OXFORD

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

Martijn Felder[1],*, Syb Kuijper[1], Pieterbas Lalleman[2], Roland Bal[1] and Iris Wallenburg[1]

[1]Erasmus School of Health Policy & Management, Erasmus University, Rotterdam, The Netherlands
[2]Research Group of Person-centredness in an Ageing Society, Fontys University of Applied Sciences, Eindhoven, The Netherlands
*Corresponding author. Email: felder@eshpm.eur.nl

ABSTRACT

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 The amendment was met with fierce opposition from within the nursing community, however, and was eventually withdrawn.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

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

INTRODUCTION

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

modified (Hampel, Lawrence and Tracey 2017; Felder et al. 2018).

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

To study the emergent organization of (open) professional resistance, we draw on insights from the literature on populism and reconstruct the 'Dutch Nurse Revolt' of the summer of 2019. As we explain in our theoretical framework, the literature on populism, and especially the seminal works of political scholars Mouffe (2005) and Laclau (2005), offer a useful lens for studying the interplay between: (1) the grievances of individual professionals (in our case nurses); (2) the politization of emergent professional group identities (in our case 'genuine nurses' versus 'nursing elites'); and (3) the organization of collective professional dissent against macro-level institutional changes (in our case targeting the reorganization of the Dutch nursing profession).

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

the issue back to field, leaving further reform to the hospital sector (Van Kraaij et al. 2022).

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

The relevance of our reconstruction is two-fold. First, it offers insight into the challenges faced in nursing in many northern countries—such as staff shortages and high turnover (Currie and Hill 2012)—and how governments seek to deal with them by intervening in nursing's occupational development. Our case specifically adds to a small but growing body of empirical research showing that legal interventions rarely help in the (re)organization of nursing work (Currie, Finn and Martin 2010; Briskin 2012; Matthias 2017). Secondly, our reconstruction foregrounds how professionals navigate increasingly complex political, social, and workplace environments (Noordegraaf 2020) and challenge those who seek to intervene in *their* work. While doing so, we move beyond some conceptual limitations of the conventional institutional (work) literature and highlight the changing relations between state actors, hospital organizations, and professional groups 'in formation' (Hardy and Maguire 2017; Schneiberg and Lounsbury 2017), discussing the inequalities and stratifications challenged and sustained by such relations (Adams et al. 2020; Noordegraaf and Brock 2021).

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

THEORETICAL FRAMEWORK

Nurses are an interesting occupational group when studying professional roles, identities, and practices in a changing institutional environment. Many healthcare organizations currently face staff shortages and high turnover among nurses (Currie and Hill 2012), problems all the more pressing in the current pandemic. The causes include work pressure, limited career opportunities, and little say in organizational and policy decision making (Van Schothorst-van Roekel et al. 2020; Van Wijk et al. 2021). Both nursing scholars and healthcare practitioners have, therefore, advocated that nurses should act more autonomously and confidently amidst other healthcare actors (Yam 2004; Allen 2014). Part of this agenda involves re-valuing the organizing work that nurses already do within healthcare organizations (Allen 2014) and emphasizing their unique knowledge (Yam 2004). Another aspect is to rethink nursing education (Van Oostveen et al. 2017) and differentiate between different kinds of nurses (Currie, Finn and Martin 2010; Van Kraaij et al. 2022), giving higher educated nurses more opportunities to take on new professional roles, such as 'expert' and 'organizer' (Van Schothorst-van Roekel et al. 2020).

Given these ambitions, Van Schothorst-van Roekel et al. (2020) recently studied how nurses, managers, and medical specialists cooperate to recraft nursing roles within different healthcare organizations. One strategy was to place more emphasis on—and clear space for—the organizing work of nurses. Drawing from their observations, the authors describe how such recrafting produced tensions in: (1) the distribution of 'professional authority' amongst health care actors within the organization; (2) the prioritization of tasks among nurses; (3) the alignment of activities between nurses and others; and (4) the remoulding of institutional arrangements. Van Schothorst-van Roekel et al. (2020) describe the development of new nursing roles as a balancing act and as relational and political in nature. The new organizational roles they observed could therefore be considered preliminary outcomes of ongoing negotiations between nurses and other organizational actors such as managers and medical specialists (see also Currie, Finn and Martin 2010; Ernst 2019).

