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Professional Values and Managerialist Practices: Values work by nurses in the emergency department

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Abstract

Interest in values work – the purposeful effort of actors to create, maintain and disrupt the values of organizations, professions and other institutions – is growing among scholars. We ask: How do frontline professionals engage in values work while enacting managerialist practices inside organizations? We investigate this question using a case study of nurses enacting managerialist practices associated with time-efficient work flow in a hospital emergency department in Australia. Our findings show that professionals engage in values work by categorizing the values of the profession and taking actions within the managerialist practice to (1) defend a superordinate value category, (2) contain erosion of a subordinate value category, and (3) integrate a basic value category. Our study brings attention to how multiple values complicate the processes of values work when particular values become implicated in organizational practices. Frontline professionals become motivated and take actions to accomplish values within a relational system of multiple values according to relative importance and relevance to the local context. Our study offers a way forward for understanding the performance of values work within the 'new normal' for professions in contemporary organizational contexts.

Keywords

health care, hospitals, institutional theory, institutional work, practices, professions, qualitative research, values

On a busy afternoon in the emergency department, nurses hustle to perform clinical and administrative tasks needed to treat patients within the government's time target of four hours. A senior nurse settles an agitated patient while a junior nurse takes a blood sample. Glancing along the corridor where other nurses are busy documenting clinical observations, recording times in the hospital's information system, and moving patients into and out of bed cubicles to comply with the time target, the junior nurse demands, 'Why do they make us work this way?' The senior nurse replies, 'There is no *they*. Doctors and nurses

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> designed this work model together and evidence shows patients have better outcomes when they spend less time in emergency departments.' The junior nurse nods at the sea of patients, 'But how can we be doing good, nursing like this?' The senior nurse counters, 'How can we not? We're emergency nurses and that means providing timely care for patients. It's up to us to figure out ways to realize our professional values in the emergency department.' (vignette from fieldnotes)

In a changing world of professional work, scholars have recently called attention to the importance of values work undertaken by individual professionals to live out the values of professions in their everyday work inside organizations (Kraatz, Flores, & Chandler, 2020; Wright, Meyer, Reay, & Staggs, 2020; Wright, Zammuto, & Liesch, 2017) and the challenges of accomplishing values in contexts with competing managerialist values and priorities (Chatelain-Ponroy, Mignot-Gérard, Musselin, & Sponem, 2018; Croft, Currie, & Lockett, 2015; Kraatz, Ventresca, & Deng, 2010). Professions emerged historically as societal-level institutions that were committed to the values of using expert knowledge and autonomy to act for the interests of clients and for the greater good of society (Abbott, 1988). Shifts in the organization of professional labour over recent decades have led to many professionals in healthcare, education and other fields being employed by large corporations and public sector bureaucracies designed to achieve profit and/or efficiency goals (Brock, 2006; Muzio, Brock, & Suddaby, 2013). Research shows that these organizations often implement managerialist practices that fuel work intensification, create deskilling, and prioritize task standardization over professional autonomy in ways that compromise values of frontline professionals (Kirkpatrick, Ackroyd, & Walker, 2005; Radnor & Osborne, 2013).

Implicit in much of this extant research are two assumptions. First, research tends to assume that managerialist practices are imposed on frontline professionals by an organization's management (Bolton, 2004; Doolin, 2002). Even studies of hybrid professionals, which blend managerial and professional obligations and identities, imply that professionals require some level of management authority to protect their work from encroaching managerialism (Llewellyn, 2001; Noordegraaf, 2015). Second, research often implies an either/or outcome (Currie, Burgess, & Tuck, 2016). Either an organization's goals are attained at the expense of the values of a profession (Bolton, 2004; Chatelain-Ponroy et al., 2018; Kraatz et al., 2010) or professionals act autonomously and potentially undermine organizational goals (Doolin, 2002; Martin, Currie, Weaver, Finn, & McDonald, 2017; van Wieringen, Groenewegen, & Broese van Groenou, 2017).

Yet, as our opening vignette illustrates, these two assumptions conceal an alternative possibility for interplay between managerialist practices and professional values inside organizations. Hospital management did not impose managerialist practices, which efficiently organized patient care routines in the emergency department to meet a government time target, on disempowered frontline professionals. Instead, frontline doctors and nurses developed these practices themselves to achieve both the hospital's efficiency goals and their professional values of better patient care. When faced with the everyday practical realities of implementation in a busy emergency department, emergency nurses 'figure out' values accomplishment in and through their work enacting managerialist practices. We propose that this figuring out represents 'values work', a form of work in which individuals and organizations purposefully invest effort to affect their social-symbolic context (Gehman, Trevino, & Garud, 2013; Kraatz et al., 2020; Phillips & Lawrence, 2012). Values are defined as 'conceptions of the preferred or the desirable, together with the construction of standards to which existing structures or behaviors can be compared and assessed' (Scott, 2008, p. 54). Values work draws attention to the activities through which values are performed in organizations (Gehman et al., 2013), the individual and collective efforts that maintain the values of professions inside organizations and resolve value conflicts (Gill & Burrow, 2018; Wright et al., 2017), and the strategic, political and emotional deployment of values to disrupt and change organizational fields (Vaccaro & Palazzo, 2015; Zietsma & Toubiana, 2018).

Emerging only recently in the literature, values work offers a means for deepening understanding of how frontline professionals make sense of and navigate potential value conflicts between professions and managerialism which play out inside contemporary organizations (Kirkpatrick et al., 2005; Martin et al., 2017; Noordegraaf, 2011). While some researchers have approached values work as performances associated with specific values-based practices like honour codes (Gehman et al., 2013) and grassroots organizing (Daskalaki, Fotaki, & Sotiropoulou, 2019), others have begun to explore values work as different actions taken by professionals and other actors to accomplish, protect and defend values by resolving episodic and systemic problems that arise between values and organizational practices more broadly (Vaccaro & Palazzo, 2015; Wright et al., 2017). While this latter research hints at a potential role for values work in enabling frontline professionals to reconcile managerialist practices as a normal part of the everyday work of modern professionals (Noordegraaf, 2011, 2015), much deeper understanding is needed. We ask: *How do frontline professionals engage in values work while enacting managerialist practices inside organizations?*

We investigate this question using a case study of the values work of nurses as they enact managerialist practices in a public hospital emergency department in Australia. We focus on emergency nurses as the frontline workers at our field-site hospital who performed standardized tasks to efficiently assess and move patients into, through and out of the emergency department to meet time-based performance targets. Collecting and analysing interview and observational data, we illuminate the values work undertaken by emergency nurses to live out three specific values of the nursing profession – patient safety, humanistic care and practitioner expertise – within managerialist practices in their situated context. Our findings show how professionals engage in values work by categorizing the values of the profession and taking actions to defend a superordinate value category, contain erosion of a subordinate value category, and integrate a basic value category. Superordinate values are prioritized as being of over-arching importance, while subordinate values are positioned as being of lesser priority in relation to them. Basic value categories give meaning to both superordinate and subordinate value categories. In our findings, patient safety is a superordinate value category, humanistic care is a subordinate value category to patient safety, and practitioner expertise is a basic value category that sustains the other two value categories.

