Chapter six
Conclusion and discussion

In this final chapter, I provide an answer to the main research question that guided my research, by briefly summarizing the main findings of this dissertation. This is followed by a further elaboration on the literatures on which these chapters built and the contributions that this dissertation makes to these literatures. After that, I reflect on the methodology and focus adopted in this dissertation. Finally, I describe some practices implications.

6.1 Summary of findings: Responses to institutional complexity and change

In this dissertation, I explore and explain how people working in the Dutch home-care sector have perceived and acted upon institutional complexity and change, and how we can understand their particular responses. My research is guided by the following main research question: How do actors in the Dutch home-care sector perceive and act upon co-existing contradictory institutional logics as well as alterations in their relative dominance over time?

The first key finding of this dissertation is that decoupling comprised an important micro-level situated response of nurses and managers to co-existing contradictory institutional logics and the alterations in their dominance over time. In the first three empirical chapters (two to four), I focus on the micro-level processes and practices of decoupling. Studying the intra-organizational level in chapter two, I render visible that the organization of caregiving processes in two differently managed home-care organizations do not contribute to the enactment of formal policy on informal caregiver involvement in the everyday practices of professional at the work floor level. Instead, I show that ambiguity about the division of responsibilities, and nurses indicating that they are unaware of any organizational policy on informal caregiver involvement.

Based on the findings in this exploratory paper, I argue that decoupling involves the symbolic adoption of policy on informal caregiver involvement because the implementation of this policy in the organization of the caregiving process remains deficient.
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Conclusion and discussion

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In **chapter three**, I examine the inter-professional level and show how and why managers and nurses are involved in decoupling. I reveal that managers and nurses had different, but aligned, roles in the process of decoupling, but nonetheless take heed of the professionals interests of the other occupational group. I show that managers facilitate decoupling through ambiguity regarding the enactment of the co-existing institutional logics, and by purposefully abstaining from enacting the logic of managed care in work processes. Nurses, in turn, deflect institutional pressures by engaging in the creative-yet-rational enactment of the practices of the logic of managed care. Essentially, I show that both occupational groups engaged in decoupling to avert the impact of the logic of managed care, while aiming to preserve organizational and professional interests, and to ensure the enactment of nurses’ values, commitments and practices in everyday work. In doing so, I stipulate that managers, in particular, colluded in decoupling with nurses.

**Chapter four** further explores why nurses engage in decoupling practices. I show how nurses’ micro-level decoupling practices are informed by a combination of anger and anxiety, as well as compassion with clients, which are triggered by a perception of threat to the enactment of nursing values and professional interests. Moreover, in this chapter, I show that decoupling as an ongoing process with emotional consequence. While decoupling allowed for the continued enactment of nursing values, the expression of compassion, and the preservation of the interests of nurses and their clients, it also helped to institutionalize—at least superficially—the logic of managed care. This, in turn, heralded more decoupling practices, which subsequently became more intricate and, thereby, emotionally distressing over time.

The second important finding of this dissertation is that the responses of community health nurses and other stakeholders to an longed-for ongoing process of regenerative institutional change, and enduring complexity, consist of differing and suspended acts as well as contradictory sentiments. In **chapter five** I study the process of regenerative institutional change, which I refer to as one of institutional reincarnation, in which members of an occupational group engage in efforts to revive and re-habitualize professional values, traits and practices that were exhibited by predecessor members of the occupational group. This process thus quite literally revolves around reincarnation of a subject, that is, a person representing particular norms, values and practices. I show that this process is characterized by four different yet entwined micro-processes and sentiments: nostalgic projection,
apprehensive questioning, disillusioned re-assumption, and imputing celebration. In essence, I detail that the symbolic and normative legacy of the institution, i.e., of the predecessor community health nurse, is imperatively and expectantly invoked and conveyed throughout the change process. As such, it both provides legitimization for the “new” role of community health nurses and entices criticism and disillusion when re-habitualization shows to be difficult in a situation where an incongruent institutional logic, i.e., the logic of managed care, persists. A such, I argue that in processes of institutional reincarnation, the nature of what is revived is integral to the particular micro-processes that characterize the process. In extension, I exemplify how the convergence of past, present and future are crucial with regard to the sentiments and experiences that actors exhibit throughout the process.

6.2 Theoretical contributions and implications

The insights developed in this dissertation contribute to the burgeoning body of literature on the micro-foundations of institutional theory, and micro-level responses to institutional complexity and change specifically. Besides, the findings speak to literature considering the intimate relationship between professions and institutions, and research on institutional and occupational change. In each of the next sections, I first provide concise elaboration on the state of the art in the respective literatures, after which I elaborate upon the contributions that this dissertation makes.