Most scholars who study relational politics among nurses, managers, and medical specialists focus on the shopfloor (Ernst 2019), the healthcare organization (Van Schothorst-van Roekel et al. 2020), or a specific professionalization project (Van Wieringen,

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

Mouffe (2005) and Laclau (2005) aspire to better understand the conditions that drive populist mobilization and their political implications (for better or worse). Importantly, unlike scholars who study populism strictly as a (party) political phenomenon, Mouffe (2005) and Laclau (2005) conceptualize it as an 'expression of various acts of resistance against a post-political condition' (Demir 2019: 541). Mouffe (2005) explains the latter as a tendency in many Western states to: (1) approach pluralism on an individual level, barring the existence of conflicting group identities and interests (Beck, Giddens and Lash 1994); (2) try to overcome differences between individual perspectives and values through deliberation and consensus (Giddens 1998); and (3) approach political problems as technical issues that can be solved rationally by scientists and experts (Centeno 1993).

Mouffe (2005) continues that there are some problems with this post-political condition. First, she renounces the idea that rational deliberation can turn pluralism into a harmonious and inclusive ensemble. Instead, every ordering (including that of professional roles and responsibilities) creates

exclusions. Consensus is therefore always—and also—a form of silencing, with the possibility of silences being broken. Secondly, individuals (professionals) may not always feel represented by their consensus-seeking (professional) representatives, particularly so because they have limited insight into the deliberations in which *their* representatives engage. Meanwhile, these representatives cannot be held accountable (by democratic means) for the outcomes of their representational activities, especially because these are often framed as negotiated, consensus-based, and/or scientifically informed (Rancière 1999). Thirdly, neoliberal policy agendas have led to new uncertainties, stemming from a retrenchment of welfare policies and a (misplaced) devotion to the regulatory qualities of markets and their experts (Crouch 2011). Having lost faith in (professional) representatives and facing new uncertainties, individuals (professionals) are sometimes disposed to search for new forms of political and professional representation. Mouffe (2018) refers to this as the populist moment.

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

First, populism is about establishing *a political frontier* that divides society into two camps: 'us' the common people versus 'them' the corrupt elite (Mudde and Kaltwasser 2017). The words *common* and *elite* refer to a certain hierarchy between those who decide and those who have to deal with the consequences. The word *corrupt*, in turn, refers to the act of rational deliberation and the criteria—but whose criteria?—on which established consensus is based (Mouffe 2005). We wish to emphasize that both the 'us' and the 'them' are political constructs that can be reconfigured idiosyncratically (Mudde

and Kaltwasser 2017). Secondly, the frontier is always constructed in response to a specific issue and can take on different forms in time and space. In the words of Žižeck (1993: 201), 'The bond of a group of members is always based on their shared relation towards a thing.' Different groups can thus come together at different times, for different reasons and in juxtaposition to different others (see further Dewey 1927). Thirdly, the frontier established is based on an *emotional* and/or *antagonistic* us/them distinction. It is here that the word *partisan* is introduced. It refers to a reasoning in lines of opposing camps and the act of joining one of these camps to challenge a threating 'other' (Schmitt 2004). Populist expressions are thus relational and constructed, the mobilization of populist movements and the delineation of group identities are dynamic and emergent, and both expressions, mobilization and delineation, revolve around antagonistic us-versus-them reasoning.

There are authors who treat the concepts of professionalism and populism as political opposites and approach populist expressions as illegitimate challenges to the rational leadership of professionals (from Diethelm and McKee 2009 to Friedman 2019). Authors that do so tend to view professional groups as stable, with specific membership criteria and control over their work content. They furthermore insist that such criteria and content are inwardly oriented, rationally construed and based on established and officially recognized bodies of knowledge and skill (Friedman 2019). Framing professionalism in such traditional terms indeed seems the opposite of the constructed, relational, and emotional nature of populist expressions and the dynamic nature of populist mobilization around emergent issues.

