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Curbing the urge to care: A Bourdieusian analysis of the effect of the caring disposition on nurse middle managers' clinical leadership in patient safety practices

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ABSTRACT

Background: Nurse managers play an important role in implementing patient safety practices in hospitals. However, the influence of their professional background on their clinical leadership behaviour remains unclear. Research has demonstrated that concepts of Bourdieu (dispositions of habitus, capital and field) help to describe this influence. It revealed various configurations of dispositions of the habitus in which a caring disposition plays a crucial role.
Objectives: We explore how the caring disposition of nurse middle managers' habitus influences their clinical leadership behaviour in patient safety practices.
Design: Our paper reports the findings of a Bourdieusian, multi-site, ethnographic case study.
Settings: Two Dutch and two American acute care, mid-sized, non-profit hospitals.
Participants: A total of 16 nurse middle managers of adult care units.
Methods: Observations were made over 560 h of shadowing nurse middle managers, semi-structured interviews and member check meetings with the participants.
Results: We observed three distinct configurations of dispositions of the habitus which influenced the clinical leadership of nurse middle managers in patient safety practices; they all include a caring disposition: (1) a configuration with a dominant caring disposition that was helpful (via solving urgent matters) and hindering (via ad hoc and reactive actions, leading to quick fixes and 'compensatory modes'); (2) a configuration with an interaction of caring and collegial dispositions that led to an absence of clinical involvement and discouraged patient safety practices; and (3) a configuration with a dominant scientific disposition showing an investigative, non-judging, analytic stance, a focus on evidence-based practice that curbs the ad hoc repertoire of the caring disposition.
Conclusions: The dispositions of the nurse middle managers' habitus influenced their clinical leadership in patient safety practices. A dominance of the caring disposition, which meant 'always' answering calls for help and reactive and ad hoc reactions, did not support the clinical leadership role of nurse middle managers. By perceiving the team of staff nurses as pseudo-patients, patient safety practice was jeopardized because of erosion of the clinical disposition. The nurse middle managers' clinical leadership was enhanced by leadership behaviour based on the clinical and scientific dispositions that was manifested through an investigative, non-judging, analytic stance, a focus on evidence-based practice and a curbed caring disposition.

What is already known about this topic?

- The clinical leadership of nurse middle managers plays an important role in realizing patient safety practices in hospitals.
- In the practice of nurse middle managers eight dispositions are in action, one of them is the caring disposition.
- Caring is seen as central to the nature of the nursing profession and in the work of nurse middle managers.

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What this paper adds

- The professional background of nurse middle managers could hinder patient safety practices in two distinct manners: (1) by solely focusing on answering the call for help and utilizing ad hoc quick fixes and (2) by caring for team members as pseudo-patients, which leads to an erosion of clinical involvement.
- The clinical leadership behaviors of nurse middle managers require a well-balanced configuration of dispositions. The combination of caring and scientific dispositions enhances clinical involvement and supports patient safety practices. A scientific disposition curbs manifestations of the disposition to care; it produces a de-escalating, non-judgmental, and inquisitive approach, with an emphasis on evidence-based practice.
- The notions of nurse middle managers' dispositions of habitus, field, and capital can be used as a thorough basis for redesigning (clinical) leadership development programs for improved patient outcomes.

1. Introduction

Patient safety practices are crucial in hospital care in both Europe and the United States (Aiken et al., 2012). They can be defined as "interventions, strategies or approaches intended to prevent or mitigate unintended consequences of the delivery of healthcare and to improve the safety of healthcare for patients" (Dy et al., 2011). The Francis report of what went wrong at Mid Staffordshire demonstrates that often hospitals have difficulties in keeping focus on patient safety practices and that they easily become preoccupied with the business of the system (finance and targets) rather than the quality of patient care (Allen et al., 2013). Such difficulties particularly manifest themselves in the work of nurse middle managers who are positioned between the ward and higher management with first-line responsibilities regarding the supervision of care workers, the management of finances and the quality of care (Hewison, 2006).

Nurse middle managers are held accountable for initiating, guiding, promoting, facilitating, and sustaining patient safety practices (Birken et al., 2012). Their clinical leadership is considered as one of the factors that determine the success of patient safety practices (Agnew and Flin, 2014; Kaplan et al., 2010; Mannix et al., 2013; Øvretveit, 2011; Taylor et al., 2011). In a previous study we explored the presumption that having a background in clinical nursing practice – which is seen as a driver or condition for clinical leadership – can potentially help but may also hinder nurse middle managers in generating authority in daily work (Lalleman et al., 2015). This study was based on a Bourdieusian analysis of observations at four hospitals in the Netherlands and the United States. We derived eight distinct dispositions of the nurse middle managers' habitus, which form various configurations. Some help and other hinder the supportive role behaviour towards the staff nurses (Lalleman et al., 2015). In this contribution, we investigate how the disposition to care, which is perceived by many as the core of the nursing profession, and is also central to nurse middle managers' habitus, influences their clinical leadership in patient safety practices.