6.2.1 Heeding the micro-level in institutional theory: Beyond decoupling as “an under-theorized key concept”

“Traditional” decoupling, as first introduced by Meyer & Rowan (1977), is widely identified as an important (organizational level) strategy in response to institutional complexity (Boxenbam & Johnson, 2017; Greenwood et al., 2011). In their seminal paper, Meyer and Rowan (1977) argue that conformity to different institutional demands can be ceremonial when conformity precludes organizational efficiency, or when organizations were facing conflicting institutional demands (see also Boxenbam & Johnson, 2017). Ceremonial conformity, Meyer & Rowan show, involves the deliberate decoupling of an organizations’ formal structure from its production activities. As such, decoupling is taken to mean that
organizations comply only symbolically or superficially to particular institutional demands and/or do not necessarily implement practices of a supposedly newly adopted organizational policy or structure (Boxenbaum & Johnson, 2017; Bromley & Powell, 2012). Such “window dressing” ensures legitimacy with external constituents, while the organization’s mission, interests, and commitments are equally safeguarded via the continuation of “business as usual” (Boxenbaum & Jonsson, 2017).

Over time, the “structure” from Meyer and Rowan’s (1977) classic form of organizational structure-action decoupling has often been replaced by “policy” or “programs”, hence the conceptualization of policy-practice decoupling (Boxenbaum & Jonsson, 2017; Bromley & Powell, 2012). Recent research further identifies other forms of decoupling (Boxenbaum & Jonsson, 2017; Greenwood et al., 2011; Scott, 2001), such as means-end decoupling (Bromley & Powell, 2012). The latter refers to a situation in which organizations may fully implement a particular policy despite knowing that it involves a poor means to the (hence superficially) pursued end (see also Wijen, 2014). In a recent article, Battard, Donnelly and Mangematin (2017) nicely summarize how decoupling can be considered a response to institutional pressures that is in-between (passive) compliance, which is found when institutional demands and organizational goals are aligned, and active resistance that allows organizations and actors to preserve their goals.

In their extensive review of the literature on decoupling, Boxenbaum and Jonsson (2017) further address when organizations decouple. Beyond the finding that decoupling has been identified as a response to maintain organizational survival and efficiency in light of pressures that are detrimental to it, the authors describe additional conditions for decoupling. For example, organizations are more likely to decouple when top-managers have the power to resist externally imposed pressures or have gained experience with decoupling in other organizations (e.g., Westphal & Zajac, 2001). Research further shows that organizations and people that engage in decoupling practices put great effort in appearing to conform to institutional pressures, or conceal their acts of decoupling (e.g., Fiss & Zajac, 2006). Ultimately, Boxenbaum and Jonsson (2017) demonstrate that when, and the manner in which organizations and people decouple is not standard. Instead, it is informed by the particular institutional context in which they find themselves. In fact, decoupling strategies in complex institutional environments are intricately associated with the micro-level
instantiations of (incompatible) institutional logics. Therefore, a micro-level perspective is warranted to fully understand this important phenomenon.

However, Greenwood, Oliver, Lawrence, and Meyer (2017) argue that for long institutional research rather implicitly heeded its micro-foundations, and that the nature of the dynamics at the micro-level remain insufficiently attended too. In this regard, Zilber (2002, p. 236) argues that “in portraying institutions as human creations turned into nature-like givens, scholars seem to have neglected the role of social actors in the maintenance of institutions.” In so doing, scholars mainly neglected that institutions “must be continuously constructed and reconstructed by social actors, as it is the continuous enactment of practices and meanings by organization members that constitutes and maintains institutions, including their appearance as taken-for-granted” (Zilber, 2002, p. 236).

Going beyond these critiques, institutional researchers recently started to conceptualize the micro-foundations of institutions and institutional processes (Greenwood et al., 2017; Powell & Rerup, 2017). However, until now, studies of decoupling taking a micro-level perspective are rare. In extension, our knowledge of the normative and emotive underpinnings of this important phenomenon in institutional theory is nearly absent. As such, despite being a key concept within institutional theory, the concept of decoupling is remarkably underexplored and under-theorized, particularly with regard to understanding processes and dynamics at the micro-level (Greenwood et al., 2011; Boxenbaum & Jonsson, 2017). More precisely, little is known about the particular roles, motivations and experiences of different actors that engage in decoupling practices.

These limitations are attended to in chapters three and four of this dissertation. As articulated, a comprehensive understanding of the “how and why” of decoupling practices necessitates a micro-level perspective. The adopted “inhabited institutions perspective” (Delbridge & Edwards, 2013; Hallet & Ventrasca, 2006; Lok et al., 2017) allowed for an identification of how and why decoupling took place. That is, by focusing on the role of managers and nurses in the process of decoupling, in chapter two and three, I identify the intra-organizational mechanisms, inter-professional relations, and situational conditions that are vital to how decoupling takes place. Then, in chapter four, I further provide an in-depth understanding of the normative and emotive antecedents and outcomes of decoupling, as well as rational (interest-based) considerations that may inform this practice. Moreover, I render visible the lived experiences of people that continuously engage in decoupling. Taken
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together, these insights contribute to a more comprehensive understanding of decoupling, and particularly allow for a more nuanced conceptualization of decoupling in terms of how, when and why it occurs in complex institutional environments. In doing so, these contributions advance efforts to bring the concept of decoupling beyond its puzzling status of “under-theorized key concept” within institutional theory.