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

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

CONTEXT OF OUR CASE STUDY

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

The 1970s saw the first vocational and bachelor level training programmes being founded as part of a movement towards a more unified nursing profession with a more generic training curriculum (compared to the training nurses received in-house, usually in a hospital). The law was amended in 1977 to encompass both vocational and bachelor training and the professional title Healthcare Nurse became Nurse. While the vocational and bachelor level

training programmes were supposed to replace in-house training, pressure from employers and in-house training organizations meant that in-house training continued until 1997 (Van der Peet 2021).

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

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

By the turn of the twentieth century, many actors had become involved in professionalizing Dutch nursing, including policymakers, employers' associations, educators (vocational and bachelor councils), professional organizations, unions, expert committees, and a plethora of public figures. They formed shifting coalitions supporting specific issues (e.g. quality improvement), or challenging one another's intentions (e.g. membership growth). Nevertheless, most of them agreed that something needed to change in the organization of Dutch nursing work (Werner Committee 1991). Particularly urgent was the high turnover among and haemorrhaging of higher educated nurses in hospital organizations (see further, Terpstra Committee 2015; see also, Zander et al. 2016 for similar issues being addressed on a European scale). They realized that besides licensing and training, more attention should go to conditions of employment. One of the challenges was to make these conditions more attractive, especially for higher educated nurses (Terpstra Committee 2015). As we will elaborate further in the results section, formally differentiating between vocationally and bachelor-trained nurses was thought to be the way to do so. It was supposed to create better career opportunities for higher educated nurses, improve the quality of nursing care and strengthen the position of nurses among other health care actors.

METHODS

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

As members of the abovementioned consortium, we started by interviewing key actors from the Dutch Nurse Revolt and others who had been involved in the professionalization of Dutch nursing over the past two decades ($N = 22$). We asked our interviewees to reflect on the amendment (why was it needed and who initiated it), why it met with a critical reception, and how nurses had organized to oppose it. We also

asked how their opposition had been received, interpreted, and acted upon. All interviews were audiotaped, transcribed verbatim, and coded. We also collected and analysed policy documents, blogs and articles posted on nursing platforms (including comments posted in their comments sections), chat-show broadcasts, and Twitter posts (Table 1).

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

Our analysis focused on: (1) better understanding why the amendment had been proposed and

Table 1. Data gathered

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

challenged; (2) identifying the different mechanisms involved in the establishment of a political frontier in opposition to the amendment; and (3) reflecting on the consequences. Our analysis took the form of an iterative process in which we moved back and forth between data and theory (Tavory and Timmermans 2014). Table 2 provides an overview of the coding process.

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

RESULTS

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

Introduction of an amendment

Many nurses in the Netherlands have received vocational and/or in-house training, often accompanied by specialized in-hospital training (e.g. ICU care, oncology, wound specialist). As nursing work becomes more technically complex, however, healthcare organizations are increasingly looking to attract higher educated nurses (bachelor or master qualifications).

'Patients spend less time in the hospital but are simultaneously more ill. Caring for these patients requires more knowledge and skills' (former representative of the Dutch Nursing Association, interview 2020). Some have argued that more weight should be given to nurses who have received bachelor training and are thus able to connect nursing work to scientific literature (Van Oostveen et al. 2017). Once part of nursing teams, higher educated nurses would be able to raise the quality of care provided by all team members, including those with a vocational qualification.

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

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

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

Table 2. Overview of analysis

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

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

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

care and meet future demand, but it also increases the pressure on the nurses who remain.

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

what nurses on either side of the vocational–bachelor divide would be called and which activities they would be allowed to do (Terpstra Committee 2015).

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

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

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

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

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

Countermobilization and establishment of a political frontier

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

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

Immediately after the announcement, some nurses posted critical remarks on social media and used the comments sections of digital nursing platforms to articulate their grievances (see below for examples). These comments would grow in frequency and intensity, eventually pushing out more nuanced responses. It was the start of a 'Nurse Revolt' against the amendment and those that supported it. Three months later, the Minister withdrew

his plan to introduce the amendment due to lack of support amongst nurses (parliament in fact never discussed the amendment). In the following, we reconstruct how the nurses who opposed the amendment managed to establish a political frontier and stop its introduction. Iteratively informed by our theoretical framework and our case, we distinguish between conditions for populist mobilization, the establishment of an alternative political frontier, and political entrepreneurship (see Table 2).

