

MAINTAINING VALUES THROUGH PERFORMANCE IN DAILY ORGANIZATIONAL  
WORK

by

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ARIZONA

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## ABSTRACT

A small but growing volume of research identifies values work as the *activities through which values are performed in organizations*. Despite contributing to overall knowledge about values in organizations, this budding stream of values work literature has yet to offer insight into how collectives such as workplace organizations maintain, or consistently enact, important but abstract values through the concrete, shared daily work of members. The ability to maintain multiple important values has performance implications for employees, organizations and the communities served by organizations. To better understand how organizations (i.e., collectives of individuals working together towards shared outcomes in the workplace), maintain multiple important values in concrete daily work, I conducted a seven-month ethnographic case study of a radiation oncology center as its team members created individual treatment plans for cancer patients. I found that in most cases organizations maintain core values by engaging in the values work of framing work projects as standard and delegating them to a set of standard means that habitually enact core values with little additional work or effort. However, in some cases, salient concerns result in framing concerning project work as an exception to the standard. In these instances organizations effortfully enact adjusted means to resolve the concern and protect core values or accommodate additional, important but non-core values.

## CHAPTER ONE: INTRODUCTION

A small but growing volume of research identifies values work as the “activities through which values are performed in organizations” (Wright et al., 2021, p. 1436). Starting with Gehman and colleagues (2013) the values work literature stream includes six pieces of empirical research (Espedal, 2020) that provide insight into how important values, or trans-situational, socially desirable conceptions of the preferred, come to be performed in organizations. This literature identifies the practices collectives use to introduce and defuse important values across groups or organizations (Daskalaki et al., 2019; Gehman et al., 2013; Vaccaro & Palazzo, 2015; Wright et al., 2017) and the practices that individuals use to enact, defend and maintain their own important values in their situated daily work (Chan & Hedden, 2023; Wright et al., 2017; Wright et al., 2021).

This growing body of literature adds a performative dimension to the study of values in organizations (Daskalaki et al., 2019). This performative dimension is important because according to both pragmatist philosophy and practice theories, organizational phenomena such as strategy, sustainability, innovation, learning and even values are only brought into existence and sustained in organizations through ongoing activity associated with performance (Feldman & Orlikowski, 2011; Gehman et al., 2013). This focus on the performative aspect of values enactment complements traditional organizational values literature that focuses on measuring values as cognitive essences held in the minds of organizational actors (Bourne & Jenkins, 2013; Gehman et al., 2013).

Despite contributing to knowledge about values in organizations, this budding stream of values work literature has yet to offer insight into how organizations consistently enact, or in other words, maintain the important but abstract conceptual values of members through daily



concrete organizational performance. Consequently, we have little understanding of how important values move from the minds of organizational members and into the concrete work they consistently perform daily. Nor do we understand how members craft daily collective performance to accommodate the multiple important, but abstract values (Bourne et al., 2019) that are conceptually held in the minds of these organizational members.

This gap in knowledge complicates our understanding of values in workplace organizations for two reasons. First, maintaining important values in organizations over time is critical to organizational success. Values maintenance is cited as a vital function of organizational leadership (Bourne & Jenkins, 2013; Cha & Edmondson, 2006). Inside organizations, employees who perceive that their organization is not living up to, or maintaining important values can experience reduced motivation and lower perceptions of job satisfaction (Bao et al., 2012; Cha & Edmondson, 2006). At the organizational level, the inability to maintain the values expected by constituents and stakeholders can threaten an organization's ability to acquire valuable resources necessary for survival (Bourne & Jenkins, 2013). At a societal level, values lost because they are unable to be maintained by organizations may be detrimental to the communities and clients who rely on values-driven organizations for support and assistance (Chatelain-Ponroy et al., 2018; Noordegraaf, 2011).

Second, organizations are sites of multiple values (Gehman et al., 2013), not all of which hold the same level of importance in the minds of organizational members (Wright et al., 2021). This means that performances designed to enact and maintain one value could conflict with performances designed to maintain a different value (Gehman et al., 2013). This could result in the inability to maintain some values that are held in the minds of members as important (Noordegraaf, 2015). It could also lead to conflict among members over which values to

prioritize through performance (Jehn, 1994). In sum, our overall understanding of how values are performed in organizations remains limited without greater exploration of how organizations consistently enact and therefore maintain multiple, abstract values through shared performance in daily concrete work. This research seeks to fill this important gap in values work literature by answering the following two questions:

- 1) How do organizations consistently enact important but abstract values through daily work performance?
- 2) How do organizations accommodate multiple values that may be important in situated contexts associated with daily work?

To answer these questions, I conducted an in-depth, inductive case study of a radiation oncology center. Members of this organization collaborated daily to develop complex radiation treatment plans for cancer patients. Using a qualitative research design informed by grounded theory methodology, I observed the daily planning huddles that team members, including physicians, nurses, social workers, radiation therapists, physicists and others, used to collectively plan radiation therapy for new cancer patients. I also conducted interviews with organizational members. Using these data, I developed a conceptual framework explaining the process and practices members used to collectively enact and maintain several values in their shared, daily, concrete work.

I found two pathways that organizations can take to maintain core values and other important values in concrete, daily work. The first pathway, called *Delegating Values Work to Standard Means*, involves delegating, or handing over values enactment for daily project work that is framed as standard to a repetitive, recognizable pattern of interdependent activities that organizational members can consistently use to perform the work they view as non-concerning,

or standard. Standard means allow organizations to consistently enact core values quickly, or almost automatically, in daily work without a great deal of deliberate effort from members. The second pathway, called *Performing Values Work Using Adjusted Means*, involves effortfully enacting adjusted means for daily project work framed as exceptions. Adjusted means are temporary modifications of standard means to fit the situated needs of concerning daily work. Adjusted means allow organizations to protect core values when use of the standard means threatens their enactment, or to accommodate additional important values that cannot be accommodated under the standard means alone.

My primary contribution to the emerging stream of values work literature is the identification of three practices that, when performed in organizations, allow them to maintain several different values in situated, daily work. The first practice is framing daily project work as standard or as an exception to the standard. This involves communicating about new project work in a way that helps team members understand or view the work as either standard and non-concerning, or as an exception and concerning. The second practice is delegating non-concerning project work to a set of standard means designed to enact core values. The third practice is effortfully enacting adjusted means for concerning project work to maintain core values when threatened or to enact other important, but non-core values. I also add to the larger stream of values literature that traditionally measures values as cognitive conceptions held in the minds of individuals (Bourne & Jenkins, 2013; Gehman et al., 2013) by identifying three observable practices that allow values to be made real through performance and maintained in daily, situated organizational work.

In the next chapter I introduce the topics of values and values work in greater depth. I explore the theoretical roots of values work research and identify existing gaps in the emerging stream of values work literature.

## CHAPTER TWO: LITERATURE REVIEW

### 2.0 Introduction

The goals of this chapter are to introduce the concepts of values more generally, and values work more specifically. I also aim to identify unexplored areas in values work research that warrant additional investigation. I accomplish these goals by first defining values and offering a brief history of their place in organizational research. I then briefly identify the theoretical foundations of values work before exploring the literature on values work in greater depth. I conclude by identifying two important gaps in this growing literature stream. .

### 2.1 Defining Values

As displayed in Table 2.1 below, scholars define values differently. However, three themes are common in these definitions. The first is that values are conceptions of what people want or aspire towards. They are described as “goals” (Perkmann & Spicer, 2014, p. 1082; Schwartz, 1994, p. 21), “conceptions of the preferred” (Rokeach, 1973, p. 5; Scott, 2008, p. 54) or that which is “desirable” (Hitlin, 2003, p. 122; Kluckhohn, 1951, p. 395). Second, desires or goals associated with values are “socially preferable” (Rokeach, 1973, p. 5) normative modes of behavior. They provide guidance about societal or group norms to which humans adhere (Schwartz, 1994) and offer “standards to which behavior can be compared and assessed” (Scott, 2008, p. 54). Third, values are stable and enduring. They are “trans-situational” (Schwartz, 1994, p.21), “fundamental” (Williams, 1967, p. 21) and “wider,” or long-term (Perkmann & Spicer, 2014, p. 1082).

Critical in these definitions of values is the term *conceptions*. Values are considered ostensive, cognitive concepts, or abstract notions about the desirable, that reside in individuals’ minds (Gehman et al., 2013; Kraatz et al., 2020). As abstract conceptions that are difficult to

define, values (e.g., benevolence, achievement, self-direction, conformity, power and universalism) are often measured based on the weight or importance that individuals cognitively assign to them (Schwartz, 1992). Summarizing these many similar definitions, one may consider values to be trans-situational, socially desirable conceptions of the preferred.

Values are often treated by researchers as traits or characteristics that individuals or entire groups possess. Individual values are the trans-situational, socially desirable conceptions of the preferred held by individuals. They are formed in a variety of ways including, needs for survival and social interaction (Schwartz, 1999), biological or genetic similarities between individuals (Kluckhohn, 1951), or childhood experiences (Meglino & Ravlin, 1998).

Group values reflect the values that members collectively view as important (Edwards & Cable, 2009; Schwartz, 1999). Groups range from small collectives of two or more individuals (for example a nuclear family) to larger groups such as organizations, institutions (for example professional societies), communities, and societies (Vaccaro & Palazzo, 2015). These values are often formed through shared socialization practices. These include for example, fraternity initiations, military boot camps, or religious indoctrination programs (Brown & Treviño, 2009; Meglino & Ravlin, 1998). In the workplace, group, or organizational values shared by individuals are thought to be shaped by factors including professional education and training, ongoing socialization and networking through professional associations, the influence of high status and high-powered leaders, and the daily shared work experiences of professionals holding similar backgrounds and experiences (Brown & Treviño, 2009; Kraatz et al., 2020; Wright et al., 2021).

In groups such as organizations, values provide a sense of shared purpose, solidarity and meaning for members (Brown & Treviño, 2009). They reduce conflict when actors' values align,

or spark conflict when values are incongruent (Jehn, 1994). They also offer norms or guidelines specifying how individuals should behave when interacting with others (Chan & Hadden, 2023; Edwards & Cable, 2009). Because the subject of this research is the values of a small organization, for the duration of this manuscript I refer to the shared values held by collectives or groups in the workplace as *organizational values*.

**Table 2.1**

*Definitions of Values*

Author (Year)	Area of Study	Definition of Values
Cha & Edmundson (2006, p. 58)	Organizational Studies	Values are shared prescriptive or proscriptive beliefs about ideal modes of behavior and end-states of existence that are activated by, yet transcend object and situation and as such are abstractions.
Hitlin (2003, p. 122)	Organizational Studies	Values are emotion laden conceptions of the desirable.
Kluckhohn (1951, p. 395)	Anthropology	Values are conceptions, implicit or explicit, distinctive of an individual or characteristic of a social group, of the desirable that influences the selection from available modes, means and ends of action.
Meglino & Ravlin (1998, p. 353)	Organizational Studies	Values are desirable modes of behavior.
Perkmann & Spicer (2014, p. 1082)	Organizational Studies	The wider goals that an actor is trying to achieve.

Author (Year)	Area of Study	Definition of Values
Rokeach (1973, p. 5)	Psychology	Values are enduring beliefs that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence.
Schwartz (1994, p. 21)	Social Psychology	Values are desirable, trans-situational goals, varying in importance, that serve as guiding principles in the life of a person or other social entity.
Scott (2008, p. 54)	Organizational Studies	Values are conceptions of the preferred or desirable, together with the construction of standards to which existing structures or behaviors can be compared or assessed.
Selznick (1957, p. 57)	Organizational Studies	Value denotes something which in the given organization is taken as an end in itself.
Williams (1967, p. 21)	Organizational Studies	Values are fundamental beliefs about what is desirable, good or worthwhile.

## 2.2 History of Organizational Values Research

Values have a long history in organizational studies (Kraatz et al., 2020). Starting in the 1950's, institutional scholars such as Selznick (1957) addressed how values shape the norms and behaviors of organizations, professions and industries. Selznick wrote that values were ubiquitous both in the external environments where organizations operated and within organizations themselves. Consequently, beyond operational performance alone, a critical



function of an organization was to adapt itself to the “values-rich landscapes” in which it operated and to infuse its membership with important values that helped shape organizational identity (Kraatz et al., 2020, p. 474).

In the 1970’s Rokeach defined important values such as benevolence, equity, freedom, and ambition (Rokeach, 1973). In the 1990’s Schwartz (1992, 1994) introduced his theory of values. This theory placed all human values along two continua. The first being humans’ orientation towards individual or collective interests and the second being humans’ orientation towards conformity with rules or openness to exploration and experimentation.

Since then, the largest stream of organizational values-related research focuses on organizational values congruence (Ostroff et al., 2005). Congruence is often defined as the compatibility of work values between a focal person and other organizational entities such as supervisors, co-workers, work groups and an entire organization (Bao et al., 2012; Edwards & Cable, 2009). It is typically measured as employees’ perceptions of how similar these other entities’ values are to their own (Brown & Treviño, 2009).

This literature identifies many positive performance implications of values congruence between employees and their organizations, leaders and colleagues. These benefits include higher job satisfaction, greater intent to stay with an employer, higher levels of workplace wellbeing, greater feelings of work meaningfulness and improved performance (Bao et al., 2012; Brown & Treviño, 2009; Edwards & Cable, 2009; Jehn, 1994).

Interest in values in organizations has increased in recent years. Institutional theorists have again turned their attention to values (Kraatz et al., 2020). An emerging stream of literature seeks to explain the role of values in shaping institutional fields and organizational structure (Greenwood et al. 2011). This work also offers values as an explanation for conformity of

professionals within organizations seeking to comply with the values of their professional fields (Wright et al., 2017) and organizations seeking legitimacy in the larger institutional fields and social systems in which they operate (Kraatz et al., 2020). More recently, Gehman and colleagues (2013) initiated values work scholarship by applying tenets of practice theory to values in the workplace in seeking to better understand how abstract, ostensive values are performed in organizations.

### **2.3 Practice Theory**

Practice theory is a general term for the related stream of many similar theories proposing that to understand a particular social phenomenon one must focus on the processes and practices through which that phenomenon emerges in and through activity (Feldman & Pentland, 2003). According to practice theories, social reality is an ongoing production that emerges through people's actions and is brought into being through everyday practices. Practices are "arrays of human activity, or doings and sayings, that are centrally organized around shared understanding" (Schatzki et al., 2001, p. 2). Practice theories prescribe that organizational phenomena (e.g., strategy, sustainability, innovation, learning) can be best understood through exploration of the practices that bring these phenomena into existence and allow them to be sustained in organizations through ongoing routines (Feldman & Orlikowski, 2011). An organizational routine is a repetitive, recognizable pattern of interdependent actions involving multiple actors (Feldman & Pentland, 2003). As Gehman and others who have written on values work and the practices that accomplish values might suggest, to truly understand values one must focus on the doings and sayings in organizations that bring these values into existence and allow them to be sustained.

## 2.4 Dewey and Values

Ideas around practice theories were shaped in part by the views of pragmatist philosophers such as John Dewey. Pragmatism suggests that reality is found in activity or action, as opposed to “high-minded metaphysics” (Simpson & den Hond, 2022, p. 128). For pragmatists, truth lies in the consequences associated with taking action to solve real world problems (Martela, 2015).

Dewey wrote extensively about values during his career (McDonald, 2011). He noted the term *value* was itself ambiguous. Sometimes it was an adjective describing something, like a “valuable tool,” or a “good plan” (McDonald, 2011). Other times it was a noun “designating an essence” (Dewey, 1925, p. 126), such as compassion, or integrity.

Dewey was less interested in values as essences and more interested in understanding activity that led existences to be of value (Dewey, 1939). He wrote that humans act in ways to achieve valued ends and avoid negative or non-valued ends. Dewey referred to the valued outcomes humans expect to achieve, or the non-valued outcomes humans expect to avoid through activity as *ends in view*. He described the activities through which ends in view are brought about as *means* (Martela, 2015; McDonald, 2011). Dewey further suggested that means themselves are often habitual or instinctual, such as a baby crying for a bottle, or a child jumping for joy over the possibility of getting ice cream. He noted that it is only when means are disrupted from accomplishing an end in view that they are subject to evaluation (Andreson, 2023; McDonald, 2011).

He further noted that the relationship between means and ends is complex. He argued the two do not occur sequentially, or linearly. Humans, Dewey believed, do not simply start with an

end in mind and work to achieve it. Rather, humans lack a complete conception of ends until they understand the course of action to lead them there (Anderson, 2023; McDonald, 2011).

In sum, practice theories and the pragmatist views that shaped them suggest that values do not necessarily exist entirely as abstract, cognitive conceptions, but are found in performance, and realized through activity. It is this perspective that inspired research into values work.

## **2.5 Values Work in Organizations**

A growing volume of literature has emerged over the past decade calling attention to the importance of values work in organizations. This literature started with Gehman and colleagues (2013), who sought to understand how important values came to be practiced in organizations. The authors offered the term *values work* as the “work that is going on at any moment as values practices emerge and are performed” (Gehman et al., 2013, p. 102). They additionally defined values practices as “the sayings and doings in organizations that articulate and accomplish what is normatively right or wrong, good or bad for its own sake” (p. 84). A later literature review conducted by Espedal (2020) identified five additional empirical pieces specifically addressing values work or values practices. Displayed in Table 2.2 at the end of this chapter, this six-article collection considers values work broadly to be “the purposeful effort of actors to create, maintain or disrupt the values of professions, organizations or other institutions” (Wright et al., 2021, p. 1435). This values work is accomplished through the practices, or “the activities through which values are performed in organizations” (Wright et al., 2021, p. 1436). This literature stream offers important insight into the relationship between abstract connotations of values, and tangible concrete performances within organizations.

Values work literature focuses on understanding values performance in two ways. The three earliest articles address values work at the organizational or group level (Daskalaki et al.,

2019; Gehman et al., 2013; Vaccaro & Palazzo, 2015). More recent work addresses values work through the practices of individuals within organizations (Chan & Hedden, 2023; Wright et al., 2017; Wright et al., 2021). Together, these articles begin to paint a picture of how values are introduced, diffused, and maintained in the workplace.

At the collective or organizational level, research on values work offers insight into how values shape, and are shaped by, member practices. In their seminal research, Gehman and colleagues (2013) explained how important values related to integrity were introduced and diffused across a large university's business school through values work that included identifying members with similar interests in implementing a college-wide honor code, uniting them into an action network, performing values practices (e.g., signing behavioral and deliverable pledges, engaging in peer reporting, establishing review panels) and circulating values discourse through dialogue about the importance of the honor code.

Vaccaro & Palazzo (2015) examined Gehman and colleagues' notion of identifying and uniting individuals sharing similar concerns as an important prerequisite to diffusing values in greater depth. They identified values as a key motivator and a strategic tool for a group of activists that successfully challenged and changed the longstanding institutional practice of *pizzo* (businesses paying protection money to the Mafia) in Sicilian society. These activists called on values (e.g., legality) to engage in the practices of hooking, anchoring, activating, securing and uniting others to work to eliminate *pizzo*.

“Inspired by Judith Butler's work on performativity” (p. 1742) Daskalaki and colleagues (2019) researched how the ongoing performances of actors in grassroots organizations created to counter the traditional Greek economic system shaped how new members viewed important values in their own personal lives and activities. Ongoing performances including leaderless

meetings, round table meeting agendas, free-exchange markets, and setting transaction rules at flea markets “helped mobilize lost non-capitalist values such as egalitarianism, solidarity, sharing and caring” that members spread in their communities (p. 1751).

In sum these three pieces explain performances that introduced and spread values in organizations, led to the creation of new practices to eliminate longstanding, undesirable practices, and helped shape what members viewed as important in grassroots group membership.

## **2.6 The Values Work of Professionals**

More recent research addresses how individuals, specifically professionals, practice professional values in daily work. Professional values are guiding beliefs and principles broadly shared among members of a profession about what is right and desirable (Gibbons, 2004). Three pieces of empirical research offer insight into how professionals work to defend professional values in daily work despite encountering obstacles and threats.

First, Wright and colleagues (2017) asked how specialists maintained professional values despite working with other professionals holding different perspectives about important values, and in settings where organizational priorities conflicted with these values. The authors found that perceived misalignment between the values of specialists or between professional values and organizational priorities elicited moral emotions. These emotions, in turn, triggered individuals to engage in value maintenance work to resolve misalignment. Maintenance work included engaging in practices such as advocating points of view, sanctioning by using authority to set rules, or brokering deals with contesting parties.

Wright and colleagues followed this with a second piece on values work (2021). This research investigated how professionals practiced important values despite working in environments where managerialist priorities for efficient, profitable operations threatened to

curtail them. The authors found that when facing situations where values were threatened by managerialist priorities, professionals engaged in practices such as voicing up, intervening, or blending that allowed them to defend core or superordinate values, contain erosion to less critical values and integrate basic values into managerialist practices.

Of note is that Wright and colleagues called on past work by Schwartz (2012) to differentiate levels of values classified by professionals as more or less important. The authors empirically demonstrated that professionals hold core values of over-arching importance. These core values were deeply ingrained and served as professional cornerstones for employees. These values were superordinate or prioritized above all other values. However, they also held secondary values that, while not as highly classified as core values, were still considered important and often vital in daily professional work. These values were subordinate, or less highly regarded than core values.

Most recently, Chan and Hedden (2023) used the concept of values work to understand how professionals maintained jurisdictional control of situations when their clients had conflicting values. The authors studied guidance counselors working with students regarding career placement. They found that professionals engaged in values practices that allowed them to mask, modulate or magnify their own core values depending on the values they discerned as important to individual students.

A key assumption in this latter stream of literature is that individuals work in dynamic, values diverse settings where members, clients and organizational leadership are vying to enact their own distinct individual or professional values. Acknowledging that workplaces are settings where multiple values of differing levels of importance are present in daily work, this body of research offers important insight into the work of professionals to maintain and defend their own

important, abstract values in their individual daily work when those values are threatened by the values of others.