Beyond the concept of decoupling, I conceptualize how the experiences, practices and sentiments that actors exhibit in the process of institutional reincarnation are integral to the convergence of past, present and future in such a process, as well as to the nature of what is revived. I describe an ongoing process of institutional change that essentially entails that existing occupational members engage in efforts to reincarnate the core norms, values and practices of predecessor occupational members. I show how former and seasoned occupational members actively spur the change process by imperatively conveying their lived experiences. As such, I render visible not only the lived experiences of existing occupational members that were in the ongoing process of institutional reincarnation, but also showed how the lived experiences and moral dispositions of those that had incarnated the institution featured prominently in the process. In attending to the normative and emotive elements and underpinnings of the process of institutional reincarnation, I develop an understanding of why process of generative institutional change may be more precarious than previous research suggests.

Taken together, I contribute to a growing body of literature aimed at developing our understanding of the micro-level dynamics of institutions. I demonstrate the value and relevance of taking an inhabited institutions perspective (Bechky, 2011; Delbridge & Edwards, 2013; Hallet & Ventrasca, 2006; Lok et al., 2017) and directing our attention to the lived experiences of people as they respond to institutional complexity and change. This allowed for conceptualizations that reflect interest-based and normative motivations of individual inhabitants (Cardinale, 2018), and for the inclusion of emotive underpinnings of institutional processes, which otherwise are not observed. Ultimately, it shows that institutional inhabitants are not at all flat, but know all to well “what is at stake for them” (Creed et al., 2014, p. 297) and are able to preserve to a large extent what they deem important and identify with. All in all, in this dissertation I go beyond predominantly cognitive and interest-based explanations of responses to institutional complexity and change, to take account of normative and emotive antecedents and outcomes of (micro-level) institutional processes.
(e.g., Voronov & Vince, 2012; Lok et al., 2017; Zietsma & Toubiana, 2018), thereby deepening institutional theorizing (Greenwood et al., 2017).

### 6.2.2 Beyond marginalization: Reconsidering roles, positions and change

Pache and Santos (2013) theorize that the micro-level responses to institutional complexity that people exhibit are influenced by the relationship between logics (the level of hybridity, i.e. competitiveness between logics) as well as the degree to which people identify with existing logics. Research also shows that individuals may combine (elements of) different institutional logics, using the latter as toolkits (McPherson & Sauder, 2013). In doing so, they relate to relevant referent audiences, such as another occupational group that identifies with another institutional logic, in important ways (e.g., Currie & Spyridonidis; McPherson & Sauder, 2013). This research has in common that it generally reveals that such mutual adjustment between occupational groups is engaged in to serve individual actors’ purposes. In extension, mutual adjustment essentially holds as long as the occupational commitments, purposes and interests of the more powerful actor involved are served (Currie & Spyridonidis, 2016; McPherson & Sauder, 2013; Reay & Hinings, 2009; Smets & Jarzabkowski, 2013; Smets, Jarzabkowski, Burke, & Spee, 2015; Voronov et al., 2013). Reay and Hinings (2009) show how a pragmatic collaboration between managers and physicians in fact entails an “uneasy truce.” Currie and Spyridonidis (2016) reveal how mutual adjustment by interdependent occupational groups is informed by actors’ positional gains and happens insofar as higher status actors do not feel threatened. Oldenhof et al. (2016) find how middle managers relate to care workers through professional talk, in either an empowering or a disempowering way, and by doing so influence the relative positioning to this group. In this regard, chapter three in particular shows an intriguing finding with regard to the mutual adjustment between managers and nurses that differed from existing research. It shows that mutual adjustment between managers and nurses entails managers closing in on nurses rather than the other way round.

Taken together, chapters three and four moreover exemplify the influence that a lower-level and ostensibly “marginalized” occupational group exerts through the creative usage of mundane tasks. To elaborate, existing research on professions in complex and changing institutional environments primarily presents the strategies, mechanisms,
conditions and motivations that enable and allow highly professionalized occupations to protect and preserve professional norms, values and commitments in their on-going professional projects (Reay et al., 2016; Suddaby & Viale, 2011). The latter are found to largely resist and avert, or have been able to adapt to, managerial demands that were considered to marginalize their professional commitments (Suddaby & Muzio, 2015). By comparison, the finding that nurses engaged in decoupling provides empirical evidence for the suggestion by Reay et al. (2016) that lower-level less-professionalized occupational groups, such as nurses, draw upon other, more hidden, strategies to exert influence than highly professionalized and powerful occupational groups, such as physicians (Reay et al., 2016). The enduring act of decoupling, I argue, stemmed from nurses’ position at the intersection of the micro-level instantiations of the co-existing institutional logics as well as their ability to reflect and act upon the conflicting logics (Battilana & D’Aunno, 2009; Suddaby et al., 2016). As nurses ostensibly perceived no alternatives to preserve the enactment of professional nursing values, non-compliance to the logic of managed care through decoupling seemed a common and largely satisfactory practice among the nurses studied. That is, decoupling allowed them to preserve the enactment of professional nursing values and commitments, as well as exert situated influence at the organizational frontline. It follows that this dissertation elaborates this literature. First, by showing how the enactment of professional norms, values and practices is pursued as much as possible in the micro-level everyday mundane practices of lower-level professionals. Second, by revealing the considerations and micro-level practices that allow a lower-status occupational group to avert the impact of the micro-level instantiations of a logic that not serves the pursuit of professional and personal interests and commitments.