Our study makes two contributions. First, we offer nuanced insight into how values work plays out as part of the normal work of frontline professionals when they enact managerialist practices. Specifically, we identify six actions that professionals can use to defend, contain and integrate multiple value categories when experiencing tensions between professional values and managerialist practices at the organizational front line. Second, we extend the emerging literature on values work. Missing in this scholarly conversation is recognition that people in organizations have multiple values and must make trade-offs between them. Our study brings attention to how multiple values complicate the processes of values work when particular values become implicated in organizational practices. Our theoretical model shows how values work is activated and accomplished within a relational system of multiple values according to relative importance and relevance to the local context. Our study offers a way forward for understanding the performance of values work within the 'new normal' for professions in contemporary organizational contexts, advancing beyond professional resistance and hybridity to engage with efficient and quality organizing as a normal part of professional work (Noordegraaf, 2011, 2015).

Theoretical Background

In post-industrialized societies, professional work has been taken over by corporate forms that are large, hierarchical and performance-focused (Brock, 2006; Muzio et al., 2013). When professional work first shifted away from traditional partnership forms of organizing, sociologists noted the

incompatibility between a profession, which responds to authority based on expertise, and an organization, which is characterized by authority based on hierarchical position and restrictions on professional autonomy (Hall, 1968). It follows that the potential for values-based conflict between organization and profession arises when bureaucracies expect professionals, as employees, to put the organization's interest ahead of the interest of clients (Roberts & Donahue, 2000). Bureaucratic structures were subsequently adapted to recognize the professional's expert knowledge by allowing for decentralized autonomy, non-standardized work and little hierarchical control, and by emphasizing collegiality in coordinating and regulating work practices (Mintzberg, 1993).

More recently, potential for values-based conflict between organization and profession has grown following the implementation of managerialist practices inside organizations (Kirkpatrick et al., 2005; Muzio, Kirkpatrick, & Aluack, 2020). These practices focus on structuring the work of professionals to promote organizational productivity and economic efficiency. Managerialist practices associated with New Public Management and lean management, for example, have been applied to organize the work of professionals in public sector organizations including hospitals, schools and universities (Farrell & Morris, 2003; Hallett, 2010; Radnor & Osborne, 2013). Managers proactively manage and control the work of professionals through target setting and performance reviews, while governments demand external accountability through policies and regulations (Chatelain-Ponroy et al., 2018; Doolin, 2002). Sociologists caution that these trends mean professions have become 'vulnerable to market and bureaucratic forces and less able to resist their pressure toward the maximization of profit and the minimization of discretion' (Freidson, 2001, p. 220). Research has drawn attention to how managerialist practices undermine professional autonomy and prioritize 'secondary' aspects of service such as organizational efficiency and reputation over traditional professional values of service to the client and society (Brint, 1994; Brock, 2006; Croft et al., 2015).

As the application of managerialist practices to professional work intensifies, scholars have called for investigation of how the social trustee values of professions can be preserved as today's professionals try to mediate between organization and profession in their everyday work (Muzio et al., 2013). Community wellbeing is enhanced when professionals can be trusted to act in their workplaces in values-oriented ways (Evetts, 2013) and to protect and serve the interests of 'patients, students, pupils, clients' in an 'autonomous yet committed' manner (Noordegraaf, 2015, p. 187). At the same time, professions are only one of many stakeholders in organizations, which must accomplish performance goals to ensure ongoing survival. Three lines of inquiry offer insights into the interplay between professional values and managerialist practices designed to achieve organizational goals.

The first line of inquiry examines how professionals defend values by resisting the intrusion of managerialist practices. Research shows that professionals can draw upon their expert knowledge and legitimacy to challenge practices perceived as undermining professional values and the standards for their achievement (Suddaby & Viale, 2011). Being required to implement managerialist practices that conflict, for example, with social trustee values of protecting the welfare of students, patients and clients may motivate resistance from professionals working in public sector organizations in education (Hallett, 2010; Kirkpatrick & Ackroyd, 2003), health care (Doolin, 2002) and social work (Harlow, Berg, Barry, & Chandler, 2012). Resistance may be active, such as when academics oppose performance-based management in public universities (Chatelain-Ponroy et al., 2018) or when medical professionals defend professional values from economic rationality (Dent, 2003). Other forms of resistance are covert, such as when nurses comply symbolically with a managerialist practice but decouple it from their everyday practice of caregiving (van Wieringen et al., 2017). Professionals can also resist by attempting to 'wriggle out' of elements of managerialist practices that seek to control their work in ways that undermine professional values and identity (Thomas & Davies, 2005, p. 700).

The second line of inquiry explores how professionals protect values from managerialist practices through hybridization of professional work. Rather than being resistant, hybrid professionals make sense of contradictory elements of professionalism and managerialism by recombining them in a more positive way (Blomgren & Waks, 2015). Hybrid professionals who move into management positions can design managerialist practices to align organizational goals with professional values (Farrell & Morris, 2003; Wright et al., 2016). In hospitals, for example, clinicians may take on management roles to mediate between management needs for resource efficiency and the values of health professions as 'the guardians of patients' interests' (Llewellyn, 2001, p. 607). Nurses in middle management positions can engage in translation work to ensure managerialist practices are implemented at the clinical front line in ways that protect professional values of patient care (Spyridonidis & Currie, 2016).

The third line of inquiry takes a different point of departure. Whereas the previous two lines of inquiry assume that professional and managerial values are inherently contradictory and must be either resisted or hybridized in 'unnatural and uneasy combinations', the third line of inquiry contends that organizing is a 'normal and natural' part of work for modern professionals (Noordegraaf, 2015, p. 197). As our opening vignette illustrates, 'new values [of, for example, speed and efficiency] are not coming merely from organizational and managerial surroundings – they are becoming part of professional work' (Noordegraaf, 2015, p. 197). This third line of inquiry takes this practical reality as its starting point (Noordegraaf, 2011). Moving away from resistance and beyond hybridity, the repertoire of professionals at the front line of contemporary organizations includes dealing with contradictions as a normal part of the job to meet the needs of patients, students and clients in a safe, efficient, and quality manner (Noordegraaf, 2011, 2015).

This third line of inquiry opens up values work as a potential avenue for modern professionals to live out professional values while performing managerialist practices inside contemporary organizations. Converging with growing interest in values work among organizational scholars more generally (Gehman et al., 2013), scholars have begun to concentrate attention on values work associated with the values of professions and other institutions (Kraatz et al., 2020; Zietsma & Toubiana, 2018). Wright et. al.'s (2017) study, for example, focused on how emergency physicians engage in values work to maintain the values of the medical profession in their everyday situated interactions with other specialists, with a later study highlighting values work during the Ebola pandemic (Wright et al., 2020). Gill and Burrow (2018) explored how the value of haute cuisine is maintained at the micro level through the values work of chefs experiencing fear.