2. Background

2.1. Clinical leadership and patient safety practices

In a recent review, Daly et al. (2014) describe common aspects of clinical leadership in hospitals: "*[. . .] the ability to influence peers to act and enable clinical performance; provide peers with support and motivation; play a role in enacting organizational strategic direction; challenge processes; and to possess the ability to drive and implement the vision of delivering safety in healthcare*" (Garrubba et al., 2011). We further argue that for patient safety practices, the influence of effective clinical leadership must extend horizontally towards peers (i.e., to other nurse middle managers), upward (i.e., to higher management), and downward (i.e., to staff nurses). Moreover, nurse leaders must also influence other hospital professionals (e.g., physicians, quality improvement staff, and clinical nurse specialists). In order to influence in all these directions, nurse middle managers will need other resources than positional power alone (e.g., authority) (Martin and Waring, 2013; Oldenhof, 2015). Research has demonstrated that physicians in managerial positions derive authority from within their own professional group by exhibiting clinical involvement and interaction with patients (Witman et al., 2011). Inspired by this research, in order to fully comprehend how nurse middle managers generate authority in daily practice, we utilize the 'practice equation': [Habitus × Capital] + Field = Practice (Bourdieu, 1984).

2.2. Nurse middle managers' dispositions of habitus

Bourdieu describes habitus as a system of dispositions (Bourdieu, 1977). Habitus is an embodied history, internalized as a second nature (Bourdieu, 1977). Dispositions are defined as durable, subconscious schemes of perception and appreciation that activate and guide practice (Bourdieu et al., 1989). Dispositions of habitus generate a limited number of behavioural strategies. These strategies are manifested in certain visible patterns of behaviour, manners, and beliefs: in activities within practices (Bourdieu, 1990). Our previous study regarding the daily work of nurse middle managers revealed eight dispositions that shape the nurse middle managers' habitus (see Table 1) (Lalleman et al., 2015).

These eight dispositions are simultaneously at play in the activities of nurse middle managers. Among the participating nurse middle managers, some dispositions were dominant, others were absent or interacted with each other, leading to various configurations that shaped nurse middle managers' practice. The genesis of these various configurations of dispositions of habitus depends on the distribution of capital and the nurse middle managers feel for the game in the field.

2.3. Game, capital and field

Bourdieu's concept of field refers to a social space with an internal logic (Bourdieu, 1989a). Field and habitus are locked in a circular relationship: involvement in a field shapes the habitus that, once activated, reproduces the field. On the other hand, habitus only operates in relation with the state of the field and on the basis of the possibilities of action granted by the capital associated with the position (Nicolini, 2013; p. 60). In a field, there is always something at stake, i.e., there are struggles for capital such as positions and other valuable resources. Capital gives authority within the field (Bourdieu, 1989b, 1986), and may be inherited through position or be based on knowledge or seniority (e.g., clinical credibility). Bourdieu's concept of field can be compared to a game with the aim of collecting valuable resources, or 'capital' (Bourdieu and Wacquant, 1992). Practices (such as patient safety practices) are conceived of as "clustered around social games, played in different social fields, in which agents act with a feel for the game, a sense of placement in pursuing of interest" (Lau, 2004).

In a special issue of *Theory and Society* on 'Bourdieu and organizational analysis' Vaughan (2008) distinguishes between two specific fields. She explains that an organization-as-field perspective presents an organization (in our study, a hospital) as a field nested in a larger professional field (in this study, nursing)

Table 1
eight dispositions of NMMs habitus.

Through a caring disposition, 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.

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.

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.

Through a teaching disposition, NMMs see themselves as tutor or mentor.

- 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 is based on sharing knowledge and teaching others.

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.

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, 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.

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.

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.

(Vaughan, 2008). In our previous study we demonstrated that, in these two fields, certain behaviours are valued differently, and some underlying dispositions create more capital (i.e., authority) than others, thereby leading to the dominance of a disposition, the absence of a disposition, or a well-balanced configuration of dispositions (Lalleman et al., 2015). For example, in the professional field of nursing, caring "for the other" (i.e., for patients) is highly valued and generates capital, in the organization-as-field perspective, caring for patients is less valued, whereas having high patient turnover and/or low levels of sick leave of nursing staff may generate capital. In order to fully comprehend how nurse middle managers navigate between what Allen et al. (2013) refer to as *"the business of the system (finance and targets)"* (i.e., the organization-as-field) and *"quality of patient care"* (i.e., the professional field) a thorough understanding of the caring disposition is of importance.