## **2.7 Performing and Maintaining Values in Organizations**

Collectively, these six pieces lay a foundation for explaining values work in organizations. They tell us how values are introduced and spread in organizations (Gehman et al., 2013). They tell us how values can spark organizational and institutional change to longstanding and entrenched practices (Daskalaki et al., 2019; Vaccaro & Palazzo, 2015). They tell us how professionals can maintain and defend their values from threats associated with the values of other actors (Chan & Hedden, 2023; Wright et al., 2019; Wright et al., 2021).

But what they do not tell us is how abstract values are enacted and consistently performed inside of organizations. Thus, we have little understanding of how the abstract, conceptual, important values shared by organization members are maintained through performance in shared, daily, concrete work.

The ability of organizations to consistently enact and maintain values has wide ranging implications, from the impact on individuals within organizations to the impact on the broader communities served by organizations. First, at a more micro-level inside of organizations, the inability to maintain important shared values may have a detrimental impact on organization members. A large volume of hiring literature has empirically demonstrated that individuals seek out and join organizations because of organizational values (Bao et al., 2012). When an organization is no longer able to enact or maintain those values, employee satisfaction, motivation and perceptions of workplace wellbeing can suffer (Ravlin and Ritchie, 2006). Likewise, intent to leave and turnover rates rise (Andrews et al., 2011).



Second, at the organizational level, the inability to consistently maintain values in daily work can threaten performance and reduce the abilities of organizations to be successful. Being able to consistently perform the values expected from its constituents and larger institutional field helps organizations to be viewed as legitimate, and to gain support and access to vital resources (Ashforth & Gibbs, 1990; Oliver, 1992). The inability to accomplish and enact values expected by these constituents may result in the loss of necessary resources for success, or possibly survival (Kraatz et al., 2020).

Finally at a macro, societal level, an organization's inability to maintain important values in its daily operations may be detrimental to the larger communities served by those organizations. Values-driven organizations such as law offices, law enforcement agencies, schools and universities, and healthcare providers exist to act in the best interests of the clients, students and patients who depend on them to help improve their lives (Chatelain-Ponroy et al., 2018; Wright et al., 2021). Important values that are not maintained are thought to be "lost" (Noordegraaf, 2011, p. 1356). Consequently, the values of organizations acting to improve the lives of their constituents that are not enacted consistently and maintained over time through practice may disappear. This may harm the constituents who rely on these organizations for support and assistance.

As noted by Cha and Edmondson (2006), there is a shortage of empirical literature explaining how values are spread and maintained inside of organizations. Yet what does exist offers clues into how values can be maintained in organizations. First, they can be maintained when they are consistently espoused by top leadership as critical and important (Bourne & Jenkins, 2013). Espoused values are those expressed on behalf of the entire organization through the sayings of members within the organization and the documentation (e.g., annual reports and

values statements) made public outside of the organization (Bourne et al., 2019; Bourne & Jenkins, 2013). Values that are consistently espoused by organizations are more likely to be consistently viewed by members as important (Bourne et al., 2019).

Values are also thought to be sustained in organizations through role modeling. This involves high status or high-powered actors (e.g., managers) performing activities that are consistent with organizational values. This could include, for instance, staff in an organization that values individual consideration witnessing a manager being kind to subordinates. Actors who see these influential others role modeling or living out important collective values in their own daily work are assumed to be likely to do the same (Brown & Treviño, 2009; Cha & Edmondson, 2006).

Finally, values are thought to be sustained through cultural artifacts such as mission, vision and values statements, organizational policies, or even cultural structures such as norms related to conduct and communication styles (Pettigrew, 1979; Simmerly, 1987). Much like espousing, employees who are regularly subjected to the writings, communications and personal interactions with others that promote specific values (e.g., egalitarianism and teamwork) are more likely view these behaviors as accepted norms and adopt them as their own (Wageman & Gordon, 2005).

These methods for maintaining and sustaining important organizational values have been empirically demonstrated in traditional values literature. However, the presence of important values in groups is typically measured as an aggregation of the individual values reported by members as important. The greater number of individuals claiming a value is important to a shared group, the greater that value is said to influence performance (Bourne and Jenkins, 2013). Rather than focusing on actual performance, this work focuses on individual perceptions of

important group values. In other words, the values that members perceive as important over time are assumed to be the values that are maintained in organizations over time. However, little remains known about how important values are consistently maintained through performance in the shared, daily work of collectives.

## **2.8 Navigating Multiple Values in Daily Organizational Work**

Further, as noted by Gehman and colleagues (2013), Wright and colleagues (2021) and Chan and Hedden (2023) in their investigations of values practices, organizations are sites of multiple values. They are, as phrased by Gehman and colleagues, a “heterogeneous landscape of values” (2013, p.106). Consequently, not only can the values of different professionals that work together clash (Wright et al., 2017), but so can the values of employees and clients (Chan & Hedden, 2023), the values of employees and organizational management (Wright et al., 2021) and even the different important values shared by organization members.

As Gehman and colleagues (2013) noted in their study of values practices in a university, practices designed to accomplish integrity by turning in cheating when observed clashed with longstanding values related to teamwork, support or loyalty. While the authors did not offer any prescriptions for managing multiple values in daily work through values practices, the authors noted addressing multiple values in daily work through practice as an area for future values work investigation.

The emphasis on the word *daily* in understanding how multiple abstract values are enacted by groups through performance is especially important. Daily work is often situated and dynamic. A pragmatist perspective suggests that knowledge claims and accompanying action are always moderated by the environments in which humans are embedded in the moment (Martela, 2015). Because of this, human action is situated within social or material structures that facilitate

or restrict acting in certain types of ways (Hilligoss, 2011; Strauss, 1993). As it applies to values, this perspective implies that because humans are situationally and contextually bound, then rather than being enduring and stable, what is considered a *value* may be determined in part by the situations we find ourselves in at any given moment. In other words, depending on the context of the situation, different values may be of more or less importance in daily organizational work performance depending on the situated, moment to moment contexts experienced by members.

Wright and colleagues (2021) called attention to the possibility of actors needing to balance and enact many different values in daily work, some of which are core and some of which may be subordinate to other values. However, as the authors noted, additional work is needed to build on these findings and offer insight into how groups manage multiple values. Existing values practice literature focused on the performance of single values (Wright et al., 2021) offers little insight into how, in their daily concrete work, organizations account for and navigate several potentially different but important values.

## **2.9 Summary and Research Questions**

In sum, research into values work offers insights into how organizations can introduce important values (Gehman et al., 2013). It offers insight into how values can ignite changes to established organizational practices (Vaccaro & Palazzo, 2015). At the individual level, it tells us how individual professionals can defend and maintain important values in dynamic organizational settings where values are threatened by differing values held by other professionals, (Wright et al., 2017) organizational management (Wright et al., 2021) or clients (Chan & Hedden, 2023). But what it does not yet tell us is how organizations can consistently enact and maintain shared values in ongoing, situated daily work. Nor does it tell us how

organizations manage multiple values of varying importance in daily performance.

Consequently, understanding of values work and values practices in organizations remains incomplete.

**Table 2.2**

*Values Work Literature Review Summary*

Author (Year) and Citation	Research Question(s)	Methods	Findings
Gehman, J., Treviño, L. K., & Garud, R. (2013). Values work: A process study of the emergence and performance of organizational values practices. <i>Academy of Management Journal</i> , 56(1), 84-112.	How do values come to be practiced in organizations, and how are they performed over time?	A ten year ethnographic study of the development and enactment of an honor code in a large university's business school.	Values emerge in organizations through values work, which includes; a) dealing with pockets of concern, b) identifying and tying local concerns into action networks, c) performing values practices and d) circulating values discourses.
Vaccaro, A., & Palazzo, G. (2015). Values against violence: Institutional change in societies dominated by organized crime. <i>Academy of Management Journal</i> , 58(4), 1075-1101.	How did a group of activists successfully challenge and change the practice of pizzo (businesses paying protection money to the Mafia) which was a key institution in Sicilian society?	A qualitative study of the Sicilian anti-mafia movement using interviews with key officials and publicly-available archival data.	Activists used values (e.g., legality) to engage stakeholders and move them through five micro-processes of hooking, anchoring, activating, securing and uniting to change the established practice of pizzo.
Wright, A. L., Zammuto, R. F., & Liesch, P. W. (2017). Maintaining the values of a profession: Institutional work and moral emotions in the	How do specialists maintain professional values inside of their organizations, when interacting with other specialists and navigating organizational goals?	A three year observational and interview study with physicians specializing in emergency medicine at a public hospital in Australia.	Perceived misalignment between values of specialists or between physician and organizational values elicited moral emotions, which in

Author (Year) and Citation	Research Question(s)	Methods	Findings
emergency department. <i>Academy of Management Journal</i> , 60(1), 200-237.			turn triggered value maintenance work to engage in new practices to resolve episodic problems or adapt practices to solve systemic problems.
Daskalaki, M., Fotaki, M., & Sotiropoulou, I. (2019). Performing values practices and grassroots organizing: The case of solidarity economy initiatives in Greece. <i>Organization Studies</i> , 40(11), 1741-1765.	How do values systems drive and sustain networks of grassroots organizations working towards country economic reform?	An ethnographic study using leader interviews and observations of assembly meetings for four grassroots exchange networks dedicated to enacting economic reform in Greece after the 2008 global financial crisis.	Grassroots initiatives accomplish social change by engaging in practices that collectively mobilize and restore "lost" humanistic values, and also organize principles challenging dominant views and practices.
Wright, A. L., Irving, G., & Selvan Thevatas, K. (2021). Professional values and managerialist practices: Values work by nurses in the emergency department. <i>Organization Studies</i> , 42(9), 1435-1456.	How do professionals engage in values work while also balancing managerialist practices inside of organizations?	A three-year observational and interview study with nurses in an emergency department at a public hospital in Australia.	When facing potentially conflicting values due to managerial practices, nurses categorize values, defending their superordinate values, containing erosion to subordinate values and integrating basic values.
Chan, C.K., & Hedden, L.N. (2023). The role of discernment and modulation in enacting occupational values: How career advising professionals	How can professionals, when interacting with others with potentially incongruent values, navigate these interactions to enact their own values	An ethnographic study of career guidance counselors at one university business school combined with guidance counselor interviews at university business	When facing customers with potentially conflicting values, guidance counselors managed tensions by carefully discerning customers' values and modulating by

Author (Year) and Citation	Research Question(s)	Methods	Findings
navigate tensions with clients. <i>Academy of Management Journal</i> , 66(1), 276-305.	without jeopardizing jurisdictional control?	schools in the United States	masking, moderating or magnifying their own professional values.

## CHAPTER THREE: METHODS

### 3.0 Introduction

In this chapter I describe my research design and methods choices. I begin by identifying the research site I used to explore my two research questions. I then justify my use of a single case study design. After this I describe the ethnographic and interview methods I used to collect study data. I conclude by describing the process I used to analyze my study data.

### 3.1 Research Site

To answer the questions of how organizations consistently enact and maintain important but abstract core values in concrete daily work, and how they accommodate multiple values that may be important in situated contexts associated with dynamic daily work, I observed the members of a radiation oncology center as they created cancer radiation treatment plans for patients. My research site was a regional cancer center located on the west coast of the United States. The center resided in a small, urban city with a population of roughly 60,000 residents and an immediate surrounding area of nearly 100,000 residents. It served a regional population base of nearly 500,000 individuals stretched over approximately 4,000 square miles in three counties. Nearly one quarter of its patients lived in rural communities and traveled distances greater than 60 miles one way (sometimes daily) to receive cancer treatment. Consequently, the center sometimes utilized the nearby hospital's 24-room, hotel-style *lodging house* so patients could receive daily treatment without the burden of extensive travel.

According to its administrator (referred to in this study as *MGR*), at the time of my data collection, the center employed approximately 25 staff members and booked revenues of approximately \$30 million per year. It treated nearly 700 unique cancer patients per year using



external beam radiation therapy for a variety of cancers including, among others, cancers of the brain, breast, prostate, lungs, bones, skin, and lymph nodes.

### **3.2 Single-Site Case Study**

To answer my research questions, I designed a single site case study focused on the daily huddles, or *morning meetings* (MGR) the team of providers at this cancer center engaged in each day to discuss and plan for upcoming patient treatments. A single-site case study design was appropriate for this study for two reasons.

First, my primary research goal was to construct new theory around values enactment in daily work environments rather than testing existing theory. Single-case studies are appropriate when one's goal is theory building (Yin, 2003). Case studies are particularly appropriate for answering descriptive and process-based "how" research questions, such as the question posed in my study, which contribute to theory building (Gehman et al., 2018; Eisenhardt & Graebner 2007). Case studies also contribute to theory building by allowing the researcher to develop a contextually sensitive understanding of the phenomenon of interest through being submersed in a particular context for an extended period of time (Flyvbjerg 2011; Lilius et al., 2011).

Second, single case studies are useful for developing deep understanding of complex phenomena. External beam radiation cancer treatment is a complex process. Studying a single site allowed me to examine in-depth, and develop a rich understanding of, the operations and interactions of the team of providers planning patient radiation treatments (Eisenhardt & Graebner 2007; Yin 2003). By focusing on one location, I was able to better understand what was going on operationally in that unit, and to better see how values played important roles in plan development. Extended access to one location helped sensitize me to the unique contextual features and dynamics of the complex setting shaping cancer treatment. Through this deep and

rich observation of one case, I was able to identify details and work practices I might have otherwise missed, but that were important in understanding values in complex and dynamic environments (Flyvbjerg 2011).

In sum, developing a nuanced appreciation of the context and culture of work at the cancer center that allowed for theory building necessitated spending considerable time embedded in that one location. I chose this site because of the access it afforded me. Spending a great deal of time in only this single center made the emergence of values in complex, dynamic, daily work transparently observable (Gehman et al., 2018).

### **3.3 Data Collection Methods**

I collected data from the regional cancer center in two ways. First, I engaged in ethnographic observations of the team's daily planning huddles. Second, I conducted interviews with huddle participants. In the next sections I describe each data collection method in detail.

#### **3.3.1 Ethnographic Observation of Huddles**

My first method for data collection was ethnographic observation. Ethnography is a qualitative method that involves collecting research data through observing subjects in their natural settings to draw conclusions about how individuals, groups, and societies function. It involves observing life as it takes place (Spradley, 1980). Ethnographic observation was appropriate for my study because it allowed me to observe humans interacting with their worlds and with each other in natural settings (Corbin & Strauss, 2008) and helped me understand the physical, social, and organizational contexts through which the work of this multidisciplinary team of caregivers was accomplished through participation in daily huddles (Lüscher & Lewis, 2008).

### **3.3.2 Daily Huddles**

Patient care huddles (*huddles*) in health service organizations (e.g., hospitals) are short, daily clinical team meetings. During huddles, teams of multi-disciplinary care providers (e.g., doctors, nurses, technologists, etc.) review and discuss patient cases and records (Franklin et al., 2020; Mayo, 2022).

Huddles began gaining prominence in hospitals in the late 1990's as a response to changing health care practices that relied less on the traditional hierarchy of physicians guiding all aspects of the patient journey and more on interdisciplinary teams coordinating patient care efforts (Derrick, 2018). They were developed to improve patient outcomes for highly acute (i.e., severe, intense, critical) patients by providing a forum for enhanced communication and coordination among different professionals who work interdependently to provide safe, high quality patient care. The goal of these huddles is to allow teams to develop comprehensive, effective care plans that increase the safety and efficacy of treatment for high-risk patients. They accomplish this goal by facilitating teamwork, fostering inclusive, supportive climates for problem solving, and providing a space for lower status team members to speak up and share opinions (Derrick, 2018; Mayo, 2022).

### **3.3.3 Why Huddles Were Appropriate**

There were three reasons I chose to study huddles in my research. First, I chose to study radiation oncology huddles instead of direct interactions between patients and providers due to the level of analysis necessary for answering my study question. While interaction in patient care often occurs at the individual level, between a provider (e.g., doctor, nurse, etc.) and a patient (Wright et al., 2021), I was interested in understanding the collective enactment of values among group members. Therefore, my study required a setting where group members interacted and

made collective decisions about important activities related to delivering patient care. In following daily huddles, I was able to observe the multi-disciplinary team collectively planning patient treatments and determining the activities that would subsequently be delivered by individual providers at the patient bedside.

A second reason I chose huddles as my study setting was because my research question required studying values in *heterogeneous* settings (Gehman et al., 2013, p. 106) marked by complexity and situatedness. By complexity, I mean situations where many elements such as available technologies, resources, people are connected and shape decision making (Reeves et al., 2020). Complexity is often associated with knowledge-based organizations such as hospitals or universities, where members of different professions collaborate and work interdependently to achieve outcomes in situations with high levels of uncertainty (Koppman et al., 2022). By situated, I mean scenarios requiring decision making where the social or material structures associated with the unique context or specifics of a given situation facilitate or restrict acting in certain types of ways (Hilligoss, 2011; Strauss, 1993). In patient huddles, unique contingencies for each individual patient being planned for potentially life-altering, risky treatments were addressed daily by a multi-disciplinary team of healthcare professionals holding different professional values. Thus, huddles allowed me to study multiple values important in decision making, that were dependent on the context of the situation. This, in turn, provided insight on how collectives navigated heterogeneous values landscapes to enact important values in situated, daily work contexts.

A third reason I chose daily patient huddles was because of the empirically demonstrated positive link between patient care huddles and values such as safety. Safety is defined as “the absence of preventable harm to a patient during the process of healthcare, or as the prevention of

errors and adverse events caused by the provision of healthcare rather than the patient's underlying disease process" (Kangasniemi et al., 2013, p. 904). Safety is considered a core organizational and professional value in healthcare (Reid & Catchpole, 2011; Rodriguez et al., 2015; Wright et al., 2017). There are over 1,000 published research articles linking daily huddles to improved safety (Franklin et al., 2020). Consequently, by studying patient huddles, I was studying a mechanism in healthcare that allowed performance of values such as patient safety in daily work.

### **3.3.4 Observation Period**

Each day a team of multi-disciplinary professionals involved in developing radiation treatment plans for cancer patients conducted an 8:00AM team huddle, which they referred to as the *morning meeting*. I observed daily morning huddles at the cancer center intermittently over a period of seven months stretching from July 2023 through February 2024. During this time, I observed 64 total daily huddles. I observed 36 huddles in person and watched another 28 huddles via Zoom.

### **3.3.5 Observation Process**

As per study IRB approval requirements, I did not video or audio record huddles. Instead, I used a notebook to record huddle events by hand. I used shorthand writing to quickly note participant interactions and discussions, which moved rapidly during huddles. In some cases, I was able to capture quotes from participants verbatim.

For each huddle I observed in person, I arrived 5-10 minutes early. I took note of the room, including the arrangement of the table and seating and the set up of equipment and technology. As participants arrived, I noted who they were, where they sat, and how they socialized and communicated pre-huddle. I spoke at the start of the first few huddles, explaining

my research and the informed consent process. As time went on, I attempted to remain unobtrusive. I typically sat in the back of the room, against a wall where I could observe the square table in front of me where participants sat. I had a direct line of sight to the head of the table, where the huddle facilitator sat. From this vantage I could also see the faces of participants who sat at each side of the table. I could see the backs of participants who sat directly in front of me at the foot of the table. There was space for approximately 12 individuals at the meeting table. Occasionally participants arriving late sat with me in the row of chairs at the back of the room. The manager (MGR) also typically sat in this back row, near me. If there were empty spaces at the table, he would sit at the table. For each huddle I drew diagrams in my notebook of where participants sat.

During initial observations I was uncertain as to what might emerge as theoretically interesting. Therefore, on different days, I focused on different aspects of each huddle. I tried to capture as much detail as possible about each phenomenon in order to understand each phenomenon and how values played into each phenomenon. For example, each huddle had a standing agenda that included discussing new patients for treatment assessment, cancellations of patients from the prior day, new patients starting that day, new patients starting the next day, and new patients starting in two business days (48 hours). On some days I focused on the new assessment patients, trying to capture every detail associated with discussions surrounding these patients. On other days I focused on patients starting treatment 48-hours post-huddle.

At other times, I focused on specific activities. Most patients generated very little discussion. The average length of time spent discussing any specific patient in huddles was 1.6 minutes. Therefore, on some days I focused on collecting as much data as possible associated with only those patients that generated discussion or required decision making. In each huddle, I

recorded anything that struck me as surprising, or topics that generated larger volumes of discussion and conversation. These often revolved around determining patient treatment starting dates, which is discussed at length in subsequent sections. As I continued gathering data and developing understanding of the daily huddle process, it became easier to notice actions that were out of the ordinary, or that generated thought and discussion from participants.

Shortly after each huddle and subsequent follow up interviews, I retreated to a small, vacant office in the cancer center where I transcribed and elaborated upon my field notes. Doing this soon after each huddle allowed me to recreate in greater detail the events that I had recorded in shorthand, while they were still fresh in my mind. In total, my transcribed field notes totaled 216 single-spaced pages.

I also kept a spreadsheet of details associated with each observed huddle. Here I captured huddle dates, start and finish times, facilitator, participants, the number of total patient cases discussed and the number of new cases. I initially tried to capture details associated with new patients in this spreadsheet, such as the type of cancer new patients were experiencing, their ages, and prior medical history. I found this process to be cumbersome as time went on. I found myself missing out on critical interactions between staff because I was busy focusing on recording the specific details of each patient case for my spreadsheet.

Further, because huddles focused primarily on the planning of “safe and effective” treatments for new patients and less on “trouble shooting or problem-solving issues with ongoing patients” (MGR, 1), the individual characteristics associated with each patient became less important, unless those characteristics were central in decision making. Under these circumstances, I captured pertinent patient information in my field notes as opposed to my spreadsheet. Through this spreadsheet, I calculated that each huddle I observed lasted on average

just under 17 minutes. The team discussed an average of 10.4 total patients, and 2.72 new patients each day. Details associated with huddle data collection are included in Table 3.1.

