

Nurse Middle Managers' Dispositions of Habitus

A Bourdieusian Analysis of Supporting Role Behaviors in Dutch and American Hospitals

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A Magnet-related program has been recently adopted in the Netherlands. Support for staff nurses from nurse middle managers (NMMs) is a key component of such a program. A Bourdieusian ethnographic organizational case study in 4 hospitals in the Netherlands and the United States (Magnet, Magnet-related, and non-Magnet) was conducted to explore NMMs' supporting role behavior. Bourdieus concepts of habitus, field, and capital guided the analysis. Eight dispositions constitute NMMs habitus. A caring, clinical, and scientific disposition enhances NMMs' capital in particular organizations-as-fields. Further research is necessary to link Magnet (-related) program characteristics to various configurations of dispositions of NMMs habitus. **Key words:** *Bourdieu, dispositions of habitus, hospital, international, Magnet, multisited, nurse middle managers, organizational ethnography, supportive roles*

THERE IS GROWING interest in the Magnet Recognition Program in the

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United States and related programs in other countries.¹⁻³ This program was developed and is administered by the American Nurses Credentialing Center. Its aim is to create a productive and healthy work environment for nurses to provide high-quality patient care.^{4,5} Support for staff nurses from nurse middle managers (NMMs) is identified as one of the key components.^{6,7} A Magnet-related program was recently adopted by the Dutch Nurses Association in the Netherlands under the name of Excellent Care (EC).^{8,9} The purpose of this article was to explore NMMs' supporting role by conducting a Bourdieusian ethnographic case study of NMMs' dispositions of habitus in 4 hospitals in the Netherlands and the United States with Magnet, Magnet-related, and non-Magnet status.

A recent publication on the introduction of EC in Dutch hospitals confirms the importance of the supporting roles of NMMs in Magnet-related programs.⁸ The article stresses that, according to staff nurses, NMMs should to create healthy working conditions,

consider team spirit and unity, address conflicts, and be visible and approachable.⁸ A study by Kramer⁶ concludes that what staff nurses desire and consider important is a NMM who demonstrates “caring” behavior by assisting them with their work. The literature mentions further supporting role behaviors, for example, being accessible and safe or “walking the talk.”^{6,7}

For NMMs, actual behavior in daily practice does not always match with these desired supportive roles.¹⁰ Staff nurses regularly experience challenges with NMMs in shaping care that meets patients’ expectations, whereas NMMs are tied to a system that emphasizes controlling costs.⁸ Many NMMs also feel torn between their clinical and managerial roles.¹¹⁻¹⁶

Boundary-spanning behavior^{17,18} could help NMMs cope with these challenges because in their role as professional managers,¹⁹ they can relate to both clinical and managerial worlds and span the boundaries between them.¹⁷ Llewellyn²⁰ describes this as a hybrid role, using the metaphor of a “2-way window” that enables managers to mediate clinical and management expertise. Witman and colleagues²¹ ethnographic study, using Bourdieusian analysis, on the dispositions of habitus of health care professionals in leading positions in a Dutch University hospital, represents an example of this hybrid role. Witman demonstrates that applying Bourdieu’s concepts of dispositions of habitus, field, and capital can improve our understanding of NMMs’ supportive and boundary-spanning role behaviors.

BOURDIEU’S CONCEPTS: DISPOSITIONS OF HABITUS, FIELD, AND CAPITAL

Bourdieu states that habitus is “history turned into nature,”^{22(p78)} or an embodied history, internalized as a second nature.^{22(p56)} He further states that habitus is a system of dispositions.^{22(p214)} Dispositions are defined as durable, subconscious schemes of perception and appre-

ciation that activate and guide practice.²³ According to Bourdieu,^{22(p214)} dispositions are the result of an organizing action, a way of being, a habitual state (especially of the body) and, in particular, a predisposition, tendency, propensity, or inclination. Dispositions of habitus generate a limited number of behavioral strategies. These strategies are manifested in certain visible patterns of behavior, manners, and beliefs: in practices.²⁴

Bourdieu’s concept of field refers to a social space with an internal logic.²⁵ In a field, there is always something at stake; there are struggles for positions and valuable resources or capital. Capital may be inherited through a position or acquired over time; it can be exchanged for other resources and has value within particular fields.²⁶ As Bourdieu argues, “capital does not exist and function except in relation to a field.”^{27(p101)} Building on Bourdieu, Vaughan²⁸ explains that an organization-as-field perspective represents an organization as a field nested in a larger professional field. For example, a hospital can be regarded as a nested organization-as-field with an internal logic of its own within the larger professional field of NMM practices. Nurse middle managers may acquire capital by being supportive of, visible to, and approachable by nurses,⁸ but they may also acquire capital by controlling costs for higher management.⁸ This example illustrates the challenges NMMs face in obtaining capital from both worlds and the importance of spanning boundaries between clinical and management worlds to create a healthy work environment.¹⁷

A few nursing studies have applied Bourdieu’s concept of habitus.²⁹⁻³¹ A limited number of studies describe dispositions such as a caring disposition³² or a critical thinking disposition.³³ There is a vast literature on the roles of caring and critical thinking in nursing practice, but none is addressing these themes using Bourdieu’s concepts. There is, to our knowledge, no literature on nurses’ dispositions of habitus in management positions. We are aware of one study on dispositions of habitus and managerial work in hospitals by Witman, but this is focused on physicians.²¹

We use the insights and knowledge from that study on health care professionals and managerial work to begin our research and address the following 2 central questions:

1. What are the main dispositions of NMMs' habitus as manifested in their daily practice?
2. To what extent do the dispositions of NMMs' habitus affect, through the attainment and distribution of capital, a supporting role in Magnet, Magnet-related, and non-Magnet hospitals?