The important finding, from chapter four in particular, that the act of decoupling, despite having become emotionally distressing over time, generally served nurses’ purposes, directs our attention to potential merits of such a concealed strategy (cf., Heese et al., 2016), and of acting from a relatively marginalized position. That is, chapter four shows that nurses exhibited ambivalent reflections with regard to their relative role and positioning in the organization of the caregiving process: while disliking it, nurses also made use of their role. One may well pose that they did so for a lack of other options. However, I direct attention to an intriguing finding from chapter five, where I found that the changing role of community health nurses with regard to regaining a considerable more central role in the organization of
the caregiving process, also caused ambivalence and other contradictory sentiments among members of the occupational group. The process of re-habitualization was precarious as predicament was encountered due to the enduring influence of the logic of managed care. As the layering and relative balance between the co-existing logics changed (Raynard, 2016), nurses were ostensibly to disaccustom (i.e., de-habitualize) roles, practices and dispositions that they had exhibited in the immediate past (Reay et al., 2013). As articulated, their decoupling practices, for example, had been implicated by their position at the intersection of logics, but presumably also by their relatively low-profile go abouts. By comparison, the central position and being put on a pedestal increased responsibilities, raises expectations amongst occupational members and referent audiences alike, and makes one subject to public scrutiny. It follows that the intriguing question arises as to whether acting from a relatively lower-level marginalized position may actually have advantages over a more central position and role for an occupational group. Future research could explore the trade-offs of both a marginalized and low-profile but influential position, and a central position for members of occupational groups, and explore under what conditions each may be satisfactory, or not.

6.2.3 Institutional and occupational change: Heeding past, present and future

The findings in this dissertation, particularly those identified in chapter five, also speak to the body of literature considering the intimate relationship between professions and “the institutions that surround them” (Suddaby & Muzio, 2015, p. 37). As articulated, research has shown that various professionalized occupations – such as medical professionals (Reay et al., 2016; Scott et al., 2000), accountants (Bévort & Suddaby 2016; Suddaby et al., 2009), architects (Ahuja et al., 2017; Lawrence et al., 2012) – have adapted to working in bureaucratic organizations. However, there seems overall agreement that these processes of institutional and occupational change have generally “occurred in conjunction with a significant deterioration in autonomy and working conditions for individual professionals” (Suddaby & Viale, 2011, p. 427), while lower-level occupational groups in particular have seen a development of de-professionalization (see Anteby et al., 2016; Brock & Saks, 2016). As shown throughout this dissertation, actors involved indeed believed that previous dynamics in the institutional environment had affected the nature of the nursing profession (Brock &
Saks, 2016). Furthermore, as the opening quote of this dissertation illustrates, previous and ongoing institutional dynamics informed both persistence and uncertainty with the occupational group of nurses.

Unlike previous research, chapter five shows the potential for occupational and institutional change to revolve around the re-habitualization of professional values, traits and practices. This process that can sensibly be labelled a “re-professionalization process.” Birenbaum (1982) described re-professionalization as an effort to upgrade (the status of) a profession in direct response to the profession’s perceived downgrading and dispossession. This process involves a re-definition and re-direction of the occupation by acquiring “qualitatively different roles from those performed by members of the profession in the past” (p. 872). Different from Birenbaum, re-direction in the case of community health nurses essentially involved reviving and re-habitualizing professional values, traits and moral attributes that had characterized members of their occupational group in the distant past. Nonetheless, like occupations that seek to professionalize and expand their jurisdictional space, a process of re-professionalization requires the legitimization of a new (rediscovered) role and the need to prove the value of the profession, which is enhanced “through the purposeful, continual actions of determined individuals” (Reay et al., 2006, p. 993; see also Fayard et al., 2017). The latter often involves jurisdictional disputes with related occupational groups (e.g., Bucher et al., 2016). In this regard, chapter five shows that a process of re-professionalization requires the recognition of important reference audiences. Moreover, a relative re-positioning with regard to important referent audiences, who themselves are in the process of working out their particular role and position in the changing institutional environment, is warranted.

Besides institutional research, I contribute to the literature on professions and occupations by attending to this unique process of institutional reincarnation and showing that reviving and re-habitualizing professional attributes is characterized by precariousness and predicament. Specifically, I stipulate how the legacy of the institution, that is, the norms, values and practices of a predecessor community health nurse, are imperatively and expectantly invoked and conveyed throughout the process. On the one hand, the legacy provides legitimization for the “new” role of community health nurses. On the other hand, it informs criticism and disillusion when re-habitualization is experienced to be difficult as the enduring existence of the logic of managed care causes predicament. To bring past
professional values, traits and practices beyond latency to being re-habitualized and recognized as such, presumably requires more effort in terms of re-contextualization over time. Paraphrasing Heraclitus (Kahn, 2001): nurses and their referent audiences did not step in the same river twice, for it was not the same river and they were not the same. Taken together, I suggest that an understanding of the micro-processes that may constitute processes of occupational change is incomplete if past and present institutional arrangements and professional attributes of the concerning occupational group are not taken into account. Heeding this insight, I suggest that future research could examine whether and how different occupational groups (are able to) heed and retain consistency with their past, and how this is vital in their response to institutional change.