Interest in values work undertaken by members of professions resonates with seminal conceptions of institutions as constituted by values (Kraatz & Flores, 2015; Kraatz et al., 2020) and is ripe for further development. While research suggests the experience of a threat to professional values will motivate individuals to engage in values work (Wright et al., 2017), it is unclear how this values work plays out when professional autonomy is constrained by compliance with a managerialist practice. What is also uncertain is how professionals balance multiple values and priorities when engaging in values work because 'institutional orders generate values which cannot be traded off against alternatives' (Friedland & Alford, 1991, p. 235). Given that 'professional values are defended and maintained or lost' in locally situated organizational contexts (Noordegraaf, 2011, p. 1356), we ask: *How do frontline professionals engage in values work while enacting managerialist practices inside organizations?*

Research Context

We examine our research question using an empirical case of emergency nurses who work at an emergency department in a public hospital in Australia which organizes service delivery using a

specific set of managerialist practices called Enzyme. The acronym ENZYME stands for 'Evaluating in Narrow Zones to Yield Managed Egress' and reflects narrow time and space zones for assessing, treating and discharging patients who present to the emergency department with acute illnesses and injuries. As a bundle of clinical and administrative routines, the design of ENZYME is informed by queuing theory (Gross, Shortle, Thompson, & Harris, 2008) and the theory of constraints (Goldratt, 1990). These theories are commonly characterized as managerialist because they emphasize organizational efficiency and economic rationality by standardizing work practices and removing obstacles caused by inefficient utilization of resources and skills. As described in our opening vignette, emergency doctors and nurses at our field-site ED designed the Enzyme model to re-organize their frontline work when the Australian government imposed a four-hour time target on public hospital EDs to reduce patient waiting times (Wright et al., 2015). Each day, around 220 people with acute illnesses and injuries present to the field-site ED and are triaged by an emergency nurse, who streams them to one of three spatial areas: (1) a resuscitation area for patients with immediately or imminently life-threatening illnesses and injuries; (2) an acute area for patients with potentially serious conditions; and (3) a fast track area for patients with minor conditions who can be treated quickly and discharged (Wright et al., 2016).

The goals of Enzyme are to quickly and safely move emergency patients triaged to the acute spatial area into, through and out of the emergency department to meet the government's time-based performance target. Enzyme sub-divides the overall four-hour target into smaller two-hour windows and separates the acute spatial area into hot and cold zones. In the first two-hour window, senior emergency physicians assess patients as soon as they arrive in the hot zone and initiate clinical investigations with the support of small teams of nurses and junior doctors to make a binary decision about whether the patient should be discharged or admitted to hospital. For discharged patients (which comprise around 80% of all ED patients), the second two-hour window is used to finalize investigations and treatment in the hot zone before the patient goes home. For admitted patients, the second two-hour window is used to facilitate patient admission to a specialist hospital ward, with stable patients moved from the hot zone to the cold zone to await transfer to the ward. If a patient is expected to recover sufficiently to be discharged from hospital within 24 hours, an emergency physician can choose to admit the patient to the ED's own short stay unit.

Emergency nurses assigned to work in the acute hot zone perform a high volume of standardized and relatively routine tasks at fast pace within the two time windows to meet the overall performance target. They also take responsibility for most of the administrative tasks of recording in the ED database the times when various patient-related tasks are performed and for moving patients through the different zones to operationalize the clinical decisions of emergency physicians. In this way, Enzyme requires nurses to take responsibility for aligning quality care and efficient care in ways that accomplish multiple values of the nursing profession and the public hospital as an organization.

Thus, the Enzyme model, as enacted by emergency nurses, offers a compelling case study for investigating our research question. Prior research highlights the key role that nurses play in frontline patient care delivery (Bolton, 2004; Carvalho, 2014; Currie & Spyridonidis, 2015; van Wieringen et al., 2017) and their commitment to the profession's values (Goodrick & Reay, 2010; Schmidt & McArthur, 2018). Core values that anchor the training and work practices of the nursing profession globally include altruism, autonomy, competence, human dignity, integrity, honesty and social justice (Fahrenwald et al., 2005; Martin, Yarbrough, & Alfred, 2004; Schmidt & McArthur, 2018). These values are explicitly defined and elaborated for the Australian context in the *Code of Professional Conduct for Nurses* (2008) and the *Code of Ethics for Nurses* (2008). These codes express values associated with the exercise of safe, competent, informed, ethical and reflective nursing practice that maintains ongoing trust and confidence in the profession. Specific value statements

relate to: provision of quality nursing care for all people; respect and kindness; diversity; access to care; informed decision making; safety in nursing and health care; ethical management of information; and a socially, economically and ecologically sustainable environment promoting health and wellbeing. Commitment to these multiple professional values suggests emergency nurses will engage in values work as they enact Enzyme, affording an opportunity for empirical investigation of how and when values work resolves tensions and contradictions between professional values and managerialist practices as a normal part of everyday work at the organizational front line.

Method

The data for this paper were collected as part of an ongoing programme of research about professional work and managerialism at a field-site emergency department (ED). The ED is attached to a large public hospital and is located in an Australian city. The primary data sources for this paper involve interviews and observations. We conducted 30 in-depth semi-structured interviews, which included interviews with 29 nurses who worked in the ED and one interview with the physician who manages the ED and led the development of Enzyme. In these interviews, nurses described the impact of Enzyme routines and practices on their everyday work, the challenges and conflicts they experienced when trying to live out the values of the nursing profession within Enzyme, and how they responded. To observe these challenges and responses in everyday practice in real time, we also collected 200 hours of observational data shadowing nurses and doctors performing Enzyme routines and practices in the acute hot zone of the ED. Observations were handwritten as fieldnotes and typed up at the end of an observational shift. We also collected background information about the nursing profession, the organization and Enzyme through supplementary data sources by: (1) attending nurse in-service meetings and training workshops; (2) reviewing archival material including Enzyme protocols and flow diagrams, hospital annual reports, organizational charts, a nursing handbook, codes of conduct and ethics for the nursing profession, training videos and ED newsletters; and (3) interviews with 25 emergency physicians in which we asked about the role of nurses within Enzyme.

Data analysis followed established procedures for building theory inductively from qualitative data by moving iteratively between the multiple sources of data and emergent themes (Corbin & Strauss, 2008). We used NVivo software to assist with data analysis, which proceeded in four stages. In the first stage, two authors open coded the nurse interviews and observational fieldnotes by grouping together text segments that expressed similar concepts. While the general nursing literature and professional codes of conduct and ethics had sensitized us to a variety of professional values that might be in play, as we coded the data we noticed that nurses perceived three values to be most important when working with Enzyme in the fast-paced ED context. We tentatively labelled these values as patient safety, humanistic care and practitioner expertise. Using the constant comparative method of comparing iteratively within and across the nurse interviews and observational fieldnotes, we developed tentative first-order concepts about the various actions nurses took to navigate tensions between these three values and Enzyme (Corbin & Strauss, 2008).