METHODS

Research design

A Bourdieusian^{22,28} exploratory, multisited ethnographic organizational case study approach was applied to gain insight into the dispositions of NMMs' habitus.^{34,35} Ethnogra-

phy was used to describe the micro practices and complexity of NMMs' everyday work.

Selection of cases and ethical considerations

A total of 16 NMMs from 4 different hospitals were recruited by purposeful sampling using the following criteria (Table 1):

NMMs: Being a registered nurse, having a middle management position in an adult care unit of an acute care hospital, and supervising a nursing unit of between 20 and 40 beds. We defined the middle management role as positioned between the work floor and higher management with first-line responsibilities regarding the supervision of care workers and the management of finances and quality of care.³⁶

Table 1. Key Characteristics of the Participants and Their Organizational Settings

	NMM	Gender	Ward Specialty	Span of Control	Beds	Nursing Education Level	Management Training	Years of Management Experience
Site 1	Kim	F	Surgical	30	28	RN	In company	15
	Pat	F	Surgical	28	28	RN/BSN	None	2
	Toni	M	Medical	38	36	RN	In company	5
	Chris	M	Medical	28	26	RN	In company	10
Site 2	Dana	F	Surgical	30	32	RN/BSN	Postbachelor's	1
	Eli	F	Surgical	26 ^a	24	RN	In company	5
	Sal	F	Mother and Child	40 ^a	38	RN/MSH	In company	2
Site 3	Sidney	F	Medical	26 ^a	24	RN/BSN	Postbachelor's	3
	Terry	F	Medical	30	26	RN	In company	15
	Tracy	F	Surgical	30	26	RN	In company	20
	Tyler	F	Step-down ICU	24	28	RN	In company	25
Site 4	Vic	F	Surgical		26	RN	In company	20
	Alex	F	Medical	34	24	RN/MSN	In company	5
	Jamie	F	Mother and Child	55	34	RN/BSN	In company	10
	Jordan	F	Medical/ICU	52	34	RN/BSN	In company	20
	Shawn	F	Surgical	35	24	RN/MSN	In company	5

Abbreviations: BSN, bachelor of science in nursing; MSH, master of science in health; MSN, master of science in nursing; RN, associate's degree or diploma.

^aShared with the comanager.

Hospitals: Nonprofit midsized general and teaching hospitals, 2 in the Netherlands and 2 in the United States. Having Magnet, Magnet-related, or non-Magnet status allowed us to show variation between NMMs' dispositions of habitus, supportive role behavior, and the attainment and distribution of capital in the various hospitals as organizations-as-fields. A brief introduction of the 4 hospitals can be found in the boxes in the "Findings" section.

Consent differed at the Dutch and US hospitals because of national policies and the various means of accessing the sites. In the Netherlands, the formal institutional review approval was not required for this type of research; the higher management of both hospitals approved the study. In the United States, ethical approval was obtained from the institutional review boards of both participating hospitals and consent was obtained from each participating NMM.

Arrangements were made with contact persons in higher management, the innovation and performance improvement departments, and shared governance councils. We asked the contact persons at each organization to recruit the NMMs. Nurse middle managers who satisfied the inclusion criteria were eligible

for participation and invited by e-mail to participate in the study. These potential participants received a letter of invitation including a description of the study and its purpose. An interview followed that discussed the aims, design, and methodology of the study. Participation in the study was voluntary, and there was no disclosure of individual findings.

The participants were asked to inform their colleagues, staff nurses, and other hospital employees of the study to avoid confusion regarding the presence of the researcher and to protect nonparticipants. The participants and nonparticipants in the units could ask the researcher to leave the room or area at any time. The researcher did not enter patient rooms, and no identifiable patient information was recorded.

Data collection

Nurse middle managers were shadowed^{37,38} for 4 days each, leading to a total of approximately 560 observation hours over a period of 19 months in 2010 to 2012 (Table 2). The first author closely followed each of the 16 NMMs for an extended period of time.³⁸ During shadowing, the researcher focused on behaviors that might indicate the NMMs' dispositions of habitus, that is, subconscious schemes of

Table 2. Design and Data Sources

Country Hospital	June 2010–May 2012					
	Phase 1: The Netherlands			Phase 2: The United States		
	Site 1	Site 2	Member check NM Site 1/2	Site 3	Site 4	Member Check NM Site 1/2/3/4
Approx. hours shadowing	150	140		140	130	
Shadowing days	Kim: 4 d ^a Pat: 6 d ^a Toni: 5 d ^a Chris: 4 d	Dana: 4 d Eli: 4 d Sal: 4 d Sidney: 4 d		Terry: 4 d Tracy: 4 d Tyler: 4 d Vic: 4 d	Alex: 4 d Jamie: 4 d Jordan: 3 d ^b Shawn: 4 d	
Field notes pages A5	700	670		640	480	
Audio in hours	22	21		11	7	

^aPilot shadowing to come to an optimum of shadow days.