Conditions for populist mobilization

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

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

the perspectives and needs of vocationally and in-house trained nurses. These critical remarks were soon shared on social media and nursing platforms (particularly in the comments sections). An example:

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

The author of this comment claimed to represent 28,500 nurses. A former representative of the Dutch Nursing Association reflected on this as follows (interview 2020): 'The Nursing Association had worked for years to integrate all the different nursing associations into one voice. Last year, however, we saw that they were unable to connect and represent the diversity of interests that make up the nursing community.'

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

Establishment of an alternative political frontier

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

> That moment when the patient suddenly has an attack: his heart races, his blood pressure drops. No doctor in sight so you have to decide quickly: what's wrong? What do we do? Nurse. . .knows exactly what needs to be done. She's had 29 years' experience and is a specialized intensive care nurse. . . .So much experience, but now she has to go back to school to

continue doing what she's done for years (nurse representatives speaking out in national newspaper, 7 June 2019).

The Nursing Association has been caught in the web of the bachelor-council (blog on nursing platform [comments section], 27 August 2019).

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

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

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

At first glance, this quote is just another accusation. By connecting the amendment to a broader debate about neoliberal governance and the future of the Dutch welfare state, however, these nurses tapped into a sentiment shared by many of their colleagues (including bachelor-trained nurses): the sense of being underpaid, overworked, and voiceless in decisions concerning their profession. In the words of a former nurse and nurse director (interview 2020), 'They put into words what we were all feeling, they were so right, nothing had been solved yet.'

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

Political entrepreneurship

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

Bachelor of nursing student: Dear nursing peers. Please try to move beyond your personal emotions and interests. Also try to imagine what the amendment can mean for our profession and for the patient (that's who we do it for, right?). I do want us to continue to look at differentiation between roles and competencies in the everyday delivery of healthcare. The competencies that I gained in my training also matter. I want better care for the patient, and I want to emancipate our profession. Be honest, is that the case at this point in time?

Partisan nurse: Your educator has deceived you. You learned things you do not need. The worst thing is that you, with your two years of training, will tell very experienced nurses what they should do. Your last point is arrogant and derogatory. Everybody wants good care. We have been providing that for many years. Obstructing factors are managers, policy-makers and overzealous students.

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

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

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

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

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

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

The three nurses had received vocational and in-house training and had been actively involved in the debate about the amendment. On the chat show, they emphasized that: (1) they would no longer be allowed to make decisions or treat complex patients; (2) it would tear apart the nursing community; and (3) the amendment was only being introduced because trained nurses had failed to make a difference in everyday nursing practice. Their message was repeated in many news outlets.

The chat-show appearance gave partisan nurses access to a larger audience and other health care actors responded by writing about and commenting on the amendment. A medical specialist, for instance, sympathized with the partisan nurses and problematized the amendment in a national newspaper (25 August 2019 [column section]). He likened nursing work to restaurant service and compared vocationally and in-house trained nurses to Cinderella and bachelor-trained nurses to illegitimate princesses. Every story covered in the conventional media—and every comment posted on social media—contributed to the political frontier established by the partisan nurses.

On 21 August 2019, the Minister of Health appeared on the same chat show that had hosted the three nurses. He explained that the amendment was a long-cherished wish of the Dutch Nursing Association and that he thought it could count on the support of the nursing community. Other guests on the show asked critical questions, for example 'Why do you want to differentiate between nurses against their will?' and 'Why is a piece of paper valued more than years of experience?' The guests—none of whom had a nursing background—echoed the objections of the partisan nurses, whose frontier became firmly embedded in the public discourse. When the chat-show host finally asked the Minister what these criticisms meant for the amendment, he

replied, 'I do not see a future for the amendment at this point in time. Differentiating between nurses, which many nurses still want, can be done in some other way' (chat-show broadcast, 21 August 2019). On 9 October 2019, the Minister officially withdrew the proposed amendment. Meanwhile, on 27 August 2019, the board of the Dutch Nursing Association had already stepped down, having lost the support of those they were supposed to represent.