**Table 3.1**

*Observation of Huddles Data Collection Summary*

Total hours spent on-site (approximately)	222
Total huddles observed	64
Average huddle start time	7:59 AM
Average huddle end time	8:16AM
Average time of each huddle	17 minutes
Average number of participants per huddle	10.7
Average number of patients discussed per huddle	10.4
Average time spent discussing each patient	1.6 minutes
Average number of new patients discussed per huddle	2.72
Average number of new patients discussed with a salient concern per huddle	0.26
Total pages of field notes collected	216

### 3.3.6 Interviews

A second method I used to collect study data was through interviews with huddle participants. Interviews, or open-ended questions asked of study participants, are useful for gathering data about the meanings people ascribe to events and the sense they make of their world. They help researchers understand and explore the behaviors, actions and thoughts of participants and better understand a phenomenon of interest from the perspective of the actors associated with that phenomenon. They also allow the researcher to tap into the concerns participants have and the challenges and problems of which they are aware (Charmaz, 2014; Corbin & Strauss, 2008).

### 3.3.7 Huddle Participants



Morning huddles averaged 10.7 participants. Huddle participation was stable across my seven-month study period. Participants regularly attended huddles except for days when they were not at work. Participants included a variety of healthcare professionals involved in the planning of treatment for radiation cancer patients.

There were three radiation oncologists who all participated in daily huddles. I labeled them D1, D2, D3 (as in *Doctor*). Radiation oncologists are physicians specially trained in radiation therapy. They oversee the entire care process during a patient's treatment.

There were two medical physicists who participated in huddles. I labeled them P1 and P2. Medical physicists manage the safety and technology of radiation use by preparing treatment machines (i.e., linear accelerators) and CTs (computed tomography) for clinical use and by measuring and modeling how prescribed radiation doses interacts with tissues in the human body.

There were two medical dosimetrists who participated in huddles. I labeled them Dos1 and Dos2. Medical dosimetrists (or *dosies*) use their knowledge and skills of cancer radiation treatment and advanced computer technology to design treatment plans specifically for each patient.

There were two radiation therapists who were the front-line staff delivering radiation directly to patients positioned on high-powered *linear accelerator* treatment machines. I labeled them RT1 and RT2.

There were three registered nurses (RNs) who rotated huddle participation, depending who was on shift a particular day. RNs are front-line caregiving staff who coordinate checkup appointments, monitor pain levels, treatment side effects, arrange for concurrent medical services

such as referrals for chemotherapy, or dietary support and generally oversee patient treatment. I labeled them RN1, RN2, and RN3.

There was one social worker, labeled SW, whose job was to provide counseling, and personal support to patients including help with housing, transportation, finances, home care and finding treatment support groups.

There was a front desk staff member, labeled FD, who scheduled assessment and patient doctor visits, answered phones, greeted arriving patients, and assisted in completing patient referral paperwork.

There was also a clinic coordinator, labeled CC. This staff member helped set up patient treatment schedules on the linear accelerator machines and managed the radiation therapists.

There was a registered dietician, labeled RD, who helped design patient diets to improve their ability to tolerate treatment, or improve quality of life during and post treatment.

Lastly, there was the center administrator, labeled MGR. MGR was a radiation therapist by training. He oversaw daily operations, staff supervision and communications. He also collaborated with physicians, physicists, nursing staff, front desk staff, and others for the smooth flow of daily center operations.

### **3.3.8 Participant Interviews**

Over the course of my study, I conducted a total of 76 interviews. I interviewed each huddle participant at least one time. A total count of interviews by participants, as well as a legend of labels for each participant, is included in Table 3.2. Most of these interviews were field interviews while some were semi-structured. I discuss both types in detail below.

### **3.3.9 Field Interviews**

Field interviews, also called ethnographic interviews (Chan & Hedden, 2023), are short, informal, and non-structured discussions used as follow-ups to what was previously observed during ethnographic observations. Field interviews provided insight into participants' thoughts and perspectives about daily huddle activities and their own actions. They also helped me to understand the motivations and perspectives of participants in navigating different values and reaching agreement.

At the conclusion of each huddle, I sought out participants, engaging them in brief conversations about what I observed in the huddle that day. For example, after observing D2 request to start a patient treatment immediately, as opposed to seven-days later which was the department norm, I followed him down the hall towards his office and spent five minutes in the hallway asking him why he made this decision. He told me he made this decision because the patient was in clear, demonstrative pain when he initially assessed the patient and that pain medications were not working. Therefore, he told me that "his assessment was that the patient needed to start treatment as soon as possible to assuage the suffering" (FN, 78).

In total I conducted 63 field interviews (see Table 3.2). These interviews ranged from a one-question, five-minute interview with D3 to a 30-minute tutorial about drawing cancer tumors on a computer with Dos1. I audio recorded 23 of these interviews, and captured participant responses in my notebook using shorthand in another 40 interviews. In many cases, I found audio-recording field interviews to be cumbersome because several were conducted as I walked with participants in hallways as they conducted daily work. In this way, like a news reporter, I kept a small, flip-page notebook with me at all times. Throughout the day I wandered the halls of the center. When I would see a participant emerge from a treatment area, I would follow them, asking questions and scribbling notes in my reporter-style notebook. I also spent a great deal of

time sitting in the break room. As participants would wander in to refill coffee or grab a snack, I would take the opportunity to ask them a series of questions.

### **3.3.10 Semi-Structured Interviews**

I also conducted semi-structured interviews with several participants. These interviews involve engaging participants with a planned set of open-ended questions while maintaining flexibility to ask follow-up questions, or off-script questions in response to emerging insights provided by participants. Semi-structured interviews offer researchers access to the personal emotions and perspectives of study participants through “deep and rich” description that is not available through other data collection methods such as surveys or observation (Gioia et al., 2012, p. 17). They also help researchers triangulate information gleaned from observation with detailed, retrospective accounts provided first-hand by participants regarding the motivation, or intent behind observed behavior (Corbin & Strauss, 2008).

As shown in Table 3.2 below, I conducted 13 semi-structured interviews, ranging from 20 minutes to 60 minutes in length. These interviews took place during work hours, typically in a participant’s office or in the small office I was using for typing my field notes. At the start of each interview, I provided participants with my IRB-approved informed consent form and asked them to indicate that they agreed to participate. I also asked for permission to audio-record interviews, which all members provided. This consent for is included in Appendix B. Several, such as SW, noted that “permission (to record) is implied (SW, 6),” and I could just start recording without offering consent or asking permission. Nevertheless, I always asked for permission to record prior to recording every interview.

I carried a small, hand-held audio recorder that I used for each interview. During these interviews I took brief notes that included key words or phrases used by participants. I followed

up on these phrases by asking probing questions such as “tell me more about X.” For example, when the Registered Dietician, RD, told me that huddles were important for the team in developing a “collective mind” (RD, 5), I asked her to follow up on this by explaining to me what she felt a collective mind was, and how a collective mind benefitted the team.

At the start of my study, I developed an initial interview protocol that was influenced by questions asked in prior values work studies conducted by Chan & Hedden (2023), Espedal (2020), and Wright et al., (2017). This protocol is included in Appendix A. During these semi-structured interviews, I found that discussing values theoretically was difficult for participants who could not grasp what I sought to understand or accurately describe values in detail beyond speaking in generalities. This was because values themselves are abstract, ostensive concepts (Gehman et al., 2013). Participants could easily describe specific scenarios or instances of values in their work such as the impact of identifying a missing component of a treatment plan in leading to a safe plan. Yet they could not always describe clearly what safety was to them, or how it was enacted in daily work. Thus, for the most part, my protocol questions about values yielded non-useful answers. For example, when asked which values were most important to her, RN1 answered “hmmm, you know, just, (pause) keeping patients safe and happy.” When I asked what keeping patients safe meant to her, she stated it meant making sure they “were not hurting during treatment” (RN1, 7). She struggled to come up with an example of this in action, when asked.

As my research progressed, I increasingly abandoned semi-structure interviews in favor of field interviews where I could ask participants about the practical, concrete situations I observed in the huddles and the accompanying tasks that members performed in their daily work. I also asked each participant about why these huddles were important to them in their daily work,

and important to the entire cancer center. In sum I found semi-structured interviews to be most useful for describing what participants did in their daily work outside of huddles, and how they felt the daily huddles helped them in accomplishing this daily work.

As with my field notes, all interviews were transcribed for future analysis. I transcribed the first five interviews myself. After finding this to be too time consuming, I paid for an automated transcription service offered by Rev.com. These were surprisingly high quality and mistake free. Though I did have to go through and correct each transcript for incorrect, mis-transcribed words that the Rev AI system was unable to understand. My interview transcripts were added to my transcribed observational field notes for detailed analysis. I combined my 175 pages of single space interview transcripts with my field notes for a total of 391 single-spaced pages of data which I used for my data analysis. In the next section, I describe my data analysis process.

**Table 3.2**

*Interview Data Collection Summary*

Participant	Job Title	Field Interviews	Semi-structured Interviews
CC	Clinic Coordinator	3	1
D1	Doctor #1	5	1
D2	Doctor #2	3	0
D3	Doctor #3	1	1
Dos1	Dosimetrist #1	5	1
Dos2	Dosimetrist #2	4	0
FD	Front Desk Lead	1	1
MGR	Manager	13	1
P1	Physicist #1	5	1
P2	Physicist #2	2	1
RD	Registered Dietician	5	1
RN1	Registered Nurse #1	6	0
RN2	Registered Nurse #2	3	0
RN3	Registered Nurse #3	0	1
RT1	Radiation Therapist #1	2	1
RT2	Radiation Therapist #2	2	1

Participant	Job Title	Field Interviews	Semi-structured Interviews
SW	Social Worker	3	1
Total		63	13

### 3.4 Data Analysis

I began my analysis by following the three-step process suggested by Bloomberg & Volpe (2008) for analyzing qualitative data. These steps include openly reviewing and exploring data for big ideas, coding data and placing it in categories, and finally collapsing categories into emerging concepts (p. 100). At the start of my analysis, I assumed this would be all I would need. However, as articulated by Gehman et al., (2013) process research is “inherently messy” (p. 89). As I progressed, I found this analysis technique was not entirely adequate for understanding the process emerging in my analysis findings. Thus, my work also incorporates data analysis strategies recommended by Corbin and Strauss (2008), Miles and Huberman (1994) and Gioia and colleagues (2012). I note in my analysis section when I used different analytical processes suggested by different researchers.

#### 3.4.1 Reviewing, Initial Coding and Comparison

As recommended by Bloomberg and Volpe (2008), I began my analysis by openly reviewing my data on a regular basis and engaging in initial coding. This involved immersing myself in my data, or becoming familiar with it, processing it, knowing it and retaining it in a deep and meaningful way (Corbin & Straus, 2008). I did this by reviewing my field notes repeatedly. This allowed me to start seeing trends in huddle data to note for future analysis.

For example, I could see that there was one decision made in every huddle each day, which was establishing a treatment timeline for new patients. This timeline involved determining how many days were required from the day the new patient was identified in a huddle to the day

the new patient started cancer treatment. In 90% of my cases, this timeline was seven-business days. However, while openly reviewing my data, I noticed a minority of cases (24) where this timeframe was shortened to 1-6 business days. I took note to watch for these exceptions as I continued observation.

I also began initial coding of my data during these reviews. This involved breaking down my data for comparison by assigning labels to specific segments of data (Saldaña, 2009). For example, one of my very first coding exercises was identifying and coding all of the practices the team used during huddles each day. To do this, I used Schatzki's (2012) definition of practices as dispersed nexus of doings and sayings that direct behavior. I identified 11 different practices the team used during huddles each day. However, there were several smaller sub-practices, or other activities embedded within each of these. Some of these included, engaging in daily case briefings, deciding on treatment starting dates, reviewing patient plans two business-days prior to a patient's scheduled start, and maintaining space on the agenda to review cases that were one-day from start or were starting that day.

I then used constant comparison techniques to engage in a deeper exploration of each of these practices to understand the properties and dimensions of each (Corbin & Strauss, 2008). I took each of the segments I had coded for a particular practice and compared them against each other, keeping memos to record my thoughts on similarities and differences, or to note concerns to follow up on in the future. As an example, for the practice I coded as *daily case briefings*, I noted that these involved the physician sharing basic case details about each new patient needing to be treated each day. I also noted that they included the physician pausing or leaving space at the end for staff to comment or ask questions. Finally, I noticed that the physician concluded these briefings by recommending a treatment starting date, which, as noted above, was typically



seven-days from the point the patient case was briefed in huddle but was shorter in some rare instances. At this point, I had *recommending a seven-day starting time* as its own separately coded practice. But, seeing that it was part of each daily case briefing, I merged my seven-day start data into the practice of *daily case briefing* to get a more complete picture of what was communicated in each daily case briefing session. Through this comparison I could see that a common property of case briefings was communicating, or sharing information about every new case, every day, and recommending a treatment starting date. From this memoing, the concept of daily case communication that is represented and described in detail in my findings section emerged.

### **3.4.2 Sorting and Categorizing Exception Cases**

As I reviewed and initially coded my data, I became curious about why some patient cases varied from the seemingly standard seven-day planning timeline. To explore this curiosity in greater depth, I abandoned following Bloomberg and Volpe's model for data analysis and instead followed recommendations from Trefault (2013) about using episodes (such as setting treatment starting dates) as units of analysis, or cases. I set aside all study data except for my 24 cases where the treatment starting date was set for under seven business days. I focused exclusively on these cases.

I extracted all of my field data associated with each of these cases. Following the recommendations of Miles and Huberman (1994) I created mini-narratives, or vignettes of each of these cases describing how the case was brought up during huddles, what the attending doctor said about the case, what timeline for treatment was recommended and how the rest of the team responded to these recommendations during huddles. I then engaged in a round of detailed

coding of each of these vignettes and constant comparison of the data within my codes, keeping track of my thoughts and observations through memo-writing.

It was during this new round of coding I noticed values emerge as factors for consideration in my analysis. For example, in one case involving a patient request to start treatment in two days, D1 noted that he wanted to do his best to meet the request, which triggered thoughts of customer service. In another, D2 noted he wanted to assuage patient suffering associated with cancer-related pain, which triggered thoughts of compassion. At this point I returned to the values literature, focusing primarily on the works of Dewey, who described values as embedded in activities, such as the activities I was observing and analyzing. I also returned to the general values literature to better understand how the outcomes I was observing related to abstract values.

From this I developed codes for my vignettes using terms from this literature. For example, I used Dewey's term *ends* to label codes where team members articulated their desired goals or *desired ends* for each early starting case. I used the label *compassion* to code data where members talked about suffering reduction.

Returning to the values literature, I noticed four types of cases begin to emerge. These were cases that started early due to intense pain the team wanted to assuage, which I equated to compassion (Larson et al., 2023). I noticed customer requests for early starts that the team wanted to meet, which I equated to customer service. I noticed oncological emergencies such as a tumor pressing a spinal nerve the team wanted to treat immediately, which I equated to humanistic care or wellbeing. Lastly, I noticed cases where the team was worried about treatment effectiveness because an upcoming holiday presented a gap or a pause in treatment or a tumor was growing rapidly. I equated these cases to maintaining efficacy, or treatment effectiveness

despite concerns that potentially challenged them. These different values, as well as the literature sources I used to better understand them are included below in Table 3.3.

**Table 3.3**

*Definitions of Emerging Values*

Value	Definition	Source	Data
Safety	The absence of preventable harm to a patient during the process of healthcare, or as the prevention of errors and adverse events caused by the provision of healthcare rather than the patient's underlying disease process.	Kangasniemi, M., Vaismoradi, M., Jasper, M., & Turunen, H. (2013). Ethical issues in patient safety: Implications for nursing management. <i>Nursing Ethics</i> , 20(8), 904-916.	My example is that [...] each organ, each part of their body, can safely get a bucket of radiation. And usually if we're giving curative treatments, we take up most of that bucket [...] [So we are] just trying to figure out how much we can give safely. It's a lot of judgment. (D1, 251)
Efficacy	Ability to produce an intended result . Clinically it is the end points that distinguish invasive disease-free survival.	Hudis, C. A., Barlow, W. E., Costantino, J. P., Gray, R. J., Pritchard, K. I., Chapman, J. A. W., ... & Zujewski, J. A. (2007). Proposal for standardized definitions for efficacy end points in adjuvant breast cancer trials: the STEEP system. <i>Journal of Clinical</i>	Ideally the goal is to cure the patient. (D3, 406)

Value	Definition	Source	Data
		<i>Oncology</i> , 25(15), 2127-2132.	
Compassion	Taking action to alleviate the suffering of another.	Kanov, J. M., Maitlis, S., Worline, M. C., Dutton, J. E., Frost, P. J., & Lilius, J. M. (2004). Compassion in organizational life. <i>American Behavioral Scientist</i> , 47(6), 808-827.	When we do that [start treatment early] we can help relieve the pain. (D3, 401)
Customer Service	Degree to which an organization meets customers' needs, requests and expectations.	Susskind, A. M., Kacmar, K. M., & Borchgrevink, C. P. (2003). Customer service providers' attitudes relating to customer service and customer satisfaction in the customer-server exchange. <i>Journal of Applied Psychology</i> , 88(1), 179-187.	I think we try to accommodate the patient [and what the patient wants] as much as possible. (P1, 138)
Wellbeing	State of having general wellness and high quality of life.	Lee, H., Vlaev, I., King, D., Mayer, E., Darzi, A., & Dolan, P. (2013). Subjective well-being and the measurement of quality in healthcare. <i>Social</i>	And on occasion we have to start sooner for different reasons. Sometimes it's an emergency patient that has a spinal cord compression that we cannot wait a week, two days, or they

Value	Definition	Source	Data
		<i>Science &amp; Medicine</i> , 99, 27-34.	could lose neurologic function. (D3, 199)

As per Dewey’s theory of values, I also coded the means the team prescribed for achieving their desired ends. In each case, these means involved shortening the treatment planning timeline from seven days to 1-5 days, and adjusting or flexing, if necessary, the team’s review of the draft plan. This review typically took place in huddles two business days (i.e., 48 hours) prior to the patient starting treatment.

This process generated more interesting findings. For example, I noticed that most data in my vignettes included the doctor sharing a concern about the focal patient case during briefings. One concern commonly shared, for example, was that a patient was experiencing significant pain. I also noticed that there were six cases in my 24 that did not include a concern made salient during the daily case briefing. I further noticed that in each of these cases where there was no concern made salient, the proposed starting treatment date was six days out. I began to wonder if there was fundamentally no difference to the team between six day starts and seven day starts.

### 3.4.3 Member Checking

During my October 2023 observation period, I engaged in member checking by asking participants about my hunch that there was no fundamental difference between six day and seven day starts. Member checking helps ensure trustworthiness and credibility in findings (Lincoln & Guba, 1986). D2 and D3 confirmed my suspicions, relaying that while seven days was the policy to which they tried to adhere, occasionally they would propose a six day or even an eight day start to make sure they would be in the office on the patient’s treatment starting date. Dos1 also

confirmed this, stating “there is no real difference between six or seven days starts. Where we start to get crunched is when starts are five days or less” (Dos1, 226). Consequently, I focused exclusively on the 17 cases where treatment starting dates were five days or fewer from the point the patient was first introduced during huddles. I refer to these in general terms as “early starts.”

#### **3.4.4 Creating a Data Display**

Again, following the advice of Miles and Huberman (1994), I took these 17 cases and created a data display table, with each case as a row, and each emerging code (e.g., concrete concerns, desired ends, means, and related values) in the columns. After later analysis discussed below, I went back and added a column reflecting the tactics staff reported using outside of huddles in their own work that I could not observe to address the concerns associated with each case. This allowed me to better understand the differences and similarities of each case. This data display, which includes codes used in my final analysis, is displayed in my findings chapter. It is labeled Table 4.2.

Using this table, I went back to my data and explored in greater depth the reasons for variances I observed in each column. For example, I explored in depth how the doctors discussed the different salient concerns or issues associated with each case when they communicated about them in daily case briefings and how the team seemed to make sense of these cases. I noted that doctors described these cases using language such as an *exception*, or *unusual*, or *non-standard*, which helped frame the case for the team as an exception. I noticed that team members seemed to make sense of these cases as deviations or exceptions and were flexible and open to adjusting timelines to start treatment for them earlier. It was through this analysis and in consulting literature about how teams develop collective thought or collective minds about a topic that the concepts of framing cases as exceptions and viewing cases as problematic emerged.

I could also see the activities, or means the team used to address these exception cases. However, at this point I could only identify the activities within huddles that the team used to address these cases, including shortening planning timelines for early starts and flexing or changing plan draft review dates from 48 hours prior to a patient's start to 24 hours prior or in some cases on the day of the patient's start. However, I did not have data on how individual team members responded to these cases in their own individual work. Thus, I did not have a complete picture of how teams responded to these early starting cases. I became curious about understanding how team members were adjusting their own work activities to accommodate these adjustments in planning activities.

### **3.4.5 Returning to the Field**

During my seventh month I returned to the field for a final round of observation. This time I focused exclusively on early starting cases. I also focused on interviewing team members about these cases to get their perspectives on them. As per IRB requirements, I could only observe huddles, I could not observe direct patient care. So as per advice from Gehman et al., (2013), I used interviews to better understand the practices or activities team members used outside of huddles to respond to early start requests.

### **3.4.6 Creating a Data Structure**

To analyze my interview data, I used analysis techniques recommended by Gioia et al., (2012) for analyzing interview data. This included coding first-order concepts, then engaging in axial coding of those concepts to develop second order themes, and ultimately aggregate dimensions, all of which are ultimately combined to create a data structure for analysis results.

I analyzed all of my interviews about how participants responded to these early start requests by coding first-order categories. As per Gioia and colleagues, these were often defined

by using participants own words. For example, when Dos1 described creating 3D plans that were easy to produce as a way to respond to early start requests, I coded this as *creating 3D plans*. When P2 described responding to these early start requests by conducting 3D plan reviews from his office instead of out on the treatment machine, I coded this as *conducting plan review from office*. When D3 articulated the goals of using a 3D plan to simply shrink tumors, as opposed to killing all cancer, I coded this as *goal tumor shrinking*. Finally, when Dos1 reported that she used lower levels of radiation in these plans to help ensure patient safety, I coded this as *lower levels of radiation used*.