^bWhich included 1 double shift from 7 AM until midnight.

perception and appreciation that activate and guide their practice.²³ Behaviors and manners of the NMMs were observed. Throughout the shadowing period, questions were asked of participants that prompted a running commentary from the person being shadowed. Some of the questions were asked for clarification, such as what was being said on the other end of a phone call or what a departmental joke meant. Other questions were intended to reveal purpose, such as why a particular line of argument was pursued in a meeting or what the current operational priorities were.³⁸ Some questions led to semistructured interviews concerning beliefs regarding NMMs' roles and challenges in the hospitals. For example, we asked questions regarding what a regular workday consisted of and how NMMs balanced the clinical, caring, and administrative aspects of their roles. In a semistructured introduction interview, we learned about NMMs' previous careers and reasons for becoming nurse managers. A Livescribe Pulse Smartpen was used, which digitally stores handwritten field notes and audio fragments from both shadowing and interviews. The field notes and audio fragments were uploaded to a laptop computer with Nvivo 10,³⁹ a qualitative software analysis program that helped manage the large amount of data. A selection of the audio files was transcribed using this program. This approach provided the opportunity to refer to the fragments after the fieldwork was completed.

Finally, 2 interactive discussion group meetings were organized with the participating NMMs. These meetings were used as member checks to strengthen the validity of our findings. Preliminary findings were discussed, which helped assign meaning to the rich data⁴⁰ and contribute to the triangulation of the observational data.

Data analysis

After completing the fieldwork, we conducted a data analysis on the basis of inductive coding.⁴¹ First, descriptive codes were developed: location codes, such as nursing station,

office, or meeting outside the ward; interaction codes referring to actors with whom NMMs frequently spoke, such as nurses, colleagues, patients, or higher management, and codes on daily work and challenges. These codes helped us navigate the data set.

Next, we used an inductive approach. After reading and re-reading all field notes and transcriptions of audio files, we selected approximately 50 fragments from each hospital in which particular role behavior was manifested and could be geared toward dispositions of NMMs' habitus. We used the descriptions of dispositions previously identified by Witman et al,²¹ but we bracketed these dispositions to ensure that our analysis of the NMMs' dispositions of habitus remained independent and focused on NMMs' work. The dispositions described by Witman et al²¹ sensitized our analysis but allowed sufficient room for tailoring and for NMMs' new, emerging dispositions. These fragments were entered into tables, and for each fragment in the table, we asked whether a disposition manifested itself and whether capital was gained or lost. We clustered the fragments, leading to a set of 8 dispositions of NMMs' habitus.

FINDINGS

In NMMs' daily work, various dispositions are simultaneously at play. Eight dispositions constitute NMMs' habitus. To answer the first research question, we constructed Table 3, which describes these 8 dispositions and their schemes of perception, strategies, and manifestations together with typical examples from the various sites.

In understanding the practice of NMMs, it is also important to address the dynamics between the various dispositions in action and the distribution of capital at the 4 hospitals employing an organization-as-field perspective. Therefore, in the next section, we demonstrate that various dispositions were valued differently at the 4 sites and that

Table 3. Nurse Middle Managers Dispositions of Habitus

Descriptions of Dispositions	Examples From Field Notes
<p>Through a caring disposition, nurse middle managers (NMMs) see patients as individuals who require care and attention. The corresponding strategies include answering the call for help of the other in the here and now; ad hoc, reactive reactions; and quick judgment. The caring disposition manifests itself by scanning the environment for calls for help. Excelling in the caring disposition provides capital that is based on taking care of and paying attention to patients.</p>	<p>This disposition is shown during patient rounds at the bedside with the physicians and nurses. During rounds, Pat stays in the background and scans the surroundings. She sees that the patient's hearing aid is not working properly. It was loudly beeping. Pat quickly helps the patient who was fiddling with his hearing aid. The physician keeps on talking. By the time Pat has the hearing aid in place, the physician turns around to walk to the next patient. Pat whispers a short summary of the physician's update in the patient's ear. Then, she quickly follows the small procession to the next patient. [Pat field book 2/ page 108]</p>
<p>Through a clinical disposition, NMMs see individuals as patients. The corresponding strategies include the search for the symptoms and causes for the conditions observed. The clinical disposition manifests itself by seeing patients, diagnosing their care needs and knowing their conditions. Excelling in this disposition provides capital that is based on having and using clinical expertise.</p>	<p>This disposition becomes evident while standing at the nursing station during a hectic morning shift. The typical position of Tracy: arms crossed, silently watching what goes on, and sometimes asking questions, mostly clinical questions, sometimes procedural. Tracy follows a nurse into a patient's room, looks at the patient and whispers to the nurse: "he seems to be more and more dependent, but we need to find out why his condition is getting worse." Tracy introduces herself to the patient: "My name is Tracy. I am one of the nurses" She looks at the patient's feet and asks the clerk to come because she speaks Spanish, like the patient. [Tracy 11/124]</p>
<p>A collegial disposition refers to NMMs ensuring a positive team dynamic. The corresponding strategies include being friendly to team members and taking care of other colleagues. This disposition manifests itself by giving attention to members of the team, encouraging feedback and tacitly knowing other individuals' needs. Excelling in this disposition provides capital that is based on being collegial and preserving a friendly atmosphere.</p>	<p>We meet Toni at the beginning of his work day. Toni is also in charge of an 8-"bed" day care for oncology patients. Two of his nurses are assigned to day care: one is pregnant, and the other does not feel well. Toni: "We have to give those ladies some extra attention today" [Toni 3/66]. Giving attention to and taking care of colleagues are important, but they also create frictions and complications. Eli reflects on the dynamics of her team: "It is about taking care of each other, being nice without having to ask what is needed. This makes it extra complicated. Everybody 'thinks' for the other, does not ask or gives feedback nor explicate what is needed." [Eli 7/138]</p>