Aftermath

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

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

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

DISCUSSION

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

The populism literature sensitized us to: (1) conditions for populist mobilization (e.g. feelings of being discarded as experienced nurses and a perceived lack of formal representation); (2) a particular action frame through which an alternative political frontier was established between 'us' (genuine, hardworking nurses) and 'them' (a corrupt elite, including anyone who supported the amendment); and (3) specific acts of political entrepreneurship through which partisan nurses sought to strengthen their position (e.g. policing social networks and connecting with a larger audience). Some observed acts of political entrepreneurship resonate well with the conventional institutional

work literature (e.g. policing) and can be interpreted as the institutional maintenance work carried out by vocationally and in-house trained nurses to protect their 'privileged' positions (Fligstein 2001; Lawrence and Suddaby 2006). However, in line with recent developments in the institutional (work) literature (e.g. Hampel, Lawrence and Tracey 2017; Hardy and Maguire 2017; Schneiberg and Lounsbury 2017), two points warrant further discussion.

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

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

At first glance, the Dutch Nurse Revolt seems to exemplify a successful emancipatory project by nurses against state interventionism (Matthias 2017). However, we also witnessed a sharp politization of *the* nursing identity (Mouffe 2005) and argue that the narratives pushed by partisan nurses reproduced intra-professional and inter-professional stratifications (Currie, Finn and Martin 2010; Adams et al. 2020). For instance, partisan nurses argued that all nurses are equal and that their work revolves around patient bedside care (and therefore nowhere else within healthcare organizations). Meanwhile, medical specialists were allowed to compare differentiated nursing work with restaurant (waitstaff) service whilst sympathizing with the partisan nurses' battle against the amendment, reproducing the position of nurses as a subordinate professional group within healthcare organizations. Nurses who saw the amendment as an opportunity to strengthen their position amongst their peers as well as within healthcare organizations were actively sought out, challenged, and othered by the partisan nurses. Currie, Finn and Martin (2010) have observed the reproduction of similar inter-professional and intra-

professional stratifications in the UK after the introduction of specialized nursing roles. There, nurses who aspired to take on such roles were seen by peers as peculiar individuals in naïve pursuit of a stronger position amongst other professionals. In our case, however, nurses who saw merit in role differentiation were castigated by their peers as enemies of *the* nursing community, making it even harder for them to speak out or do things differently.

CONCLUSION

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

Our reconstruction has some limitations. Most importantly, we focused on events that took place in the summer of 2019 and on the way in which opposition was mobilized, using the literature on populism as analytical framework. In doing so, we have skimmed over the fact that attempts to differentiate between vocationally and bachelor-trained nurses go back 30 years (Van der Peet 2021) and were made in various institutionalized settings. A more institutionally layered and historical analysis of the reorganization of nursing work is needed to explain why nurse differentiation is both an enduring ambition and a persistent problem (Van de Bovenkamp, Stoopendaal and Bal 2017). In addition, while there is a larger body of literature focusing on the emergence of social movements and their political consequences (e.g. Bennett, Segerberg and Walker 2014), we focused specifically on the seminal works of Mouffe (2005) and Laclau (2005). This choice has been iteratively informed by our case (e.g. the political frontier that was established and the way in which this occurred). We also believe, however, that this is only a first step in studying organized dissent amongst emergent professional groups and the mechanisms involved.

REFERENCES

Adams, T. L., Kirkpatrick, I., Tolbert, P. S., and Waring, J. (2020) 'From Protective to Connective Professionalism: Quo Vadis Professional Exclusivity?', *Journal of Professions and Organization*, 7/2: 234–45.

Ahuja, S., Heizmann, H., and Clegg, S. (2019) 'Emotions and Identity Work: Emotions as Discursive Resources in the Constitution of Junior Professional's Identities', *Human Relations*, 72/5: 988–1009.