I then took all of my first order categories, and engaged in axial coding, where I identified larger themes that each of my first-order categories held, or did not hold, in common. For example, *creating 3D plans*, *conducting plan reviews from office*, *goal: tumor shrinking* and *lower levels of radiation used* were first order categories that all related to simplifying treatment plans. This concept, *simplifying plans*, consequently, became a second order theme that is unpacked in detail in the findings section. I applied this same process to all of my interview data to reveal two additional second order themes, *speeding up task completion timelines*, and *offloading work*. These three second order themes together comprised my aggregate dimension of *Adjusting tasks*. This mini data structure is displayed below, in Figure 3.1.

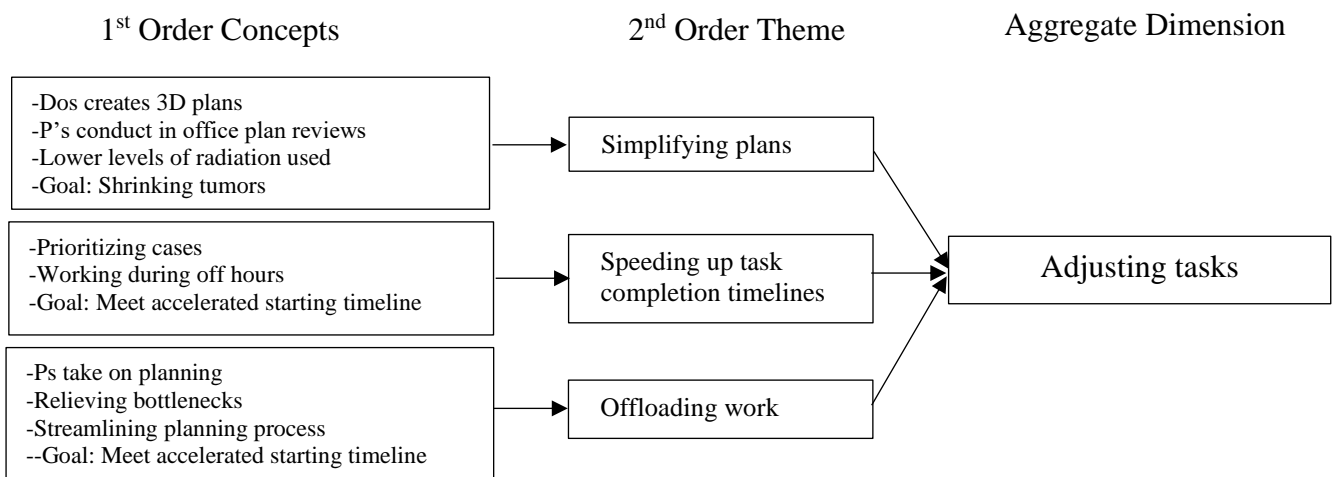
Through this intensive case by case analysis of each early start case, a process began to emerge describing how the team handled these early starting exception cases. This process also explained how, through addressing concrete patient concerns associated with a given case, the team was engaging in work designed to accomplish a particular value such as (described above) compassion, customer service, wellbeing and efficacy. However, at this point, these were only the cases relating to exceptions made to the standard seven-day planning timeframe. I had not yet



addressed how the team enacted and maintained values for the 90% of the cases I observed that followed the seven-day timeline determined during daily huddles. I became curious about better understanding this seemingly consistent, standard process the team used for planning the majority of its cases. I was also interested in better understanding if the same values I was observing in these exception cases (compassion, customer service, efficacy) were also important to the team in their standard planning for standard cases.

**Figure 3.1**

*Mini Data Structure for Adjusting Task Activities*



### 3.4.7 Analyzing Non-Exception Cases

I next returned to my set aside field data and interview data that did not relate to my 17 exception cases. I began by following a process similar to that described above for my exception cases. I took all of my observational cases (for which I had data) and previously coded data about practices. I organized this data chronologically to get a better sense of the flow of each of these cases in the planning process. I used this information to write vignettes about cases.

After writing and coding three or four vignettes about individual standard cases I noticed that they were all following the same basic pattern of activities within the huddle. Cases were introduced by doctors at the start of each huddle, they were agreed to start in seven days (or in some cases six or eight). They were then set aside and did not reappear until two days, or 48-hours prior to their scheduled start. When they were reintroduced, the team would review a draft of the patient's treatment plan. After this, the team was done discussing the individual patient case unless an issue came up during the 48-hour review. Then the case was brought up again the next day, 24 hours prior, to ensure the issue had been addressed. These issues most often revolved around making sure that all patient treatment documentation, such as intent to treat forms, were signed and in the patient file.

I captured this flow in a spreadsheet using advice provided by Miles and Huberman (1994). I used this spreadsheet to create categories explaining this observed flow of huddles. These categories included *patient introduction*, *setting seven-day planning window*, *reviewing 48-hours prior to treatment start* and *reviewing 24-hours prior to treatment start*. I then returned to my field data and interview data for these cases (i.e., my non-exception cases) and coded all of them using one of these five codes. My goal was to understand in great depth the process used by the team to plan treatment cases. As with my 17 exception cases described above, I also added a category for *desired ends*, as a great deal of my interview data involved asking staff what they hoped to achieve through planning via daily huddles.

### **3.4.8 Comparing and Grouping**

I then began intensely comparing my data within each of these categories. This comparison helped me to refine these categories. For example, I noticed that I had very little data in the *reviewing 24-hours prior to treatment start* category. As I analyzed this, I came to the

realization that the little data I did have in this category related to outcomes associated with the *reviewing 48-hours prior to treatment start* category. A common data segment in the *reviewing 24-hours prior to treatment start* for example, was confirming that chemotherapy paperwork was also in the patient file. This issue, however, had emerged the day before during the *reviewing 48-hours prior to treatment start* category when it was discovered the case file still lacked this paperwork. Consequently, I merged this data into the *reviewing 48-hours prior to treatment start* and labeled it as an outcome of reviewing plans 48 hours in advance.

As per guidance offered by Corbin and Strauss (2008) I created memos for each emerging category where I grouped the codes within each according to similarities. This allowed me to see differences between groups of codes in each category and begin teasing out different dimensions of the category. For instance, in the first category labeled *patient introduction and briefing*, I could see the team was only sharing a basic, standard set of details about each patient case. They were also using words such as standard, or routine, to describe these cases. Yet despite this sharing of little information, there seemed to be a shared understanding (i.e., it seemed to be implied) that team members understood exactly how to view these cases and how to plan accordingly for them in their own daily work. It seemed as though they had a given idea or assessment of these patients as non-problematic, or as MGR stated “non-concerning” (MGR, 46). This thought process, driven through activities associated with framing cases, appeared to be almost automatic. It allowed team members to instinctually categorize cases as standard without a great deal of work or cognitive effort. Seeing this, I refined my *patient introduction and briefing* category into new categories labeled *standard case communication, framing* and *viewing patients as non-concerning*.

Further, as I reviewed expected outcomes, I had many codes or instances of participants talking about general desired ends held for each case they planned. Most of this, as described in the findings section, related to values of safety and efficacy. Team members consistently and regularly reported the desired ends of creating treatment plans for patients that were safe and effective.

It also became clear that, as predicted by Dewey, these desired ends were themselves almost automatic, or taken as a given for each patient's plan. In other words, participants expressed that the huddle and the planning process for treating patients was in place to ensure that the team created a safe and effective plan for each patient, each time. This helped them enact safety and efficacy each time they developed a treatment plan for a new patient without a lot of additional thought or cognition. Because this fit my emerging definition of viewing work as non-concerning, I moved data related to desired ends data to this category, and sub-labeled it as an automatic, or taken for granted ends in view associated with planning treatment for standard patients.

### **3.4.9 Creating Narratives**

I next focused on the data I collected regarding the action the team took in huddles to plan treatment for these patient cases framed as standard. As with the exception cases listed above, I again ran into the problem of only being able to observe action taken during huddles. Data associated with these actions comprised my *setting seven-day planning window, reviewing 48-hours prior to treatment start* categories as these were the tangible planning activities associated with standard cases that I could observe. Yet I did not know what individual members were doing outside of huddles to create plans.

To better understand the activities of each individual staff member in developing general treatment plans for patients I returned to my semi-structured interview data where I had spent considerable time asking each participant to explain their roles, duties and responsibilities in their daily work. I coded all instances of participants describing what they did in their individual work to create cancer treatment plans. I originally intended to analyze this in a similar manner to my interview data above, using the Gioia method (Gioia et al., 2012). However, I quickly realized that this would not work, as each member of the team had a vastly different set of very individualized task responsibilities. Breaking these apart through coding and combining them with all of the other staff descriptions of their own individual tasks would have yielded very little accurate or informative insight into the roles of each individual staff member. Using the work of Gehman et al., (2013) as guidance, I created mini narratives for these cases. I took all of my data provided by each member about their roles and responsibilities and put them together, categorized by staff role. Thus, all the doctor data was together, all the nurses data was together, all the dosimetrist data was together, etc.

I then used the data to write short narratives or vignettes (Miles & Huberman, 1994) for each role. These vignettes detailed, in the words of participants, what they did in developing treatment plans for general patients. I used these vignettes to describe the role of each staff member in planning for general cases. I grouped each of these descriptions together to form the category of *standardized task activities* in my emerging model.

From this analysis, I could see a tentative outline of constructs emerging, and the relationships between them, that explained how teams were consistently enacting and maintaining important values related to safety and quality. I combined this emerging outline with the outline developed for exception cases and began to see an entire process taking shape that

explained how teams consistently enacted and maintained values, and how they navigated situated contexts where additional values were important.

I next engaged in one final, holistic review of my data, applying each case to one of the two tracks in my model to ensure fit. I also compared each parallel construct in my two tracks against each other one final time, and memoing to tease out any differences or similarities. This process helped me refine some of my emerging categories. It also allowed me to ensure that all of my data fit my emerging theory, which it all did. In one instance, I found that an outlier case for which I originally set aside because it did not seem to fit anywhere in my observations actually fit quite well when explained through the lens of my emerging theoretical model. This was exception case 57.1, where the team declined an early start request. I initially did not know how to explain this case in my early attempts at theorizing. Yet I found that under my emerging model it became clear that the doctor's request was rejected by the team because he did not engage in the practice of framing the case as an exception, and the team had not come to view this case as concerning. The team was still viewing this case as non-concerning, and thus treated it as standard. From this analysis, a theoretical model emerged explaining my two research questions.

### **3.5 Trustworthiness and Ethics**

Throughout my data collection and analysis process I took steps to maintain trustworthiness in my research. Trustworthiness involves the reduction of potential biases that might be present in a project's design, implementation and analysis (Lincoln & Guba, 1986).

I maintained a detailed audit-trail, where I documented and detailed each of my steps and procedures throughout the research process. This contributed to my study's dependability and confirmability by allowing me to identify potential errors and inconsistencies in my work and to

easily review my processes with my advisor and committee members. I maintained a reflexivity journal. In it I identified and memoed about how my own thoughts and perceptions about data and analysis (Jootun et al., 2009) contributed to my study's credibility, dependability, and confirmability by allowing me to identify and understand how my own thoughts and perceptions influence my study data collection and analysis. I noticed in doing this, for instance, that in early observations I was paying a great deal of attention to the MGR, because he was my source of primary information. I was also paying a great deal of attention to D1, Dos1 and SW, who were always willing to talk to me. As time went on, I realized I needed more data from participants who were quiet, such as P2, D2 and RN2. Thus, on my second or third observational trips, I focused on talking with these participants, to ensure I was capturing thoughts from all team members, not just the most vocal. In full disclosure, I quit doing this journaling after my first two or three months of observation. This was because as time went on I found myself more intently focused on the activities in huddles that explained my research questions. I would often use my memos about specific phenomena I was observing to capture my reflections and thoughts about both my data collection techniques and future questions that came to my mind.

I also ensured trustworthiness by triangulating my data. I would back up what I observed with interviews from participants. And, as discussed above, I engaged in member checks regularly, where I asked participants if what I was observing and interpreting was correct in their views. I engaged in regular conversations about my data with, primarily two, of my committee members skilled in qualitative data collection and analysis (Miles & Huberman, 1994). And I ran my emerging thoughts and models by them regularly. I also regularly submitted writings to my primary committee chair for review and consideration.

Finally, in accordance with ethical standards associated with high-quality research, my study was approved by the University of Arizona's Human Subjects Protection Program and Institutional Review Board. My study approval number was STUDY00002829. I followed all requirements associated with this IRB to ensure participant safety and ethical standards in my research.



## CHAPTER FOUR: FINDINGS

### 4.0 Introduction

In this chapter I present the findings from my empirical study of the daily huddles at the radiation oncology center. Overall, I found that the team of treatment planners held two values that members espoused as most important or as core. Those were safety and efficacy. As MGR stated in the quote below, safe and effective treatments were the most important consideration to the organization when creating radiation treatment plans for patients. Other evidence of members providing similar quotes about safety and efficacy is included in Table 4.3 at the end of this chapter.

*[Interviewer: What are the most important things about your planning routine?]*

*Developing safe and effective treatments for patients. (MGR, 128)*

Though safety and efficacy were the core values held by the organization, members also expressed that other values were important. These included compassion and customer service. This is reflected by P1 below, who noted the importance of providing good customer service by trying to accommodate the patient's desires for things such as fulfilling patient requests for specific treatment starting dates.

*So I think we try to accommodate the patient as much as possible. (P1, 138)*

Core values related to safety and efficacy, and other values that were important to organizational members are discussed in detail in the following sections. Data examples associated with members espousing safety and efficacy and other important values are also included in Table 4.3 at the end of this chapter. This table provides representative data associated with each of the components discussed in this findings section.

Overall, I found the team engaged in two different processes to perform the values work required to enact core and other values in the daily work of creating cancer treatment plans. The goal of this chapter is to describe the different components that make up each of these two distinct processes. In the following chapter, Chapter 5, I put these components together to offer a theoretical model. This model highlights the two distinct pathways used to perform the values work of consistently enacting, and therefore maintaining, core values or accommodating other values in daily work.

I begin this chapter by describing the components that make up the process the team used to enact core values in daily work. I next discuss the process the team used to protect core values when threatened and to accommodate additional values in the team's daily work of creating treatment plans for individual patients receiving radiation therapy to cure cancer.

#### **4.1 Enacting Core Values in Daily Work**

The first significant finding emerging from my data was that the treatment planning team had an established process used for developing safe and effective treatment plans for each patient. In other words, they had a process for consistently enacting, and therefore maintaining, the core values of safety and efficacy in their daily planning work. This process began through daily huddles, which were used to engage in daily case communication. Through daily case communication, many patients were framed as standard. This framing of patients as standard resulted in patient cases being considered by the team as non-concerning. Non-concerning patient cases were delegated to a standard operating procedure that enacted core values of safety and efficacy in treatment planning. Each of these components is described in detail in the next sections.

#### 4.1.1 Daily Case Communication

Daily case communication involved the entire planning team meeting together and sharing relevant information associated with each new patient case. This activity took place in each daily huddle. It was the very first agenda item. Members described it as the most important purpose of daily huddles. This included RN2, who stated that the process of communicating daily about each new patient case was the “most important” part about huddles.

*The most important [part of huddles] is learning about new patients. It's awesome that everyone can start off on the same page and we kind of all can get on the same page about knowing what everyone needs to do for [each patient]. (RN2, 32)*

Daily case communication included the huddle facilitator beginning each daily huddle by announcing each new patient to be planned for treatment that day. An example of this opening is included in the following field note.

*RT1 says good morning to the team and begins the meeting by announcing, “first new SIM [the term used for patients needing to be planned for treatment] today is [Patient name]. (FN, 38)*

After this introduction of the new patient, the attending doctor shared a set of basic details about the patient. These details included the patient’s name, age, gender, type of cancer, prescribed radiation dose and frequency and a proposed treatment starting date. The following field note from one huddle observation offers an example typical of this set of basic details. In it, D1 introduced basic details about a 66-year-old male with right hip bone cancer for whom he was prescribing a 28-course treatment of radiation therapy that he wanted to start on Monday the 16<sup>th</sup>.

*Today's meeting displays the same exact patterns as the days before. The team starts at 809 with RT1 announcing, "good morning, first SIM patient is [Patient name]. This cues DI who says "this is a 66-year-old gentleman with right hip bone cancer, I'm recommending a 28 dose SBRT course of treatment, regular start of Monday the 16th." (FN, 27.410)*

After sharing basic details for each patient case, doctors then paused, leaving space for staff to ask questions or seek clarification about the case. They did this because up to this point, doctors had been the only staff to significantly interact with new patients during earlier initial intake and evaluation visits. Thus, doctors held most of the knowledge about each patient's case.

Daily case communication was the opportunity for that knowledge to be exchanged and collectively shared. Daily case communication also offered the opportunity for concerns about a specific case to be made salient. In approximately 90% of the patient cases that I observed, there were no salient concerns associated with daily case communication about individual patients. After the sharing of basic case details, the team moved on to the next new case. The 10% of cases where there were salient concerns are discussed at length starting in Section 4.2.

Daily case communication was important for several reasons. First, daily case communication gave team members the basic case details that they needed to begin their part of the planning process. Second, daily case communication allowed the team to establish a treatment starting date for each patient. This date was typically seven business days from the day the patient was introduced during daily huddles. This date gave the team a window of time to conduct their individual work in developing treatment plans. These individual tasks are discussed at length later, in Section 4.1.4. Third, it made salient any concerns associated with each patient that needed to be considered when developing treatment plans. Fourth, based on the presence or

absence of salient concerns, daily case communication helped the team collectively frame each case. This activity is discussed next.

To summarize, daily case communication was the first activity the team engaged in as part of the process for enacting core values. Members stated it was the primary purpose for engaging in daily huddles. Daily case communication involved doctors sharing a set of basic details about each patient during daily huddles. The sharing of this information allowed others on the team to gain the basic details they needed to start planning treatment for each patient, it established a seven-day window of time until treatment was to begin, it provided the team a chance to learn if there were any salient concerns associated with each patient case and it helped them frame each case, which is discussed next.

#### **4.1.2 Framing Patient Cases as Standard**

Framing patient cases as standard involved communicating about each new patient case in a way that helped team members understand or view the patient case as normal or “routine” (FN, 50). Framing patient cases as standard occurred during daily case communication. The activity was driven by the doctors, who as mentioned previously, were the only staff in daily huddles who had significantly interacted with patients during intake evaluations that occurred prior to the patient being introduced in daily huddles.

There were two ways new patient cases were framed as standard. The first way was through doctors sharing only the basic case details described above during daily case communication. These details included the patient’s age, gender, type of cancer, treatment prescription and proposed treatment starting date. The sharing of only basic case details was important because it signaled to the rest of the team that the work to be done was basic, or standard. As the quote below indicates, once a patient case was framed as standard, team

members came to see the case as “routine” and not requiring a great deal of additional deliberation or consideration.

*In sum, there was discussion for only three of the patients presented and the huddle lasted a total of 11 minutes. I asked the manager after the meeting why this was the case. He said, “We get a lot of routine cases that we don’t necessarily need to go over in depth.” (FN, 50)*

The second way that patient cases were framed as standard was through the language the doctors used to describe each new patient case. As doctors introduced and described new cases, they often used phrases such as recommending a “standard,” or “usual” treatment plan and treatment starting date. One example of this is in the case described below, where D2 prescribes a “standard” course of treatment for a breast cancer patient.

*RT2 announces “First patient is [Patient name]. D2 says this is a 53-year-old female with triple negative left breast and regional lymph nodes. He is suggesting a standard course. He recommends starting on the seventh of the month, which he notes is a week and two business days [away]. He then pauses. Nobody says anything. RT2 quickly announces the next patient, stating “next is [Patient name].” (FN, 69.1)*

In a second example, D3 recommended a “usual” start for a hip cancer patient that was seven business days later.

*D3 says, “hmm, when to start? Let’s see, I think the usual – let’s see today is Thurs, so two Mondays from now?” (FN, 59,1)*

To summarize, framing patient cases as standard occurred when engaging in daily case communication about new patients. It involved the doctor sharing only basic case details and describing the case using language such as “standard,” “usual” or “routine.” The result of

framing patient cases as standard was that the team came to consider the standard patient case as non-concerning. This is addressed in the next section.

#### **4.1.3 Patient Cases Considered Non-Concerning**

An outcome of framing patient cases as standard was the consideration of these cases as non-concerning by team members. The phrase “non-concerning” was adopted directly from MGR, who used it in the quote below to describe cases framed as standard.

*My guess is that 90% of the patients they are just flipping through really fast – “saw him, good, saw her good, saw her, good. [They] are non-concerning.” (MGR, 46)*

This view, which was shared by members of the planning team, was not related to the severity of illness faced by a patient or the specific type of cancer a patient was experiencing. Rather, viewing a patient case as non-concerning was based on an implicit understanding in team members that standard cases would result in no planning related problems or issues. This understanding was formed, in part, through past experiences. This is reflected in P2’s quote below, who indicated that in the past, the team had a 95% success rate in treating standard patient cases without additional complications arising.

*I think, over time, we probably have a 95% success rate [treating patients without complications]. (P2, 105)*

This view of patient cases as non-concerning signaled to team members that, like most of the patient cases that came before it, the upcoming patient case was standard or routine and would require standard or routine work processes for plan development. In other words, using terms related to values described by Dewey, it signaled to team members that standard *means* (McDonald, 2011) were appropriate for standard, non-concerning work. This is reflected in Dos1’s quote below. She stated that the team had a “standard process” (i.e., standard means) for

setting up treatment for “straightforward” (i.e., non-concerning) work. In the next section, I refer to these standard means as a *standard operating procedure*.

*Most patients are straightforward [...] Even if it's a complicated treatment, their setup is standard. (Dos1, 67)*

The team also held standard, desired outcomes for patient cases considered non-concerning. Again, using terms borrowed from Dewey, the team held a shared, standard set of desired *ends* (McDonald, 2011) for each patient case. These desired ends, as expressed by several team members, were based on the values of safety and efficacy. As reflected in RN1’s quote below, the standard, desired ends of the team were to create safe and effective treatment plans for each patient.

*These huddles are really important. [Why?] Just keeping everybody on the same page. Just to keep patients safe, and to develop a good treatment plan. (RN1, 252)*

Safety, as described by team members, meant plans that did not harm patients due to excessive, unnecessary exposure to radiation. As Dos2 stated below, over exposure to radiation could result in harm, such as paralysis, blindness or even death.