2.4. The caring disposition

In this paper, we focus on the caring disposition, a central disposition for the nursing profession. Nursing's claim to professional expertise has been expressed in terms of its caregiving function as a cornerstone of nursing practice (Allen, 2014a). However, this framing of caring as central to the nature of nursing, is under continuous debate and inquiry (Allen, 2014a; Latimer, 2014; Rolfe, 2009; Scott, 2012). Allen (2014a), for example, puts forward the suggestion that this frame is ideological and hides the dominant work of nurses—i.e., their organizational work. Although we support this line of reasoning, in this paper we focus on the caring disposition because its importance in the practices of nurse middle managers.

In our previous study, we turned to Levinas to understand the notion of care. Levinas emphasizes the importance of being there for the "Other" and immediately responding to needs (Lalleman et al., 2015; Levinas and Cohen, 1985). Levinas' philosophy helped us to understand that being there for the "Other" implies an indisputable duty of "not letting the Other alone" (Levinas and Cohen, 1985, p. 119) (i.e., immediate responding to needs driven by a notion 'to take care of the other', in French, 's'occuper de l'autre', p. 92). We used his philosophy as a "high level frame" to recognize behaviours that are, *prima vista*, not visible in nurse middle managers' work. The principle of not letting the other alone and immediately responding to needs, is closely related to the caring disposition. It is present in various configurations of nurse middle managers habitus (Lalleman et al., 2015). Interestingly, in the work of nurse middle managers, we have observed that "the Other" was not per se a patient but could also be a staff nurse, higher

management, peers or numerous *others* working in the organization. In order to investigate the impact of the caring disposition on nurse middle managers' work the following research question is formulated: how does the caring disposition in various configurations of dispositions within the habitus of nurse middle managers influence their clinical leadership in patient safety practices?

3. Methods

3.1. Design

A Bourdieusian (Bourdieu, 1977; Vaughan, 2008) multi-site ethnographic case study approach was applied (Van Maanen, 1979; Ybema et al., 2009), to gain insight into the role of the caring disposition in the various configurations of dispositions of the nurse middle manager habitus. Ethnography was used to assess and describe the practices and complexity of nurse middle manager clinical leadership in patient safety practices at a micro level. The design and execution of our study complied with the Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist (Tong et al., 2007).

3.2. Participants

Sixteen nurse middle managers of adult care units of acute care hospitals from four non-profit hospitals in the Netherlands and the United States (U.S.) participated in the study. The inclusion criteria were: being a registered nurse, supervising a nursing unit of between 20 and 40 beds, and being positioned between the work floor staff and higher management. The primary responsibilities of these nurse middle managers included supervision of direct care workers, management of budgets, and quality of care.

First, contact was made with higher management of each hospital. Further arrangements were made with contact persons in innovation and performance improvement departments and/or shared governance councils. We asked each contact person to recruit eligible nurse middle managers, by inviting them by e-mail to participate in the study. During this procedure the pattern at each site was the same; in the week after the first mailing, one or two managers responded. Then a second invitation was sent in order to motivate those who did not respond immediately. After three to four weeks the required number of four nurse middle managers had been reached. At none of the sites more than four managers showed interest. Prior to obtaining consent, the first author met with each potential participant to discuss the aims, design, and methodology of the study. One potential participant decided not to participate because a recently diagnosed illness which would not allow for the expected intensity of being shadowed. To find another participant we had to send a third invitation.

3.3. Ethical considerations

Consent differed at the Dutch and U.S. hospitals because of different national policies and the various means of accessing the sites. In the Netherlands, formal institutional review approval is not required for this type of research; the higher management of both Dutch hospitals approved the study. In the U.S., ethical approval was obtained from the institutional review boards (IRBs) of both participating hospitals and consent was obtained from each participating nurse middle manager.

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. 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. However, on several occasions during field work the researcher was invited into the patients' rooms by the nurse middle managers and asked to 'check' a wound or witness patients rounds. Standing in the door opening and keeping some distance was not always appreciated and could create some tension between researcher and nurse managers. These and other minor tensions (e.g. regarding conflicting audiences, unasked questions, revealing and concealing or concerns) are not uncommon when sociologist do field work in medical settings, see for example (Anspach and Mizrachi, 2006).

3.4. Role of the researchers

The first author (PL) can be considered as an 'insider' at site one and two. At site one, he worked as a student nurse between 1996 and 2000 and at site two, he worked as a nurse manager between 2004 and 2005. Although an 'insider' at both organizations, PL had not worked with the eight nurse middle managers that participated in the study. PL did not have any prior knowledge about the organizations or the nurse middle managers at sites three and four in the U.S. The third (ML) and fourth (LS) authors supported PL by obtaining access to both hospitals, clarifying IRB procedures, and contributing understanding of local customs and cultures in the U. S.

3.5. Data collection

Each nurse middle manager was shadowed (Czarniawska-Joerges, 2007; McDonald, 2005) by the first author (PL) for 4–6 days. This resulted in a total of approximately 560 observation hours over a period of 19 months between 2010 and 2012 (Table 2).

During shadowing, the researcher focused on behaviours that potentially indicated the habitual dispositions of the nurse middle managers. Examples of such instances are, among many others, frictions during rounding, meetings with higher management or

Table 2
Design and data sources.