In the second stage, we uncovered deeper patterns in our data through axial coding. Struck by how nurses understood the three values in relationship to each other within the situated context of the ED, we consulted the literature on systems of value classification for guidance (Schwartz, 2012). Distinctions between superordinate, subordinate and basic categories were helpful for making sense of our data (Barsalou, 1991). We speculated that when nurses worked with Enzyme, they invoked a relational values system in which patient safety was judged as a superordinate category of over-arching importance, humanistic care was a subordinate value category to safety, and practitioner expertise was reminiscent of what the literature labels a basic category because it gave

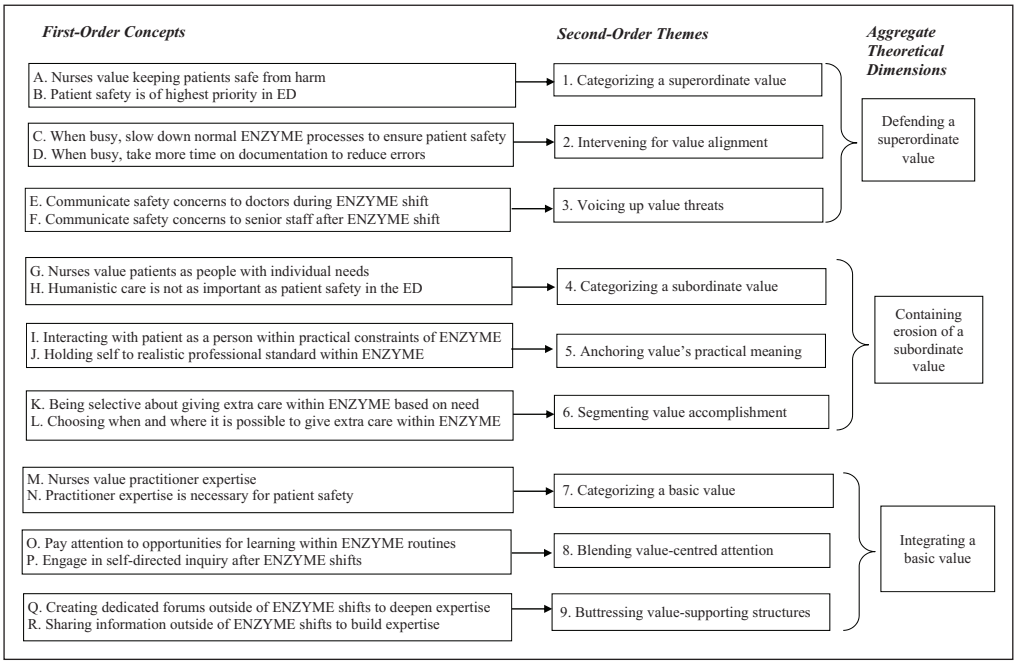

Figure 1. Structure of Data Analysis.

meaning to both safety and humanistic care. Through constant comparison of interview and field-note data, we teased out the tentative links between our first-order concepts to derive second-order themes associated with superordinate safety, subordinate humanistic care and basic practitioner expertise. We then revisited the interview and observational data to verify and elaborate our interpretations of how nurses responded when they perceived and felt tension between a particular value category and Enzyme. Speculating that these actions constituted 'values work', we developed and refined, through discussion and agreement, theoretical labels for the types of actions associated with values work directed at living out each value category.

In the third stage, we collapsed the second-order themes into three aggregate dimensions that captured the overarching forms of values work in our data. We theorized that nurses engaged in these particular forms of values work when they perceived the presence of heightened tension between a value of the nursing profession and Enzyme which they felt a responsibility to resolve. We labelled these forms of values work as defending a superordinate value, containing erosion of a subordinate value, and integrating a basic value.

Finally, in the fourth stage, we improved the interpretive rigor of our findings by using the supplementary data sources to verify and deepen our emergent understandings of the three value categories and the values work that nurses used to defend, contain and integrate them within Enzyme. Figure 1 presents the final structure of our data analysis. In the presentation of our findings, we use identifier codes (N1 to N29) to distinguish individual participants in our nurse interviews. Physicians are identified as D.

Findings

Our findings show that emergency nurses relied upon values work through categorization to make sense of Enzyme and live out the values of the nursing profession. This entailed separating values

into three distinct value categories and ordering each category by its relative importance in the organizational context of an emergency department. The three value categories were (1) patient safety as a superordinate value, (2) humanistic care as a subordinate value and (3) practitioner expertise as a basic value which sustained the other two categories. Nurses engaged in values work within the Enzyme model through a repertoire of actions to protect the superordinate value category, contain erosion of the subordinate value category, and integrate the basic value category. Below, we explain in detail the particular actions taken by emergency nurses within each form of values work.

Defending a superordinate value

The nursing profession is committed to the value of patient safety, which is expressed in 'the age old [ethos], first do no harm' (N1). Patient safety encompasses preventing harm to patients, identifying hazards and patient deterioration, and reducing risks of avoidable errors and adverse events. Because people present with undiagnosed illnesses and injuries that are potentially life and limb threatening, patient safety is foundational to quality care in emergency nursing.

Our analysis shows nurses interpreted the Enzyme model as having the potential to support patient safety by ordering time and space in the ED to facilitate patient flow. Some nurses were aware of research showing that timely and accurate assessment is a critical factor in keeping emergency patients safe from harm. As a nurse explained, 'If patients can move quicker through the ED, have less complications, be referred to the right places, and as long as we're effective, efficient, and accurate, I think that's the best thing for the patient' (N21). Other nurses emphasized how the 'theory' underpinning the Enzyme model is consistent with increased patient safety: 'looking at Enzyme as a sort of big picture, it can work, which is great' (N13).

In practice, however, conditions in the ED were not always ideal for the model's implementation. On busy shifts, excess patient demand stretched the capacity of staff and physical resources. When this occurred, moving a high volume of patients quickly through Enzyme's spatial zones to meet time targets created threats to safe care through missed symptoms, incomplete investigations, obliviousness to patient deterioration, and miscommunication at nursing handovers. This potential misalignment between Enzyme and the value of patient safety was apprehended cognitively and affectively by nurses. They perceived that an overcrowded ED with backlogged patient flow 'is just a safety nightmare' (N3) when working within the narrow temporal and spatial prescriptions of the Enzyme model and they feared for 'everybody's safety if you have a heap of patients in the corridors' (N5). A nurse explained:

> On a very busy day, especially under the Enzyme model, you can just feel this weight on your shoulders because instead of worrying about your sickest patient, you're worried about getting people in and out as quick as possible and that's where things go wrong and get missed. (N19)

Categorizing a superordinate value. Our data indicates that emergency nurses made sense of their experience of living out the profession's values in Enzyme by categorizing patient safety as a superordinate value. A nurse explained, 'Patient safety obviously has to be key, so making sure that things are done in a safe manner is always a priority and always the focus' (N10). Another asserted, 'I think in ED and as individuals, we're more focused on patient care and making sure everything's done and everyone's safe' (N4). In our fieldnotes of busy shifts, nurses spoke about being concerned about patient safety above everything else.

When nurses perceived and felt tension between safe care and enacting Enzyme, our data show they took two types of action to defend the superordinate value as a natural part of their frontline work. These were intervening for value realignment and voicing up value threats.

Intervening for value realignment. Nurses who felt that situated capacity constraints were compromising Enzyme intervened in the normal flow of the model's routines to realign the model's time prescriptions with the nursing profession's patient safety priorities. These interventions targeted the tempo of work by 'slowing things down and making sure that everything's done step by step, even if you are pushed for time' because if 'people are so focused on the Enzyme numbers things get missed . . . and it's unsafe' (N5). Nurses became 'quite meticulous in terms of documenting everything' (N11) to reduce potential errors from miscommunication and took extra time to 'get everything done for that patient before I move them anywhere because I think that's safer' (N4). A nurse explained, 'I say to myself take that extra five minutes now . . . [otherwise] at some point there is going to be some confusion' and potentially unsafe care (N22). These situated interventions also realigned Enzyme with the superordinate value of patient safety by supporting nurses to manage fatigue, which could contribute to errors and adverse events. We observed in our fieldnotes, for example, an experienced nurse on one particularly busy shift performing tasks prescribed by the Enzyme model at relentless pace. After inserting yet another patient cannula, the nurse stopped and said to the other members of the nursing team, 'Enough. I physically can't go any faster. It's not safe. We have to slow down even if we don't meet the Enzyme times' (fieldnotes).