On the whole, the case of community health nurses allows for a reflection on the thesis of neo-institutional theory regarding inexorable rationalization (Suddaby, Ganzin, & Minkus, 2017). The considerable body of literature on occupational and institutional change, alluded to above, which shows that highly professionalized occupations have quite well adapted to more rationalization and bureaucratic ways of organizing, essentially confirms neo-institutional theory’s thesis in this regard. By comparison, cases that offer a competing view are rare. Nevertheless, recent research shows examples of “the persistence of ritualistic thinking” (Suddaby et al., 2017, p. 294), and details how this results in institutional maintenance. Examples include the persistence of “traditional” modes and schedules in the training of physicians (Pratt et al., 2006), the maintenance ritualistic dining routines in British universities (Dacin, Munir, & Tracey, 2010), or the persistence of rules and rituals in the training of advocates (Siebert, Wilson, & Hamilton, 2017). Besides, recent studies reveal the re-appreciation of crafts, such as the craft of traditional beer brewing (Kroezen & Heugens 2018; Lamertz et al., 2016).

By comparison, the case of community health nurses ostensibly involves a unique effort of re-enchantment, involving the celebration of the art and craft of caregiving and other professional and moral attributes over the rationalization of care delivery. This open re-enchantment essentially occurred after decades of relative latency, or at the least the ostensible marginalization of professional values and practices. That is to say, the first three empirical chapters (two to four) essentially show the resilience of professional nursing norms, values and practices in the reflections of nurses, and related actors, as well as their pursued enactment in micro-level practices through decoupling. In turn, chapter five shows their re-
enchantment and celebration by and beyond members of the nursing profession, for example, by consecutive Secretaries of State and policy-makers more broadly. In seemingly going backwards, these reflections on and celebrations of the past are actually progressive and inform projections for a future in the home-care in which rationalization and managerial demands may not necessarily play first fiddle. In further heeding the call for a focus on re-enchantment, which is important and fascinating, it would be of particular interest for future research to consider how enchantment, after it has arisen in response to widespread rationalization, evolves in such largely rationalized contexts.

6.3 Reflections on methodology and focus

Like any other research, the research reported on in this dissertation has its strengths and limitations. In terms of methodology, the chosen method is informed by a particular goal and informs a particular focus in the research, while foreclosing other foci. In this dissertation I purposefully chose to take a micro-level perspective, as I aimed to study actors’ responses to institutional complexity and change. As a consequence of my focus on the micro-level (i.e., intra-organizational, inter-professional and individual level), the level of the field was only addressed when delineating the the context: a complex and changing institutional environment. Yet, I paid significant attention as to how dynamics at the field level affected the nature of the everyday work of actors, which was inherent to the “inhabited institutions perspective” adopted, and which allowed me to develop rich insights in what constituted actors’ responses. However, I could only speculate about the extent to which the micro-level responses and acts of various actors, in turn, informed and influenced institutions and institutional dynamics at the field level.

In this dissertation, the main method of data collection – in-depth interviews – involved self-reports of perceptions and actions of the actors. Joining nurses during care delivery would have complemented the interview data. For example, it would have allowed me to see actual acts of decoupling – that is to say, actually seeing nurses delivering other types of care and help than they were formally allowed to provide. However, despite various requests, I was not given permission to join nurses and observe the everyday work of the actors under study due to privacy reasons. Yet, considerable time was invested in data
collection and building rapport with research participants. Showing from the honesty in the quotes presented throughout this dissertation, I do believe respondents shared truthful and extensive accounts of their everyday practices, experiences and struggles as well as the nature of their response and micro-level strategy adopted.

Besides, the dissertation builds for a large part on interviews with managers and nurses. In so doing, most attention was paid to nurses, which had as a trade-off that I primarily presented their (partial) view(s) on, experiences with and responses to institutional complexity and change. Considering the obvious reverse, mainly focussing on this group led to the comprehensive and detailed understanding of the how and why of their views, experiences and practices that was developed in this dissertation. However, it remained rather disconnected from their relevant referent audiences and stakeholders involved in the process of care delivery and care allocation, such as care recipients, informal caregivers or employees from the (now dissolved) Care Assessment Centres or current insurance companies. While these stakeholders are mentioned, they did not form the focus of study. In light of the identified (ongoing) act of decoupling of managers and nurses as well as their motives for doing so, it would be of particular interest to study in future research both the perceptions and actions of these other groups of actors in response to institutional complexity and change, and how these relate to the identified responses of the occupational groups studied in the present research. As such, I propose for future research to study the wider range of actors mentioned above, and their responses to institutional complexity and change. In light of the finding that decoupling was supposedly also done to protect the interests of service recipients, I particularly encourage future research to study clients and their informal caregivers. Doing so could, for example, provide insight into the potential role of service recipients and informal caregivers in the process of decoupling, or could, conversely point out their non-involvement. Such research could indicate, for instance, whether decoupling may also be a response to requests by informal caregivers, and would further designate whether care recipients and informal caregivers are familiar with the formal tasks of nurses and/or whether they are (kept) ignorant in this regard.