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

[a] Pilot shadowing to come to an optimum of shadow days.
[b] Which included one double shift from 7 A.M. until midnight.

while supporting staff nurses double checking medication. The researcher occasionally asked questions that prompted comments from the participants. A few of them were asked for clarification, such as "what was being said on the other end of a phone call?" or "what was the meaning of this departmental joke?". Other questions were intended to reveal the purpose of an action or communication, such as why a particular line of argument was pursued in a meeting or what the current operational priorities were (McDonald, 2005). Some questions led to short semi-structured interviews about beliefs regarding nurse middle manager roles and challenges in the hospitals. In semi-structured introductory interviews, we learned about the previous careers of the nurse middle managers and their reasons for becoming nurse managers. A Livescribe™ Pulse™ Smartpen was used to digitally store handwritten field notes and audio fragments from shadowing and interviews. The field notes and audio fragments were uploaded and stored on a computer on which Nvivo 10 was installed. Nvivo 10 is a qualitative software analysis program that was used to manage the large amount of data. Selections from the audio files were transcribed. This approach provided access to recordings after the fieldwork was completed. Finally, two interactive discussion group meetings were organized with the participating nurse middle managers. Preliminary findings were discussed, and these discussions helped to assign meaning to the rich data (Balogun et al., 2003).

3.6. Data analysis

After reading and rereading all field notes and transcripts of audio files, descriptive codes emerged. Firstly, location codes, such as nursing stations, offices, or meetings outside the ward. Secondly, interaction codes, which refer to actors with whom nurse middle managers frequently spoke, such as nurses, colleagues, patients or higher management. Thirdly, codes regarding quality improvement, safety issues, mediation errors and reports of concern. These codes helped navigate the data set.

The first (PL) and second (GS) authors selected characteristic sample fragments from each hospital that showed the presence of particular clinical leadership behaviour, as described by Garrubba et al. (2011), in relation to the patient safety practices defined by Dy et al. (2011). Levinas's description of caring (Levinas and Cohen, 1985) and previous findings regarding the configurations of nurse middle manager habitus dispositions (Lalleman et al., 2015) were used as sensitizing concepts (Bowen, 2006) to guide the analysis. For each of the selected fragments, we examined the visible patterns of behaviour and read them as behavioural strategies (i.e., dispositions in action) of nurse middle managers (Bourdieu, 1990). We determined whether the disposition to care was dominant, absent, or well-balanced with other dispositions. Finally, we focused on the influences of these configurations on the clinical leadership of nurse middle managers in patient safety practice.

4. Findings

We observed three distinct configurations of dispositions with the care disposition in the centre of the habitus of nurse middle managers that influenced their clinical leadership in patient safety practices. Below, we first illustrate how a dominant caring disposition helps and hinders the patient safety practices of nurse middle managers. Second, we demonstrate how the interaction between the caring and collegial dispositions can lead to a minimal clinical involvement and discourage the patient safety practices of nurse middle managers. Third, we demonstrate how a dominant role of the scientific disposition can lead to a well-balanced configuration of the dispositions in the nurse middle managers' habitus and positively contribute to their clinical leadership in patient safety practices.

4.1. Configuration 1: a dominant caring disposition

Caring, as being there for the other and immediate responding to needs, helps nurse middle managers solve urgent issues related to patient safety practice. Our field notes indicate that nurse middle managers' daily work is burdened with numerous issues (e.g., clinical, organizational, and procedural) that require on-the-spot attention. Addressing these issues immediately has advantages in terms of patient safety practices. We provide as an example a fragment with a situation in which nurse middle manager Kim seizes an opportunity to improve care when she runs into a few medical residents:

> *Kim: "Listen, this is what I hear: a patient was disconnected from telemetry, and a new patient directly took his or her place and was connected without doing a proper report. Like last Friday, we had a transfer from ICU connected to a telemetry assigned to a patient that only minutes before was discharged from our ward . . . "*
> Resident: " . . . and the name in the system was not yet changed."
> *Kim: "So, what do you get? The patient got an AV-block, we directly call, the cardiologist comes running to the ward and goes directly to the woman in room 7; but no, she is already discharged. Yes, what do you do then? Luckily, one of the nurses knew that she gave that telemetry device to the patient in room 19. This should not have ever happened; there will be casualties, and we will end up facing inspection or court. Therefore, as soon as you have a cancelation, make a report. OK?"* [Kim, field notebook 1/page 41]

A root-cause analysis of the safety issue illustrated above was initiated and granted by Kim. This fragment illustrates Kim reacting on-the-spot in an ad hoc manner when she runs into the residents, questioning them and explaining the proper discharge procedure. Her knowledge and skills were appreciated by the medical residents; they listened to her and appreciated her judgment. This behaviour is valued (creates capital) in the hospital because it directly supports patient safety practice by immediately solving critical issues and can only be done if the nurse middle manager is knowledgeable about the procedures and clinical implications.