Voicing up value threats. In addition to intervening for value realignment, nurses defended the superordinate value of patient safety through voicing up value threats. When a nurse perceived that enacting the normal routines associated with Enzyme might pose a risk of harm to a particular patient's care, they voiced up by communicating their concerns to doctors and other senior staff. A nurse might voice up concerns, for example, about safely moving a patient to meet the Enzyme target of discharge or admission within a four hour time-frame: 'If people are pushing to move someone out before you think they're ready, you just have to advocate for your patient and say that you don't think it's safe for them to move yet' (N4). Believing that hierarchy should not be an obstacle to maintaining the superordinate value, nurses used voicing up as a means of 'escalating that [safety concern] up to more senior medical staff' (N10). Our fieldnotes show, for example, a nurse approaching a doctor to move a patient from the Enzyme cold zone back into the hot zone for closer observation because of concerns that the patient's condition had become unstable. The doctors we interviewed noted that 'usually the nursing staff have a greater awareness for the patients that are there, and that's a good channel for them to then approach us and ask for treatments to be done' (D2). Another doctor stressed that 'our nurses are much more likely to come up to us to troubleshoot things. . . . and they do a good job at that' (D11). This example of voicing up from our fieldnotes illustrates a nurse becoming concerned that following Enzyme's usual routine is unsafe for a deteriorating patient:

> It is early evening and the ED is crowded. Patients sitting in chairs line the corridor and all of the bed cubicles are occupied. Senior doctor Dr S checks the database which tracks each patient's progress against the four-hour time target, including time from arrival to being seen by a doctor in the hot zone and time to discharge or referral. Seeking to clear some bed cubicles so new patients can be seen, Dr S enacts the Enzyme model. Dr S directs a nurse (N) to move Patient P, who is sitting up in a bed cubicle and has already been examined by a doctor, into a chair, 'Patient P is just waiting on some test results to come back before being discharged. Move P from the bed into a chair and move a new patient into that bed so a doctor can see them.' N moves P into a chair. As another nurse changes the bed linen in preparation for the new patient, N notices that P is now looking very unwell. Concerned, N speaks with P and reports the patient's deterioration to Dr S. 'Can we move P back into that bed? The dizziness has returned and they're not safe to wait in a chair.' Dr S agrees. (fieldnotes)

Together, these actions of intervening for value realignment and voicing up value threats represent values work of defending patient safety as a superordinate value. Our analysis indicates

prioritizing and defending the superordinate value category is an important form of values work for emergency nurses to resolve situated tensions in frontline work involving Enzyme.

Containing erosion of a subordinate value

A core value of nursing as a traditional helping profession is humanistic care. This category of professional value encompasses caring for a patient as a sick and vulnerable person with individual human needs and seeking to understand and attend to those needs and comforts. Humanistic care, as one nurse (N3) emphasized, is 'the whole reason why we're nursing – we're taking care of patients, they're people, they're human beings'. Another nurse explained, 'I like to remind myself constantly that despite the drama and the hysteria of emergency nursing, the core job of a nurse – at the end of the end – is to provide care for a patient' (N12).

Our analysis shows that emergency nurses sometimes apprehended misalignment between the value of humanistic care and their experiences of Enzyme, particularly on busy shifts in the hot zone: 'It does challenge your professional values' (N14). By shifting the focus of nursing work to timely performance of a standardized bundle of tasks, Enzyme redirected nurses' attention away from humanistic care of individual patients towards flow through the department and 'task-based nursing' (N3). A nurse explained, 'Sometimes we forget when it's so task-oriented [that] the patient is a person' (N20). Describing working within Enzyme on a busy shift, another nurse said 'We just rotate [patients] like a conveyor belt and it feels like you've taken out the love and the care of emergency nursing' (N19). Our fieldnotes show that on busy shifts in the hot zone, 'some of the little comfort care things can get missed' (N5), such as getting a patient an extra blanket or a cup of tea. There was also less time for conversations about a patient's holistic and psycho-social needs and for patient education and communication about ongoing care: 'the busier the department gets . . . your communication, your touch, your feel, that sort of stuff goes out the window' (N1). The perceived misalignment between Enzyme and the nursing profession's commitment to the value of humanistic care is illustrated below:

> A nurse (N) retrieves two tablets for pain relief from the medication cupboard. 'We don't get as much time to connect with patients as individuals, to actually provide that care. It's all about flow and moving on to the next task, the next task, the next task,' N tells the researcher as they fill a paper cup with water and hurry back to the patient. (fieldnotes)

Categorizing a subordinate value. Our data shows that emergency nurses made sense of Enzyme by distinguishing humanistic care as a subordinate category of the nursing profession's values and imposing a relational ordering that positioned it beneath patient safety as a value category. They subordinated humanistic care as needing to 'come as a low[er] priority . . . in an emergency setting [where] it's kind of life or limb threatening things' (N11). Compared to ward contexts, where nurses cared for less acutely ill patients for extended stays with higher nurse–patient ratios, 'ED is about brief intervention . . . and that's all it can ever be' (N27). The ED context of high volume, high acuity and rapid turnover of patients placed natural limits on, and subordination of, humanistic care to patient safety, as a nurse explained:

> It's a balancing act . . . trying to achieve our [time] targets and do so in a safe way and still feel like patients are getting the right care that they deserve . . . Whether or not we actually achieve that patient-centred care is variable. If you're very busy, obviously your ability to provide patient-centred care declines, because you don't have time to really interact with that patient on an individual level . . . So it's not necessarily that our emergency department doesn't value [humanistic] care. It certainly does. It's just whether or not we can actually physically achieve that is another question. . . . You're competing with

> these other competing values or requirements, which sometimes really impact upon your ability to [achieve humanistic care]. (N3)

While nurses subordinated humanistic care as a category of professional value relative to patient safety in their organizational context, our data shows that they engaged in two actions to contain complete erosion of the subordinate value: anchoring the value's practical meaning and segmenting value accomplishment.

Anchoring the value's practical meaning. Nurses constructed a practical meaning for humanistic care which served as an anchor for their frontline work within Enzyme. Humanistic care was contextualized as striving to understand and interact with the patient as a person who had presented to the ED 'on a really bad day in their life' and is feeling 'vulnerable and scared and in an unfamiliar environment . . . and in pain' (N25). This practical meaning provided an anchor for nurses to be 'compassionate', 'empathetic' and 'calming' while performing the Enzyme tasks required to get patients assessed and moved quickly to the best place for their care, and to communicate respectfully with patients and their families (N1, N4, N11, N14, N15, N16, N20). Even when a nurse was pushed for time completing tasks to meet Enzyme targets, anchoring prompted the nurse to still 'endeavour to at least touch base, say hello to the patient . . . and acknowledge that they are there' (N16) and to take an 'opportunity to inform the patient about what is going to happen' (N12), as shown below:

> A nurse (N) enters the bed cubicle where the patient (P) is resting, pulling the curtain closed as P opens their eyes. 'How are you feeling?' N asks with a reassuring smile. 'The doctors are still waiting on your tests to come back to decide whether you're okay to go home.' N chats with P and exits the cubicle after less than two minutes, pulling the curtain shut and scurrying off to hook up a bag of intravenous fluids for another patient. Later, N tells the researcher, 'I try to focus on the patient in front of me as if they are the only patient here. No matter how busy it is outside the curtain, they are the most important person to me in those few moments. That's how I'd like to be treated if I was a patient. If I can do that, I figure I can feel good about myself as a nurse at the end of a shift.' (fieldnotes)

As this example illustrates, nurses anchored their frontline Enzyme work in a practical meaning of humanistic care that reflected 'the realities of being an emergency nurse' (N12). Anchoring the value's meaning gave the nurse a realistic 'professional standard' (N16) to hold themselves to personal account and 'have a bit of self reflection' (N1), which helped to contain erosion of humanistic care as a subordinate value category.

