middles, but also reveals how this work is reconfigured and partially distributed to clients and professionals. Moreover, the analysis provides an answer to the main question: 'How is the daily work of middle management enacted and reconfigured in the Dutch care sector?' This thesis focuses particularly on care organizations for people with physical and mental limitations and neighbourhood-based care projects. These organizational settings are suitable for investigating changing responsibilities in the current care sector and welfare state.

Ethnographic research methods are used to explore mundane routines and embedded perceptions of actors. By shadowing middle managers during their daily work, a clear picture was developed of what the activity of middle managing entails in practice. To deepen the empirical analysis, ethnographic observations were triangulated with semi-structured interviews and document analysis. During data collection and analysis, various sensitizing concepts from literature were used to focus on specific aspects of work, such as 'values', 'justifications' and 'boundaries'. The result is an ethnography of managerial work that is both theory-based and inductively developed.

Chapter 2 reveals how middle managers engage in *valuation work* by valuing what good care is and dealing with different conceptualizations of good care. Since the introduction of client-linked budgets (2009), middle managers are expected to provide more 'client-centered' and 'affordable' care. While policy reports frame client-linked budgets as a win-win situation (i.e. better affordability and client-centered care), middle managers experience ambiguity and tensions in the operationalization of different values. On the basis of semi-structured interviews, light is shed on the way managers conceptualize abstract values of affordability and client-centredness on location level. Moreover, this chapter shows how managers deal with tensions between affordable and client-centred care. On the basis of our interview data, four modes of dealing with value tensions are distinguished: 1) balancing values individually and collectively; 2) prioritizing one value over the other; 3) establishing compromises between values; and 4) making healthcare workers responsible for balancing

different values. The findings demonstrate that managers increasingly feel pressure to more tightly manage their financial budget on location level. As a consequence, managers try to find solutions to keep care affordable, which they often feel ambivalent about. Yet, managers also create flexibility in the new financing system by accomplishing compromises between values, reframing responsibilities for care as 'core' and 'additional' and involving care workers in valuation work. The results show that it is necessary to raise awareness of moral distress that managers may experience when managing value tensions.

Chapter 3 reveals how middle managers and executives of small-scale care facilities deal with value conflicts by conducting *justification work*: i.e. the construction of compromises and the justification of these compromises towards significant others. In public administration literature, a variety of responses to value conflicts have been described, such as trade-offs, decoupling values, and incrementalism. Yet, little attention is paid to the possibility of constructive compromises that enable public managers to deal with conflicting values simultaneously rather than separately.

The results demonstrate that the ideal of small-scale care is not uniform but can be operationalized through different compromises. As part of a broader trend of deinstitutionalization, a civic/domestic compromise is constructed that allows clients to live in a domestic household with other clients and perform civic duties in the neighbourhood. Because this compromise is based on different justifications (civic/domestic), it is fragile. New value conflicts emerge and criticism is voiced by various actors. For instance, neighbours complain about noise disturbances and clients criticize the lack of privacy. Moreover, managers argue that 24-hour care at small-scale facilities puts a financial burden on society thereby creating new value conflicts with regards to affordability. To deal with critique and value tensions, managers rebuild and adjust the civic/domestic compromise. They use monitoring devices to guarantee 24-hour care provision at a distance and ask family members to participate more. In addition, managers also build a new compromise based on market and industry justifications. This compromise is materialized in new collective apartment buildings, which contain private apartments for individual clients. This new form of small-scale care appeals to choosing consumers who want more privacy and options (market), while at the same time allowing for a more efficient planning of personnel (industry). This chapter demonstrates that both compromises co-exist in practice as 'varieties of goodness'.

While justification work is conventionally associated with mere rhetorics, this chapter shows that justification work entails not only the use of language (e.g. framing of compromises), but also the adaption of behavior of professionals (e.g. new work methods and schedules) and the recrafting of objects (e.g. reordering buildings). By inscribing compromises into materials and behaviour, managers are able to solidify compromises, thereby creating temporary stability.

Chapter 4 turns to the question of how middle managers perform *professionalization work* by strategically using the discourse of professionalism to steer the behaviour of care employees at geographically dispersed locations. While the label of professional is usually reserved for exclusive occupations such as doctors and lawyers, this research shows that it is used much more widely. Middle managers frequently frame care workers with little formal education as 'professionals'. In order to distinguish different uses of the label 'professional', a discourse analysis of professional talk by managers is conducted. The discourse analysis reveals different professional talks that co-exist in practice: 1) appropriate looks and conduct; 2) reflectivity about personal values and 'good' care; 3) the use of methodical work methods; and 4) competencies for teamwork.

Jointly, these professional talks constitute an important discursive resource for middle managers to facilitate change on the work floor while governing from a geographical distance. Change involves the reconfiguration of care work. For example, 'professional' care workers formulate goals for client supervision and write these down in the recently introduced Care Living Plans. Change also involves different relations as care workers are expected to function as self-steering professionals and middle managers as coaches. This chapter concludes that middle managers use professional discourse in both enabling and disenabling ways vis-à-vis care workers. Given these findings, a more nuanced portrayal of the relationship between managers and professionals is suggested. Rather than being based on an intrinsic opposition, i.e. 'managers versus professionals', this relationship is flexibly reconstructed via professional talk. Moreover, since many middle managers previously worked as care workers, they are able to bridge professional and managerial discourses.

Chapter 5 reveals that not only classic middle managers, but also professionals operate in the middle of organizational boundaries. The existence of specialized care providers and individual 'care products' creates coordination challenges for professionals. This chapter investigates how neighbourhood nurses in the Visible Link project perform organizing work to establish new connections between services and actors, here defined as *articulation work.* As the historical analysis reveals, organizing work was gradually removed from the domain of neighbourhood nurses due to scale enlargements and subspecialization in home care from the 1980's onwards. This resulted in a taylorized separation between the execution of professional work and the planning of work by central departments. Neighbourhood nurses were viewed as simple implementers with little autonomy. However, in the 2000's public discontent about this separation and the fragmented nature of professional work led to the reorganization of home care. By bringing back organizing into professional work, the Visible Link project allowed neighbourhood nurses to organize a more encompassing arc of work: not only by organizing their own care work, but also by joining-up different services, such as home care, housing, primary care and social support.