(continues)

Table 3. Nurse Middle Managers Dispositions of Habitus (*continued*)

Descriptions of Dispositions	Examples From Field Notes
<p>Through a teaching disposition, NMMs see themselves as tutors or mentors. The corresponding strategies include creating moments for coaching, instructing, and learning. It manifests itself through teaching or instructing both patients and colleagues. Excelling in this disposition provides capital that is based on sharing knowledge and teaching others.</p>	<p>As always, Pat starts at the nursing station, listening to the handover from the night to day shifts. Today, they are short of staff, so she will coach one of the senior-level nursing bachelor's students. Pat: "I will read a report with you. We are short of staff." Pat asks questions about the patients, their parameters, and conditions. She asks the student to plan the care. First, they will give medication and then wash the patient and dress the wounds. After the student heads off, Pat checks the turnover on the whiteboard and walks to her office [Pat 2/26]. In the next fragment, Jamie emphasizes the importance of teaching in relation to patient care. Jamie talks with her nursing staff about the higher unexplained death rates of infants: "We are missing a lot of teaching. We have to remind ourselves how important assessments are. It takes an adult learner 7 times to have things sink in." [Jamie 14/137]</p>
<p>Through a professional disposition, NMMs perceive themselves as both personally and collectively accountable for good patient care. The corresponding strategies include putting the interest of patients first and being accountable and taking responsibility. This disposition manifests itself by feelings of responsibility and sharing responsibilities. Excelling in this disposition provides capital that is based on being responsible and accountable both personally and collectively for patient care.</p>	<p>Jordan reflects on issues that concern sharing responsibly and accountability. Jordan: "I do not believe that I am in control. I am an educator and need to provide support in different phases, emotional, clinical, environmental, and patient safety. They want you to make the decision and blame you afterwards if it was incorrect. It is about accountability, of which we all have a piece." [Jordan 16/3]</p>
<p>A scientific disposition refers to NMMs' work as a scientific and reflective practice. The corresponding strategies include referring to, gathering, and using scientific evidence and asking reflective questions to enhance the quality of patient care. This disposition manifests itself through an investigative stance, postponing reactions, refraining from judging, and focusing on research/EBP and reflection on action. Excelling in this disposition provides capital that is based on using scientific knowledge and asking reflective questions rather than ad hoc action.</p>	<p>"It is not about feeling bad. Feeling bad gets us nowhere; we have to analyze the process" [Alex 14/52]. During observations, we frequently heard the phrase: "There is no literature for that." This reasoning provides some insight into the impact of the scientific disposition on NMMs. Another typical reaction of one of the nurse managers on acute events was: "I have to chew on that for a while." [Shawn 16/102]</p>

(continues)

Table 3. Nurse Middle Managers Dispositions of Habitus (*continued*)

Descriptions of Dispositions	Examples From Field Notes
<p>Through an administrative disposition, NMMs view administrative work as legitimization of their activities. The corresponding strategies include the use of checklists, guidelines, benchmarks, and reports. This disposition manifests itself through a focus on writing reports, filling out checklists, addressing administrative issues, and performing clerical work. Excelling in this disposition provides capital that is based on the correct use of checklists and guidelines and handling administrative procedures.</p>	<p>Terry spends most of her days at the nursing administration office working on the schedule, floating staff, trying to cover each ward, filling out forms and checklists, and making phone calls begging nurses to do a double shift or come for an extra shift. After 30 minutes, she has everything well documented. Terry: “I think I covered everyone, thank the Lord!” [Terry 10/46]. In the next fragment, Eli explains that having clear guidelines are key. Eli: “It is all about money. We need some financial guidelines to work it out; otherwise, you start dreaming and they blow the whistle on you. We need a good and clear assignment from higher management.” [Eli 6/77]</p>
<p>A control disposition views NMMs’ work as a way to create order and serenity. The corresponding strategies include controlling daily situations by tidying up. This disposition manifests itself through a focus on controlling (complex) situations, creating order and clarity, cleaning up, and clearing up. Excelling in this disposition provides capital that is based on being in control of situations.</p>	<p>Similar to most of the other nurse managers, Pat loves to create order, control, and clean up her desk, agenda, office and ward. I see a lot of the nurse managers clearing up corridors, nursing stations, or laundry rooms. They do it on the run, scanning the environment for clutter, it also cleaning up and clearing up. Making it orderly, neat, and well-organized. Pat: “I really love to clean up this mess!” [Pat 2/69]</p>

some dispositions created more capital than others. Furthermore, the dispositions affect one another; thus, particular combinations of dispositions in particular fields generated capital in unique ways. The analysis of relationships among the various configurations of dispositions provides insights into our second research question regarding the distribution of capital and NMMs supporting role behavior in Magnet, Magnet-related, and non-Magnet hospitals.

We present the 4 sites in chronological order. First, various examples from hospital 1 (Magnet-related) are reported to demonstrate how both caring and clinical dispositions create capital in NMMs’ daily work. Second, various examples from hospital 2 (non-Magnet) are provided, whereby we demonstrate how caring and collegial dispositions can become

entangled and overshadow the clinical disposition. Third, we introduce hospital 3 (non-Magnet) and illustrate how administrative and control dispositions can create friction with the professional and teaching dispositions. We conclude with examples from site 4 (Magnet) and demonstration how a scientific disposition can positively affect caring and other dispositions of NMMs’ habitus.