Segmenting value accomplishment. The second action emergency nurses undertook to contain erosion was segmenting value accomplishment. This involved selectively carving out opportunities to deliver higher levels of humanistic care to patients without compromising tasks that contributed to timely Enzyme flow and the superordinate value of patient safety. Nurses segmented their frontline practice between Enzyme spatial zones, between shifts, and on the basis of patient need. Our fieldnotes show, for example, that nurses accepted they should offer lower levels of humanistic care during task-focused shifts in the Enzyme hot zone but switched to more person-focused nursing when assigned to work in those Enzyme zones with more clinically stable patients and less patient turnover. A nurse explained, 'You make sure that you do those sorts of [humanistic] cares in the cold zone, you make sure you do those sorts of cares in the short stay unit' (N21) where there is more time for conversations about ongoing care needs, patient education and social chats.

Nurses also segmented their accomplishment of humanistic care to shifts when the ED had excess capacity, with nurses noting 'some days it's easy to provide [person-focused] care because there's not that many patients in the department' (N25). On these shifts, nurses would consciously dedicate 'time to do all the fluffy stuff or make the patient a cup of tea and everything like that and feel like that you're giving fundamental nursing care' (N23). In our fieldnotes, for example, we observed a nurse retrieving an extra pillow for a patient, who said, 'I've also had a chat to two of my patients this morning, which was lovely. I make that a priority when it's not busy because you can't when it is' (fieldnotes). A final example of segmenting value accomplishment pertains to patient need. Nurses identified segments of the patient population in the ED who would most benefit from higher levels of humanistic care and invested more time and effort in personal interactions with these particular segments:

> I think you have to pick your opportunities . . . [for] having a personal connection. Now I restrict that to just the people that I feel like really need it. . . like if they're quite vulnerable, if they're from a marginalized group, or they're alone, or they might be in the end stages of terminal illness, something like that. I try and make sure that those people I spend a lot of time with. (N8)

Our data shows that nurses undertake these actions of segmenting accomplishment of humanistic care and anchoring the value's practical meaning to help contain the value's erosion in their frontline work enacting Enzyme. Nurses use containing erosion of the subordinate value category as a form of values work to live out the values of the nursing profession.

Integrating a basic value

Finally, our data show that emergency nurses were committed to practitioner expertise as a value of the nursing profession. Practitioner expertise represents the normative ideal that emergency nurses should possess up-to-date knowledge and skills and apply them with good judgement to deliver a high standard of evidence-based care. Because high acuity patients present to EDs with undifferentiated conditions, emergency nursing is more demanding than ward nursing with respect to 'having to learn a lot about a lot of different things to be able to care for a patient in emergency' (N12) and be skilled in general patient assessment and 'a master of many things' (N11). Thus, practitioner expertise, as a professional value, is rooted in the identity of emergency nurses as practitioners who are actively engaged in the practice of nursing as a profession that requires special knowledge and education. An emergency nurse is 'not just a hand-maiden' (N1) who does 'the lackey work' (N2) of physicians in the medical profession. Rather, nurses have distinctive professional knowledge to contribute to the patient's journey through the ED:

> 'The profession of emergency nursing is definitely changing. . . . Nursing in a sense has gone from probably 30 years ago as definitely being an under-maiden to [the profession of] medicine. And then I would say probably in the last 15 years, there's a strong drive that we are our own autonomous practice that collaboratively work very well with medicine. . . . We are our own practitioners as well and we do have positive things to deliver outside of just doing jobs for other professions.' (N9)

Our analysis shows that some emergency nurses experienced tension between Enzyme and the professional value of practitioner expertise. While the triage, fast track and resuscitation zones offered scope for autonomous nursing practice and clinical judgement, other Enzyme zones had the least scope for autonomy and the highest demand for nursing staff. When assigned to the short stay and cold zones, nurses cared for relatively stable patients with predetermined

plans who did not stretch assessment skills in emergency nursing (fieldnotes). When assigned to the hot zone regulated by Enzyme's two-hour assessment window, nurses could 'feel like a secretary' (N8) who recorded doctors' plans and 'like a task monkey . . . [because] I'm not using my own clinical judgement' (N26). On busy shifts, our fieldnotes show nurses had to 'bunker down' and move quickly through repetitive tasks. Front-loading the input of senior physicians meant emergency nurses feared 'losing their assessment skills because too much is happening too quickly and doctors are taking control' (N19). While nurses recognized that early physician input was better for patients, emphasis on task-oriented processes and 'factory nursing where you're churning through patients' (N3) created the risk of 'de-skilling' emergency nursing as a profession (N29).

Categorizing a basic value. Our data shows that emergency nurses made sense of Enzyme by discerning practitioner expertise as a basic category of the nursing profession's values and positioning it as necessary for the achievement of the superordinate value category of patient safety and consistent with the subordinate value of humanistic care. Expertise sustained the other two values by 'keeping your patients safe, well-informed, comfortable and providing those basic core skills' (N12). Developing and maintaining skills kept patients safe from harm under the Enzyme model because nurses played an important role in assessing the urgency of patient need and in identifying deteriorating patients. Explaining this categorization of practitioner expertise as a basic value, a nurse said:

> 'I obviously value high quality care . . . and I like the compassionate side of things. . . . Focusing on providing high quality, efficient, thought-through care to good processes is the safe thing to do. . . . Staff that are skilled in assessing very quickly become able to identify the sick at-risk person . . . and you've got plenty of time to do all those fluffy things if you do a really thorough, high quality assessment in the first place of what that person's going to need.' (N15)

Nurses apprehended Enzyme as having the potential to undermine patient safety by reducing practitioner expertise through 'dumbing them down' (N1). A nurse explained, 'There's an underlying fear that the nurses that we're training aren't going to have the skills they need to be safe, that they're just task-oriented' (N8), an outcome that would also be inconsistent with providing humanistic care. Given these concerns, nurses sought to better integrate practitioner expertise as a basic value into their frontline work within Enzyme. This values work comprised two key actions. These were blending value-centred attention and buttressing value-supporting structures.