*Whatever you do [...] you don't want to overdose. If you exceed dose constraints like on the lung, you can cause radiation pneumonitis and they'll be on oxygen the rest of their life. If you overdose a spinal cord, they can be paralyzed the rest of their life. If you overdose the optic nerve, they can be blind the rest of their life. [...] I mean, you can cure any cancer if you can treat enough dose to it, but then you can kill the patient to with all the treatment in the process. To the lay person, you just don't realize how much radiation you're hitting them with to cure that. [...] We need to avoid errors. (Dos2, 235)*



Efficacy, as expressed by team members, meant killing 100% of the patient's cancer. As P1 stated below, if treatment did not effectively kill the cancer, the patient would be subjected to having to do the whole treatment over again in the future. Thus, it was critical to kill the cancer during treatment.

*If you give them too little [radiation] then you didn't, you didn't cure, you didn't kill cancer, right? [...] And then what is the purpose of even going through treatment? (P1, 242)*

Team members seemed to implicitly understand that engaging in standard means for non-concerning patient cases would result in maintaining safety and efficacy through the development of treatment plans that were safe and effective. MGR's comments below provide evidence of this. He stated that the team's standard means, or established processes for developing treatment plans were "great" for accomplishing safety and efficacy.

*MGR says that safety and efficacy is why the team holds daily meetings. He notes that many cancer centers do not have these processes in place for planning. He says, "that is why we started these several years ago, and they are great for safety and effectiveness in planning." (FN, 2.413)*

To summarize, considering patient cases to be non-concerning signaled to members that standard means, or a standard operating procedure, could be used to achieve standard desired ends. These ends were related to values in that they involved creating plans for patients that were safe and effective. In total, framing patient cases as standard in daily case communications helped the team consider the patient case to be non-concerning. This consideration prompted members to make sense of upcoming patient cases as requiring standard means to achieve the standard, desired ends of safety and efficacy. Based on this, the team delegated the enactment of

safety and efficacy for non-concerning patient cases to a standard operating procedure. This standard operating procedure is discussed next.

#### **4.1.4 The Standard Operating Procedure**

The *standard operating procedure* was a repetitive, recognizable pattern of interdependent activities that team members consistently used to structure their planning work for patient cases they viewed as non-concerning and for enacting the desired ends of creating safe and effective treatment plans. In enacting these desired ends, the team was enacting the core values of safety and efficacy. The standard operating procedure included prescribed methods, or standard means, to be followed for the enactment of safe and effective treatment plans (i.e., the enactment of core values). There were two components making up the standard operating procedure. The first included standardized group tasks. The second component included standardized individual tasks.

**Standardized group tasks:** Standardized group tasks were the group activities used to collectively plan work. They were standardized because they were used repeatedly for non-concerning patient cases. These were the means performed inside of each daily huddle for enacting safety and efficacy. They included setting a seven-day planning window for non-concerning patient cases and reviewing the draft plans for these cases as a team two business days prior to a patient starting treatment.

Setting a seven-day planning window for non-concerning work involved setting a timeframe of seven business days from the day when a patient was first introduced in morning huddles to the day when that patient started cancer treatment. The seven-day planning window was the timeframe used for developing treatment plans in 90% of the cases I observed. The expectation of team members was that this seven-day planning window would be used for non-

concerning patient cases. Several team members referred to it as a department policy, though MGR stated it was not a formal policy (FN, 269).

This timeline was important for enacting the core values of safety and efficacy because it gave team members time to do their work without feeling rushed. MGR noted that the timeline was important because when staff were rushed to plan, details could “fall through the cracks,” and mistakes could be made.

*There were too many details to address and set in just a few days. So we use seven days.*

*When you're rushed, things fall through the cracks and mistakes happen. (MGR, 74)*

During a field interview, Dos1 expressed a similar sentiment. She stated that having a week and two days gave her time to reflect on plans and improve on earlier drafts, which helped her enact efficacy by improving on them to better treat patients. She relayed a story about a past plan that had to be done in a rushed manner but that she felt she might have improved with more time.

*And if I would've had say the week and two days with her, I don't know if things would've been, maybe I would've come up with a different treatment plan instead of getting one out in four and a half hours. And if I would've had [two days] to work on it, maybe the plan would've been better. Maybe I don't know. It's hard to say, but I know that having the week in two days when I do treatment planning, I'll do a plan and I'll be like, yeah, this looks good. And then I'll copy it and I'll see what I can do to make it better. And if you are on too much of a time crunch, you don't have time to do that, you're like, okay, this looks good. I'm going to show the doctor. A week and two days it gives us leeway to be like, okay, well can I bring this dose to these structures down? Maybe I could look at changing this angle because I don't like it as much. Things like that. It gives us extra time to do this*

*[think about and revise plans]. And oftentimes when I have a complex case, and even though usually I'll have it done in a day, I won't even put it for the doctor to review usually until the next day because I don't know, maybe I'm weird, but I like to sleep on it. Because I've been staring at this screen all day long in this one particular case all day long and I just want to put it to bed and then I'll come in the next day and look at it with fresh eyes and then I can really say, okay, well, I like it or I don't like it. It's ready to show the doctor or it's not if it's a really complex case. So it's nice to have the time to do that, not have everything super, super rushed. (Dos1, 64)*

The seven-day planning window for non-concerning patient cases also enacted the values of safety and efficacy by building in time for reviews, or as D1 called them, plan “checks and double checks for accuracy” (D1, 59). During these seven days, the doctor reviewed and approved the plans created by the dosimetrists. The physicist reviewed the approved plans and confirmed the machines could accomplish them. The team reviewed plans two business days prior to a patient’s scheduled starting date, and the radiation therapists did one final chart review the day prior to the patient’s starting date. Dos2 stated that this system of checks and double checks ensured safety and efficacy by giving “everyone a chance to check everyone’s work” and adjust plans if necessary to make them safer or more effective.

*We'll sometimes review plan and it doesn't happen with this group very frequently, but you'll have one [a patient case] that [someone asks] “did you think about this? Why are you treating to that dose? I don't generally treat to that dose. I may treat higher or I may treat lower.” And sometimes changes are made based on the meeting when everybody's reviewing the plan together. [...]. It gives everyone a chance to check everyone's work. (Dos2, 95)*

The second standardized group task involved reviewing draft plans for each patient as a team two business days prior to the patient starting treatment. Reviewing draft plans two business days in advance of the patient's treatment start was a standing morning huddle agenda item that occurred every day. This review helped the team catch errors or issues in developing plans that could threaten the patient's safety or prevent the enactment of efficacy. This review involved placing the draft plan on the computer projector screen for the team to review. In most cases, the team scrolled through the images in silence before moving on to the next patient.

I observed one instance where a planning step designed to protect patient safety was missed during initial planning but caught during the two-day review. This occurred when, during a plan review, RN1 noticed that there was no pregnancy disclosure form included in the plan for a female in her 30's being treated for breast cancer. After voicing the concern, RN1 volunteered to address it by getting a signed disclosure form from the patient that day.

*At this point during the plan review, RN 1 makes an observation. She says, reading the patient bio on the treatment report, "She wants to get pregnant again. Would we stop treatment for that if she gets pregnant? Is she planning to get pregnant soon?" To this D1 replies "I don't know, I forgot to ask." At this point MGR [in the back of the room interjects]. "Is there anything in the notes about her plans for getting pregnant?" The group is silent as D1 says "no. I don't know what her plans are. I forgot to ask." D3, then says, "yes it is a safety concern, but I have been doing this for 25 years, and I have probably only seen one patient get pregnant during treatment, so it is probably not a significant concern." RN1 then says "so we need to determine if she intends to get pregnant? I can follow up with her" D1, agrees and thanks RN1 for doing this. (FN, 2.1)*

After the meeting, MGR praised the team for catching this gap. He stated this was a safety issue that could have serious ramifications for both mother and fetus should a pregnant person be unnecessarily exposed to radiation. He articulated that this example showed why the reviews were important. They helped the team catch gaps in planning that could compromise the team's core values of safety.

*What you saw here could happen regularly. And that would put, well in this case, that puts women, and unborn children at risk. As you saw, it was raised here, [in huddle] so I'm glad we caught it [...] That is why these meetings are important. They help us catch gaps. (MGR, 89)*

In sum, there were two standardized group tasks that were part of the standard operating procedure used by the team to consistently enact safety and efficacy for non-concerning patient cases. These were setting a seven-day planning window and reviewing draft plans as a team two business days prior to a patient starting treatment. There was also a set of standardized individual tasks that team members used in planning for non-concerning patient cases. These are addressed next.

**Standardized individual tasks:** Standardized individual tasks were the individual activities used to accomplish planning work for cases without significant planning concerns. They were standardized because they were used repeatedly and consistently. These were the means performed outside of each daily huddle. They were the daily work activities performed by each team member.

Developing cancer treatment plans was a highly interdependent, often reciprocal activity. First, the doctor identified where a patient's cancer tumor was located and where the team would be targeting treatment efforts. This involved drawing, or *contouring*, the cancerous area targeted

for treatment on CT, MRI or PET scan images of the patient that were combined into a single 3D image using computer technology.

For example, if a patient had brain cancer, the attending physician would take all available medical images of that patient's brain and use them to pinpoint exactly where, and how large, the cancer was in patient's brain. They would then *contour* the cancer or draw it on those images so that others involved in planning could also see exactly where the cancer tumor was located. As described below, this process took approximately one to two days on average after the patient case was identified in morning huddle.

*Okay. So they [doctors] get the images; CTs, MRIs or Pet scans, or contrast CTs or whatever other images they need. Then they do their contouring, where they outline the, where they draw the tumor. They draw the target and then they'll put the prescription into the computer, and hand it back to us. [...] Sometimes they do it that same day [day of huddle] unless we're waiting on additional imaging. Sometimes they contour, and have it to you the next day. (Dos1, 230)*

After this, the dosimetrists took the contoured images and spent another day or two creating a radiation beam delivery plan. This involved determining the shape of the beam that would be delivered by the linear accelerator machine, where the beam would hit the patient's body and how the patient would need to be positioned for the machine's arms to effectively deliver radiation beams while avoiding healthy patient tissues.

In treating a brain cancer the size of a small BB, for example, the dosimetrist would create a plan that contoured the radiation beam to the shape of a BB. She would also determine the best positioning of the arms of the linear accelerator machine that delivered the radiation beam to align perfectly with the BB-shaped tumor while avoiding important body structures such

as eyeballs and optic nerves. Discussing this planning process, Dos1 explained that she had to figure out what angles to use for the beam to effectively and uniformly hit a patient's cancer without hitting "healthy stuff" such as a patient's eyes. She described this process as involving figuring out the angles that the machine could be maneuvered to effectively hit the cancer with radiation. She described this work as taking one to two business days.

*Then we come up with the treatment plan. That is figuring out how to do the actual delivery. We're figuring how to do it, the treatment plan is figuring out what angles we're going to use, what beam of energy to get a nice uniform dose. Here's one in the works, a nice uniform dose to the target while avoiding all the healthy stuff around it [Shows image of a tumor on a brain scan]. In this case, here's the brain, the eyes, the brainstem, all of that. When I'm done, I sit down with the doctor, we go over it. The doctor either okays it or wants changes. So we do that until we have a plan that we're happy with. [...]*  
*And maybe on day three or day four, my planning is totally finished. (Dos1, 233)*

Next, a physicist conducted a plan check, or QA (quality assurance) on each developing plan. This process involved running the draft plan on a phantom machine to ensure the machine could deliver accurate doses of radiation to accurate points in the patient body as identified in the dosimetrist's plan. It also involved making sure the linear accelerator machines were calibrated and tuned up to handle the proposed plan. Finally, as described by P1 in the following quote, the physicists rechecked the planned dose prescription to ensure it was accurate for the type and size of cancer being treated. If the physicists felt the machine could not deliver radiation as planned or if the dose prescriptions did not align with the type of cancer being treated, they would return the plan for rework. P1 reported needing *about a day* (P1, 240) to conduct QA on a plan draft.



*Yeah it is kind of a technical standpoint...[we test if] the machine can deliver this, can it stand up to this, can it deliver this accurately. You can develop a really nice looking plan, but in reality, if the machine can't deliver it because the plan is so complicated, then we can't do it. So that is what we check. We also check doses because sometimes things can slip through. A fresh set of eyes looking at doses is good. If you work with things a while, you can get blind to things. We want to make sure everything is as good as we can get it. We will send it back to [dosimetrist] if we do not like it. (P1, 240)*

Lastly, the radiation therapists needed a day to conduct one final chart review prior to the patient starting treatment. This involved ensuring all treatment paperwork was in order, and that the patient had signed an informed consent to be treated. They also rechecked radiation prescriptions to make sure they matched treatment plans and double checked that each plan was approved by the attending doctor and a physicist. Finally, they visually confirmed through photos and diagrams that the planned positioning of a patient for treatment on the linear accelerator machine matched the positioning specified in the treatment plan. MGR, a radiation therapist by training, described this process as making sure everything, such as consent forms, and plan double checks, were “in place.”

*The therapists [...] they have their own checklist. They do, and they have a QI checklist or a QA checklist that they're going through. And making sure that all the pieces close to them fit. By the time the patient hits the table, they know everything's in place. Consent is signed and the plan is checked and all those sorts of things. (MGR, 246)*

In sum, the interdependent activities of each team member that comprised the standardized individual tasks used to develop treatment plans for non-concerning patient cases included the doctors drawing, or contouring the cancer on images, the dosimetrists developing

treatment plans that determined how radiation would be delivered from the linear accelerator machine to the patient's cancer, the physicists reviewing and double checking each plan for accuracy and ensuring that the linear accelerator machines were capable of delivering the radiation plan created by the dosimetrist, and the radiation therapist doing one final chart review to make sure all treatment orders were accurate and all necessary paperwork was in place. This interdependent process of developing cancer treatment plans, as well as the approximate time needed for each component of this planning process, is illustrated below in Table 4.1.

**Table 4.1**

*Individual Tasks Associated with Developing Standard Treatment Plans*

Timeline	Team sets a seven-day planning window	Days 1 and/or 2: Doctor Draws Contours	Day 3 and/or 4: Dosimetrist Creates Plan	Day 4 and/or 5: Physicists Conducts Quality Assurance	Day 5: Team Reviews Draft Plan in Huddle	Day 6: Radiation Therapists Performs Final Chart Review
Data	RT1 announces the next new [patient]. D3 says that [Name] is a 71 year old female with five spots of cancer on the brain. She says the plan for now is to treat four of them with single fractions [single doses of radiation]. She notes this is a complex case because of the number and tiny size of spots. She suggests a	D3 reports she is working on contours that day [day of huddle]. She reports that because the case is complex, it might take longer than usual. She reports that usual time for contours is 24-48 hours. (FN 12)	Dos1 points to the images of the brain that is displayed on her computer screen. She says " this is the plan I am working on now. We need to hit those tiny spots with very precise beams. It is a high dose treatment to several different spots. So the planning is more difficult. We have a lot of structures and normal brain tissue we need to be	We need about a day. Usually we will need about a day. This area is really small, and the dose is so high, we have a strict criteria of how we will deliver the beam. It is a lot of preparation. We only get one shot. (P1, 12. 237) For this case we recalculated this [brain] plan on that phantom sitting back there. It's like	RT1 says "New starts Monday (48 hours from now), [Name]. D3 says "[Name] is our brain cancer case. Treating several spots. This was a complex case. Thanks for your hard work to have it ready." RT1 puts image on screen. D3 says "here are the bothersome tumors and our margins. Thank you	The last step is the therapists, they review the whole chart. So they're reviewing from the beginning, was the consent signed? Does it have the patient's signature in the right area? What's the setup from the simulator? What's the plan from the dosimetry? Has the treatment schedule been

start date of a week and two days from now. (FN, 12)	aware of.[...]. She reports she hopes to have this done today, but it might be tomorrow. Her work usually takes one day or two days. (FN, 12.289)	this little cylinder back there that has a plane of diodes on it. [...] So we delivered out there to make sure the dose matches up. (P1, 245)	(looking at side of table where Dos's and P's sit), for the great plan here." (FN, 80)	created? Is the prescribed dosage accurate with the medical records? [...] It's called chart qa.. (MGR, 249)
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Together the standardized group tasks and the standardized individual tasks made up the standard operating procedure used to enact the values of safety and efficacy in the development of treatment plans for non-concerning patient cases. The standard operating procedure was important because by using it, team members felt they were accomplishing core values related to safety and efficacy in each patient plan they created. Enacting core values is addressed next.

#### 4.1.5 Enacting Core Values

Enacting core values involved establishing, or putting core values into action, though daily work. Core values were the values that team members emphasized were most important in daily work. Recall from above that the two values (i.e., desired ends) that team members consistently espoused as critical in daily work were safety and efficacy. This is reflected in D3's quote below, who states that when creating cancer treatment plans, the "first" goal of the team was always safety and effective treatment (i.e., efficacy).

*My goal is patient care and safety first, and they know that. That is their goal too, we are all working towards the same outcome. They know I am thinking about the best way to treat the patient effectively and safely." (D3, 405)*

Enacting core values included all organizational members involved in the treatment planning process. Team members felt core values were enacted when the team used the standard

operating procedure to achieve desired ends of safety and efficacy in planning for non-concerning patient cases.

Standardized group tasks such as the setting a seven-day planning window allowed team members time to conduct their individual planning tasks thoughtfully and completely without, as MGR stated, “being rushed.” Being rushed, the MGR stated, could lead to errors that could compromise both treatment safety and efficacy (MGR, 74). Reviewing draft plans of work as a team two business days prior to a patient starting treatment allowed the team to collectively scan each developing plan for errors or opportunities for improvement. One example of improving a case through the team review two business days prior to the patient starting treatment occurred during the review of a perianal cancer case. In this case, the team returned the plan to the physicist for additional work after talking through the possibility that lying flat on the treatment table could cause the patient’s cancerous tissues to spread in ways unaccounted for in the draft plan. P2 described it as a little thing that rarely ever happened, but one that could reduce treatment efficacy by causing the radiation beam to miss cancerous tissue during treatment.

*Again, it's just one of those, one out of five out of 100 chance that something gets missed. And then that could be a big something in one case if it does. And it's relatively simple things too. A patient, the perianal case that D1 has and [...] we notice that when she lies down tissue will get smushed down and spread out. That can actually affect the dose [to that area] a tremendous amount. But how big of a detail is that? It's pretty small. So it's just trying to make sure there's little things that make it through. (P2, 71)*

The standard operating procedure was important because when enacted, it resulted in the team feeling that they were creating treatment plans that were safe and effective. In other words, it helped enact the desired ends of accomplishing the core values of safety and efficacy in daily

work. As RN2 stated, the standard operating procedure helped “keep everyone on stable ground for providing good and safe care for patients.”

*And I think it [the team process for planning] helps keep everything organized and everyone together and provides a good, like, stable ground for everyone to be able to provide good and safe care for patients. (RN2, 32)*

In sum, enacting core values was the process of establishing, or putting core values of safety and efficacy into action through use of the standard operating procedure. This standard operating procedure was comprised of standard means used to develop treatment plans for patients considered non-concerning. These means included standardized group tasks such as setting a seven-day planning window and reviewing draft plans of work as a team two business days prior to a patient starting treatment. When this standard operating procedure was regularly engaged, team members felt core values were being maintained.

To re-cap the entire process, the first significant finding emerging from my data was that the treatment planning team used a standard operating procedure, or a set of standard means to develop treatment plans that they described as safe and effective. In developing these treatment plans, the team was consistently enacting core values of safety and efficacy. The standard operating procedure, designed to develop safe and effective treatment plans, was used when patient cases were framed as standard and viewed as non-concerning.

As discussed above, this was the process used for 90% of the patient cases I observed during my study. However, in 10% of the cases, patients were not framed as standard and were considered “concerning.” Consequently, core values for these cases could not be addressed using the standard operating procedure. In the next section, I discuss the process that the team used to treat these exception cases. By engaging in this second process, the team was able to protect and

enact core values when they were threatened. The team was also able to accommodate the emergence of different but important values.

## **4.2 Protecting Core Values and Accommodating Additional Values**

The second significant finding emerging from my data was that the standard operating procedure used to enact the core values of safety and efficacy did not work for every patient case for which the team planned. In some patient cases, either the standard operating procedure was not able to accommodate the development of a safe and effective plan, or a new desired end (i.e., value) emerged as important that could not be enacted using the standard operating procedure. These cases were framed as exceptions during daily case communications, which resulted in them being considered concerning. Concerning cases prompted the team to put effort into adjusting the standard operating procedure to protect core values of efficacy or safety when they could not be enacted using the standard operating procedure, or to accommodate a new, important value in addition to safety and efficacy. This process for protecting core values or accommodating different values is described in detail in the next sections.

### **4.2.1 Framing Patient Cases as Exceptions**

Framing patient cases as exceptions involved doctors communicating about each new patient case in a way that helped team members understand or view the work as atypical or non-routine. Framing occurred during daily case communication. This framing was driven by the doctors, who as mentioned previously, were the only staff in daily huddles who had significantly interacted with patients during intake evaluations that occurred prior to the patient being introduced in daily huddles.

There were two ways patient cases were framed as exceptions. The first way was through doctors making a concern about a new patient salient to the rest of the team during daily case

communication. The second was through the language doctors used to describe the case. First, making a concern salient signaled to the rest of the team that the work involving the patient case was an exception to the standard. Salient concerns were details about the patient that the team made sense of as potentially impacting treatment planning. As RD stated, these were not minor issues or “little nuances” associated with work. Rather, these were big issues that could negatively impact treatment outcomes or threaten desired ends of enacting the core values of safety and efficacy if not addressed.

*Sometimes there's like little nuances and it's easy to talk about that in the meeting. But sometimes the issues are really big [...]. Those are the things that can really impact treatment in a bad way if we don't address them. (RD, 117)*

I observed 17 cases where I coded the presence of salient concerns. These included three cases where a patient was experiencing excruciating cancer-related pain, four cases where the attending doctor was worried about the fast speed of cancer growth in a patient, two cases the team referred to as “oncological emergencies” (RN2, 204) where a patient’s life was at risk due to a cancerous tumor, five cases where there was concern about holiday office closures delaying the start of treatment (this was because one of my observational periods was near Christmas), and three cases where a patient requested to start treatment on a specific date that was earlier than the seven-day planning window associated with the standard operating procedure.