Site 1: Caring and clinical disposition as key for NMMs’ daily work

Site 1 participates in the Excellent Care program of the Dutch Nurses Association. It is a vibrant city hospital near the center of town. The open, tolerant, and outspoken city atmosphere is reflected in both the patient and employee populations. Each ward primarily

has 4-bed patient rooms, with some single patient rooms. The nurse managers' offices are on the ward, at the beginning or end of the corridor. Nurse middle managers (NMMs) refer to them as "my closet or hut." The nursing stations are open and at the center of the wards. NMMs frequently talk to physicians, nursing staff, and patients. The hospital has an average ratio of nurses to patients. Two of the nurse managers had issues with high absenteeism; the others did not. All NMMs collaborated closely and floated personnel to guarantee an optimum nurse-patient ratio.

Three NMMs at site 1 gained capital by prioritizing the caring and clinical dispositions in their work, as demonstrated in the fragments below.

We start at the nursing station. It is 7:30 AM, and the nurses are reading their assignments and patients' files. Toni listens to a discussion between the night shift and a day nurse about giving extra insulin. Toni interrupts: "I would give the extra insulin if I were you." It is noisy at the nursing station. Toni frequently asks the nurses to lower their voices: "Sssshh, don't talk so loud." He does it with a smile, but the nurses know he is serious about it. [Toni 3/66]

The fragment clearly demonstrates caring and clinical dispositions. Toni directly responds to a call for assistance related to a clinical issue. He deliberately remains at the nursing station in the morning to be available and answer ad hoc questions. Thus, he can demonstrate his clinical expertise and involvement with patient care without actually seeing the patients. The nurses on the ward valued these interactions that focused on patient care in the here and now. The direct involvement and availability were especially appreciated. In the next fragment, we meet Kim, who follows the same strategy of being clinically involved and heeding patients' calls for help.

Kim prepares for a round with the thoracic surgeons; she picks up the patient files on the ward. Kim: "This is my chance to see how the patients are doing. Aah, look at him sitting there; yesterday he was still lying in bed wearing his gown and now he is sitting up, completely dressed." [Kim 1/ 5]

For Kim, seeing patients is a key part of her work. Again, the emphasis is not on actually providing care but knowing the patients' conditions and seeing their faces. Both physicians and nurses value Kim's knowledge of the patients admitted to the ward. Being clinically involved and demonstrating one's skill in action provide capital, but there can be a trade-off between clinical and administrative work.

In the next fragment, we meet Chris, who seldom spends time on the ward or speaks with physicians or about performance improvement. He has conflicts with several physicians and does not make rounds with them or the nursing staff. Seeing patients is not his priority. In an exit interview, a disappointed nurse reports that she does not find Chris accessible or visible or to exhibit clinical interest.

Nurse: "I have to tell the medical residents that we give fraxiparine injections at 10 am, but it never changed [the residents kept prescribing at 6 PM]. No matter how many times I wrote a report or addressed it with you (Chris) or my colleagues, everyone just shrugs their shoulders. It is without obligation, informal. First thing I do when I start my shift is clean up the mess of the other colleagues, and if you address that, you are seen as having a big mouth. Many of my colleagues stopped saying anything; they felt unsafe. I never stopped addressing them, but now I am glad I am gone and do not have to do that anymore." [Chris 5/22]

The fragment illustrates the nurses' frustrations with Chris's behavior of shrugging his shoulders and not taking action. Not "doing" anything is an atypical reaction for NMMs in this hospital and does not provide capital in relation to the caring disposition. Not seeing patients and not discussing patient care with nursing or medical staff reduce capital and erode the supportive role.

Site 2: Gaining capital through the collegial disposition: Employees as quasi-patients

Site 2 is situated in a relatively new building that was built in 2000 after a merger of 3 smaller local hospitals. It does not participate in the Excellent Care program of the

Dutch Nurses Association. The building is light, with a calm atmosphere and long, wide corridors with natural stone on the floors. The nurse middle managers (NMMs) have spacious modern offices situated off the wards, which they often share with another NMM with whom they jointly run the same ward. Most of our time was spent in the office; we saw few patients or physicians. The hospital has an average nurse-patient ratio; however, because of a relatively high absentee rate, they struggle to have enough nurses to work the shifts. For the previous 2 years, the hospital has been in what they call an “organic change” process toward a new organizational structure, which creates uncertainty and ambiguity for both managers and nursing staff.