Studying institutional and occupational change as it unfolds has as a limitation that real-time accounts of experiences and perceptions of stakeholders, i.e., in blogs, interviews and during observations, revolve around the immediate thinking and issues, and may reflect (magnified) situated sentiments that could be subject to change as the process advances. Yet,
this is probably also its major advantage, complementing the more longitudinal view and older data sources. That is, I was able to capture real-time experiences and perceptions – instead of solely retrospective accounts in which experienced sentiments and past perceptions may be blurred, though some of the data obviously did also include retrospective elements – that allowed me to delineate the micro-processes within the ongoing institutional change process.

Considering the empirical setting and my respondents, the vast majority of respondents interviewed for the present research worked in different organizations in urbanized areas. This presumably had implications for the findings, for several reasons. First of all, people in urbanized areas tend to be somewhat more insulated and lonely once they are confined to their homes as a result of their illness and ailments, as the connection with neighbours is less strong than might be the case in rural areas, where a larger sense of community is assumed to exist. Moreover potential informal caregivers may have moved out of the city, and may not be readily available to provide support. It follows that the clients of the nurses studied in the present research may have been more dependent on professional nursing care and, more so, on other forms of support that nurses were actually formally not allowed to provide than would be the case in more rural areas or village communities. Then again, the sense of community and proximity in village communities may result in a closer connection between clients and nurses, and spur the latter to provide a wider range of services, beyond those formally allocated. Besides, municipal budgets differ, for example with regard to funding available for home-making services. Taken together, whether decoupling occurs at all, the extent to which it occurs and for what reasons, might differ depending on the area studied. Future research could compare the micro-level practices of nurses working in different urbanized and rural contexts, and explore whether and how these are different.

6.4 Practice implications

Beyond its theoretical contributions, this dissertation warrants the formulation of several implications for practice. These, first of all, relate to the main strategy – decoupling – that I identify in response to institutional complexity and change. Second, I provide some implications regarding the changing role of nurses and their relationship with regard to
important referent audiences. Considering the changing role of community health nurses, I also reflect on the notion of “returning” to the past. Throughout this section, I draw on insights developed from the research presented in this dissertation, and from the larger research project “Care networks of frail older adults” of which this dissertation was part. In addition, I draw on insights from ongoing research projects beyond the research described in this dissertation that I have been involved in.

As was shown throughout this dissertation, and indicated in the opening quote of chapter one, working in the complex and changing institutional environment of the Dutch home-care sector was perceived to be challenging in both a positive and negative sense. I show how nurses, in particular, struggled to respond to both the local situated needs of care recipients and the pressure to cut costs, while also facing extensive accountability requirements. In essence, the nurses’ decoupling practices lay bare the relatively easy way to circumvent both the process of care assessment and allocation that existed when I entered the field in 2012, and the eligibility requirements when the responsibility of care assessment and allocation was re-attributed to community health nurses after the reform of 2015. According to nurses, and also managers, not engaging in decoupling would oftentimes compromise the delivery of good quality of care to vulnerable people in need of help. As such, through decoupling nurses felt they could avoid professional mediocrity. While it may be laudable that nurses exposed such responsibility and commitment, it also directs our attention to the fact that a gap exists between formally attributed publicly financed types of care and the needs of individual clients that nurses came across in situated encounters. In extension, it requires a (re)consideration of how the care needs of clients can be responded to in a way that has a less clandestine sense to it. At present, it further seems important that policy-makers acknowledge and pay due significance to the moral distress that nurses experienced to deliver what they deemed the best possible care, as shown in chapter four in particular. Intriguingly, I also show that, besides causing distress, nurses’ decoupling practices also preserved their sense of (professional) self. Either way, a prerequisite for attending to both the identified gap in care needs and what care can be delivered, as well as for diminishing the distress experienced by nurses, is that nurses themselves open the black box of, and be more open about their mundane everyday practices.

As became evident in the most recently announced policy program for the long-term care sector (VWS, 2018), the emphasis on self-reliance of clients and their informal caregivers
is here to stay. Consequently, the important role and interests of informal caregivers in the process of care delivery need to be attended to. I have disclosed reasons why nurses as well as managers were sometimes hesitant to involve informal caregivers as well as non-caregiving family members of the care recipient. The findings in chapters three and four indicate that the formalization of informal caregiver involvement primarily continued to be regarded as a means to supplement and substitute parts of formerly publicly funded professional care, the budget for which could therewith be cut further. As such, it seems essential to carefully consider the framing of policy with regard to informal caregiver involvement. Doing so forecloses the partial perception that involvement of informal caregivers is solely a prerequisite to substituting, and therewith cutting costs on professional nursing care and services. Moreover, careful framing may lessen the accompanying, but presumably unintended, negative emotions that I identified with the nurses, that is, those who are actually intended to involve informal caregivers. Besides, the question as to who is responsible for the supervision of, and the quality of care delivered by, informal caregivers and volunteers hitherto is not solved (Suanet, Van Wieringen, De Boer, Beersma, & Taverne, 2018). This similarly informed reluctance with nurses with regard to informal caregiver involvement as well as the perception of threat to both their professional and clients’ interests. Such negative emotions blind people from seeing alternatives or positive elements with regard to particular policy measures (Elfenbein, 2007), cause resistance and leads actors to subside in their own ostensibly counterproductive acts.