Allen, D. (2014) *The Invisible Work of Nurses: Hospitals, Organisation and Healthcare*. London: Routledge.

Aslanidis, P. (2016) 'Populist Social Movements of the Great Recession', *Mobilization: An International Quarterly*, 21/3: 301–21.

Beck, U., Giddens, A., and Lash, S. (1994) *Reflexive /er*. Stanford: Stanford University Press.

Bennett, W. L., Segerberg, A., and Walker, S. (2014) 'Organization in the Crowd: Peer Production in Large-Scale Networked Protests', *Information, Communication & Society*, 17/2: 232–60.

Bévort, F., and Suddaby, R. (2016) 'Scripting Professional Identities: How Individuals Make Sense of Contradictory Institutional Logics', *Journal of Professions and Organization*, 3/1: 17–38.

Briskin, L. (2012) 'Resistance, Mobilization and Militancy: Nurses on Strike', *Nurse Inquiry*, 19/4: 285–96.

Centeno, M. A. (1993) 'The New Leviathan: The Dynamics and Limits of Technocracy', *Theory and Society*, 22/3: 307–35.

Crouch, C. (2011) *The Strange Non-Death of Neo-Liberalism*. Cambridge: Polity.

Currie, E. J., and Hill, R. A. C. (2012) 'What Are the Reasons for High Turnover in Nursing? A Discussion of Presumed Causal Factors and Remedies', *International Journal of Nursing Studies*, 49/9: 1180–9.

Currie, G., Finn, R., and Martin, G. (2010) 'Role Transition and the Interaction of Relational and Social Identity: New Nursing Roles in the English NHS', *Organization Studies*, 31/7: 941–61.

Demir, G. (2019) 'For a Left Populism: By Chantal Mouffe', *Rethinking Marxism*, 31/4: 541–5.

Dewey, J. 2016 (1927) *The Public and Its Problems*. Athens: Ohio University Press.

Diethelm, P., and McKee, M. (2009) 'Denialism: What Is It and How Should Scientists Respond? *The European Journal of Public Health*, 19/1: 2–4.

Dimaggio, P. J. (1988) Interest and Agency in Institutional Theory. In: Zucker, L. (ed.) *Institutional Patterns and Organisation*, pp. 3–22. Pensacola: Ballinger.

Egenes, K. J. (2017) 'History of Nursing', In: Roux, G., and Halstead, G. A. (eds) *Issues and Trends in Nursing: Essential Knowledge for Today and Tomorrow*, pp. 1–26. Burlington, MA: Jones & Bartlett Learning.

Ernst, J. (2019) 'The Curse of Bureaucratisation or the Blessings of Professionalisation? Nurses' Engaged Adoption of Quality Management in Hybrid Managerial Positions', *Scandinavian Journal of Management*, 35/3: 101050.

Felder, M., van de Bovenkamp, H. M., Maaijen M. H., and de Bont, A. A. (2018) 'Together Alone: Organizing Integrated, Patient-Centered Primary Care in the Layered Institutional Context of Dutch Healthcare Governance', *Journal of Professions and Organization*, 5/2: 88–105.

Fincham, R., and Forbes, T. (2019) 'Counter-Rhetoric and Sources of Enduring Conflict in Contested Organizational Fields: A Case Study of Mental Health Professionals', *Journal of Professions and Organization*, 6/3: 342–56.

Fligstein, N. (2001) 'Social Skill and the Theory of Fields', *Sociological Theory*, 19/2: 105–25.

Friedman, A. L. (2019) 'Juxtapositioning Populism and Professionalism', *Professions and Professionalism*, 9/2: e3201.

Giddens, A. (1998) *The Third Way: The Renewal of Social Democracy*. Cambridge: Polity.

Hampel, C. E., Lawrence, T. B., and Tracey, P. (2017) Institutional Work: Taking Stock and Making It Matter. In: Greenwood, R., Oliver, C., Lawrence, T. B., and Meyer, R. E. (eds) *The SAGE Handbook of Organizational Institutionalism*, pp. 558–90. London: Sage.