Based on our interviews with neighbourhood nurses and document analysis, different types of organizing work are defined: i.e. intra-professional (integrating care tasks, such as medication and showering), inter-professional (coordinating actions of professionals from different service providers) and lay articulation work

(organizing informal care). These results contribute to existing literature about organized professionalism by revealing that there is not an intrinsic opposition between professional and organizational logics. Rather, the relationship between professional and organizational logics is a reciprocal one. This chapter also goes beyond organized professionalism by showing that organizing work does not necessarily come on top of existing professional work, as is often assumed, but can be inherent to professionalism. It is concluded that articulation work traditionally lies at the heart of professionalism, but acquires new meaning due to changing organizational conditions and policy changes.

Chapter 6 addresses the key question of how leadership is being reconfigured in neighbourhood governance. Building on theories of distributed leadership (DL), this chapter argues that neighbourhood leadership should not automatically be equated with the notion of an individual leader, but must be researched as a distributed activity enacted by a collective of local actors. A qualitative study of Dutch neighbourhood collaboratives by public service providers offers important insights into 'how' leadership is distributed and to what effect. Rather than a spontaneous bottom-up process, DL is very much steered by middle managers of public service providers. Middle managers do not only *distribute* leadership to local actors, but also *reshape* responsibilities of citizens, professionals and themselves in the process. Three important consequences of distributing leadership are: 1) organizational responsibilities for citizens and professionals to locally solve problems, 2) the repositioning of middle managers as coach, 3) new maneuvering room for professionals. The findings also demonstrate that DL is a two-way street: parallel to distribution, new centralization occurs via emerging coordinating roles. This chapter concludes by outlining the bright and dark sights of DL: it provides opportunities for locally tailored services, but also carries the risk of overburdening citizens and professionals.

Chapter 7 explores how middle managers conducted *boundary work* in the reform program 'The Neighbourhood Based Approach' (NBA) by (re)constructing organizational boundaries and coordinating service provision in new ways. In healthcare provision, organizational boundaries are often conceptualized as fixed barriers to service integration. However, this chapter emphasizes the constructed nature of boundaries and their change potential. The ethnographic observations of middle managers in the NBA-program reveal that middle managers first create a sense of urgency for inter-organizational collaboration on a neighbourhood scale by emphasizing the existence of cumbersome boundaries between service providers, such as different financial systems and professional work methods. After having drawn boundaries, middle managers reconfigure these boundaries by means of boundary transcending language and boundary objects.

Middle managers act as important rhetorical change agents by using new vocabulary such as 'social-return-on-investment' to describe the societal gains of a cross-sector approach and inter-professional neighbourhood teams. This new vocabulary is linked to boundary objects, such as a 'societal cost-benefit analysis' that renegotiates the meaning of profit beyond traditional organizational production targets. As a result of boundary work, new arrangements of neighbourhood-based support are

developed. Although the change motto of the NBA-program 'de-velop, de-regulate, de-institutionalize' suggests that it is desirable to eradicate organizational boundaries altogether, daily work practices of middle managers show otherwise. In fact, drawing boundaries is crucial for change. This chapter also demonstrates that middle managers have to carefully manage their legitimacy as boundary people by switching identities: while sometimes they present themselves as project leader of the NBA-program, other times they introduce themselves as manager of their own home organization. The end of the chapter reflects on the challenging nature of boundary work and outlines some conditions for doing boundary work.

Chapter 8 provides a reflection on the multiple and shifting middle in healthcare management and formulates an answer to the main research question of how daily work of middle management is enacted and reconfigured in new ways. This chapter concludes that the existence of multiple middles (between conflicting values, justifications, organizational boundaries, professional and managerial discourses) necessitates a conceptual shift from positional management to management as an activity. Rather than strictly demarcating middle management as a clear position in the organizational hierarchy, middle management should be viewed as a fluid activity that can be enacted by various actors that deal with (multiple) middles. This conceptual shift in management thinking aligns with increasing expectations of active patients and self-steering professionals in the changing welfare state. Furthermore it is concluded that the distribution of management responsibilities to clients and professionals has both advantages and drawbacks as it allows for tailor made solutions but potentially overburdens clients and professionals with responsibilities they do not want or are not able to perform.

In addition, the conclusion provides an overview of different types of work that are characteristic of middle management as an activity: i.e. valuation work, justification work, professionalization work, articulation work and boundary work. Although the constructed typology of work is specific for middle management, it does have broader explanatory power and could therefore be used as a conceptual tool kit to analyze changing configurations between citizens, professionals and managers in the emerging participation society. Moreover, the conclusion reflects on the contribution of middle management to governance of 'good' care. Given the plurality of good governance, middle managers need to manage value tensions well, actively establish varieties of goodness and openly justify compromises to significant others like clients, client's relatives and care workers. The conclusion ends with theoretical and practical implications. Theoretically, the possibilities and limits of post-bureaucratic organizing are emphasized. It is also argued that the dispersed nature of management requires a methodical shift: from shadowing persons to shadowing processes. Finally, practical recommendations are made to revise educational curricula for middle management and to embrace diversity of management practices rather than uniformly implementing self-management across the whole care sector.

Samenvatting

De toekomst van de middenmanager is onderwerp van discussie; niet alleen in de gezondheidszorg, maar ook in andere sectoren. Aan de ene kant wordt de middenmanager gezien als een belangrijke strategische vernieuwer, aan de andere kant als een relict uit het verleden. Ondanks deze tegengestelde visies, is de onderliggende definitie van het middenmanagement één en dezelfde: het middenmanagement is een plaats ergens 'in het midden' tussen de werkvloer en het hoger management. Deze plaatsgebonden definitie van middenmanagement legt de nadruk op management activiteiten die 'omhoog' (hoger management) of 'omlaag' (werkvloer) gericht zijn, terwijl andere managementactiviteiten minder zichtbaar zijn of buiten beeld blijven. Het gevolg is dat we slechts een beperkt en gedeeltelijk beeld hebben van wat middenmanagement inhoudt.

Het centrale doel van dit proefschrift is om het midden open te breken door de meervoudigheid van het midden te onderzoeken in de gezondheidszorg. Hierdoor is het mogelijk nieuwe inzichten te krijgen in het dagelijks werk van het middenmanagement, evenals in belangrijke transities in dit werk. Dit proefschrift richt zich specifiek op alternatieve 'middens' die tot nu toe weinig aandacht hebben gekregen in de literatuur: het midden tussen 1) conflicterende waarden van goede zorg; 2) verschillende rechtvaardigingen naar stakeholders; 3) professionele- en managementdiscoursen; en 4) organisatiegrenzen in zorg, welzijn en wonen. De empirische analyse maakt niet alleen inzichtelijk welk type werk er wordt verricht in het meervoudige midden, maar ook hoe het werk verandert en deels gedistribueerd wordt naar cliënten en professionals. De resultaten geven een antwoord op de centrale onderzoeksvraag: 'Hoe wordt het dagelijks werk van middenmanagement uitgevoerd en op nieuwe wijze vormgegeven in de Nederlandse gezondheidszorg'? Dit proefschrift richt zich in het bijzonder op zorgorganisaties voor cliënten met mentale of fysieke beperkingen en op buurtgerichte zorgprojecten. Deze organisatorische contexten zijn geschikt om veranderende verantwoordelijkheden te onderzoeken in de huidige gezondheidszorg en verzorgingsstaat.