One example of a salient concern occurred when, after sharing basic details about a patient case, D2 shared with the team that the patient was in excruciating pain and was mostly immobile because of it. He shared it was a priority to him to relieve the pain.

*D2 shares this is a patient with spine cancer who is in significant amount of excruciating pain and can barely move - is mostly immobile. D2 says he wants to work fast to relieve the pain. (FN, 13.51)*

As highlighted in the example above, in each instance involving a salient concern, the concern was made salient by the attending doctor. This was because as mentioned earlier, the attending doctor was the only staff member to have significantly interacted with patients during earlier intake appointments. It was during these intake appointments that the doctor assessed whether the patient case included a concern to be made salient to the team. For example, when considering the salient concern of excruciating patient pain, D2 noted that during intake visits he would observe patients in pain. If he assessed their pain as intolerable, he would bring this concern to the team during daily case communication.

*I assess patients by talking to them about their pain and quality of life. If it seems they can hardly move or are in significant pain, or if I see a patient is clearly struggling with movement, or is wincing or clearly uncomfortable, I will ask about [adjusting the standard operating procedure] for an urgent start as soon as we can. (D2, 209)*

The second way that work was framed as an exception was through the language the doctors used to describe each new patient with a salient concern. As doctors introduced and described new patient cases, they often used phrases that compared the work to standard, non-concerning work. These comparisons suggested that the work was different from non-concerning work. These phrases suggested work was concerning because of the presence of a salient concern that could result in negative outcomes for the patient. One example of this was D1 sharing a concern about a patient's growing cancer tumor in the spine. He described the situation as being "more urgent and serious" (compared to non-concerning work) because of the threat of paralysis



(a threat that is not present in non-concerning work). He shared that the patient had been hospitalized because of the tumor and was “in the hospital for a reason” (unlike non-concerning work that did not include hospitalizations).

*RT2 states [Patient name]. D1 shares that [Patient name] is a myeloma patient with a growing tumor located between the L3 and L5 spinal vertebrae. He said the patient had been hospitalized due to the tumor. D1 states that the situation is urgent and serious. He says the concern [in this case] is that the tumor is pressing the patient's spinal cord. He noted that this could result in [patient] paralysis, or worse. He says "she's in the hospital for a reason. It's a more serious and urgent situation. So we just want to get it going as fast as possible." (FN, 68.43)*

The presence of a salient concern and the language used by doctors that unfavorably compared the salient concern to non-concerning work caused team members to take note and reconsider their work as concerning rather than non-concerning. In other words, it motivated them to view upcoming work as concerning.

As P2 stated, as soon as he heard a concern such as patient pain made salient, he immediately took note of the case as different from the standard. He started thinking about what came next in planning for that patient. The outcome of this framing was a view of patient cases as concerning, rather than as non-concerning.

*And as soon as they announce, “hey, this person's in a lot of pain,” you start listening to the next part, which is ‘let's get them in as soon as possible’ and that's fine. (P2, 211)*

To summarize, framing patient cases as exceptions occurred when engaging in daily case communication about new patients. It involved the doctor making concerns about the patient case salient to the rest of the team and using language such as “more than,” “unusual” or

“concerning,” to describe the concerns. This helped the team compare the patient case to standard, non-concerning patient cases, and led the team to update its view of the patient case as concerning rather than as non-concerning. Patient cases considered to be concerning are addressed next.

#### **4.2.2 Patient Cases Considered Concerning**

Patient cases considered concerning were cases that presented a challenge or difficulty in planning. This consideration was formed through framing patient cases as exceptions during daily case communication. Through this framing, members made sense of patient cases that were exceptions to the standard as being concerning.

Considering cases to be concerning helped members problematize the standard operating procedure. By this I mean members viewed the standard operating procedure as inadequate, or problematic, for addressing the concerns associated with a concerning patient case. There were two types of situations where the team problematized the standard operating procedure. The first was when the standard operating procedure prevented the enactment of core values (i.e., safety and efficacy). Under these circumstances the standard operating procedure was a threat to the enactment of core values. The team had to consider using different means to accomplish core values. An example of this occurred when D1 expressed during daily case communication that treatment efficacy (i.e., the core value of efficacy) would be negatively impacted if a patient did not start in two days’ time to get a full week (i.e., five straight days) of radiation before a long, upcoming holiday break. D1 stated that the standard start of seven days later meant the patient would start on a Tuesday after the holiday, which was too far out. He expressed that a full Monday through Friday week would keep treatment from being “compromised.” For this case, the standard operating procedure represented a problem in that it would be unable to enact the

core value of efficacy. This was because starting late posed the threat that treatment would be less effective.

*In this case Monday through Friday would be most appropriate. Normally, this would not be an issue, but in this case, because of the holiday, I think the patient treatment schedule would be compromised. (D1, 167)*

The problem, in this instance, was that the standard operating procedure threatened the core value of efficacy by potentially reducing treatment effectiveness. The team's response was to deliberate about new means. This included, as illustrated in the field notes below, D1 asking the team to move the starting date up from seven days later to five days later and team members thinking about, and then agreeing to do so.

*[D1 says] "If we start her as scheduled, that would land on Labor Day, so she would have to start on Tuesday and get a short week." He adds, "I'm hoping we can start her Monday [five business days ahead] instead?" [...] P1 says this should be ok and MGR notes he can check with Dos1 to confirm. Dos1 arrives later and MGR meets her at the door. They have a private conversation and Dos1 nods affirmatively. [...] After the huddle I ask MGR about this who confirms he was asking Dos1 if she could do an expedited plan. Dos1 says she will get a plan done in 48 hours that can be QA'd by physics and ready to start by Monday, but that it will be "crunch time." (FN, 17.19)*

The second situation where the standard operating procedure was problematized occurred when the standard operating procedure prevented the enactment of a new desired end. In the case below for instance, D1 made salient a concern about a patient wanting to start treatment in two days to be done by the end of the month to attend a statewide arts festival. In sharing this concern with the team, D1 stated that this was something the patient really "wants," and something he

wanted to accommodate. However, the standard operating procedure posed a problem in this case because it prescribed that the patient would not be able to start treatment for seven days. He requested starting the case in two days as opposed to the standard seven. In response, Dos1 stated that despite having to rush to plan treatment, the team would “get him to that festival!”

*D1 shares that [Patient Name] has prostate cancer. He is prescribing a standard course of treatment to be administered over 28 sessions. He then smiles and says that the patient wants to finish the 28 treatments before the start of the state MAJOR ARTS festival taking place at the end of the month. And that to accomplish this the patient would have to start treatment Monday [today is Friday]. D1 asks "can we start him on Monday?"*

*Considering this request, Dos1 says she has capacity in her schedule to work on this plan that day. [...] She states, smiling, “yeah, we can get him to that festival!” (FN, 6.11)*

In this instance, a new desired end of getting the patient to the festival emerged as important. And as Dos1 implied in the quote below, the standard operating procedure was a barrier to accomplishing this new desired end. Consequently she said she would have to “rush” planning to accomplish this new desired end.

*In a post huddle follow up interview, Dos1 stated that “in him [D1] making that request, things will be tight. I will have to get the planning done today so that physics can QA over the weekend and we can do a review on Monday. It is going to be rush, rush. (Dos1, 6.11)*

These new desired ends represented new, or different values that emerged as important in the team’s work. In the case above for instance, the team desired to address a customer’s request. In follow-up interviews, several participants stated that while the core values of safety and efficacy were always important, sometimes other valued, desired ends were important as well.

One of these was customer service. As RT1 noted below, the team would always try to “honor” patient requests. Consequently, when the standard operating procedure prevented the enactment of a new desired end such as meeting a patient’s request for a starting date, the standard operating procedure was preventing the accomplishment of a different value (in this case customer service).

*We will try to honor patient requests. The patient is number one. (RT1, 137)*

As both cases above reflect, patient cases considered concerning resulted in team deliberation about new means to address problems. In both instances above, D1 proposed an adjustment to the standard operating procedure that included starting the patients earlier than the standard seven days later. And in both cases, team members considered the request before agreeing to it. Thus, the importance of considering patient cases to be concerning was that it signaled that work was not standard and that different means would be required. As D2 stated below when talking about cases considered concerning, the team would have to plan for (i.e., put effort into adjusting means) to address the concerning case.

*I kind of tier patients in different ways. Most patients are normal, which is just a week and two days. There is also urgent, and emergent [like crisis or significant pain], which could be something [significant] that we need to plan for. (D2, 210)*

In sum, patient cases were viewed as concerning when they were framed as exceptions to the standard due to salient concerns. These concerns could not be addressed using the standard operating procedure because the standard operating procedure either prevented the team from enacting a core value of safety or quality, or a different value emerged as important that could not be adequately addressed using the standard means. This led to the team deliberating and considering new means to address the salient concern. This resulted in the team putting in effort

to adjust the standard operating procedure to resolve the concern associated with the patient case. Adjusting the standard operating procedure is next addressed.

#### **4.2.3 Adjusting the Standard Operating Procedure**

To address concerning patient cases, the team adjusted its standard operating procedure. These adjustments were temporary modifications of the standard operating procedure to fit the situated needs of patient cases that were considered concerning. These adjustments were made on a case by case basis for concerning patient cases.

**Adjusted group tasks:** Adjusting the standard operating procedure included adjusting group tasks and adjusting individual tasks. For group tasks, the primary adjustment was shortening the planning window from seven to a shorter period of one to five days. This adjustment took place for all concerning cases. It was initiated by doctors. An example of this included D1 asking for a two day start for the patient wanting to go to the arts festival (FN, 6.11) and a five day start for the case he hoped to get started one full week before a Labor Day holiday break (FN, 17.19). Sometimes doctors would propose earlier starts for other reasons, such as “oncological emergencies” (RN2, 204). These involved concerns that cancer threatened a patient’s life or wellbeing. These emergencies could include a tumor that negatively impacted a patient’s breathing, or a tumor that put a patient at risk of paralysis and, as D3 stated below, needed to be addressed immediately.

*And on occasion we have to start immediately for different reasons. Sometimes it's an emergency patient that has a spinal cord compression that we cannot wait a week, two days, or they could lose neurologic function. (D3, 199)*

In seven of the 17 instances of concerning patient cases that I observed, staff quickly agreed to a doctor’s request to shorten the planning timeline. This included the example below,

where the team quickly agreed to D2's request to start a patient in three days due to extreme pain.

*D2 shares this is a patient with spine cancer who is in significant amount of pain and can barely move - is mostly immobile. [...]D2 asks the team if the patient can start in three days' time [today is Thursday, so that would be Monday]. Dos1 says she can work on the treatment plan and will have it expedited and ready for Monday. P2 is in the meeting and confirms that he can do QA checks on the equipment. (FN, 13.51)*

I also observed ten instances that involved negotiation among staff regarding timelines for completing individual planning tasks. In eight of these instances the negotiation involved asking the doctors to get their drawings or contouring of the cancer done immediately so the rest of the staff had time to do their individual tasks. If the dosimetrists had contours from the doctor, they could begin their individual tasks. Without contours, they were waiting. Consequently, a frequent response to a request to shorten the planning timeline for concerning patient cases was a dosimetrist saying they could create an early plan if the doctor could get them contours that day. The arts festival case above offers evidence of this negotiation. After D1 asked for an early starting date, Dos1 replied she could do this if D1 got her contours that day, which D1 agreed to (and ultimately accomplished).

*D1 asks "can we start him on Monday?" Considering this request, Dos1 says she has capacity in her schedule to work on this plan that day. But she asks that D1 get her contours that day. He says he will have them done by afternoon. (FN, 6.11)*

This negotiation was important because, as P2 stated, accomplishing an early start request was dependent on the doctors completing the first critical step of contouring the cancer. Waiting for the doctors to finish contouring hindered others' abilities to accomplish their own individual

tasks because their planning timelines were, P2 stated, “crunched and compressed.” Thus, as P2 also stated, the team “really pushed” the doctors to get their contours done for patients starting earlier than seven days out.

*We also really push the doctors to get their contours done as soon as possible. Take this five-day start. If they can get the drawings to us tonight, then the dosimetrist still has two days to put together a plan before it is ready for Friday review, which is basically normal for them. So they won't notice it at all. But if it takes three days to get the contours, then we are really in trouble. Because then the dosimetrist can't start planning until Friday. Then we have two days to put it all together, and that is just not enough. It really crunches and compresses everything. (P2, 349)*

In two cases, rather than negotiating timelines for individual task accomplishment, the team negotiated the planning window timeline and subsequent treatment starting date. In both cases, negotiation was triggered by RT2 noting that the treatment machines were filled with appointments on the days proposed by doctors. This was the case in the example below, where RT2 countered D2's request for a four-day start by suggesting a five-day start when there was machine availability. D2 ultimately accepted this counter and means were adjusted to start the patient in five, instead of seven days.

*RT1 says "good morning, first sim today is NAME." D2 says the patient has cancer in left breast. "A really small amount." He prescribes partial breast radiation – 30 fractions.... D2 notes that "we are running into holidays. D2 says if we don't start next week, the next opportunity is on the 27th, which is too far out." He says he would like to get several treatments in before the long holiday break He asks about starting next Wednesday, which is four days out. "I can get my contours done today." RT2 asks, "Can we start Thursday*



*[five days out]? Thursday has some open spots after 4PM. And that would still give her two treatments before the break." D2 thinks this through and says "Yes, and confirms that "I can get my work [drawing the contours] done fast." [...] After the meeting I asked RT2 why she countered with Thursday as the starting date and she noted it was because the machines were booked solid on Wednesday. She said there were a lot of cases getting radiation before the holiday break. (FN, 62.4)*

In a second instance, RT2 countered D1's request for a five-day start by asking if the team could do the standard seven days. This case represents my only observed denial of a request to start treatment early. Of note is that D1 did not frame this case as an exception. He went directly to proposing an adjustment to the standard operating procedure. It was only after his request was not accepted that he offered reasoning, stating that he wanted to start early because of the holidays.

*D1 says the patient is his. He asks about a five-day start on Monday. RT2, looking at the schedule of the linear accelerator on her computer responds by saying "hmmm, can we do Wednesday? That is a week and two days?" D1 pauses, considering the request. He says "yes, but," and he pauses. Then he asks, "is it really busy next week?" RT2 says "yes, the machines are booked." Clearly thinking about this response, D1 says "yes, I was thinking with the holidays I wanted to get it started early. But it's no problem. It is a small thing." (FN, 57.1)*

As the above evidence demonstrates, adjusting timelines was a process that involved thought and negotiation, or effort. This was because adjusting timelines impacted the timelines of the interdependent individual work of team members. These interdependences were accounted for under the standard operating procedure, where seven days for planning was enough for all

staff to accomplish their individual tasks. Consequently, negotiation was unnecessary using the standard operating procedure to treat non-concerning patient cases.

A second adjustment the team made to the standard operating procedure for concerning patient cases was by flexing the standard team review. This review was typically scheduled for two days prior to a patient's treatment start. I labeled this adjustment *flexing* because the team did not concretely set a different review date for these patients like they did when shortening their planning window to a defined time period of one to five days. By flexing, I mean that while the team planned to review a draft plan two days before treatment was set to begin, if the plan was not ready, the team would flex their huddle agenda to review the plan the next day, which was one day before treatment was to begin. And if a draft plan still was not ready one day before treatment was to begin, then the team would flex their huddle agenda one more time to review the plan on the day treatment was supposed to begin. In other words, as articulated by the MGR below, for concerning patient cases, the team exercised flexibility in reviewing draft plans during huddles. This was because there was uncertainty around when plans would be ready for review.

*If the plan is not ready two days in advance, we can compensate for not being able to do 48 hour reviews. We can do 24 hour reviews. If it is only day of, then the dosimetrists and physicists have had a lot of opportunity to discuss the plans among the five of them [outside of the huddle].(MGR, 412)*

Each concerning patient case was brought up in the huddle two days before treatment was set to begin. However, as Dos1 pointed out, because these concerning cases had shortened planning timeframes and earlier starting dates, they were rarely ready for review two days prior. She said most reviews for concerning patient cases were flexed during the huddle to take place one day before treatment was set to begin.

*Dos1 notes, those cases [early starts] typically are not ready for a 48 hour review and comprise the 24 hour review. (FN, 342)*

An example of this was D1's patient that was scheduled for a five day start due to the upcoming Labor Day office closure. Dos1 accurately predicted that the plan would not be ready for the team huddle that upcoming Thursday, which was two days prior to the patient's scheduled treatment start. She worried that if the plan was not ready for approval by Friday, the team would not be able to review it until the day of.

*But him [D1] asking about the patient for Monday, that means that we will cover the patient in meeting this Thursday morning ideally, but we probably wont be ready. That is two days away. We probably wont be able to cover this patient in morning meeting until Friday. And if it is not approved Friday, now we are looking at talking about the patient plan in morning meeting on Monday, which is the day of treatment. When the patient starts. Which, all of this will get done. We will get a plan done. I's dotted and t's crossed. But it is going to be crunchtime. At the end as far as presenting it and going over it. (Dos 1, 228)*

In this case, the plan was ready and approved Friday, which was one day in advance of the patient's scheduled Monday treatment start. However, if a draft plan for a concerning patient case was still not ready one day prior to scheduled treatment start, the team could flex their review a second time, to the day of treatment start. I observed this happen once, with an early starting brain cancer case.

*RT1 says "new starts today, [Patient name]." Dos2 asks, "did we look at her yesterday?" D2 says "no, the plan was not done. She has a right brain mass, we are treating it with 18ss and one fraction. This was a fast start. And thanks for the great plan*

*on this one.” RT1 scrolls through the plan on the screen. The team watches silently. (FN, 83)*

Finally, if a plan was still not ready for huddle review on the day of the patient’s scheduled treatment start, the team reserved the right to delay starting treatment. MGR explained that reserving the right to delay treatments helped the team preserve the core values of quality and safety in plan development.

*If we need to push it back to get a good plan and to get a safe plan, then that is what we will do. (MGR, 188)*

I observed one instance of a plan being delayed because it was not ready. This was an early start for a patient with five tiny spots of fast-growing brain cancer. I did not observe the patient being introduced originally during daily huddles. These small spots each required a tightly contoured radiation beam, which made planning the case complex and time consuming. On the day treatment was set to begin, Dos2 stated it was still not ready and the team would have to delay the patient for one day.

*RT2 announces “New starts, first is [Name].” At this point Dos2 speaks, he says he was working on this plan most of yesterday evening but it is not ready and they will have to delay the patient. I ask him about this later. This was an early start due to fast growing brain cancer. Dos2 says there were five tiny spots that had to be individually treated. He said creating individual, adjusted radiation beams for those spots was challenging and took time, primarily because he had to repeat the process five times. He suggests he will get the plan done today, but treatment might need to be pushed back a day or two for physics to have time to do their QA activities. (FN, 181)*

While I was not in attendance to observe the outcome of this case, I asked MGR about it. He reported that they did delay the case a day, to give time for physics to complete QA, because as he described, that was necessary for a “safe treatment.”

*I ask MGR about this. He reports that Dos2 got his plan done, but the case was delayed due to insufficient time for the physicist to conduct QA. MGR said, “after today’s meeting [the huddle], P1 and I got together, and we looked at what was going to be needed for a safe treatment and we made the decision that wasn’t going to work. And so then we went to the physician and we said, this is not going to be a safe treatment because the physics check was incredibly difficult to verify that the setup was correct and physics did not have an opportunity to be able to do it [QA] within the timeframe given. And so, we really needed to back it out. [...] We need to bump it to the next day so that all the work is done and there is time to review it, and the physician agreed. (MGR, 182)*

In sum there were two group tasks that were adjusted for concerning patient cases. The first was shortening the planning timeline from seven days to between one and five days. The second was flexing, as necessary, the review day of draft plans from two days prior to treatment start to one day prior, or to the day of start. Neither activity was automatic like the activities associated with the standard operating procedure. Rather, they took effort or consideration from the team. This could involve negotiation. It could involve putting work into flexing the review date. This work could even include effort expended to postpone treatment if a plan for a concerning patient case still was not ready the day treatment was to begin. For these reasons, the team had to put effort into adjusting the group tasks that were part of the standard operating procedure. In addition to group tasks, the team also had to put effort into adjusting their own individual tasks.

**Adjusted individual tasks:** Some individual tasks were also adjusted specially for concerning patient cases. These tasks were the work that individual staff members conducted outside of daily huddles as their part in collectively developing treatment plans. Individual tasks adjusted to meet the needs of concerning patient cases included simplifying plans, speeding up task completion timelines and offloading work to others. Each is discussed below.

*Simplifying plans:* Simplifying plans was one way the team adjusted individual tasks to meet the specific needs of concerning patient cases. As the quote below states, a simplified plan was a treatment plan where the radiation beam hit a wider field of the patient’s body instead of being shaped to specifically match the shape of the patient’s cancer tumor. Because the radiation beam was not shaped specifically to the measurements of the patient’s cancer, as stated below, these plans were simpler to design and took less time to produce.

*So we can start the patient with a simpler, more basic plan. That means we will hit a wider area with the beam, it will not be as exact. [...] They are a little more broad, and cover a wider field. [We are] not getting into very specific beams with higher doses of radiation and much tighter margins. With those, [...] they require more detailed planning. Which takes time. (P2, 319)*

Simplifying plans involved the dosimetrists, who created the radiation delivery treatment plans and the physicists who conducted QA on all plans. For instance, with an emergency spine patient needing immediate treatment to prevent paralysis (FN, 68.43), it was Dos1 who created a “simple” plan. This simplified plan allowed treatment to get started within 24 hours and reduced the possibility of paralysis due to the tumor pressing on the patient’s spinal cord.

*Dosimetry was able to do a pretty great, simple plan [for the spine case] and we were able to push it through quickly. (D1, 326)*

Physicists were also involved in simplifying plans. For simple plans, which used what the team referred to as 3D technology, the physicists did not have to conduct QA checks on the treatment machines. As P2 explained, they could review the plan details on their computer screen and sign off on plan approval from their offices. This helped them save time for concerning patient cases with shortened planning timelines.