Blending value-centred attention. Nurses made an intentional effort to pay attention to the everyday clinical situations that arose while enacting Enzyme as a stimulus for learning and a source of self-directed inquiry. They blended attention to deepening practitioner expertise and their priority for safe care within Enzyme by thinking critically about the patient's symptoms in tandem with physician front-loading and trying to predict what tests are needed to investigate them 'before a doctor tells you' (N15). As a nurse explained, 'You're working out in your own mind, similar to what a doctor would do, what [illness] the patient is likely to have and what their ultimate disposition will be and . . . doing it at high pace and a high volume' (N3). Another nurse described striving to 'challenge myself' with clinical cases: 'This person is coming in with A, B and C . . . A, B and C usually is this, and this is what happens' (N24). Working as a member of a nursing team in Enzyme, a junior nurse with less experience could pay attention to developing their own practitioner expertise by 'watch[ing] the senior nurses do something and [asking] . . . Why did you do that? I don't understand,' enabling them to 'learn through challenging' (N6). The example below illustrates how

attention to developing practitioner expertise can be blended into the normal routines of the Enzyme model:

> Noticing the patient with chest pain, a senior nurse SN says to two junior nurses, 'That person's been here and you haven't done an ECG.' They reply, 'Well, the doctor hasn't asked for one.' SN is incredulous. 'Are you for real – because a doctor hasn't asked for it?' SN talks them through what they need to initiate for the patient and why. SN explains afterwards, 'I'm trying to make them think critically. Emergency nurses are not here to diagnose, but you still need to know the path that it's actually taking.' (fieldnotes and N1)

Blending attention to developing practitioner expertise with their normal practice of Enzyme kept nurses alert to unfamiliar experiences and puzzles that arose and motivated them to initiate their own learning and inquiry. For example, a nurse who notices that the needs of a particular patient category are not well serviced under Enzyme could contribute to the evidence base by undertaking a special project to investigate: 'There's lots of different places you can do different projects' (N21). Our fieldnotes show that a nurse wrote an Honours research project on self-harm patients, while other nurses were involved in special projects on mental health, frequently presenting patients and women's health. This self-directed inquiry affirmed professional commitment to evidence-based practice: 'in order to give patients the best possible care . . . we have to be looking at what's been proven to work for them' (N8). Paying attention to situational experiences with Enzyme, such as being exposed to an unusual illness or unfamiliar test, could also motivate self-directed inquiry of the relevant evidence base: 'I maintain my own knowledge through research . . . read a lot of papers and a lot of blogs' (N19). Overall, our data show that blending attention to developing practitioner expertise into everyday experiences with Enzyme helped nurses achieve values work of integrating the basic professional value into their own practice:

> Doing the level of care to a high standard . . . [and] make sure that the care that you give is evidence-based and backed by current literature – so these are the professional values I find important. . . . If I am curious about something or I've looked after someone that day, I could go home and then consult a current textbook that I might have. Or I'll go on to Clinical Knowledge Network at home and just have a look for some current research. . . . You don't always get time to [research current evidence while working within Enzyme] . . . so if I don't have time to do it at work, I'll go home and look it up. (N25)

Buttressing value-supporting structures. A second action that nurses used to integrate the basic value of practitioner expertise was to buttress value-supporting structures around Enzyme. This involved nurses creating dedicated times and spaces outside of the usual practices and routines of Enzyme to share their knowledge and experiences to deepen practitioner expertise. For example, junior nurses used 'that time between when you start a shift, approximately 45 minutes' (N29) to initiate a staff forum, which took the form of an 'information-giving session. . . [or] sometimes we go in with nothing and we get feedback from the group' (N17). Staff forums supported the basic value of practitioner expertise by helping junior nurses to stay up to date with recent research. For example, at one staff forum a nurse spoke about research on asthma and encouraged other nurses to change the treatment they provided for low to medium acuity patients (fieldnotes). Alongside the staff forum, emergency nurses shared findings of clinical trials through the department's social media group (fieldnotes), and used their lunch breaks in the staffroom as opportunities for informal discussions about best clinical practice, such as how often to change a patient's cannula (fieldnotes). By buttressing these supporting structures around Enzyme and blending attention to learning and inquiry within their Enzyme work, emergency nurses integrated practitioner expertise into their

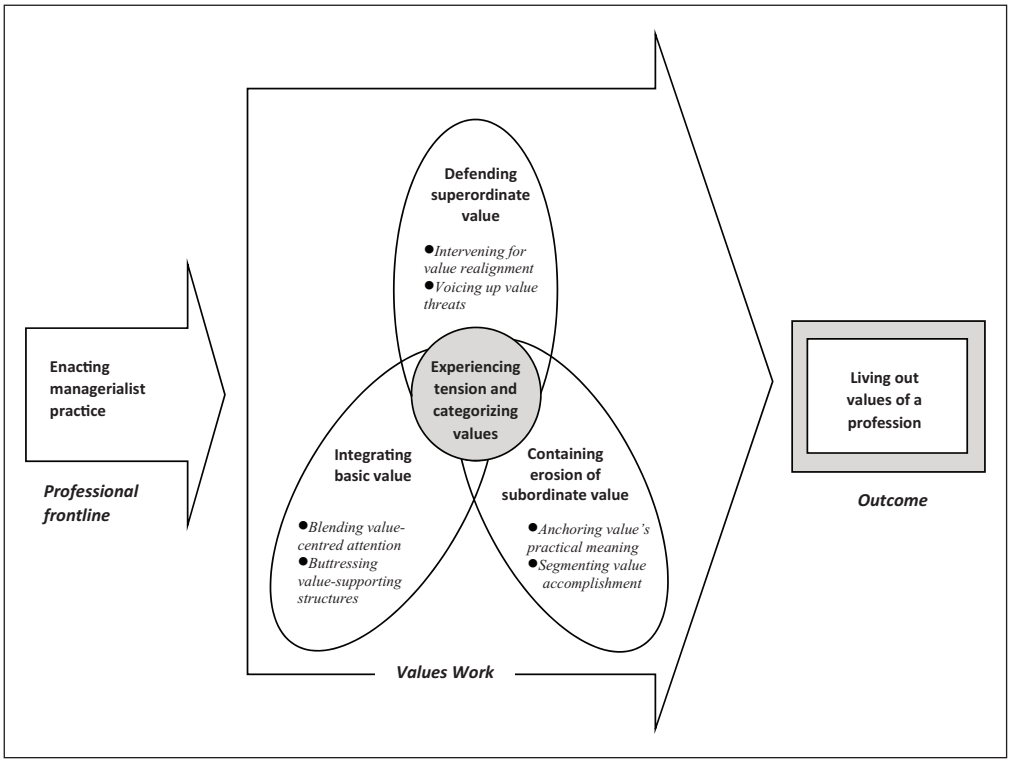

Figure 2. Model of Values Work in Managerialist Practices.

everyday work. Through these actions nurses integrated the basic value category into their experiences of Enzyme as a form of values work.

Discussion

We examined how professionals engage in values work while enacting managerialist practices through a qualitative study of emergency nurses in a hospital emergency department. For the nurses in our study, dealing with situated tensions between efficiency, safety, humanistic care and expert learning through the investment of purposeful effort in values work occurred naturally as a normal part of their everyday frontline professional work. We present the theoretical model that emerged from our findings in Figure 2. Our model shows that when frontline professionals enact a managerialist practice, particular values enter awareness when they are experienced as being in tension with the practice. Accepting that a profession's multiple values cannot be fully and equally accomplished at all times, professionals categorize the values implicated by the managerialist practice based on importance relative to each other and relative to the local context. The most prized values within the local context which cannot be traded off against other values are categorized as superordinate (patient safety is all-important in the emergency department context). Values that are perceived as being able to be traded off against superordinate values in the local context are categorized as subordinate (less humanistic care can be traded off against more safety in a hospital emergency department). Values that are seen as underpinning both superordinate and subordinate values are categorized as basic (practitioner expertise is necessary for patient safety; practitioner expertise

enables humanistic care). This system of values categorization guides a professional's actions in situations when they feel tension between enacting the managerialist practice and a particular implicated value.