Etnografische onderzoeksmethoden zijn ingezet om dagelijkse routines en contextgebonden percepties van actoren te verkennen. Door middenmanagers te schaduwen tijdens hun dagelijks werk, was het mogelijk om een helder beeld te krijgen van wat 'managen in het midden' als activiteit inhoudt. Om de empirische analyse te verdiepen zijn etnografische observaties getrianguleerd met semi-gestructureerde interviews en documentanalyses. Tijdens de dataverzameling en analyse zijn verschillende 'sensitizing concepts' uit de literatuur gebruikt om te focussen op bepaalde aspecten van werk zoals 'waarden', 'rechtvaardigingen' en 'grenzen'. Het resultaat is een etnografie van het werk van middenmanagers die zowel theoretisch gefundeerd als inductief ontwikkeld is.

Hoofdstuk 2 laat zien dat middenmanagers *waardenwerk* verrichten door het (e) valueren van goede zorg en het omgaan met verschillende vormen van goede zorg. Sinds de introductie van Zorg Zwaarte Pakketten (2009), wordt van middenmanagers verwacht dat zij meer cliëntgerichte en betaalbare zorg leveren. Alhoewel beleidsrapporten de mogelijkheden van Zorg Zwaarte Pakketten framen als een 'win-win' (i.e. betere betaalbaarheid en cliëntgerichtheid), ervaren middenmanagers ambiguïteit en spanningen bij de operationalisering van verschillende, soms conflicteren waarden. Op basis van semi-gestructureerde interviews wordt inzichtelijk gemaakt hoe managers

abstracte waarden als betaalbaarheid en cliëntgerichtheid in de praktijk van hun locatie operationaliseren. Daarnaast laat dit hoofdstuk zien hoe managers omgaan met spanningen tussen betaalbare en cliëntgerichte zorg. Op basis van de interviewdata, worden 4 verschillende omgangsvormen met waardenconflicten onderscheiden: 1) het balanceren tussen waarden op individueel en collectief niveau; 2) het prioriteren van de ene waarde boven de andere; 3) het tot stand brengen van compromissen tussen waarden; en 4) het verantwoordelijk maken van zorgmedewerkers voor het balanceren tussen waarden. De resultaten beschrijven hoe managers toenemende druk ervaren om een financieel budget te managen op hun locaties. Het gevolg is dat managers oplossingen creëren waar zij zich tegelijkertijd ambivalent over voelen. Desalniettemin proberen managers ook flexibiliteit te creëren in het nieuwe financieringssysteem door het maken van nieuwe compromissen, het herframen van wat 'basis zorg' en 'aanvullende zorg' is, en het betrekken van zorgmedewerkers bij waardenwerk. De resultaten tonen aan dat er meer aandacht nodig is voor morele stress die managers ervaren bij het omgaan met conflicterende waarden.

Hoofdstuk 3 maakt inzichtelijk hoe middenmanagers en bestuurders van kleinschalige zorglocaties omgaan met waardenconflicten door het verrichten van *rechtvaardigingswerk*: i.e. het construeren van compromissen en de rechtvaardiging van deze compromissen naar belangrijke stakeholders in de omgeving. In de bestuurskundige literatuur wordt een variëteit aan omgangsvormen met waardenconflicten omschreven, zoals trade-offs, het ontkoppelen van waarden en incrementalisme. Er bestaat echter weinig aandacht voor constructieve compromissen die managers in staat stellen om gelijktijdig in plaats van sequentieel met conflicterende waarden om te gaan.

De resultaten geven aan dat het ideaal van kleinschalige zorg niet uniform is, maar vertaald kan worden in verschillende compromissen. Als onderdeel van een bredere trend van deinstitutionalisering is ten eerste een compromis gecreëerd tussen huiselijkheid en burgerschap. Dit compromis stelt cliënten in staat om in een normaal huishouden te leven en tegelijkertijd als burgers mee te doen in de buurt. Omdat dit compromis gebaseerd is op verschillende rechtvaardigingsvormen (burgerschap/huiselijkheid), blijft het vaak kwetsbaar voor nieuwe waardenconflicten en kritiek van belanghebbenden. Zo klagen buren bijvoorbeeld over geluidsoverlast en ervaren sommige cliënten een gebrek aan privacy. Daarnaast geven managers aan dat 24-uurs zorg voor kleinschalige woonlocaties een financiële last is voor de samenleving en daardoor waardenconflicten rondom betaalbaarheid veroorzaakt. Om te kunnen omgaan met deze kritiek en nieuwe waardenconflicten, passen managers het huidige compromis aan. Ze gebruiken bijvoorbeeld monitoring op afstand om 24-uurs toezicht te garanderen en vragen familieleden om meer te participeren om ondersteuning te bieden. Daarnaast creëren managers ook een nieuw compromis dat gebaseerd is op rechtvaardigingsvormen van de markt en de industrie. Dit nieuwe compromis krijgt de vorm van gebouwen die meerdere privé appartementen bevatten voor cliënten. Deze nieuwe vorm van collectieve kleinschalige zorg appelleert aan de behoeften van de kiezende consument die meer privacy en keuzeopties wil (markt), terwijl tegelijkertijd een meer efficiënte planning van personeel kan worden georganiseerd (industrie). Dit hoofdstuk laat zien dat beide compromissen in de praktijk naast elkaar bestaan als 'varieties of goodness'.

Alhoewel rechtvaardigingswerk voornamelijk wordt geassocieerd met retoriek, laat dit hoofdstuk zien dat het niet alleen gaat om het gebruik van taal (e.g. het framen van compromissen), maar ook gaat over de aanpassing van professioneel gedrag (e.g. nieuwe werkmethoden en roosters) en objecten (e.g. gebouwen). Door compromissen in te bedden in gedragspatronen en fysieke infrastructuren, kunnen deze verder verstevigd worden. Rechtvaardigingswerk van managers draagt op deze wijze bij aan tijdelijke stabiliteit.