*We can do a simple, 3D plan instead of something more complicated. Those are plans we don't need to do QA on the machines to address. We can review the plan from our office. So that saves time. (P2, 319)*

As MGR stated, simpler 3D plans were used primarily for concerning patient cases that involved pain reduction or oncological emergencies that needed to get started as soon as possible. This included the spine case referenced above where there was threat of paralysis without immediate treatment.

*We will use 3D [simpler] plans for pain [...] And, well, let's take that emergency spine for instance. So a spinal cord compression that comes over from the hospital that has to get started right away to reduce the tumor's pressure on the spine. That could be same day, so not just three days. That could be same day treatment. So the patient comes, the physician's contouring their volumes, and the dosimetrist is creating kind of a simple plan just to get started. (MGR, 222)*

As P2 stated, simplified plans were used when the goal was “shrinking the tumor.”

*Because the goal is to shrink the tumor. 3D beams are great for that. (P2, 319)*

Shrinking tumors by starting patients quickly using simple plans allowed the team to quickly reduce pain and suffering, or to quell a possible ontological emergency. This was the case with the emergency spine patient, who was able to start early to avoid potential paralysis

through a simplified plan designed to shrink the tumor. As Dos 1 stated, getting the patient started was not about effectively killing cancer, it was about “shrinking the tumor,” to avoid future paralysis.

*Yes, that plan was a 3D [24 hour starting spine case]. That's right. I kept him. Yeah. So this will be what a 3D three plans look like then [Shows me the plan on the screen]. Okay. And [...] it was purely about shrinking that tumor. Just like the other spine we looked at. (Dos1, 333)*

However, by widening the treatment field on a patient’s body using 3D plans, the team was also exposing healthy structures to radiation, which threatened the core value of safety. To account for this threat, simplified plans were created using lower doses of radiation to, as Dos1 said, “not compromise safety” by preventing radiation overdose to “healthy structures.”

*We would lower the dosage so we are not compromising safety, but the margins aren't as tight [with simpler plans]. But we're still not overdosing [normal tissues] structures. So there might be some give and take there, but really the 3D plan probably is safe the whole way through. It's just not necessarily the ideal plan. So we wouldn't want to do that the whole way through necessarily [to effectively treat and cure cancer]. (Dos1, 303)*

In sum, simplifying plans involved creating plans for concerning patient cases that utilized wider, less precise radiation beams to treat cancer. Because these plans were less precise, they required less planning time. Thus, concerning patient cases could get started immediately through use of a simpler plan. However, because these plans used a wider, less precise beam, radiation also hit healthy tissues and structures which compromised the core value of safety. The team compensated for this by lowering radiation dosages used with simpler plans. The desired end of using a simpler plan was to shrink tumors that were threatening the lives of patients or



causing them significant pain. In this way, the team was accomplishing different values associated with patient wellbeing in the case of avoiding paralysis, and compassion in the case of reducing suffering by shrinking tumors to reduce pain. As RN2 noted about compassionate treatment, “if a patient is suffering,” the team wanted to treat the patient right away.

*Pain...pain relief. If a patient is suffering, we need to get that going [a plan to treat] right away. (RN2, 204)*

*Speeding up task completion timelines:* Speeding up task completion timelines was another way the team adjusted individual tasks to meet the specific needs of concerning patient cases.

Speeding up tasks involved team members getting their own tasks done sooner than they would normally using the standard operating procedure.

Doctors sped up their contouring tasks. Dosimetrists also sped up their plan creation tasks. The physicists and radiation therapists, who team members felt still had to carefully go through their standard QA checks to ensure safety, did not speed up their task work. This was because, as Dos1 noted below, the team “did not skip” steps. The quality and safety reviews conducted by the physicist and radiation therapists were in place to enact the core values of safety and efficacy. These were not compromised by being sped up.

*But if I [create] the plan the day before the patient starts, then it's expected for physics to then QA it on the machine for the patient to start the next day. We've all kind of decided that this has to happen [...]. We don't skip steps. Things are still done safely. (Dos1, 267)*

Speeding up was used when the team felt a simplified plan was not appropriate for the type of cancer being treated. This included, for instance, a fast-growing lung cancer that D3 asked to start in three days' time (FN, 33.24). It also included the prostate cancer patient who was going through his second round of treatment and wanted to start early to be done in time for

the statewide arts festival. In these instances, the desired end was not to quickly shrink a tumor, but to effectively kill cancer, or enact the value of efficacy.

The team sped up individual tasks to meet adjusted starting times for concerning patient cases. Adjusted starting times could result from a customer request, such as the patient who wanted to start early to be done in time for the arts festival later that month. Adjusted starting times could also result from the need to get a complex case started early due to its fast-growing nature. In these cases, the speed of cancer growth threatened the core value of efficacy. This was because as D3 noted below, if a tumor had grown in the seven days the team planned to treat it, then the laser beam would no longer be contoured to exactly match the cancer tumor.

*D3 reports the patient, [Name] has a new small legion in the lung. This is his second treatment. She says this will be a single fraction, [one treatment] and she says she is hoping to get it done soon, next week. Monday. For a single treatment. [...] I ask D3 about this as the huddle ends and she is walking back to her office. She tells me that the concern is the speed of the cancer's growth. It is a tiny tumor now, but in a week it could be much bigger. So she wants to treat it as soon as possible to make sure they catch it all.*  
(FN 33.24)

There were two ways staff sped up individual tasks. The first was prioritizing the concerning patient case ahead of other case planning. When a case was considered concerning, staff would set aside other cases to work on the concerning case. For instance, Dos1 reported that she prioritized finishing work for the prostate cancer patient to be done for the arts festival by focusing only on it for an entire day.

*I ask Dos1 about this case on Monday [the next business day after this case was introduced the prior Friday]. She reports that "I had to move super fast on Friday. This*

*was mostly what I worked on. But I put together the plan. My work is done. But now it goes to PI for sign off, and then the RTs. That is why it takes time.” (Dos1, 225)*

The second way that staff sped up task completion timelines was by working on concerning patient cases during off hours. MGR described doctors staying until 11PM or later to finish contours for concerning patient cases (MGR, 2). D1 described coming in on Saturday and Sunday to get his work done for an emergency spine case that was starting that upcoming Monday (FN, 68.43). D3 shared that when she was working on a concerning patient case, she would generally stay late to finish her contouring that first evening, and the dosimetrists would come in earlier than usual the next day, sometimes at 4AM, to do their planning.

*So I will finish volumes after work in the evening, and the next morning Dos2 will have shown up at four in the morning and we'll already have a plan. (D3, 122)*

In sum, speeding up task completion timelines was a second way the team adjusted individual tasks for concerning patient cases. This work involved the physicians and the dosimetrists setting aside other cases to focus on concerning cases. It also involved staff members working during off hours to complete tasks. Team members sped up planning timelines for cases that needed to start as soon as possible due to a patient request to start on a specific date, or due to fast growing tumors that threatened the team's ability to successfully treat and cure cancer. This allowed them to accommodate new desired ends, or values, related to customer service. It also allowed them to help maintain core values of efficacy in cases such as fast-growing cancers where there was a threat that waiting too long to start could reduce treatment effectiveness.

*Offloading work:* Offloading work was a third way the team adjusted individual tasks to address concerning patient cases. This involved shifting tasks from one staff member to another.

Offloading occurred when planning duties were shifted from the dosimetrists to the physicists, who took over responsibility for creating radiation beam delivery plans. It was most likely to take place when dosimetrists were overloaded or as P2 stated, “bogged down” with planning many cases. P2 stated this also occurred when plans were particularly complex and time consuming.

*I pick up stuff for people that are either maybe just a little bit more complicated or time consuming or [our] dosimetrists are bogged down with other work. Then I'll take it over. But to be honest, I love planning, so I'll take anything away from them, but I also don't want to step on any toes. They're good at their job and they're paid to do it. They might as well let 'em. (P2, 161)*

There were two reasons that the team offloaded planning activities from the dosimetrists to the physicists. The first was to relieve potential bottlenecks that could result in planning delays for concerning patient cases needing to be completed on shorter timelines. P2 noted that physicists could get plans done faster because they didn't have other planning obligations like the dosimetrists (P2, 162), while P1 said it was easier for physicists to put all their effort into one single plan because they were not working on multiple plans at once (P1, 159). Dos1 said this was the case when P1 stepped in to plan a complicated nose cancer case (FN, 76.164). She noted that when dosimetrists were “overwhelmed” the physicists could help by taking planning responsibilities from them.

*The three of us [Dosimetrists] can usually handle all of the planning cases. But if there are an overwhelming number [of cases] physics is great. So they could step in. I would say it's some more complex, timely stuff that they step in and do. There was actually a case this week that P1 took, and so that is the nose and then also the node that she had in*

*the nose. And so I logged on Tuesday and I saw that he [P1] had taken that case and was like, "oh, what's that?" So I pulled it up, took a look to look at her. I was like, "oh, yeah." When he takes the complex cases, that frees us up to work on all of the other cases. (Dos1, 164)*

A second reason the team engaged in offloading planning from dosimetrist to physicists was because offloading helped streamline, and thus speed up, the planning process. By taking over planning, dosimetrist no longer had to run their plans by the physicists for check and approval before sending them to the doctors for approval. The physicists ran their own plans by each other and then submitted them to the doctors. In this way, as P1 described it, when he took over planning, they were *cutting out the middleman*. He could work directly with the doctors on final plan approval in cases where the team had a "tight window" for creating plans.

*If we have a tight window and it seems like it's going to be really complex, I can step in and plan it myself. Then you don't have that back and forth with dosimetry. You just come in, and you just do in your mind what you are expecting the plan to look essentially. You kind of cut out the middleman where if it was the dosimetrist and the doc were doing that, then physics would come in and then be asking [dosimetry] probably a lot of questions, like "why did you do [plan] stuff this way?" So you kind of cut out that middleman. That kind of speeds things up quite a bit. (P1, 159)*

There were two ways I observed the team engaging in offloading. The first was when a physicist approached a dosimetrist during non-huddle times and asked to plan a case. I observed this, for instance, when P1 approached Dos2 and asked him about taking over planning of the complex nose cancer case that needed to start in three days' time due to the fast-growing nature of the cancer.

*P1 interrupts my interview with Dos2. He comes into the room and says "hey, that nose [a patient with a complicated plan because she has no nose]? I could take that one if you want." Dos2 says almost immediately, "sure, that would be helpful." I ask Dos2 about this and he says it is a very complex plan because the patient has no nose and because they want to start it early. He says sometimes physics will help with plans. Especially complex ones that take time and need to start faster [than in seven days]. He says they can do them faster because they know what they want in a plan and what they are looking for. (FN, 158)*

A second way I observed teams offload planning cases from the dosimetrists to the physicists was during the huddle. I observed this in one case. P1 offered to take on planning responsibilities as the team negotiated adjusting the standard operating procedure to accommodate a patient in need of an early start due to fast growing brain cancer spots. Dos1, however, elected to keep the plan, saying she had time to complete it.

*RT2 says, "first new patient is [Name]. D1 says "she is mine. Brain cancer. She has had multiple previous courses. 7-8 previous spots treated. These are new and enlarging. Not previously radiated. I have a favor to ask. How fast could we get her going? If I start her volumes tonight, can we get her going Wednesday? She has been through this before." Dos1 says "Wednesday should be fine. How many isos are we talking about?" D1 says "Maybe five isos (five spots). One hit per spot." The group laughs, as this is a lot and means the plan is complicated. Dos1 says jokingly "well, never mind Wednesday." [...]*  
*P1 then says to Dos1, "if you are busy I can plan it." Dos1 replies "Well, if D1 draws them tonight, I can plan it tomorrow." (FN, 83.1)*

Offloading planning occurred when the dosimetrists gave planning duties for concerning patient cases to the physicists because they did not have the bandwidth or because the case required extra time for thought and development due to being complex. Offloading relieved potential bottlenecks in planning for dosimetrists and streamlined the review process by cutting out the dosimetrist as a member of the planning team for that case. The result was the ability to get the work involved in concerning patient cases done in a timely manner.

In total, the team had three task activities they adjusted to address concerning patient cases. First, for cases where the goal was simply to shrink the cancer tumor to relieve pain or prevent potential harm, injury or death, the team could simplify plans. For concerning patient cases that could not be simplified, the team could adjust individual tasks by speeding up task completion timelines or by offloading planning from the dosimetrist to the physicists. The goal of all these adjustments was to get patients started earlier than seven days later.

To summarize, the team made temporary modifications to the standard operating procedure to fit the situated needs of concerning patient cases. These adjustments included adjusting group tasks by shortening treatment starting date timelines and flexing the date for the team review of draft plans during huddles. Adjusted individual tasks included simplifying plans, speeding up individual tasks and offloading tasks to accommodate adjusted treatment starting date timelines.

As demonstrated in the data above, these adjustments were not necessarily easy, or automatic like the activities using the standard operating procedure. They required effort from team members who had to negotiate treatment starting dates, flex schedules for team reviews of plans, come in on personal time to speed up planning, and coordinate offloading. All of this work

took effort that was not required for non-concerning patient cases delegated to the standard operating procedure.

Adjusting the standard operating procedure helped the team to address concerning patient cases where core values of safety or efficacy were threatened by use of the standard operating procedure. This included the threat of reduced efficacy associated with starting fast-growing cancers too late. Adjusting the standard operating procedure also helped the team address concerning patient cases where the standard operating procedure would be unable to accommodate different, emerging values such as customer service or compassion. Protecting core values from threat and accommodating different, additional values are expanded upon in the next sections.

#### **4.2.4 Protecting Core Values**

Protecting core values involved team efforts to preserve, or keep safe, the core values of safety and efficacy when concerning patient cases threatened their enactment. The team protected core values when addressing concerning patient cases where use of the standard operating procedure represented a threat to either core value of safety or efficacy. These types of concerning cases could include, for example, fast growing cancers. In these cases, the use of the standard operating procedure's seven-day planning window meant that the cancer the team took seven days to plan to treat could be smaller than the actual cancer in the patient's body. This threatened efficacy by introducing the possibility that by waiting seven days to treat fast growing cancers, the team would only be treating a portion of the cancer, not the entire tumor. Thus they would not fully "kill" the cancer (D1, 167).

To protect efficacy and enact core values in these concerning patient cases, team members adjusted the standard operating procedure. In the case of the fast-growing nose cancer



described above for instance (FN, 76.164), they shortened their planning timeline from seven days to three days. They sped up individual tasks by having the doctor finish her contouring on the first day, and they offloaded planning from the dosimetrist to the physicist to get the plan done faster. The result was starting patient treatment as soon as possible, before the cancer had the opportunity to outgrow their treatment plans.

Protecting core values by adjusting the standard operating procedure, allowed the team to enact core values in situations where they could not be streamlined (i.e., enacted with little effort) through use of the standard operation procedure. In doing so the team could protect its core values from threat. In sum, protecting core values involved adjusting the standard operating procedure to safeguard, or ensure that the team's core values of safety and efficacy could be enacted in concerning patient cases. These were cases where the use of the standard operating procedure was problematic because it threatened the enactment of core values.

#### **4.2.5 Accommodating Additional Values**

Accommodating additional values involved making sufficient space in planning for additional values such as customer service (Bourne et al., 2019), compassion (Kanov et al., 2004), or values associated with individual wellbeing and health (Wright et al., 2021) to be enacted along with core values of safety and efficacy.

The team accommodated additional values when addressing concerning patient cases where these additional values could not be enacted through use of the standard operating procedure. For example, as described above, waiting seven days to start treatment through use of the standard operating procedure did not help enact the value of compassion (i.e., suffering reduction) in patients experiencing extreme cancer-related pain. Likewise, waiting seven days to

start treatment did not allow the team to enact the value of customer service for patients requesting early treatment starting dates.

Like protecting core values, when planning to treat concerning patient cases, the team accommodated additional values by adjusting the standard operating procedure. In the case of a patient experiencing significant pain, for example, (FN, 13.51), the team shortened the planning timeline from seven days to three days. Members sped up individual tasks by having the doctor finish his contouring on the first day. The team also used a simplified, 3D treatment plan which could be created faster. The result was starting patient treatment as soon as possible to relieve suffering and to enact the value of compassion.

In these cases, however, core values of safety and efficacy were still important for enactment. To both accommodate an additional value and enact core values, the team made further adjustments to the standard operating procedure. In the pain case described above for instance, they enacted safety by lowering the radiation dose the patient received during treatment to avoid overdosing healthy tissues. They also flexed their team plan review from two days prior to treatment start to the day before treatment start. In making these adjustments, the team was able to accommodate the additional value of compassion while still enacting core values in treatment planning.

Accommodating additional values by adjusting the standard operating procedure allowed the team to accommodate additional values in situations where they could not be accomplished through use of the standard operation procedure. These adjustments also allowed the team to continue to enact core values related to safety and efficacy.

Accommodating additional values involved adjusting the standard operating procedure to enact other important values and the team's core values of safety and efficacy in concerning

patient cases. These were cases where using the standard operating procedure was problematic because it could not on its own accommodate these other important, non-core values.

In sum, protecting core values and accommodating additional values was the second process the team used to consistently enact abstract values in daily, concrete work. This process was enacted for patient cases with concerns that could not be addressed using the standard operating procedure. These cases were framed as exceptions and considered to be concerning. In these patient cases, the standard operating procedure was problematized in that it could not enact a core value of safety or efficacy, or it could not accommodate the emergence of an additional, important value such as customer service or compassion. In these concerning patient cases, the team adjusted the standard operating procedure to protect core values of efficacy or safety when they could not be enacted using the standard operating procedure, or to accommodate an additional value while continuing to enact core values. They adjusted the standard operating procedure by adjusting group and individual planning tasks to address the concerns associated with concerning patient cases. In doing so, the team was protecting the enactment of core values or accommodating additional important values when developing treatment plans for concerning patient cases. As referenced above in Chapter Three, the data codes used to analyze and summarize each exception case is included in Table 4.2 below.

**Table 4.2**

*Early Start Case Codes Display Table*

Case #	Concrete Concern	Desired Ends	Means	Means Outside of Huddle	Related Value	Negotiation	What is Negotiated?
2.2	Customer request	Patient home for holiday	Start in three days	Unknown	Customer service	Yes	Doc contours fast
6.11	Customer request	Patient can go to festival	Start in two days	Speed up task completion	Customer service	Yes	Doc contours fast
7.13	Onc. emergency	Avoid new hip rejection	Start in one day	Simplifying plan	Wellbeing	No	
13.51	Patient pain	Pain reduced	Start in three days	Simplifying plan	Compassion	No	
16.18	Patient pain	Pain reduced	Start in five days	Simplifying plan	Compassion	No	
17.19	Upcoming office closure	Patient get full week of treatment	Start in five days	Speed up task completion	Efficacy	No	
23.29	Fast growth	Treat all of the cancer	Start in five days	Speed up task completion	Efficacy	Yes	Doc contours fast
33.24	Fast growth	Treat all of the cancer	Start in three days	Speed up task completion	Efficacy	No	
38.27	Patient pain	Pain reduced	Start in five days	Simplifying plan	Compassion	Yes	Doc contours fast
57.1	Upcoming office closure	Patient start before holiday break	Start in five days	Unknown	Efficacy	Yes	RT2 says the request cannot be accommodated
60.38	Upcoming office closure	Patient start before holiday break	Start in five days	Unknown	Efficacy	Yes	Doc contours fast
62.4	Upcoming office closure	Patient start before	Start in five days	Unknown	Efficacy	Yes	Machine booked up on request date

Case #	Concrete Concern	Desired Ends	Means	Means Outside of Huddle	Related Value	Negotiation	What is Negotiated?
		holiday break					
62.41	Upcoming office closure	Patient start before holiday break	Start in five days	Unknown	Efficacy	Yes	Machine booked up on request date
68.43	Onc. emergency	Avoid paralysis	Start tomorrow	Simplifying plan	Wellbeing	Yes	Doc contours fast
76.164	Fast growth	Treat all of the cancer	Start in three days	Offloading to P1	Efficacy	No	
82.1	Fast growth	Treat all of the cancer	Start in four days	Speed up task completion	Efficacy	Yes	Doc contours fast
84.1	Customer request	Start before customer leaves town	Start in five days	Simplifying plan	Customer service	Yes	Doc contours fast

### 4.3 Summary

Two processes emerged from my findings that explained how this team of radiation oncology professionals enacted important but abstract values in their shared, daily work. The first process explained how the team enacted core values of safety and efficacy in daily work. This process included daily case communication where the team framed cases as standard, considered them to be non-concerning, and delegated values work to a standard operating procedure which allowed them to enact safety and efficacy with little additional effort.

The second process explained how the team addressed threats to core value enactment and accommodated the enactment of other values that, while not necessarily core values, were

important in specific patient cases. This process included daily case communication where the team framed cases as exceptions, considered them to be concerning, and put effort into adjusting their standard means to either protect core values from concerns that threatened their enactment or to accommodate additional values that emerged as important in specific, concerning patient cases. Together, these two processes provide a picture of how values, both those the team espoused as core values, and those they did not, were enacted in the daily work of the members of this organization.

In the next chapter, I organize these two processes and their individual components into a theoretical framework. This framework illustrates two distinct pathways that organizations use to enact multiple, important values in the shared, daily work of members. In doing so, I move to a higher level of abstraction to generalize my findings to a wider range of organizations and theoretically explain how organizations can maintain abstract values in daily concrete work.