We also identified fragments in which the practices of nurse middle managers were solely focused on fixing immediate issues without involving others in the organization or without identifying the root cause of the issue. For example, in the next fragment, Toni reflects on the dominance of the caring disposition and its consequence in relation to physician involvement in improving patient safety:

> *During a performance improvement meeting with all nurse middle managers in the internal medicine units and the staff of the quality improvement department, several hospital-wide quality improvement projects and patient safety issues were discussed. A nurse middle manager vented her frustration about the lack of physician involvement in improving patient safety. Nurse middle manager: "We are not succeeding in getting the physicians involved, which is strange; it's their process, too." Toni: "It is not strange; we spoiled them by taking care of the process for them."* [Toni 3/120]

This fragment demonstrates that although patient safety is a concern for both physicians and nurses, nurse middle managers address the issue on their own. Their practice of taking responsibility for immediate issues is an essential element of this configuration with the dominant care disposition. However, this practice can hinder clinical leadership because it prevents others from taking action and jeopardizes interdisciplinary quality

improvement. Although appreciated by some physicians, this practice does not contribute toward patient safety because it undermines multi-disciplinary cooperation, which is an important aspect of improving patient safety.

As both fragments illustrate, a dominant caring disposition can both help and hinder the clinical leadership of nurse middle managers. We conclude with another example, in which nurse middle manager Kim, unreflectively yields to her caring disposition to provide help but hinders patient care:

Kim continuously monitors what goes on in her ward by, e.g. talking with patients, making sure that there are clean bed linens, and checking patient admissions. This last task is assigned to the unit coordinator for the day. When we returned after the lunch break, Kim checked the admission board in the nursing station to determine whether an agreed transfer of patients between rooms had taken place. It had not. She rolled her eyes and sighed. Kim did not hesitate and began to assign various nurses to start moving patients as agreed during handover that morning. At that moment, the unit coordinator returned with an acute patient from the ER, who was announced during Kim's lunch break. The unit coordinator deliberately did not move the patients because she needed one of the single rooms for this acute and very ill patient. Kim apologized for the interference. When we walked back to her office, she said, "I got them out of the frying pan and into the fire" and laughed. The unit coordinator was not amused. [Kim 2/78]

Kim was clearly involved in the daily operations on the ward. However, this ad hoc reaction and quick judgment regarding the immediate situation, i.e., "Why hasn't that patient been moved? Let's take care of this right now," did not contribute to the safety of the patient in this particular situation.

A caring disposition manifests itself throughout the daily work of nurse middle managers. It is one of the fundaments that drives their authority and leadership. However, the fragments above demonstrate that in the process of acquiring authority, a dominant caring disposition does not always result in the capital needed to guide patient safety practices and display clinical leadership behaviour.

4.2. Configuration 2: the interaction of caring and collegial dispositions

In the configuration in which the caring and collegial dispositions interact in such a manner that they become closely knit, nurse middle managers perceive and approach their nursing team as quasi-patients. This easily leads to minimal clinical involvement and a repressed nurse middle manager clinical disposition. This configuration discourages patient safety practices. For example, in this configuration, the work routine of a nurse middle manager consists of monitoring sick leave, discussing the workload and work-life balance of staff nurses, recruiting nurses, and adjusting work schedules. This administrative work can still be framed as 'caring work', because it is completely focused on the satisfaction of the nursing staff, not on the patients. At one site, the continuous call for attention from the nursing team and the on-the-spot response of the nurse middle managers to this call, overshadowed their other work activities. When patient safety issues were discussed, the conversation had a negative connotation. For example, after a long day of administrative work in her office, Eli looked out of her window and sighed, *"Quality of care is a disaster here"* [Eli 6/105]. Eli was overtly frustrated about the third lost set of dentures of patients scheduled for surgery that month. The guidelines were clear: when patients are transferred to surgery, they are not allowed to wear their dentures and have to bring with them a small box with a name sticker such that they can have access to their dentures after surgery in the recovery room. Despite this relatively simple guideline, dentures were still regularly lost, leading to complaints and unsafe situations in which patients had difficulty properly communicating in the recovery unit. For Eli, this was a clear indication that patient safety was at risk. "*If this simple guideline is not followed, what else goes wrong*?" she asked herself.

The next fragment describes Sidney having a meeting with a representative from the quality department. This was a rare event: at this hospital site, this was the only meeting between the quality department and a nurse middle manager during the entire shadowing period at that site.