Hoofdstuk 4 besteedt aandacht aan middenmanagers die *professionaliseringswerk* verrichten. Dit doen zij door op strategische wijze gebruik te maken van professioneel discours om het gedrag van zorgmedewerkers die werken op geografisch verspreide zorglocaties te sturen. In de literatuur wordt het label 'professional' vooral gebruikt voor exclusieve beroepen zoals artsen en advocaten. Echter, dit hoofdstuk toont aan dat het label 'professional' veel breder wordt ingezet. Middenmanagers framen zorgmedewerkers met een lagere beroepsopleiding steeds vaker als professionals. Om verschillend gebruik van het professionele discours te onderscheiden is een discoursanalyse uitgevoerd van het taalgebruik van managers. Uit de analyse blijkt dat het label professional verschillende betekenissen heeft: 1) gepast uiterlijk en gedrag; 2) reflectie over persoonlijke waarden en goede zorg; 3) het gebruik van werkmethoden; en 4) competenties voor teamwerk.

Tezamen vormen deze professionele discoursen een belangrijk hulpmiddel voor managers om veranderingen op de werkvloer te realiseren terwijl zij zelf fysiek op afstand zijn. Veranderingen gaan deels over de inhoud van de zorg zelf. Van 'professionele' zorgmedewerkers wordt bijvoorbeeld verwacht dat zij gerichte doelen formuleren voor cliëntbegeleiding en deze vastleggen in zorgleefplannen. Veranderingen hebben ook betrekking op de relatie tussen managers en zorgmedewerkers. Van professionele zorgmedewerkers wordt in toenemende mate verwacht dat zij zelfstandig werken in teams. Middenmanagers positioneren zichzelf als coach ten opzichte van deze teams. Dit hoofdstuk concludeert dat de inzet van het professionele discours door middenmanagers zowel bevorderend als beperkend kan uitwerken voor zorgmedewerkers. Gezien deze bevindingen is een meer genuanceerde voorstelling van de relatie tussen managers en professionals nodig. Deze relatie is niet gebaseerd op een inherente oppositie – 'managers versus professionals' –, maar wordt flexibel geconstrueerd aan de hand van professioneel discours. Het feit dat middenmanagers in het verleden zelf als zorgmedewerkers hebben gewerkt, stelt ze daarnaast in staan om professionele en management discoursen bij een te brengen.

Hoofdstuk 5 toont aan dat niet alleen klassieke middenmanagers, maar ook professionals 'in het midden' van organisatiegrenzen werken. Het bestaan van gespecialiseerde zorgaanbieders en individuele 'zorgproducten' creëert nieuwe uitdagingen voor professionals om hun werk te coördineren. Dit hoofdstuk onderzoekt hoe wijkverpleegkundigen in het 'Zichtbare Schakel project' coördinatiewerk verrichten door connecties tussen verschillende diensten en actoren te leggen; hier gedefinieerd als *articulatiewerk.* Uit een historische analyse van de thuiszorg blijkt dat articulatiewerk langzaam weggeorganiseerd werd uit het professionele domein van wijkverpleegkundigen dankzij schaalvergrotingen en een toenemende mate van subspecialisatie

vanaf de jaren 1980. Dit resulteerde in een tayloristische scheiding tussen de uitvoering en planning van werk door centrale ondersteunende diensten. Wijkverpleegkundigen werden hierdoor gezien als simpele uitvoerders met weinig autonomie. In de jaren 2000 leidde de groeiende publieke onvrede over deze scheiding en het gefragmenteerde karakter van professioneel werk tot een reorganisatie van de thuiszorg. Door het terugbrengen van articulatiewerk in het professionele domein, stelde het project van de Zichtbare Schakel wijkverpleegkundigen in staat om een overkoepelende 'arc' van werk te organiseren: niet alleen door hun eigen werk te coördineren, maar ook door verschillende publieke diensten – zoals zorg, wonen, huisartsenzorg en welzijn – met elkaar te verbinden.

Op basis van interviews met wijkverpleegkundigen en documentanalyse worden verschillende vormen van articulatiewerk onderscheiden: i.e. intra-professioneel (het integreren van zorgtaken, zoals medicatie geven en douchen), interprofessioneel (het coördineren van activiteiten van zorgverleners die bij verschillende dienstverleners werken), en informeel (het organiseren van mantelzorg en vrijwilligers). Deze resultaten leveren een belangrijke bijdrage aan literatuur over georganiseerd professionalisme door aan te tonen dat er geen intrinsieke oppositie bestaat tussen professionele en organisatorische logica's. Er is eerder sprake van een wederkerige relatie tussen beide logica's. Dit hoofdstuk gaat tevens een stap verder dan bestaande literatuur over georganiseerd professionalisme. Het maakt inzichtelijk dat organisatietaken en articulatiewerk niet bovenop bestaand werk van professionals komt, zoals vaak wordt aangenomen, maar dat het inherent is aan professioneel werk. Geconcludeerd wordt dat articulatiewerk traditioneel gezien al de kern was van professionalisme, maar dat het nu nieuwe betekenis krijgt dankzij veranderende organisatorische condities en beleidsveranderingen.

Hoofdstuk 6 beantwoordt de vraag hoe leiderschap wordt verdeeld en anders wordt vormgegeven in wijkgovernance. Voortbouwend op theorieën over gedistribueerd leiderschap wordt beargumenteerd dat leiderschap niet automatisch gelijk gesteld moet worden met de notie van een individuele leider, maar onderzocht moet worden als een gedistribueerde activiteit die door een collectief van lokale actoren kan worden uitgeoefend. Een kwalitatieve studie van Nederlandse wijkgerichte samenwerkingen tussen publieke dienstverleners geeft belangrijke inzichten in 'hoe' leiderschap wordt verdeeld en in de effecten van deze verdeling. Dit hoofdstuk toont aan dat de distributie van leiderschap niet een spontaan bottom-up proces is, maar in sterke mate gestuurd wordt door middenmanagers van publieke dienstverleners. Middenmanagers distribueren niet alleen leiderschap naar lokale actoren, maar herconfigureren verantwoordelijkheden van burgers, professionals en managers op nieuwe manieren. Drie belangrijke consequenties van gedistribueerd leiderschap zijn: 1) organisatorische verantwoordelijkheden voor burgers en professionals om problemen lokaal op te lossen; 2) de herpositionering van middenmanagers als coach; en 3) nieuwe manoeuvreerruimte voor professionals. De resultaten tonen aan dat gedistribueerd leiderschap tweerichtingsverkeer is: gelijktijdig aan het proces van distributie en decentralisatie, vindt er ook nieuwe centralisatie plaats via de opkomst van coördinerende rollen. Hierdoor is er slechts sprake van een gedeeltelijke distributie van leiderschap: in plaats van een democratisch collectief van actoren zijn een paar actieve actoren 'in the lead'. Door de positieve en negatieve kanten van gedistribueerd leiderschap te

beschrijven, concludeert dit hoofdstuk dat distributie van leiderschap kansen geeft voor maatwerkoplossingen, maar ook het risico met zich meebrengt dat burgers en professionals worden overbelast met nieuwe verantwoordelijkheden.