At site 2, the collegial disposition generated more capital than the other dispositions. It was the most valued disposition for staff nurses, nurse managers, and higher management. Capital from the caring and clinical dispositions decreased because the NMMs’ main object of care was not the patients but the nursing staff. Employees who played quasi-patient roles provided a special connotation for a caring disposition among NMMs. This was first indicated by the prominent role of the company medical officer, who was the only physician with whom NMMs had regular contact. Instead of discussing patients or patient care, they discussed their sick personnel. In the next fragment, NMM Sidney meets with the company medical officer regarding her sick personnel and discusses a certain case. Company Medical Officer:

“It is not that she [a nurse on Sidney’s team] does not like you, but you did not give her enough attention.” This surprises Sidney; she did give that nurse a lot of attention lately but it never seemed enough. [Sidney 9/39]

The next fragment provides a second indication. Sidney meets with someone from quality improvement (QI). They discuss dynamics on the ward and the team’s condition instead of discussing the next step in enhancing patient care:

QI: “How are things?” Sidney: “It is slowly getting better, but the quality keeps simmering; the nurses are in survival mode”. QI: “Do you have concerns about the quality of care on the ward?” Sidney: “Last month, we had a lot of missing items from patients, complaints and issues with the attitude of nurses toward medication errors. They also stopped reporting errors. I think half of the errors are not reported; reporting takes too much time. My biggest worry is the fact that the nurses appear less alert. It is a vicious circle; we are monitoring it and try to spend as much time on the ward as possible; every hour we do rounds on the ward to determine how the nurses are feeling and to show our faces. QI: “How do they experience that?” Sidney: “OK, I think. They really need structure. They lost everything; they felt like victims of the situation, turned inward, complaining and feeling like they did not have the capacity to get the work done.” [Sidney 9/90]

In these fragments, the NMM gives less priority to the clinical disposition. A clinical disposition facilitates a focus on clinical issues and QI and supplements the caring disposition’s focus on responding to calls for help from patients. However, these NMMs are preoccupied with caring for the staff instead of the patients, which could ultimately compromise quality of patient care. The nursing staff, NMMs, and higher management at this hospital had a strong focus on caring for one another in addition to the patients. Ultimately, by shadowing NMMs and examining the organization from their perspective, we found that at this site, the patient perspective was frequently lost and the main issues in the NMMs’ roles concerned employees as quasi-patients. This was what gave the NMMs the most capital.

Site 3: Hard play: The administrative and control dispositions versus the professional disposition

Site 3 is a city hospital that serves an area of nearly 1 million individuals in one of the most ethnically and linguistically diverse communities in the United States. It does not have a Magnet recognition. It is a hectic place with

a huge turnover in patients. Patients come to the hospital only if there is no other choice, and a majority of patients suffer from severe illness. The wards are clean, but they are worn out and overcrowded. The NMMs' offices are on the ward, do not have windows, and are the size of a closet. During shadowing, we hardly spent any time in the offices; more time was spent at the nursing stations on the ward or in the nursing administration offices on the ground floor. There is a lot of noise from shouting patients and staff, alarms from beds, drip infusions, and telemetry. Although the patient-nurse ratio complies with the norm, the complexity of patients, the high absenteeism, and the high turnover place a great deal of pressure on the patients, staff nurses, and nurse managers.

At site 3, the administrative and control dispositions became visible in the NMMs' work. Both dispositions generated the capital necessary to address a general feeling of distrust between the NMMs and the employees. At this site, there were ambiguities regarding responsibility and accountability, which are part of a professional disposition. Nurse middle managers attempted to control these ambiguities via the creation of checklists and guidelines, which generated a substantive administrative burden. A teaching disposition was also manifested as an instrument of control rather than an instrument for learning, which affected and compromised a professional disposition. Instructing nurses on precisely how to use the checklists and guidelines was emphasized. The following fragment reveals an NMM's controlling and administrating dispositions. It demonstrates that the nurses avoided taking responsibility and attempted to avoid trouble. In the next fragment, we meet NMM Tyler who has to check a 2:1 (refers to a patient-staff ratio of 2:1 employed for wandering or at-risk patients).

Tyler walks into a room and finds a checklist filled out in advance; the nurses' aid (NA) "worked ahead" and checked the boxes for the hours to come. Tyler, in a loud voice: "Don't do that again." NA: "Ok Miss." Tyler: "You are documenting be-

fore it happened; I don't want that." Tyler grabs the checklist and shouts: "If I catch you again!" [Tyler 12/119]

This fragment emphasizes a preoccupation with monitoring, checking boxes, and following correct administrative procedures. Both middle management and higher management manifested these behaviors in daily work at this site as is shown in the next fragment.

After a full day on the ward, we finally sit down in her little office. Tyler reflects on what she sees in the organization. She tells me that the lack of trust and double-checks are driving her crazy: "Everything has to be approved by higher management." [Tyler 12/46]

As the examples demonstrate, the roles of the NMMs at this site were influenced by dispositions to control and administer, which were promoted by the organizational field and the controlling approach of higher management. Surprisingly, this approach did not lead to reduced NMM visibility or involvement in clinical and patient-related issues. The NMMs needed the capital from the clinical disposition to teach and instruct: all NMMs were clinically very strong and could be regarded as the *primus inter pares* of the group. The teaching disposition became an instrument with which the NMMs attempted to control the employees and address the ambiguities of the professional disposition regarding responsibility and accountability.

Site 4: The scientific disposition as capital generator

Site 4 is a top-100 Magnet hospital that has won numerous awards and prizes for its care, treatment, and services. In 2005, it moved to a completely new building. It is a calm and quiet place, with little noise, soft piano music in the corridors, and art on the walls. Green colors and plants suggest a healing environment. All wards have single-bed rooms, with many different pods for the nurses and large, well-lit break rooms for the personnel. The patient-nurse ratio is above the norm, and there are numerous support staff members

on each ward. The hospital increased nursing staff over the previous 7 years despite a decrease in admissions. Performance improvement and patient safety are key issues. The nurse managers' offices are immediately off the wards. We spent more time in the office and in meetings, but this approach did not compromise the visibility of or contact or communication with the team and patients on the ward because the NMMs participated in rounds and multidisciplinary meetings and frequently had short visits to the ward.