QIS (Quality Improvement Staff): "How are things?" Sidney: "It is slowly getting better, but the quality keeps simmering; the nurses are in survival mode." QIS: "Do you have concerns about the quality of care in the ward?" Sidney: "Last month, we had a lot of missing items from patients, complaints, and issues with the attitudes of nurses toward medication errors. They also stopped reporting errors. I think that half of the errors were not reported. My biggest worry is the fact that the nurses appear less alert. It is a vicious circle. We 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." [Sidney 9/90]

This last sentence of the fragment expresses that the nurse managers were often on the ward, focusing on how the nurses feel; however they did not discuss patient-related issues, only relational and personal issues within the team. This demonstrates the blending of caring and collegial dispositions, i.e., a repression of the clinical disposition and lack of focus on patient safety practices. When this configuration manifested itself in the daily work of nurse middle managers, hardly any fragments of patient safety issues were found in the field notes and audio transcriptions. This configuration leads to a modus operandi which hindered the patient safety practices of nurse middle managers.

This configuration was dominant at site 2 and resulted in nurse middle managers primarily focusing on their staff. The behaviour of these nurse middle managers was highly valued by higher management, who predominantly focused on maintaining low sick leave numbers and budgetary restraints. However, this configuration resulted in minimal clinical involvement among the nurse middle managers. Here, a practice in which clinical expertise and involvement did not generate capital for nurse middle managers had developed. Furthermore, we did not observe these nurse middle managers being involved in patient care or patient safety practices with physicians, other nurses or interdisciplinary teams.

4.3. Configuration 3: a dominant scientific disposition

A dominant scientific disposition curbs and postpones ad hoc reactions and leads towards a more critical, investigative, and reflective stance towards patient care quality issues, employee satisfaction, and performance improvement in general. This scientific disposition manifests in formal and informal settings. In the following fragment, a nurse middle manager focuses on an important patient-related evidence-based performance improvement measure.

During an early morning 'check in' at the nursing station between Shawn and an orthopaedic surgeon before rounds. Shawn: "Hi boss, what is wrong?" Orthopaedic surgeon: "Nothing is wrong, everything is wrong." Shawn: "My worry is that you are going to knee surgery right away" (instead of doing rounds first). Orthopaedic surgeon: "Our responsibility is to fix the bone." Shawn: "That is the problem, you have more responsibilities. What do you got for me?" Orthopaedic surgeon: "Nothing . . . I did my total knee without a urinary catheter!" Shawn and the orthopaedic surgeon give each other a high five. [Shawn 16/146]

In this fragment, Shawn was not simply having a polite conversation with the surgeon. She was checking in on the orthopaedic surgeon and determining whether he was planning to walk rounds on the ward or leave early for the operating theatre. Shawn argued that the surgeon has more responsibilities than only fixing bones, such as doing rounds and helping out by preventing urinary tract infections by not putting in urinary catheters before surgery. Each morning, Shawn monitored urinary catheter use to decrease usage and thereby lower the prevalence of urinary tract infections. Shawn was able to convey this practice to the surgeon, as evidenced by the 'high five'. Moreover, he did not 'escape' to the operating theatre but did his patients rounds accordingly.

When this configuration manifested, we observed nurse middle managers consulting their peers (other nurse middle managers), staff nurses on their units, higher management, clinical nurse specialists, physicians, and many others to determine possible causes of undesirable clinical patient outcomes. This practice prevents nurse middle managers from looking for quick fixes and ad hoc solutions and stimulates them to strive for more sustainable and evidence-based interventions that require thorough analysis and inquiry. This behaviour was developed in a context in which dialogue between professions and hierarchical roles is common, and being inquisitive and conducting analyses are valued positive by all stakeholders (i.e., create capital). The focus on analysis and evidence-based practice was typically catalysed by the clinical nurse specialist at this hospital site. In the next brief fragment, Jamie speaks with a clinical nurse specialist assigned to her ward:

Jamie: "Should we go this way based on the evidence? Compile literature and research, ethics commission, state laws, intervention studies, what else have we got?" [Jamie 14/150]

The fragment demonstrates Jamie's focus on using research and benchmarking her patient outcomes to the literature. It, as well, shows a investigative stance which fits the scientific disposition well. In addition to these larger studies, Jamie maintained an interest in single-patient cases that required further inquiry:

Jamie: "So you do not think we missed anything? I think it has to do with her blood alcohol content labs, definitely very interesting for an obstetrics case study." [Jamie 15/22]

As demonstrated by these examples, in this configuration, using research, being consultative, asking questions and doing analyses is nearly second nature. In the next fragment, Alex advocates an analytical approach and explicitly refrains from reacting emotionally to an event:

When we walked back to the ward after the medication error meeting, I asked Alex what she thought the theme of the meeting was. Alex: "For me, the theme was feeling sorry and regretting, which should not be the theme." (During the meeting, a fellow nurse middle manager told a story that made her staff feel bad about the error). Alex: "It is not about feeling bad; feeling bad gets us nowhere. We have to analyse the process." [Alex 14/52]

The nurse middle managers at the site where this configuration manifested itself were reflective and aware of their daily actions and behaviour. A dominance of the scientific disposition seemed to produce this behaviour. The clinical leadership behaviour that emerged with this configuration can be framed as consultative, with a clear focus on clinical outcomes. In the next fragment Jamie reflects on how she addressed errors and patient safety issues on her ward:

"Issues needs to be addressed; gentle is not the word. Respectful, not firmly, but kindly, don't cover it up." [Jamie 15/92]

Jamie tried to explain how to be caring without expressing emotions or resorting to an ad- hoc helping practice. She kept focus on the issue at hand, in her case, improving the care for a mother and child in her ward. In the next fragment Alex, who just had a discussion with one of her staff nurses about a patient who did not want to be taken care by that particular nurse anymore, puts it even stronger:

Alex toward staff nurse: "We are escalating and we should not." [Alex 14/97]

It does not matter what situation Alex is in, she always curbs emotions and de-escalates, trying to analyse and listen carefully. It is almost as if emotions do not play a role and if Alex does not care, but she does. In the next fragment we pass a patient, lying in bed, in the corridor of her ward. He is on his way for CT-brain; she looks at him, sighs, and says:

"That guy is not in good shape, and he is going 43 . . . "[Alex 14/42]

When Alex discusses processes or concerns with others in the organizations she stays calm and curbs her emotions but she is not made from ice, she cares about her patients.

5. Discussion

In this analysis, we investigated how three specific configurations of dispositions of habitus of nurse middle managers interact and influence their clinical leadership in patient safety practices. These configurations were: (1) a dominant caring disposition, which helped and hindered; (2) an interaction of caring and collegial dispositions that led to an erosion of clinical involvement; and (3) a dominant scientific disposition, which led to a well-balanced configuration of the clinical and caring dispositions.

Regarding the literature about patient safety practices and clinical leadership behaviour (Kaplan et al., 2010; Mannix et al., 2013; Øvretveit, 2011, 2010; Taylor et al., 2011; Daly et al., 2014; Bohmer, 2013; Ham, 2003; Parand et al., 2014), our findings confirm that having technical knowledge of the micro practice of direct patient care, being clinically involved, and working in an interdisciplinary manner, increases the capital of nurse middle managers and enhances their clinical leadership. These practices are related to the clinical and caring dispositions in nurse middle managers' work. However, our findings also demonstrate that a caring disposition can complicate matters and potentially jeopardize the clinical leadership of nurse middle managers in patient safety practices. This is a new finding that requires careful evaluation and discussion.

Two distinct behaviours do not generate the authority required by nurse middle managers to enhance patient safety and portray clinical leadership behaviour. The first behaviour indicates a lack of clinical involvement as a result of the erosion of the clinical disposition and a caring disposition directed mainly toward the nursing team. Much of the literature regarding nurse middle manager leadership supports the need for clinical knowledge and involvement in maintaining patient safety (Daly et al., 2014; Bohmer, 2013; Ham, 2003). What makes our findings unique is that we demonstrate that this lack of clinical involvement was a result of a caring disposition geared toward caring for the nursing staff instead of caring for the patients, as shown in configuration 2. This configuration ultimately erodes the clinical disposition of the nurse middle manager habitus. Previous studies ascribe this lack of clinical involvement primarily to a dominant managerial field that emphasizes, for example, controlling costs (Kieft et al., 2014), leading to nurse middle managers feeling torn between their clinical and managerial duties (Orvik et al., 2015; Sorensen et al., 2008; Taylor et al., 2015). In addition to this external managerial influence, our findings suggest that the professional background of the nurse middle managers, especially their caring disposition, also contributes to the minimisation of clinical involvement. When the

"being there for the other" behaviour is solely geared towards the nursing staff, nurse middle managers run the risk of losing sight of patients. This finding is a refinement on the vast literature from policy, management and leadership in nursing that promotes nurse managers being supportive of nursing staff wellbeing and job satisfaction (de Brouwer et al., 2014; Maben et al., 2012; Schmalenberg and Kramer, 2009; Upenieks, 2002). We, as well, underline the importance of staff wellbeing but stipulate there is a risk of eroding the clinical disposition, which can ultimately lead to leadership practices in which nurse managers avoid acting responsively, efficaciously, or decisively to improve patient safety (Jackson et al., 2013).

The second behaviour that does not generate authority and as a consequence does not portray clinical leadership, is a dominant urge to care, with as modus operandi, 'always' answering calls for help and focusing on quick fixes and ad hoc solutions. A recent article by van Oostveen regarding nurse staffing issues describes this type of behaviour as *"acting in an ad hoc and reactive fashion to processes over which they have little influence"* (van Oostveen et al., 2015). This behaviour links to what McNamara frames as a "compensatory mode". This mode unreflectively leads to constant compensations for deficiencies and gaps in service and care provision. According to McNamara, a "compensatory mode" is largely a by-product of a dysfunctional healthcare system (McNamara and Fealy, 2010). We take this argument further and argue that this compensatory mode is also unintendedly internalized in the nursing profession and through that in the behavioural repertoire of nurse middles managers. The unintended erosion of clinical involvement leads to erosion of nurse middle managers' conscientious responsibility and liability for patient safety. This paradox is produced by the practices of the hospital organization itself and can be seen as an example in which field and habitus are locked in a circular relationship.