In essence, nurses continued to focus on care recipients in particular, while the sense of urgency and responsibility to support informal caregivers to ensure their caregiving role was less pressing or, at least, more difficult to attend to (see Suanet et al., 2018). In this regard, the findings of chapters two to four combined indicate that the translation of field-level directives with regard to furthering informal caregiver involvement requires better hand-off mechanisms. For example, the fact that there is no compensation for time spent on informing or deliberating with informal caregivers, nor for time spent on providing support ostensibly raised a barrier for caregiver involvement by nurses. Therefore, for nurses to assimilate and enact their vital role in enhancing the self-reliance and resilience of citizens

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20 See Van Wieringen et al. (2018, in Dutch) for similar findings and reflections with regard to informal caregiver involvement in nursing homes.
and informal caregivers, it seems important that insurance companies provide compensation for time spent by nurses on deliberating with (potential) informal caregivers and providing guidance. Combined with the aforementioned careful framing in policy by the government when it comes to the intended role of informal caregivers, these measures could contribute to limiting any reluctance with regard to informal caregiver involvement with nurses, and subsequently contribute to (further) unleashing any untapped potential of informal caregivers. As discussed by Jacobs (2016), such untapped potential may be found with “proximate social network members who could possibly take up a role as informal caregiver” (p. 35) as well as volunteers.

As articulated, nurses are attributed an important initiating role in this. Beyond the abovementioned measures to enhance the assimilation and enactment of this role, it is presumably further enhanced through socialization. Elaborating on this, surely, ongoing developments in the Dutch home-care sector implicate a new role for nurses when it comes to relating to care recipients and their (potential) informal caregivers as well as volunteers. The finding that the nurses under study showed reluctance with regard to fully partaking in these ongoing changes raises questions as to how educational institutes are socializing (future) nurses. Essentially, relating in a different way to care recipients and their social networks concurrently requires a change in professional role identity of nurses, the latter referring to how people define themselves in terms of what they do (Chreim, Williams, & Hinings, 2007; Pratt et al., 2006). Such a professional role identity is to a large extent developed during the socialization of nurses during their training (Goodrick & Reay, 2010), though socialization continues once nurses start working by means of encounters with colleagues and supervision by managers. In addition to acquiring technical skills and capacities and social skills during their training, nursing students are educated about their own tasks and responsibilities as a member of the occupational group. Expectantly, this includes attention to the relationship with, and responsibilities of, important referent audiences and other stakeholders, like informal caregivers, in the caregiving process. Simultaneously, a prerequisite for doing so is that the educational programmes of nurses are aligned with changes and expectations in the wider institutional environment, for example with regard to formally allowed tasks and responsibilities. This, in turn, requires tuning between policy-makers, education institutes, professional associations, actors in home-care organizations, and perhaps even insurance companies. The current bachelors programme of
community health nurses, called “Nursing 2020”, provides a promising example in that it was developed by means of a close cooperation between these various key actors and stakeholders. However, it remains to be seen to what extent the professional role identity of its first graduates in 2020 aligns with tasks and roles envisioned in government policy as well as ongoing societal developments more broadly. Besides, at present, the training programmes of vocationally trained nurses have hardly received reconsideration in this regard (Hamers et al., 2012). Yet, such a reconsideration is indispensable, because due to the nature of their work as well as the current division of tasks and responsibilities between nurses trained at different levels, vocationally trained nurses spend most time in a client’s home. Consequently, they presumably have a vital role in furthering informal caregiver involvement.

With regard to the repositioning of community health nurses, there seemed overall agreement that it was needed and important that this occupational group – in the words of some respondents – was “put on a pedestal.” Yet, considering the considerable changes in the home-care sector, affecting a far broader range of occupational groups, one may question this (initial) somewhat partial focus on this particular occupational group. That is to say, if one occupational group is put on a pedestal, others may stand in its shadow feeling neglected. The quote from an auxiliary nurse below, addressing a representative from the Ministry of Health, shows how this actually happened with regard to auxiliary nurses:

“I myself work in the home-care sector [...] [where] actually a large part of auxiliary nurses work. And particularly with regard to the home-care sector, this occupational group is hardly discussed. When I see and hear Secretary of State Schippers or State Secretary Van Rijn, they are always talking about community health nurses. Our experience – I’m 55 years old and probably a seasoned worker, a lot of us I think – is disregarded and so much is taken from us! [...] I feel slighted and underappreciated. So my question to you would be: why is it always about community health nurses, and never about auxiliary nurses?” (Auxiliary nurse, observation, October 2016)

This question was followed by applause and appreciative murmuring by the other 150 auxiliary nurses attending a symposium for their occupational group in which developments in the long-term care sector were discussed. Surely, this is neither to disregard nor question the significance of re-attributing the task of care assessments and allocation to community
health nurses. Instead, it is to emphasize the importance of bearing in mind the position and role of related occupational groups. That is, because auxiliary nurses have also faced enduring institutional complexity and change equally affecting the nature of their work, it is important to also preserve their sense of belonging, which, in turn, is vital for ensuring sustainable employment (Both-Nwabuwe, Dijkstra, Klink, & Beersma, in preparation).