Hoofdstuk 7 verkent hoe middenmanagers *grenzenwerk* verrichten in het transitieprogramma Wijk-en Buurtgericht Werken (WBW). Grenzenwerk wordt in dit hoofdstuk gedefinieerd als het trekken van organisatorische grenzen en het coördineren van dienstverlening op een nieuwe wijze. In de gezondheidszorg worden organisatorische grenzen vaak geconceptualiseerd als gegeven barrières die integratie van dienstverlening verhinderen. Dit hoofdstuk laat echter zien dat grenzen niet gegeven zijn, maar steeds weer geconstrueerd worden en veranderpotentie hebben. De etnografische observaties van middenmanagers in het WBW-programma maken inzichtelijk dat middenmanagers allereerst een 'sense of urgency' creëren voor inter-organistorische samenwerking op wijkschaal. Dit doen zij door het bestaan van hinderlijke barrières, zoals gefragmenteerde financiering en uiteenlopende professionele werkmethoden, discursief te benadrukken. Na grenzen te hebben getrokken, herconfigureren zij vervolgens deze grenzen door het gebruik van grensoverstijgende taal en grensobjecten.

Dit hoofdstuk laat zien dat middenmanagers belangrijke retorische vernieuwers zijn doordat zij een alternatief vocabulaire gaan gebruiken. Een voorbeeld hiervan is de term 'social return on investment' die de maatschappelijke meerwaarde van een intersectorale aanpak en interprofessionele wijkteams tot uitdrukking brengt. Dit nieuwe vocabulaire wordt door middenmanagers verbonden met grensobjecten. Een voorbeeld is de maatschappelijke kosten-batenanalyse die een meer maatschappelijke betekenis geeft aan winst voorbij de traditionele productietargets. Het resultaat van grenzenwerk is de totstandkoming van nieuwe dienstverleningsarrangementen en wijkgerichte ondersteuning. Alhoewel het centrale verandermotto 'ont-wikkelen, ont-reguleren, ont-schotten' van het WBW-programma suggereert dat het wenselijk is organisatorische grenzen uit te roeien, laten de werkpraktijken van middenmanagers juist het belang van grenzenwerk zien voor verandering. Dit hoofdstuk toont tevens aan dat middenmanagers hun legitimiteit als grenzenwerkers moeten managen door te switchen in identiteit: soms presenteren zij zichzelf als WBW-projectleider en soms als manager bij de eigen moederorganisatie. Het hoofdstuk sluit af met een reflectie op het uitdagende karakter van grenzenwerk en benoemt enkele voorwaarden voor grenzenwerk.

Hoofdstuk 8 geeft een reflectie op het meervoudige en verschuivende midden in de gezondheidszorg en formuleert tevens een antwoord op de centrale vraag hoe het dagelijkse werk van middenmanagers wordt uitgevoerd en op nieuwe manieren wordt vormgegeven. Dit hoofdstuk concludeert dat het bestaan van het meervoudige midden (tussen conflicterende waarden, verschillende rechtvaardigingen, organisatorische grenzen en professionele en management discoursen) de noodzaak van een conceptuele shift aantoont: van positioneel management naar management als een activiteit. In plaats van middenmanagement strikt te demarkeren als een duidelijke positie binnen de organisatorische hiërarchie, moet middenmanagement meer gezien worden als een fluïde activiteit die door meerdere actoren in het (meervoudige) midden kan worden ingevuld. Deze conceptuele shift in managementdenken valt samen met toenemende verwachtingen van actieve patiënten en zelfsturende

professionals in een veranderende verzorgingsstaat. Tevens wordt geconcludeerd dat de distributie van managementverantwoordelijkheden zowel voor- als nadelen heeft: het kan maatwerk bevorderen, maar ook professionals en cliënten overbelasten met verantwoordelijkheden die ze niet wensen of in staat zijn te vervullen.

Daarnaast geeft de conclusie een overzicht van de verschillende typen werk die karakteristiek zijn voor middenmanagement als activiteit: i.e. *waardenwerk, rechtvaardigingswerk, professionaliseringswerk, articulatiewerk* en *grenzenwerk.* Alhoewel de geconstrueerde typologie specifiek is voor middenmanagement, heeft de typologie tegelijkertijd bredere zeggingskracht en kan daarom worden gebruikt als een conceptuele toolkit voor het onderzoeken van veranderende relaties tussen burgers, professionals en managers in een emergente participatiesamenleving. Ook reflecteert de conclusie op de bijdrage van middenmanagement aan de governance van 'goede' zorg. Gegeven de pluraliteit van good governance, moeten middenmanagers waardenconflicten goed managen, 'varieties of goodness' inbouwen en compromissen openlijk rechtvaardigen naar belanghebbenden zoals cliënten, familieleden van cliënten en zorgmedewerkers. Tenslotte sluit de conclusie af met theoretische en praktische implicaties. Theoretisch worden de mogelijkheden en grenzen van post-bureaucratisch organiseren aangegeven. Gezien de gedistribueerde aard van management is een methode nodig die niet zozeer gericht is op het schaduwen van personen maar op het schaduwen van processen. Een aanbeveling voor de praktijk is het aanpassen van het onderwijscurriculum voor middenmanagement en het advies om zelfmanagement niet als een uniform format op te leggen aan de gehele zorgsector, maar juist een variatie van managementvormen te omarmen.