To resolve tension, our model shows that professionals are motivated to invest effort in values work to defend a superordinate value, contain erosion of a subordinate value, and integrate a basic value. We illustrate these processes of values work in Figure 2 as three ellipses representing the defending, containing and integrating forms of values work we uncovered in our study. In the upper ellipse, professionals who experience tension between the managerialist practice and a superordinate category of the profession's values can work to defend the value by intervening to realign the practice with the value and by voicing up perceived value threats to higher levels of authority in the organization. In the lower right ellipse, professionals experiencing tension between the managerialist practice and a subordinate value category can work to contain erosion of the value by anchoring its practical meaning within the practice and segmenting value accomplishment. In the lower left ellipse, professionals experiencing tension between the managerialist practice and a basic value category can work to integrate the value by blending attention centred on the value into the practice and buttressing value-supporting structures. The three ellipses overlap at a common centre in Figure 2 to symbolize that the system of superordinate, subordinate and basic values has a shared core in a profession's multiple values and that actions directed at any particular value category can be mutually reinforcing of other value categories. That is, actions a professional predominantly takes to defend, contain or integrate one value category can also help to support other values. Through continuously performing these three forms of values work as a normal and mundane part of their everyday work, our model shows how professionals live out the values of a profession inside managerialist practices.

Our study makes two important contributions to the literature. First, we offer a counterpoint to the literature on professions which has tended to assume that managerialist practices are imposed on professional work (Bolton, 2004; Doolin, 2002; Kirkpatrick et al., 2005) and that these practices achieve organizational goals at the expense of professional values (Chatelain-Ponroy et al., 2018; Croft et al., 2015; Kraatz et al., 2010). Our analysis of the Enzyme case study challenges both of these assumptions. In our empirical case, doctors and nurses – and not hospital management – designed the managerialist practices that comprised Enzyme, while Enzyme's implementation in the emergency department increased organizational efficiency and improved patient outcomes. In contrast to prior research that suggests professionals will resist managerialist practices that undermine values (Dent, 2003; Hallett, 2010; Suddaby & Viale, 2011; Thomas & Davies, 2005; van Wieringen et al., 2017) or take on hybrid roles to protect them (Bévort & Suddaby, 2016; Blomgren & Waks, 2015; Farrell & Morris, 2003; Llewellyn, 2001; Spyridonidis & Currie, 2016), our model illuminates how values work within managerialist practices operates as a normal frontline alternative to professional resistance and hybridization. This theorizing builds on and extends Noordegraaf's (2015, p. 202) view that contemporary organizing trends mean 'acting professionally in an organized way becomes normal work . . . to guard the multiplicity of service quality'. Our study of emergency nurses illuminates how the normal work of acting professionally plays out with and through values work as frontline professionals naturally take responsibility for navigating managerialist practices to absorb them into, and reconcile them with, existing and evolving professional values.

Second, our model contributes to the nascent literature on values work. Although the concept of values work has emerged only recently, a handful of prior studies indicate that values work is performative and involves people and groups 'working' to (re)construct organizational life through purposeful and reflexive human effort to affect the values of institutions, professions and organizations (Gehman et al., 2013; Phillips & Lawrence, 2012; Wright et al., 2017; Wright et al., 2020).

Our findings add clarity to the concept of values work by identifying six types of actions people can engage in as they 'work' to shape relationships between values and practices. Prior studies have tended to approach these relationships through the lenses of collective action and formal change, with values work investigated as encoding and embedding values by creating new practices (Daskalaki et al., 2019; Gehman et al., 2013) and by mobilizing changes to entrenched practices (Vaccaro & Palazzo, 2015; Wright et al., 2017). Our six types of actions in Figure 2 reveal that values work can also affect relationships between values and practices in less formal ways as persons take mostly individual actions to creatively and reflexively live out values within existing practices. The process of values work in our model is also more mundane than is suggested by studies that find moral emotions associated with special problems or extraordinary events can motivate individual and collective effort in values work (Vaccaro & Palazzo, 2015; Wright et al., 2017). Our model sheds light on how values work can be activated by human experience of tension between a value and a practice as an ordinary part of organizational life.

In addition, our study advances the literature on values work by recognizing the presence of multiple values in organizational life, something which has been largely missing in scholarly conversations about values work. Despite scholars in the broader literature highlighting value conflicts and the inevitability of making trade-offs among multiple values (Friedland & Alford, 1991; Kraatz et al., 2020; Schwartz, 2012), the early research into values work has tended to focus on a single value. While this approach has been helpful in fostering an initial understanding of values work as a new concept (Gehman et al., 2013), it has also meant that accounts of values work have mostly ignored the critical issue of how individuals make trade-offs between multiple values. Thus, we contribute to the literature by offering an explanation of performing values work that accommodates multiple values.

Resonating with Schwartz's (2012) work in psychology on value systems, our findings reveal that multiple values enter values work as a relational system that furnishes actors with a repertoire of actions to defend, contain or integrate a value according to its relative importance and relevance in the local context. All nurses in our study had a clear understanding of a superordinate-subordinate relationship between patient safety and humanistic care in an emergency context, while experienced emergency nurses could articulate practitioner expertise as a basic value and sought to socialize novice nurses into this value construction. These findings suggest that the relational system guiding values work in a local context is reasonably stable among frontline professionals who work closely together. We speculate that the position of any single value within a relational system is a social construction that is reproduced over time through shared professional experience and serves as a cognitively efficient guide for values work involving multiple values. Investigation of values work processes involving multiple values in a variety of contexts is needed to explore the stability of these relational value systems across individuals and across time.

While our empirical study was limited to a single case study of professional values in one organizational setting in the public sector, future research could extend our insights about values work to other professional and organizational settings. We expect our model to apply to frontline workers belonging to other caregiving professions in medicine, allied health, education and social work. Researchers could explore generalizability to more business-like professions such as law and accounting as well as professions belonging to culture and the arts. Further research is also needed to unpack the outcomes of values work. Of particular interest is what happens when different professional groups stake a claim to values work when enacting a managerialist practice. Nurses defending values of safe patient care, for example, may be challenged by hospital administrators guarding the standards by which safe care is measured. How do the forms of values work we uncovered accommodate for inter-professional contests over value categories? Moreover, how do professionals respond individually and collectively if continued attempts at

values work by defending, containing and integrating within a managerialist practice prove to be unsuccessful?

These questions are deserving of the attention of scholars because they allude to a more comprehensive understanding of the values work that maintains professions within contemporary organizing (Evetts, 2013; Muzio et al., 2020) and may deepen insight into the interplay of organizing with other elements of professions, such as identities, practices, jurisdictional boundaries and power (Muzio et al., 2013). We invite researchers to continue investigating the role of values work in aligning professional values and organizational goals as a normal part of professional work at the frontline of organizations.

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