Hence, a caring disposition – solving ad hoc issues and being there for the other – is vital for the daily operations of contemporary, high-paced, and complex healthcare organizations such as hospitals. In short, nurse middle managers and their disposition to care, and through that, to compensate, keep the hospital running. However, our findings demonstrate that when this caring disposition is dominant in the work of nurse middle managers, they run the risk of producing short term quick fixes and non-sustainable solutions, which can jeopardize patient safety practices. This insight has consequences for those who advocate for professionals in leading positions. A recent review regarding the engagement of professionals in hospital management concludes that hospitals run by professionals perform better. However, the authors suggest that further research is required to determine the impact of specific professional backgrounds on hospital performance and patient safety (Lega et al., 2013). Here, we demonstrate how specific behaviours stemming from the professional background of managers might contribute to but also hinder patient safety unintentionally.

Our findings are consistent with the literature regarding clinical leadership and patient safety, which emphasizes the importance of evidence-based practice to address the root causes of patient safety issues (Fleiszer et al., 2015, 2016). The reflective and inquisitive nature of the scientific disposition curbs – when dominant – the ad hoc reflexes of the caring disposition and gives way to the clinical disposition. Furthermore, a dominance of the scientific disposition enhances the positive impact of the caring disposition with respect to patient safety practices (i.e., a balance is created between narrow focus on quick fixes and immediately answering the calls for help on the one hand, and analyses and evidence-based practice on the other hand).This finding is in agreement with Allen's re-conceptualization of the contemporary nursing mandate, which is *"with its exclusive focus on care-giving (. . .) no longer serving the profession or the public"* (Allen, 2014b). A broader repertoire that incorporates both caring and scientific dispositions will enhance the clinical leadership of nurse middle managers in patient safety practices. Furthermore, this repertoire counters the pervading "just do it" culture of many performance improvement programs such as the Nottingham University Hospitals Trust in the United Kingdom, which encourages members of staff to quickly champion and action good ideas. According to Weggelaar these kind of programs, lead to what she calls 'the projectification of quality improvement' in which a focus on 'low hanging fruit' with easy to achieve objectives overshadows thorough analyses and a focus of evidence-based practice (Weggelaar-Jansen, 2015, p. 247).

This study has a few limitations that warrant consideration. First, this study was performed at only four hospitals in the Netherlands and the United States of America. Although the findings might be transferable to other Dutch and American hospitals, they cannot be generalized to all hospitals in these or hospitals in other countries. Secondly, the material in this study is much richer then we can present in this paper. It would have been interesting, for example, to differentiate between the various forms of capital (e.g., economic capital, cultural capital, social capital, symbolic capital) (Bourdieu, 1986). However, we do not believe it would contribute to a deeper understanding of the empirical material and might complicate analysis unnecessary.

Further studies should elaborate on the various configurations of dispositions of habitus addressed herein and on other possible configurations in relation to clinical leadership and patient safety practices. The impact of other organizational contexts should also be studied in more detail. Finally, we recommend a thorough study of the possibilities to develop a well-balanced configuration of the various dispositions of nurse middle managers. Our experiences in the member checking sessions indicate that shadowing is a very promising learning tool.

6. Conclusions

The dispositions of habitus of nurse middle managers influence their clinical leadership in patient safety practices. The caring disposition of nurse middle managers has an important role in maintaining daily operations in the hospital but can also hinder their clinical leadership, especially when the caring disposition is primarily focused on ad hoc actions. This potentially leads to short-term solutions and a "compensatory mode" of quick fixes. When a caring disposition becomes closely knit with a collegial disposition, the clinical disposition is suppressed and clinical involvement can even disappear from the habitus of nurse middle managers. In that case nurse middle managers do not exhibit clinical leadership or focus on patient safety practices. When a scientific disposition is dominant in a nurse middle manager's habitus, the caring disposition becomes curbed or "restrained", creating a balance between the caring, clinical, and scientific dispositions, leading to clinical leadership behaviour and focus on patient safety. This improves the quality of care through the use of a non-judgmental, inquisitive, analytic, and de-escalating approach based on evidence-based practice.

7. Relevance to clinical practice

This study addressed a critical and difficult topic. By understanding the impact of a caring disposition and its consequences for clinical practice and realizing the significant role that a scientific disposition plays in nurse middle managers' habitus, the insights from this study contribute to improvement of practice in patient safety and quality of care. In order to realise this improvement, leadership and management development

programs should incorporate the notion habitus, capital, field and game in their curricula and stimulate future nurse manages and leaders to reflect on their own professional habitus, feel for the game and field specific capital.

Conflict of interest

None declared.

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Ethical approval

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