Dankwoord


STUCK IN THE
MIDDLE WITH YOU
(From the A&M Album SP-4377 "Stealers Wheel")
(Joe Egan - Gerry Rafferty)
PROMOTIONAL
COPY
NOT FOR SALE
A&M
RECORDS
MONO
The Hudson Bay
Music Co.
(BMI)
Time: 3:24
(2432)
STEALERS WHEEL
A Leiber-Stoller Production
℗ 1972 A&M Records, Inc.
1416

Clowns to left of me
Jokers to the right
Here I am
Stuck in the middle with you
(Stealers Wheel, 1972)

'Stuck-in-the-middle': een penibele positie waar men zich liever niet in bevindt, als we Stealers Wheel mogen geloven. Het kan verkeren, gelukkig. De middenmanager is in staat zich uit het midden te bewegen en ook als promovenda zit je niet eindeloos 'stuck' met een proefschrift. Wat betreft de clowns en jokers: daar wordt de analogie iets gevaarlijker. Alhoewel, ook de universiteit kent clowns en jokers, ontspanning, en wetenschappelijke nerd grappen. Serieus onderzoek gecombineerd met lichtheid. Hierdoor was het schrijven van mijn proefschrift niet alleen spannend en enerverend, maar ook gewoon leuk. De werkvorm bepaalt in belangrijke mate de inhoud: en die is goed bij Health Care Governance als vakgroep en iBMG als instituut.

In de eerste plaats wil ik mijn (co)-promotoren duo bedanken: Kim Putters en Annemiek Stoopendaal. Een fantastisch duo, maar ook afzonderlijk speciaal. Kim, een ware duizendpoot: van jou heb ik geleerd dat wetenschap, beleid en politiek geen aparte werelden hoeven te zijn, maar juist goed met elkaar verbonden kunnen worden. Vertrouwen schenk je je aio's vanaf dag één. Ik kan me de dag nog goed heugen dat je mij als beginnend aio een workshop liet geven aan een zaal vol met grijze gedistingeerde zorgbestuurders. Dat vertrouwen was daar en is gebleven in het vervolg van mijn aio-traject. Dat waardeer ik enorm: juist hierdoor heb ik kunnen groeien. Daarnaast schiep jij eigenhandig een sociaal-inhoudelijke infrastructuur: van BBQ's in Hardinxveld-Giessendam tot en met aio-weekenden in Kerkrade en Genève. Deze dagen waren niet alleen belangrijk voor een esprit de corps, maar ook voor het scherp krijgen van de inhoudelijke focus: waar gaat je onderzoek in de kern over? Annemiek, de meest bevlogen antropologe die ik ken en tevens mijn geliefde afdelingsmoeder. Jij hebt mijn proefschriftperiode gemaakt tot een geweldige én leerzame tijd. In onze relatie is de inhoud altijd verweven met het persoonlijke. Boekentips en kritisch commentaar op het proefschrift gaan naadloos over in levensadviezen over huis, haard en vent. Onze data-verzamelingstijd in Zeeland was onvergetelijk, evenals de dagen in Woudrichem bij je familie. Je vraag aan het begin van mijn promotieonderzoek om de ontologie van het midden te benoemen (waar bestaat het midden uit?), is mij altijd bij gebleven en heb ik als laatste bewaard voor de introductie van het proefschrift, nota bene geschreven op jouw zolderkamer. Ik kijk er naar uit om nieuwe artikelen samen te schrijven en op z'n tijd kordaat afgekapt te worden met een karakteristiek "en nou echt doei!" Dank voor al je steun.

Ook ben ik veel dank verschuldigd aan Roland Bal voor het altijd betrokken meedenken en het aandragen van precies de juiste auteurs op het juiste moment. Je bent de smaakpaus van de afdeling: dit geldt niet alleen voor wetenschappelijke auteurs, maar ook voor films, boeken, muziek en what (not) to wear (e.g. new balance: eerst wel, nu passé). Zonder dat je het misschien door hebt, ben je het bindende element van onze vakgroep.

Daarnaast wil ik Pauline Meurs graag bedanken voor het scherp en geïnteresseerd meedenken in de beginfase van mijn promotieonderzoek: dat had ik niet willen missen.

Maarten, Jeroen en Femke: jullie zijn voor mij – ieder op een eigen manier – erg belangrijk. Als aio's hebben we veel samen beleefd en doorleefd. Maarten, je bent de perfecte roomie en onderzoekspartner in crime. Attentie zit bij jou in kleine dingen: van een uitgeknipt krantenartikel over wijkgericht werken tot en met bonbons bij feestelijke momenten. Jeroen: met jou is geen gesprek saai. In het begin vond ik je maar een gladde consultant (onterecht), maar nu zou ik niet meer zonder je kunnen als discussie- en schrijfmaatje. Femke, wij zetten onze gesprekken over het proefschrift (en het leven) gewoon door tijdens het hardlopen of saxofoonles. Dan komen de beste ideeën boven borrelen. Nu ondersteun je mij ook nog als paranimf: een hele geruststelling. Dank jullie alle drie!

Ook veel dank aan mijn (afdelings)maatjes. Hester: je steun en droge humor zijn ongeëvenaard. Zelfs een NS treinreis is een feest met jou. Iris: als mede chocolade verslaafde weet jij als geen ander hoe Côte d'Or kan helpen bij een goede schrijfsessie. Ik kijk uit naar al onze nieuwe tripjes en schrijfdagen! Anne: dank voor alle goede gesprekken tussendoor bij het koffieapparaat, de lift en het paviljoen.

De vakgroep Health Care Governance is meer dan de som der delen. Toch wil graag mensen individueel bedanken voor ideeën, samenwerking en gezelligheid: Rik, Kor, Antoinette, AnneLoes, Paul, Sharon, Dara, Marcello, Pauline, Bert, Marianne, Bethany, Josje, Jos, Martijn, Wilma, Andreea, Suzanne, Jacqueline en Maarten Kok. Ook collega's die afgelopen jaren bij HCG hebben gewerkt zijn belangrijk geweest: Esther, Jolanda, Tineke, Sarah, Bert, Stans, Katharina, Eelko, Julia, Juul, Teun, Sonja, Lonneke, Marleen, Sam, Marlies, Maartje en Thomas. Daarnaast ook dank aan de fijne buren van het CMDz: Petra, Zita en Annette.

Naast iBMG, is de Raad voor Volksgezondheid en Zorg (RVZ, nu: de Raad voor Volksgezondheid en Samenleving) mijn tweede thuis geweest. Als een soort grenzenwerker heb ik mij de afgelopen jaren bewogen tussen de wereld van beleid en wetenschap. Juist daar werd duidelijk dat grenzen tussen deze werelden niet van te voren gegeven zijn, maar telkens onderhandeld worden tijdens uitwisselingen tussen allerlei beleidsmedewerkers, adviseurs, raadsleden, wetenschappers en politici. Bij de RVZ heb ik ook geleerd hoe belangrijk taal -en het vinden van nieuwe combinaties van woorden- is om onderstromen in de samenleving te duiden en nieuwe trends in de zorgsector uit te drukken. Door de jaren heen heb ik met verschillende mensen samengewerkt, maar ik wil in het bijzonder bedanken: Karin, Ingrid, Flip, Nathalie, Willem-Jan, Bart, Vijianthie, Ayeh, Alies, Pieter, Wendy, Monique, Angelique, Petra en Theo.