In this hospital, a scientific disposition was prominent. The 2 examples of the scientific disposition from Table 3 were both from this site and typical of the NMMs' manners and beliefs. This disposition was manifested in the form of NMMs who were analytic, strategic, in control, and less emotional and ad hoc in their decision making. Postponing reactions and de-escalation were second nature for the NMMs at this site. This leads to a proactive rather than reactive stance, which we observed at the other sites. For example, at the other sites a patient in need would generate a direct reaction, these NMMs would immediately respond to the call for help, thereby embracing the "calamity" and "doing something." At site 4, the NMMs curb this reflex, they postpone and analyze. The next fragment illustrates the analytical aspect of the scientific disposition.

After a medication error meeting I asked Alex about a discussion between her and several other NMMs on a mistake made by one of the nurses who apparently felt bad about her error. Alex explained: "It is not about feeling bad; feeling bad gets us nowhere. We have to analyze the process." [Alex 14/52]

Alex demonstrates that in this field, the caring and collegial dispositions provide capital, but they are applied in a more analytical and investigative stance. The emergence of the scientific disposition affected the manifestations of the other 7 dispositions. The caring disposition was less ad hoc and reactive, and clinical practice became more evidence based. Within the collegial disposition, greater feedback was provided, and reflec-

tive questions were asked; teaching became less about instructing and more about critical thinking. The professional disposition was characterized by taking responsibility for patient outcomes, and the administrative and control dispositions profited from this analytical stance by the availability of the data necessary to improve performance and the quality of care. In the next fragment, Shawn shares her analysis of a situation with an orthopedic surgeon.

Shawn: "We are at the high end of LOS (length of stay),—1.8 is best practice; we are at 3.2. We can improve if we focus on no nerve block during the operation, physiotherapy on the day of surgery, coaching, bowel regimen and pain regimen. We need to gain market." [Shawn 16/136]

The scientific disposition at this site positively affected NMMs' role behavior. The NMMs expressed no sense of role ambiguity or feelings of being torn between professional and managerial work, which resulted in a strong focus on nurse-sensitive patient outcomes and performance improvement.

DISCUSSION

This article depicts NMMs' habitus as a set of 8 dispositions: caring, clinical, collegial, teaching, professional, scientific, administrative and control. Together, these dispositions give rise to a limited number of behavioral strategies. The findings demonstrate that, from an organization-as-field perspective, in particular hospitals, certain dispositions create more capital than others, thereby enhancing or decreasing NMMs' supporting role behavior. The caring and clinical dispositions were crucial to nurse managers' support at site 1. At site 2, a collegial disposition generated capital but also compromised a focus on patient care when NMMs related to staff nurses as quasi-patients. A strong emphasis on control and administration at site 3 affected the professional disposition, leading to excessive monitoring and checking, which hindered the deployment of a supporting role. At site 4 the scientific disposition

positively affected all the other 7 dispositions of NMMs habitus, leading to an increase in capital related to NMMs role behavior.

The findings contribute to the existing literature regarding the importance of supporting roles of NMMs.^{6,8,17,42} The manifestations of caring and clinical dispositions at site 1 are in line with studies that emphasize the importance of visibility, availability, and clinical involvement for nurse managers.^{6,8,17,42} The manifestations of the administrative and control dispositions at site 3 extend recent research emphasizing the challenges involving staff nurses and management in shaping care that meets patients' expectations and the impact on nursing management of a system dominated by controlling costs.⁸

In addition, the Bourdieusian analysis led to 4 new insights that demand further discussion because they explain how the interactions among the various dispositions of habitus influenced the supporting role in Magnet, Magnet-related, and non-Magnet hospitals. We first discuss hybrid, boundary spanning roles of NMM's followed by an elaboration on the definition of the caring disposition from Table 3. Next we address the ambiguous role of the collegial disposition of NMMs at site 2 and reflect on the importance of the scientific disposition for supportive practices of NMMs at site 4.

First, the analysis contributes to the existing literature on hybrid management and boundary spanning behavior¹⁷⁻²⁰ by demonstrating that habitus, as a dynamic system of dispositions in a nested organization-as-field, extends beyond the "2-way window" metaphor, which denotes the hybridity of "managerial professionals."¹⁹ Nurse middle managers do not necessarily balance between "2 windows" (ie, management and clinical), but they do have to balance between a wide variety of dispositions: caring, clinical, collegial, teaching, professional, scientific, administrative, and control. The findings also indicate that the daily challenges of NMMs are more varied and fine-grained than the challenges between "the managerial domain and the clinical domain" as studies of Sørensen¹¹ and Orvik¹² portray.

Second, in Table 3, we described the caring disposition as follows: "NMMs see patients as individuals who require care and attention. The corresponding strategies include answering the call for help of the other in the here and now; ad hoc, reactive reactions, and quick judgment. The caring disposition manifests itself by scanning the environment for calls for help." It is important to realize that caring is viewed as a central aspect in the field of nursing. In our study, the caring disposition also plays an essential role. However, despite its fundamental place in clinical practice, researchers and scholars have failed to reach a common definition.^{43,44} Our description builds on Levinas' notion of care. He explained and justified why being there for the "Other" is an indisputable duty. This responsibility for the "Other" consists in "not letting the Other alone,"^{45(p119)} in other words, "s'occuper de l'autre,"^{46(p92)} (French for "to take care of the other"). Analogous to Levinas' notion of care, a publication by the researcher Kim refers to "an enthusiasm to respond to a patient's needs."^{47(p38)} At site 1, 2, and 3, the NMMs unreflectively "took care of the other" and responded immediately to needs. This disposition to care gave them capital and enhanced their supportive role; however, our findings also revealed the tradeoff of this disposition, which is underexposed in contemporary nursing literature.