At present, the identified perception of neglect among auxiliary nurses has led the Dutch Nursing Association to organize a so-called “ambassador trajectories” for this occupational group, like the ones (mentioned in chapter five) for community health nurses.21 Like in the trajectory for community health nurses, an important element in the ambassador trajectory for auxiliary nurses is the development of “voice” for members of this occupational group. Voice essentially refers to the capacity to convey in a constructive manner to referent audiences information, suggestions, ideas, worries, and opinions on issues related to work, so as to bring about change (Van Dyne & Le Pine, 1998). In this case, the primary change that is aimed for is a reconsideration and re-appreciation of the indispensable role of auxiliary nurses in the process of care delivery. Yet, while it seems important for various occupational groups to develop voice and convey their occupations’ worth, careful attention and consideration is needed regarding their relative positioning. That is to say, it seems important to ensure that occupational groups strengthen and supplement each other in doing so, instead of suppressing each other. This relates to the above described socialization into a professional role identity of an occupational group, as ideas about who you are and what you do as a member of an occupational group also inform your perception of what members of other occupational groups do (Bucher et al., 2016). At present, collaboration in local contexts is complex and still evolving, which implies that roles and tasks are diverse and are also evolving. It is therefore a great challenge for professionals in care and welfare to find their new professional identities in relation to other professionals who are in a similar situation in a dynamic organizational and institutional context. As touched upon above, attention is thus required as to how the relatedness and interdependence of different occupational groups are

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21 I conducted an ethnographic study on the first trajectory as part of my ongoing research. See the research report by Van Wieringen, Kee, Beersma, Groenewegen & Nies (2018) or the summary (in Dutch) for the general public [Publiekssamenvatting] or the for an overview and the results of the trajectory.
subject to change, while efforts are simultaneously required to ensure their alignment in a dynamic institutional environment.

Finally, as detailed in chapter five, an essential change in the home-care sector in recent years was the re-attribution of the task of care assessment and attribution to community health nurses. Notably, both an increased interest in the past and the actual identification of nostalgia generally “reflects a concern with the speed and scale of change” in present-day societies (Strangleman, 1999, p. 728). This is important as the Dutch health care sector, in particular, is characterized by ongoing dynamics, and recurring waves. As articulated, nurses projected that within a matter of years, the next major change could involve a return to the bureaucratic way of organizing, and result in the atrophy of their autonomy, status and practice domains. In this regard, I suggest that lessons are drawn from ways of organizing in multiple pasts. While specific elements of history “ebb and flow through time” (Hatch & Schultz, 2017, p. 686), people simultaneously tend to forget things selectively. This is shown from the fact that arguments for dismantling the role of community health nurses decades ago were similar to the arguments for their revival. Either way, this indicates that learning from the past should not only pertain to what to revive, but also to (re-)assessing the grounding of decisions taken previously. As such, the findings in this dissertation may entice actors who envision change in ways of organizing to take heed of and (re)consider the rationale that informed both the introduction and dismantling of past ways of organizing. Doing so not only makes decision-makers more conscientious to their predecessors, it may also prevent the introduction of (new) ways of organizing on the same grounds that may later inform the decision to dismantle it, only to return to what was there first.

6.5 Concluding remarks

In this research, I sought to understand how people working in the Dutch home-care sector perceive and act upon institutional complexity and change. Taking an “inhhabited institutions perspective” allowed me to gain a deeper understanding of how the micro-level instantiations of conflicting institutional logics, and their shifts in relative dominance over time, informed actors’ micro-level situated practices and perceptions pertaining to their role and responsibilities. Also it allowed me to develop insight into how actors experience institutional
complexity and change, and how the roused emotions are integral to their practices. In attending to the micro-level, I thus provide conceptualizations of responses to institutional complexity and change that go beyond predominantly cognitive and interest-based considerations with regard to institutional inhabitants. That is, I show the merits of attending to the normative and emotive underpinnings of micro-level responses. Besides, I demonstrate the value of heeding past and present institutional arrangements as well as professional attributes. Doing so contributes to a more comprehensive understanding of the micro-foundations of institutional processes.

Whereas I began my research and entered the field of home-care with a rather straightforward focus and question, I encountered a myriad of theoretical and empirical puzzles and other questions. I have spent about six years studying the Dutch home-care sector, and the long-term care sector more broadly. Like many of my respondents, I am still intrigued, and sometimes puzzled, by its complexities and ongoing developments. Surely, this dissertation shows what was commonly experienced and conveyed across my respondents, that “care is not just about care anymore”. At the same time, I show that most actors engage in purposeful efforts, informed by rational, normative and emotive considerations, to actually make care about care as much as possible. For now, the empirical question remains as to whether current the balance of institutional logics is temporary, or whether it will permeate and solidify in organizational structures as well as micro-level practices and perceptions of the people working in the sector. Therefore, in the coming years, it will be intriguing to see how institutional dynamics in the Dutch home-care sector unfold.