Hardy, C., and Maguire, S. (2017) Institutional Entrepreneurship and Change in Fields. In: Greenwood, R., Oliver, C., Lawrence, T.B., and Meyer, R.E. (eds) *The SAGE Handbook of Organizational Institutionalism*, pp. 261–80. London: Sage.

Laclau, E. (2005) *On Populist Reason*. London: Verso.

Lawrence, T. B., and Suddaby, R. (2006) Institutions and Institutional Work. In: Clegg, S. R., Hardy, C., Lawrence, T. B., and Nord, W. R. (eds) *The SAGE Handbook of Organization Studies*, pp. 215–54. London: Sage.

——, Leca, B., and Zilber, T. B. (2013) 'Institutional Work: Current Research, New Directions and Overlooked Issues', *Organization Studies*, 34/8: 1023–33.

Lok, J., Creed, W. E. D., DeJordy, R., and Voronov, M. (2017) Living Institutions: Bringing Emotions into Organizational Institutionalism. In: Greenwood, R., Oliver, C., Lawrence, T.B., and Meyer, R.E. (eds) *The SAGE Handbook of Organizational Institutionalism*, pp. 591–620. London: Sage.

Maaijen, M. H., Felder, M., de Bont, A. A., and Bal, R. (2018) 'Mapmaking and the (Re) Organization of Professional Practice: A Case Study of Dutch Primary Care', *Journal of Professions and Organization*, 5/3: 230–47.

Matthias, A. (2017) Educational Pathways for Differentiated Nursing Practice: A Continuing Dilemma. In: Lewenson, S. B., McAllister, A., and Smith, K. M. (eds) *Nursing History for Contemporary Role Development*, pp. 121–40. New York: Springer.

Meurs Committee (2019) *Verpleegkunde op Niveau: Een Overgangsregeling in Het Kader Van BIG II Register*. The Hague.

Morris, E. (2019) *American Dharma [documentary film]*. Los Angeles: Utopia.

Mouffe, C. (2005) *On the Political*. London: Routledge.

—— (2018) *For a Left Populism*. London: Verso.

Mudde, C., and Kaltwasser, C. R. (2017) *Populism: A Very Short Introduction*. Oxford: Oxford University Press.

Noordegraaf, M. (2020) 'Protective or Connective Professionalism? How Connected Professionals Can (Still) Act as Autonomous and Authoritative Experts', *Journal of Professions and Organization*, 7/2: 205–23.

——, and Brock, D. M. (2021) 'Protective and Connective Professionalism: What We Have Learned and What We Still Would Like to Learn', *Journal of Professions and Organization*, 8/2: 228–36.

Rancière, J. (1999) *Disagreement: Politics and Philosophy*. Minneapolis, MN: University of Minnesota Press.

Roberts, M. L. A., and Schiavenato, M. (2017) 'Othering in the Nursing Context: A Concept Analysis', *Nursing Open*, 4/3: 174–81.

Schmitt, C. 2004 (1962) *The Theory of the Partisan: Commentary/Remark on the Concept of the Political*. East Lansing: Michigan State University Press.

Schneiberg, M., and Lounsbury, M. (2017) Social Movements and the Dynamics of Institutions and Organizations. In: Greenwood, R., Oliver, C., Lawrence, T. B., and Meyer, R. E. (eds) *The SAGE Handbook of Organizational Institutionalism*, pp. 281–310. London: Sage.

Seremani, T., Farias, C., and Clegg, S. (2021) 'New Order and Old Institutions: South Africa and the Institutional Work of the Truth and Reconciliation Commission', *Organization Studies*. First Published April 16, 2021. DOI: 017084062110062

Smets, M., and Jarzabkowski, P. (2013) 'Reconstructing Institutional Complexity in Practice: A Relational Model of Institutional Work and Complexity', *Human Relations*, 66/10: 1279–309.

Sweet, P. L., and Giffort, D. (2021) 'The Bad Expert', *Social Studies of Science*, 51/3: 313–38.