Mijn aio-weekend possy 'op locatie' had ik niet willen missen: William, Ron, Arjo, Joyce, Sophie, Eelko, Jeroen, Maarten en Femke hebben verschillende proefschriftversies voorbij zien komen en van scherp inhoudelijke commentaar voorzien. Het fileren van elkaars stukken gebeurde altijd in een hoogst gemoedelijke sfeer waarbij aandacht was voor elkaar, heerlijk eten en de omgeving (zij het een obscure bar of een winderig strand). Het waren prachtige weekenden in Kerkrade (Rolduc), Leeuwarden, Vlieland en Genève! Niet alleen aio's van iBMG, maar ook van bestuurskunde hebben bijgedragen aan een prettige tijd: het gezamenlijk optrekken tijdens de NIG cursusdagen was altijd een feest.

Wellicht mijn grootste dank ben ik verschuldigd aan alle geschaduwde managers: Jopie, Tamara, Rianne, Petra, Addi, Anja, Natasja, Huub, Sjon en Anneke. Met een grote vanzelfsprekendheid hebben jullie mij op sleeptouw genomen naar verschillende zorglocaties, wijkcentra en achteraf gelegen vergaderzaaltjes. Ik heb veel van jullie geleerd door juist jullie 'werk in actie' te mogen observeren. De managers die ik heb geïnterviewd ben ik tevens veel dank verschuldigd. Ook wil ik graag de verschillende zorgorganisaties en opdrachtgevers hartelijk danken: Aart Bogerd van Syndion, Jord Neuteboom van Viatore, Patty van Belle-Kusse en Mirjan de Heus van Arduin en Mieke Reynen, Yasna Tomala en Annamarie van der Velden van Samen één in Feijenoord. Dankzij jullie kwam ik op transitieplekken waar nieuwe (zorg)praktijken werden uitgevonden.

Helma en Matthijs: bedankt voor het maken van de prachtige voorkant en het binnenwerk van dit boek. Eigenwijze ontwerpers zijn wat de mens nodig heeft.

Thoos, Jorieke en Syl: onze basis ligt in Groningen bij geschiedenis, maar inmiddels is Den Haag al weer heel wat jaren onze stad. Onze etentjes zijn een ankerpunt in mijn week: om bij te kletsen en weer opnieuw op te laden. Jullie zijn een echte stadsfamilie! Tom hoort hier zeker ook bij: op afstand in Groningen, maar nu dichtbij als paranimf. We delen niet alleen onze proefschriften maar ook de voorliefde voor Gronings geknauw en retro spullen.

Ook wil ik Hanneke bedanken: de kopjes koffie en zelfgemaakte muffins kwamen altijd zeer gelegen op mijn thuisschrijfdagen.

Dr. Fabienne: later begonnen, eerder klaar. Jou haal ik niet meer in! Dank voor je aanmoediging op afstand.

Hester uit Enschede: samen opgegroeid in Twente, bestuurskunde gestudeerd en allebei promotieonderzoek in de Randstad. Een parallel leven: wat fijn dat we elkaar al zo lang kennen.

Alice, au-pair kindje uit Engeland: bedankt voor het editen van het justification artikel en alle gezelligheid door de jaren heen.

Mijn lieve ouders, broertjes Jort en Jelle, en Jaike en Lea: dank voor jullie steun en betrokkenheid bij het promotieonderzoek! Ondanks onze verschillende werkachtergronden, zit het zorg-DNA in de familie: Jort als zorgmiddenmanager in de dop, Jaike als ondersteuner in de gehandicaptenzorg, mam als opleider van zorgassistenten bij het ROC en pap tot voor kort bij de gemeentelijke sociale dienst. Dit levert altijd mooie discussies op aan de keukentafel waar allerlei dwarsverbanden worden gelegd. Een betere familie kan ik me niet wensen.

Lieve Hermen, je hebt mijn laatste eindje proefschrift zoveel leuker gemaakt! Op Vlieland, in Woudrichem en Midwolda hebben we gezamenlijke schrijfvakanties gehouden: getik achter computer werd afgewisseld met mooie natuur en een koude duik in de Merwede. Dank voor je humor, dagelijkse liefde en kopjes koffie. Ik hoop nog heel veel moois met jou te beleven! Tijdens de komende vakantie hangen we de laptop in de palmboom.

Curriculum Vitae

PhD portfolio

Name: Lieke Oldenhof
Department: Institute of Health Policy and Management (iBMG)
PhD period: 2009-2014
Promotor: Prof. dr. Kim Putters
Copromotor: dr. Annemiek Stoopendaal

Courses

Netherlands Institute of Government (NIG), Course Core Themes	2009
NIG General Methodology	2010
NIG Course Qualitative interviewing	2011
NIG Skills Course/ Formulating research questions	2011
NIG Skills Course/Operationalization	2011
NIG Skills Course/Presenting your research	2011
NIG Skills Content analysis	2011
NIG Case Study Research	2011
NIG Getting it Published	2011
NIG Postdoctoral Career	2011
Ready in four years	2010
Tutor Skills for Problem-based Education (PGO)	2010
Atlas-ti	2010
KWALON Course Observation	2010
Academic Writing in English	2012
Teaching Study Skills to students	2012
jBMG Career Event & Branding Course	2013
Shadowing Workshop, Birmingham	2014

Presentations at conferences

University of Amsterdam (UvA), Ethics Healthcare and Anthropology	2009
Dutch Associations of Executives in Care (NVZD), Ermelo	2010
European Health Management Association (EHMA), Porto	2011
Netherlands Institute of Government (NIG), Rotterdam	2011
European Group for Organizational Studies (EGOS), Helsinki	2012
International Research Society for Public Management (IRSPM), Rome	2012
NIG, Leuven	2012
Viatore, Conference Neighbourhood Based Care, Utrecht	2012
Aedes-Actiz, Conference Local Power, Den Bosch	2012
Critical Management Studies (CMS), Manchester	2013
IRSPM, Prague	2013
NIG, Enschede	2013
EHMA, Birmingham	2014
Pfizer, Conference Primary Care, Terschelling	2015
IRSPM, Birmingham	2015

Dutch non-peer reviewed publications & contribution to policy reports

Oldenhof, L. (2010). *Organisatiestructuren in het middenveld op drift.* Achtergrondstudie voor het RVZ advies 'Patiënt als sturende kracht'. Den Haag: Raad voor de Volksgezondheid en Zorg (RVZ).