Third, at site 2, the tradeoff of the caring dispositions became visible. The NMMs at this site could not cope with the calls for help. This occasionally led to feeling drained and stressed, which is in line with other literature on NMMs' role challenges.¹¹⁻¹⁶ Because NMMs did not interact directly with patients or physicians on a daily basis, neither caring nor clinical dispositions manifested themselves unequivocally, leading to a decrease in capital. However, these NMMs' tendency to take care of the "Other" remained and manifested itself in typical relationships with staff nurses. This, in turn, resulted in a collegial disposition infused with characteristics of the caring disposition. This interplay between 2 dispositions led to a supportive and caring role of the NMMs regarding the hospital's

employees but ultimately isolated them from direct patient care, which led to a loss of capital.

Finally, a very interesting finding of this study concerns the role of the scientific disposition at the fourth site. This disposition enhanced the capital-generating aspects of the other dispositions of NMMs' habitus and aligned most closely with the caring and clinical dispositions. It resembles the critical thinking disposition described by Profetto-McGrath.³³ It was manifested by curbing or postponing ad hoc reactions and asking critical questions regarding both patient care and employee satisfaction. One could argue whether the label "scientific" fits the description, and perhaps a label of a "reflective" or "investigative" disposition would be more appropriate and aligned with NMM reflective practice literature.⁴⁸ In defining this disposition, we follow Horton-Deutsch and Sherwood,⁴⁹ who compare reflection to the scientific process. They concisely describe the particular value of profound, third-level reflection in the scientific process: "Reflection is like the academic process of describing, analyzing, synthesizing and evaluating with the addition of self-awareness."^{49(p949)} Third-level reflection can therefore help to systematically examine experiences and situations from various perspectives to increase self-awareness and promote learning from experience.⁴⁹ The scientific disposition at site 4 facilitated third-level reflection, which helped the NMMs curb ad hoc reactions and the urgency of responding to the needs of the "Other" that can easily accompany the caring disposition. Moreover, the scientific disposition helped NMMs avoid compromise in being attentive to patients and clinically involved.

One limitation of this article is that the central focus on habitus and dispositions of NMMs in the empirical analysis may have inadvertently downplayed the role of organizational fields in our analysis. The shadowing method was crucial for the description of dispositions and "in situ" behavior in managerial work, but appeared less suitable for capturing the organization-as-field perspec-

tive. This led to a less explicit analysis of organization-as-field characteristics related to Magnet, Magnet-related, and non-Magnet hospitals. According to Vaughan,²⁸ the separation of Bourdieu's concepts and the difficulty of using them relationally are not limited to ethnographic organizational case studies. Sallaz and Zavisca⁵⁰ found that of all articles citing Bourdieu in 4 prominent American sociology journals between 1980 and 2004, only 9% (21 of 235) employed all of his main concepts relationally. We believe that the thorough description of habitus as system of dispositions could potentially help researchers to further explore the relationship between NMMs habitus and the field characteristics of the various sites in the near future. By doing so, a more relational analysis of Bourdieu's concepts of habitus, field, and capital can be developed. Second, the effect that a researcher has on the situation he or she is researching, called the observer effect, is an obvious issue in shadowing. We cannot be certain whether the NMMs altered their behavior when the researcher was present. McDonald,³⁸ therefore, argues that the observer effect can be neither ruled out nor measured. However, we noticed that the fast pace of NMMs' work allowed them to not take into account that they were being shadowed. McDonald,³⁸ moreover, suggests that it is possible to directly discuss observer effects with those being observed. During shadowing, we discussed how "normal" the NMM's day had been. All managers responded that the shadowing either did not alter their behavior or only had a small influence on their daily work.

Future study on the scientific disposition is also warranted. The scientific disposition did not manifest itself as strongly in the Dutch EC hospital as in its US counterpart. To further implement EC as potential new model of care, we recommend the development of an educational program for NMMs that emphasizes the use of reflective and investigative stances within a scientific disposition. Second, we recommend a more in-depth investigation of how NMMs' habitus influences the leadership practices of nurse man-

agers and the impact of organizational context on nurse managers' work and challenges. These recommendations may contribute to the improved training and development of future nurse managers, who must cope with increasingly complex demands and work environments.

CONCLUSION

Both caring and clinical dispositions enhance NMMs' capital and contribute to their supportive roles by fostering practices of being visible and discuss patient-related issues. Solely being supportive toward employees and seeing them as quasi-patients, without emphasis on patient-related caring and clin-

ical issues, jeopardizes nurse managers' supportive role and ultimately decreases their capital. A scientific disposition, however, enhances NMMs' supportive role through practices of avoiding ad hoc reactions and the tendency of unreflectively answering the call for help. Hence, asking reflective questions crucially enhances the capital of NMMs. With regard to the further introduction and development of Magnet (-related) programs, it is important that caring, clinical, and scientific dispositions are combined to facilitate the supportive role of NMMs. Especially investigative and reflective role behaviors are a central component for creating a productive and healthy work environment for nurses and high-quality patient care.

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