Tavory, I., and Timmermans, S. (2014) *Abductive Analysis: Theorizing Qualitative Research*. Chicago, IL: University of Chicago Press.

Terpstra Committee (2015) *Toekomstbestendige Beroepen in de Verpleging en Verzorging*. The Hague.

Tonkens, E. (2013) Professionaliteit Tussen Mondigheid, Markt en Bureaucratie. In: Schermer, M., Boenink, M., and Meijen, G. (eds) *Komt Een Filosoof Bij de Dokter*, pp. 305–19. Amsterdam: Boom.

Van de Bovenkamp, H. M., Stoopendaal, A., and Bal, R. (2017) 'Working with Layers: The Governance and Regulation of Healthcare Quality in an Institutionally Layered System', *Public Policy and Administration*, 32/1: 45–65.

Van der Peet, R. (2021) *Van Verpleegster Tot Verpleegkundige: Honderd Jaar Wet- en Regelgeving in de Verpleging 1921 – 2021*. Rotterdam: Mijnbestseller.

Van Kraaij, J., Lalleman, P., Walravens, A., and van Oostveen, C. J. (2022) 'Differentiated Nursing Practice as a Catalyst for Transformations in Nursing: A Multiphase Qualitative Interview Study', *Journal of Advanced Nursing*, 78/6: 165–75.

Van Oostveen, C. J., Goedhart, N., Francke, A. L., and Vermeulen, H. (2017) 'Combining Clinical Practice and Academic Work in Nursing: A Qualitative Study about Perceived Importance, Facilitators and Barriers regarding Clinical Academic Careers for Nurses in University Hospitals', *Journal of Clinical Nursing*, 26/23-24: 4973–84.

Van Schothorst-van Roekel, J., Weggelaar-Jansen, A. M. J. W. M., de Bont A. A., and Wallenburg, I. (2020) 'The Balancing Act of Organizing Professionals and Managers: An Ethnographic account of Nursing Role Development and Unfolding Nurse-Manager Relationships', *Journal of Professions and Organization*, 7/3: 283–99.

Van Vugt, L. (2016) *De Witte Woede: Verpleegkundigen en Verzorgenden in Opstand 1988-1991*. Nieuwegijn: Nu'91.

Van Wieringen, M., Groenewegen, P., and Broese-van Groenou, M. I. (2017) 'We're All Florence Nightingales': Managers and Nurses Colluding in Decoupling through Contingent Roles', *Journal of Professions and Organization*, 4/3: 241–60.

Van Wijk, M., Lalleman, P. C. B., Cummings, G. G. and Engel, J. (2021) 'Public Opinion Leadership in Nursing Practice: A Rogerian Concept Analysis', *Policy, Politics, & Nursing Practice*, online first January 18, 2022. https://doi.org/10.1177/15271544211071099.

Varvasovszky, Z., and Brugha, R. (2000) 'A Stakeholder Analysis', *Health Policy and Planning*, 15/3: 338–45.

V&VN. *About V&VN: history* <www.venvn.nl> accessed 28 Dec 2021.

Wallenburg, I., Hopmans C. J., Buljac-Samardzic, M., den Hoed, P. T. and IJzermans, J. N. M. (2016) 'Repairing Reforms and Transforming Professional Practices: A Mixed-Methods Analysis of Surgical Training Reform', *Journal of Professions and Organization*, 3/1: 86–102.

Waring, J. (2014) 'Restratification, Hybridity and Professional Elites: Questions of Power, Identity and Relational Contingency at the Points of 'Professional–Organisational Intersection', *Sociology Compass*, 8/6: 688–704.

Werner Committee (1991) *In hoger beroep*. Rijswijk.

Yam, B. M. (2004) 'From Vocation to Profession: The Quest for Professionalization of Nursing', *British Journal of Nursing*, 13/16: 978–82.

Zander, B., Aiken, L. H., Busse, R, Rafferty, A. M., Sermeus, W., and Bruyneel, L. (2016) 'The State of Nursing in the European Union', *EuroHealth*, 22/1: 3–6.

Žižeck, S. (1993) *Tarring with the Negative*. Durham: Duke University Press.