RVZ (2010). *Patiënt als sturende kracht.* Den Haag: RVZ.

Oldenhof, L. (2012). *De middenmanager: sleutelfiguur bij transities in de langdurige zorg.* Den Haag: RVZ.

Oldenhof, L. (2012). *Wijkgericht werken: intersectorale samenwerking in de wijk dankzij grenzenwerk.* Achtergrondstudie bij het RVZ advies 'Regie aan de Poort'. RVZ: Den Haag

RVZ (2012). *Regie aan de poort. De basiszorg als verbindende schakel tussen persoon, zorg en samenleving*. Den Haag, RVZ.

Putters, K., M. Pijnappel-Clark, M. Janssen en L. Oldenhof (2012). Voor zorgvernieuwing is geen stelselwijziging nodig. *Financieel Dagblad* 9 oktober 2012.

Janssen, M., L. Oldenhof, M. Pijnappel-Clark and K. Putters (2012). Wijkgericht werken zonder fratsen, *Zorgvisie*, 21 oktober 2012.

Oldenhof, L. en M. Janssen (2012). *Werken aan grensoverschrijdende innovatie: een wetenschappelijk blik op het verbredingsprogrammma Wijk-en Buurtgericht werken.* Rotterdam: iBMG.

Oldenhof, L. (2013). Wijkgerichte samenwerking dankzij grenzenwerk. *Gerón. Tijdschrift over ouder worden & maatschappij* 15 (4): 43-46.

Oldenhof, L. and K. Putters (2013). *Wijkgericht samenwerken in een netwerk: een kwalitatieve effectanalyse van 'Samen één in Feijenoord'*. Rotterdam: iBMG.

Oldenhof, L. (2014). *De wijkprofessional: specialist met generalistische competenties.* Achtergrondstudie bij het RVZ advies 'Gemeentezorg'. Den Haag: RVZ.

RVZ (2014). *Gemeentezorg. Randvoorwaarden voor een succesvolle decentralisatie van langdurige zorg naar gemeenten*. Den Haag: RVZ.

Wouter van den Elsen (2014). Vijf vragen aan Jeroen Postma en Lieke Oldenhof. Waarom de wijkverpleegkundige niet 'gesplitst' mag worden. *Zorgvisie Weekoverzicht* 39, 26 september 2014.

Bart Kiers (2014). Experts: wel degelijk knip in wijkverpleging. *Zorgvisie Weekoverzicht* 40, 3 oktober 2014.

Oldenhof, L. and A. Stoopendaal (2014). *Het situationeel delen van leiderschap in de wijk: nieuwe onderhandelingen, invloed en verantwoordelijkheden in cliëntondersteuning.* Rotterdam: iBMG.

Oldenhof, L. and R. Bal (2014). *Wijkgovernance 'in the making': het verplaatsen van zorg en ondersteuning naar wijken.* Rotterdam: iBMG.

RVZ (to be published 2015). *Working Title: Ruimte voor Redzaamheid.* Den Haag: RVZ.

Teaching Activities

Supervising and co-evaluating bachelor and master thesis	2010-2015
Mentorship first year students	2010-2012
Workgroups Philosophy of Science (BA)	2009
Workgroups Writing Skills (BA)	2010-2012
Workgroups Policy Sciences (BA)	2010
Workgroups Qualitative Research Methods Healthcare (BA)	2010-2015
Workgroups Healthcare Governance (Master)	2015
Workgroups Advanced Research Methods (Master)	2015
Lecture 'The role of theory in qualitative research' Course: Qualitative Research Methods Healthcare	2012-2015
Lecture 'The administrative aspects of the Social Support Act' Course: Health Insurance	2013-2015
Lecture 'Doing discourse analysis in healthcare research' Course: Advanced Research Methods	2014
Lecture 'Introduction to healthcare governance' Course: Healthcare Governance	2015
Lecture 'How to write an academic essay in the social sciences' Course: Healthcare Governance	2015
Lecture 'Middle managers and their contribution to organizational change' Course: Change management in healthcare	2015
Coordinatorship, Healthcare Governance	2015
Co-coordinatorship, Advanced Research Methods	2014

Research projects

Middle Management, Syndion	2009-2012
Program Neighbourhood Based Care, Viatore/VWS	2012
Qualitative Evaluation of Neighbourhood Networks, Samen één in Feijenoord	2012-2013
Distributed Leadership in Care, Arduin	2013-2014
Neighbourhood Governance, Samen één in Feijenoord	2014-2015

Honoured grant proposal

Klein maar Fijn Call, ZonMw	2014

Additional activities

Policy Advisor for the National Council for Public Health and Care	2009-2015
Development of Masterclass for Projectmanagers Neighbourhood Based Care, together with Maarten Janssen	2013
Board Member of PhD Council jBMG	2010-2014

About the author

Lieke Oldenhof was born in Enschede on the 15th of September 1982. She studied history at the University of Groningen and public administration at Leiden University (2002-2009). She obtained a Research Master in history and a Master of Science in public administration (with honours). When writing her thesis in Leiden on the influence of Diagnosis Related Groups on professional work of psychiatrists, she got intrigued by the governance of the care sector. From 2009 onwards, she could further pursue this interest by doing a PhD at the Institute of Health Policy and Management (iBMG) on the daily work and dilemmas of middle managers. During the course of her PhD research, she also worked as an advisor at the National Council for Public Health and Care (now: National Council for Public Health and Society). Lieke Oldenhof has published academically in national and international peer reviewed journals and has written various policy and advisory studies. In addition to her research and advisory work, she taught various courses at the institute of Health Policy and Management, including qualitative methods, philosophy of science, policy sciences. She currently works as an Assistant Professor in Health Management and Policy at iBMG.

Lieke Oldenhof: *oldenhof@bmg.eur.nl*
Institute of Health Policy and Management, Erasmus University.

What does managing ‘in the middle’ actually mean in a changing healthcare sector?

Lieke Oldenhof sheds light on this question by shadowing middle managers during their daily work and interaction with professionals and clients. The Multiple Middle reveals that middle management is much more than just the middle between the workfloor and higher management. Rather than a singular middle, the middle is multiple and concerns conflicting values of good care, organizational boundaries, professional-managerial worlds and different justifications. Being a middle manager is less about a clearly circumscribed job on paper and more about a changing state of being. Because management responsibilities are shifting and being redistributed, professionals and clients become enaged in the collective endeavour of middle managing. This book will be of interest for those studying and practicing management in transition.