**Table 4.3**

*Representative Data Illustrating Study Concepts*

Concept	Illustrative Data
Daily case communication	<p>-RT2 says “next patient is [Name]. D3 says that this is an older female, age 69. She has one small spot of brain cancer and she is prescribing a 4 millimeter, single fraction of treatment. She pauses and there is silence in the room. She then adds, “starting date a week and two days.” (FN, 69.2)</p> <p>-We usually share some [basic] patient details [in huddles]. Thing I don’t know but need to know to get going [in plan development]. Like what the doctor's intent is. What the treatment dose is. What kind of cancer it is. Those kinds of things. (Dos2, 29)</p> <p>-MGR says the goal of huddles are talk about each upcoming patient and what would be the safest, most effective courses of action. (MGR, 3)</p>

Concept	Illustrative Data
Framing patient cases as standard	<p>-The 4th patient is a patient seeing D3, as his name is read by RT1, D3 takes over the discussion. She says “NAME is a doctor. He is a retired OB/GYN and he is really cute and such a sweetie. But he is really, really formal. He has prostate cancer and I am recommending a standard course. [...] D3 says "recommending a normal starting date of a week and two days.” (FN, 22)</p> <p>-D1 says “this is a routine right breast, diagnosis is curative, treatment is standard course 14 days.” For today’s one patient RT1 pulls up an image of the patient’s tumor and the group looks at it, but nobody says anything. (FN, 72)</p>
Patient cases considered non-concerning	<p>-We don’t talk a lot about patients in huddle. I don't think it's pertinent to talk about every patient every day. Because we'd be in there for hours. [...] A lot of things are pretty generic, like it's a prostate or breast or a lung. (RT2, 48)</p> <p>-Some more common cases, like for example right breasts are easy, we almost always just agree with the [established process for treatment] plan and move on [i.e., no discussion]. (MGR, 4)</p> <p>-[After introducing the patient and sharing basic case facts] D2 then pauses. The room is silent and remains this way for a moment. RT1 then says ‘next new [patient] is NAME. And D3 begins talking. (FN, 38)</p> <p>-But most of the time it's [new patients are] pretty straightforward. (RT2, 49)</p>
Standard operating procedure	<p>-We have standards for each of those setups and they're all pretty generic. (RT2. 48)</p> <p>-There's a routine [to planning]. You've obviously seen it, right? There's definitely a cadence to what we do, and it's when that cadence is broken, that's when the potential gap is created. (MGR, 173)</p> <p>-There is kind of a rhythm to [our] planning [process], I think. (P1, 174)</p>
Standardized group tasks	<p>-[Seven day planning timeline] Yes, a week and two days is standard. (D2, 57)</p>

Concept	Illustrative Data
	<p data-bbox="618 233 1427 373">-[Seven day planning timeline] No, it's not a policy. It is a norm, because we have found over time with the complexity of the plans, it is not something you turn around in three days. (MGR, 279)</p> <p data-bbox="618 415 1427 520">-[Seven day planning timeline] We do like that week and two days for every patient, to give every single person involved in the sequence of events time to do their job. (D3, 277)</p> <p data-bbox="618 562 1427 850">-[Seven day planning timeline] Usually we like to have a week and two days because sitting in morning meetings, while you see us talking about patients who are two days out, having that week before hand gives us time to do all of our planning, and pass things through physics and everything. And have the plan printed and ready to look at in our meeting. It is so that we can develop effective plans, and safe plans that don't miss important details. (Dos1, 272)</p> <p data-bbox="618 892 1427 1102">-[Two day plan review] Yeah, and it's just to make sure that everything is done for that patient to make sure that we have our plan done, and our stuff is checked off and then our stuff goes to physics. [...] But as far as that goes, it's just to make sure that I have my stuff done or dosimetry as a whole and nothing slipped through the cracks. (Dos1. 69)</p> <p data-bbox="618 1144 1427 1285">-[Two day plan review] And so ideally when we present a patient [plan] in morning meetings [for review], the doctor or nurse can call out and say "yep they're all being taken care of." (MGR, 75)</p> <p data-bbox="618 1327 1427 1537">-[Two day plan review] That [48-hour review] gives us [time] to make sure everything is in order – our timeline is not compressed. We can resolve open issues like beam placement. If we didn't have that, or if we just looked at plans the day of [treatment start] we'd be rushed. When you are rushed, that is when things fall through the cracks. (P1, 93)</p>
Standardized individual tasks	<p data-bbox="618 1587 1427 1799">-The physician draws the targets, draws the volumes, and then it goes to dosimetry, which makes a plan, and then the physician checks the plan and then it goes to physics and they have to check the plan and also communicate with a therapist that is deliverable on the machine. And so that's encompassed in that I guess seven business days. (D1, 283)</p>



Concept	Illustrative Data
Enacting core values	<p>-The physician draws volumes. The dosimetrist has to plan it. The physicist has to check it and then it gets presented in our morning meeting that it is ready to go. (MGR, 279)</p>
	<p>-So in theory then, let's say you [get the doctor's] contour, and you have it next day. So on day two, do your plans. And maybe on day three or day four, your planning is totally done. And you can then kick it to QA with physics, they can run their QA on it, and then on day five, it gets to the 48 hour review in the meeting. And everything is all done. That's the ideal. That's the ideal. That's what we strive for. (Dos1, 176)</p>
	<p>-We do the best we can for the patient to have an effective and safe treatment. (Dos2, 129)</p>
	<p>-Each role is really important. We are here for the safety of the patient and the care of the patient. I feel very comfortable chiming in [during plan reviews]. (FD, 130)</p>
	<p>-Yes, that [focusing on plans that are two days out] is how we help ensure safety and quality. These face to face meetings keep things from slipping through the cracks. (MGR, 134)</p>
	<p>-[Safety] We have a week and two days for a reason and those are to try to not take any shortcuts, [to] make sure we can really do the quality assurance afterwards, to make sure everyone has time to do their parts as well as possible in creating a safe plan basically. (D1, 58)</p>
	<p>-[Safety] When you rush planning, that's where mistakes happen and you can't take back a mistake that's been treated. So I've been here 15 years and I'm telling you that it is not so frequent. We just don't make mistakes. (Dos2, 273)</p>
	<p>-[Safety] And so I think in the past we did a week and a day and it seemed like maybe that was too fast, just too many rushed and last minute things and maybe not able to do some of the checks or double checks. (D1, 59)</p>
	<p>-[Safety] It takes time to develop an effective plan that does not risk safety. (P2, 133)</p>
	<p>-[Efficacy] Ideally the goal is to cure the patient. (D3, 406)</p>

Concept	Illustrative Data
Framing patient cases as exceptions	-[Efficacy] And then the planning is, a lot of it is how can we cure cancer in those areas? (P2, 53)
	-[Efficacy] A week and two days. That gives the dosimetrist enough time to get an accurate plan done. (MGR, 279)
	-[Patient name] was a new patient to be scheduled for treatment. D3 shares that the case is quite complicated. The patient has a fast-growing cancer in the nasal area. The complication is that the patient has already had surgery to remove the majority of her nose. But the cancer has reappeared quickly and is growing fast. D3 says the plan for this case [the nose] will be difficult. D3 notes that because of the fast growing cancer she wants to start ASAP. (FN, 76.164)
	-We change things for some patients [i.e. do things differently than standard]. [,,,] If a patient is in significant pain or if there is a scheduling issue, or if it is an emergent issue where perhaps there is a threat to their health, such as a tumor pressing on the spine, or a tumor that is impacting breathing. We want to address those issues fairly quickly. (D2, 201)
	-Sometimes the doctor will say something in the [morning huddle] meeting and [I'll be like] 'oh, hey, here's a little flag of something.' And that brings it [the concern] to my attention that this patient has, maybe something unique [for planning]. (RD, 9)
Patient cases considered concerning	-We go over [new patients] for the day, they are the first thing. So that is really important as far as what is needed. A lot of times [nothing is] really said in there. But sometimes the doctor will specifically say, 'We need to start on this date,' and they'll actually say it out loud. And so when the therapist is leading the meeting, pulls it up. That's kind of one of the things I cue on is whether the patient needs [something special] that I need to plan for. So I kind of cue on those things and it's really helpful for me to have that discussion. (Dos1, 34)
	-If it [the concern] is something that can impact the way we set up patients [for treatment]. Those are things I like to know. [...] We're talking about that specific patient just to make sure we have 'em set up right. So that's something that's really important to me. (Dos1, 34)

Concept	Illustrative Data
Adjusting the standard operating procedure	<p>-Well, we will list patients on the docket [for the meeting] and you will see them up on the screen, but they are not going to generate much discussion unless there is an issue [...]. Then we will discuss as a team what to do about that patient and how to get that patient in for treatment. (MGR, 407)</p>
	<p>-So with the spine last week, and I remember who you're talking about now, so that was emergent a lot of pain at T4 and 5. We saw imaging and it was bad. So it made perfect sense and that was a unique situation. (P2, 320)</p>
	<p>-We will typically do rush starts for two reasons. The first is pain, the second is for an oncological emergency such as a vein or artery being blocked by a tumor, or a spine being compressed, because those patients are at threat for paralysis. So we need to get them addressed immediately.” (RN2, 204)</p>
Adjusted group tasks	<p>-Some things [cases] we can't address using the seven-day [planning window]. [...] For some patients, we have to have a meaningful discussion about changing the way we plan [patient] treatments. [...] But some patients we have to talk through. Like, what is the best way to treat them. (MGR, 4)</p>
	<p>-And so if the doctor has a specific date in mind, and then usually the answer is, oh, a week in two days, which is the standard, unless it's something that needs to get going earlier. Then, they'll look at the schedule briefly and be like, "we can start it on a Monday", you heard [that] talk this morning. (Dos1, 66)</p>
	<p>-[Adjusting the seven day planning timeline] And yeah, a week and two days is sometimes close on normal cases, so shortening it to one week or [less] is not ideal [...] But we will do that if we have to. (P2, 62)</p> <p>-[Adjusting the seven day planning timeline] So if [...] they're in incredible pain, they want to get started sooner later, unfortunately, there's a big question that has to happen, right? The first question is the obvious one. Do we have the schedule to accommodate? (MGR, 206)</p>
	<p>-[Adjusting the seven day planning timeline] D3 requests a starting date of five days from now, and then pauses and asks the team or room in general “do you think that would be OK?” (FN, 38.27)</p>

Concept	Illustrative Data
Adjusted individual tasks	<p data-bbox="621 270 1414 558">-[Flexing the team review of draft plans date] Once it has been presented at the 48-hour meeting, if everything is done and good to go in meeting, we don't talk about them again until the new patient rounds [a different, once weekly meeting for discussing new patients currently undergoing treatment]. But if something is still waiting, the therapist [RT1 or RT2] will put a note in [the system] and we will review them the next day [at 24-hour mark] (Dos1, 91)</p> <p data-bbox="621 600 1414 848">-[Simplifying plans] Usually for emergency patients, they will be 3D. So we don't have to do the qa. And so the plans are usually fairly straightforward and simple where they're not too complex to plan. So that's where we can get away with doing a quick turnaround is because we're not doing something like an IMRT plan, something crazy complex. (P1, 313)</p> <p data-bbox="621 890 1414 1104">-[Simplifying plans] We get urgent starts sometimes. If someone was bleeding and needed to start today we could make that happen. We would just need to drop everything and focus on them. And in that case we would get them started with a simple, basic plan [...] So we have different options when someone is an emergency case. (Dos1, 299)</p> <p data-bbox="621 1146 1414 1289">-[Speeding up task completion] So with these quick starts, I mean we'll mention it, but kind of the unspoken agreement with the doctors is to get their stuff done as soon as possible. So dossie can start working as soon as possible. (P1, 119)</p> <p data-bbox="621 1331 1414 1398">-[Speeding up task completion] D1, I know he came in on the weekend to go over that spine. (P2, 357)</p> <p data-bbox="621 1440 1414 1625">-[Speeding up task completion] Yeah, speeding everything up is exactly it. And it starts with the physician. So instead of the physician waiting to do the contours, they're more than likely to try to adjust their schedule to do contouring during the [first] day. (MGR, 221)</p> <p data-bbox="621 1667 1414 1799">-[Speeding up task completion] So everybody sees it as a priority. So I may have three other patients that I need to draw volumes on, but my patients that I want to start tomorrow go to the front of the line to get those volumes in. (D3, 219)</p>

Concept	Illustrative Data
Protecting core values	<p data-bbox="621 233 1409 338">--[Offloading work] This is what I am doing on that three day [nose]. It is not going to be a straight, yeah, it's just going to be messy. So I'm just going to take it. (P1, 159)</p> <p data-bbox="621 380 1409 447">-[Efficacy] If it [cancer] is growing too fast we are going to try to do it [start treatment] within a week or so. (D1, 214)</p> <p data-bbox="621 489 1409 594">-[Efficacy] For faster turnaround we start thinking about a simpler plan and if that still works or if that still gives good treatment. (D1, 327)</p> <p data-bbox="621 636 1409 703">-[Efficacy] Sometimes we prefer to start early in a week, to get several treatments before a [Holiday] break. (D1, 168)</p> <p data-bbox="621 745 1409 919">-[Efficacy] There's also a time sensitivity between like a brain patient getting an MRI and starting treatment. Like you don't wanna wait too long after the MRI because that's their most up-to-date imaging. And things can change pretty fast if you wait a long time. (RT2, 111)</p>
Accommodating additional values	<p data-bbox="621 968 1409 1073">-[Compassion] Generally if it's an early start, it's usually because the patient needs to get going due to pain or the symptoms they're having that we want to treat. (Dos1, 205).</p> <p data-bbox="621 1115 1409 1255">-[Compassion] Sometimes it's patients who have just pain, their pain is severe and we want to get them going as soon as possible. When we do that we can help relieve the pain. (D3, 401)</p> <p data-bbox="621 1297 1409 1507">-[Customer service] The less common reason [for urgent starts] is maybe because see the patient for consult, maybe they've talked to the patient and for whatever reason the patient needs to finish treatment by a certain day. And we've had a couple with vacations and so we want to honor their vacations. So we'll start earlier. (P2, 136)</p> <p data-bbox="621 1549 1409 1801">-[Patient wellbeing] Cord compression causes symptoms and paralysis by pressing on their spinal cord and causing either full paralysis, partial paralysis, tingling in the legs, whatever. And so they need to get on right away. And so cases like that will start maybe even the same day. And so the doctor will need to have those contours done immediately after the sim. (Dos1, 123)</p>

## CHAPTER FIVE: DISCUSSION AND CONCLUSION

### 5.0 Introduction

The purpose of this study was to understand how organizations consistently enact, or in other words maintain, multiple important values through performance. My findings suggest there are two processes through which organizations maintain important core values and accommodate other important but non-core values in daily work. These two pathways form the theoretical framework presented in Figure 5.1 below.

The first pathway I labeled *Delegating Values Work to Standard Means*. The second pathway I labeled *Performing Values Work Using Adjusted Means*. In the following sections, I describe the key practices, or the *values work*, allowing organizations to maintain and protect core values, or accommodate other important values in both pathways. I describe the theoretical significance of each pathway. I then revisit my original research questions and answer them through the lenses of these two identified pathways. After this, I offer conclusions about my study findings and articulate its contributions to the values work and organizational values literatures. I conclude by identifying limitations of my study and identifying my study's contribution to the growing stream of values work literature.

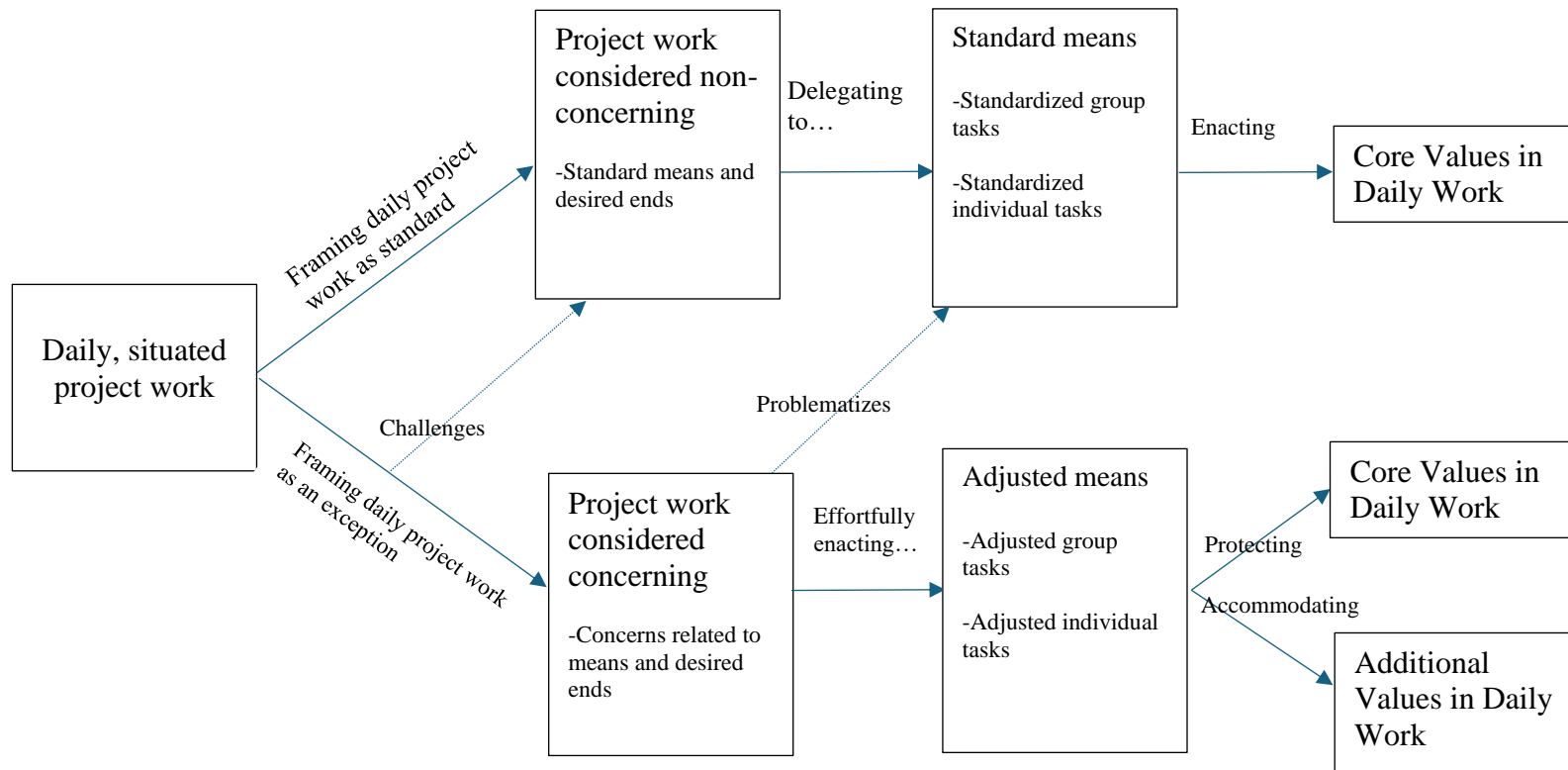
### 5.1 Delegating Values Work to Standard Means

I labeled the first pathway organizations take to maintain core values in daily work *Delegating Values Work to Standard Means*. This pathway involves delegating values enactment to a standard set of practices, or standard means, which allow organizations to consistently enact core values quickly, or almost automatically, in daily work without a great deal of deliberate effort from members. In following this pathway, organizational members frame daily work

**Figure 5.1**

*Pathways for Maintaining Values in Daily Organizational Work*

Delegating Values Work to Standard Means



Performing Values Work Using Adjusted Means

projects as standard. This framing results in project work that is viewed as non-concerning. Non-concerning project work is delegated to standard means that are in place to enact core values. I expand on this pathway in the following sections.

### **5.1.1 Framing Daily Project Work as Standard**

The first important activity in the *Delegating Values Work to Standard Means* pathway is framing daily project work as standard. Here I use the term *project* to mean the unit of work being attended to at any given point in time by organizational members. In my findings, these units of work were referred to as individual patient cases. However, this work need not involve clients, or cases, but rather could more generally be the projects and work-related issues that organizations are focusing on at any given moment.

Framing daily project work as standard involves members sharing details about projects that positions them as, in the words of two of my study participants, “routine” or “generic” (RT2, 48). This framing occurs when members are interacting and communicating about upcoming projects. It is often accomplished through the sayings of members that signal the projects are standard. An outcome of framing daily project work as standard is that members consider these projects as, using an in vivo term from one of my study participants, “non-concerning” (MGR, 46).

### **5.1.2 Project Work Considered Non-Concerning**

Project work considered non-concerning is the collective understanding of members that daily work associated with units or work, or project work, is standard and without significant concerns. This understanding is an outcome of framing daily project work as standard. Considering project work to be non-concerning shapes how members approach and plan for daily work. It implies that because there are no salient, significant concerns, then core values can



be maintained through standard means. In my study for example, considering project work, or specific patient cases, to be non-concerning implied to members that standard means could be used to enact the core values of safety and efficacy. Consideration of work on specific projects as non-concerning helps members to, in a sense, delegate the values work of maintaining core values to a set of standard means.

### **5.1.3 Delegating to Standard Means**

The next important activity in the *Delegating Values Work to Standard Means* pathway is the actual delegating, or handing off responsibility for, values enactment to standard means. Delegating values enactment to a set of standard means is used when project work is considered non-concerning. In my findings, I referred to these standard means as the *standard operating procedure* used to plan treatment for non-concerning patient cases.

Members trust that the carefully designed practices that make up the standard means will enact, and therefore maintain core values. These practices are built over time, based on members' expertise. They are shaped through experiences which result in understanding of how core values can be consistently accomplished in daily work. This might include, for instance, a team of writers who value creativity engaging in the practice of holding daily morning table brainstorming sessions to flesh out original story ideas (Paulus & Brown, 2007).

Standard means can also emerge from industry-level, evidence-based guidelines developed over time to achieve core values. These can include, for example, enacting quality and safety in the medical field by following a clinical protocol in surgery that asks patients to mark their surgical sites with a Sharpie pen. This prevents operating on the wrong site (Pikkel et al., 2014). Another example would be enacting safety in the airline industry through pilots' regular use of a pre-flight checklist to make sure planes are properly serviced and ready (Nevile, 2005).

In short, these are practices crafted over time and through experience and expertise that, when utilized, do the work of maintaining core values for members.

As this suggests, the result of delegating to standard means is that maintaining core values in daily work requires little deliberate effort on the part of members. As Dewey might say, maintaining core values using standard means is habitual or instinctual (Anderson, 2023). By following established standard means that do the work, members can trust that core values will be enacted for project work considered non-concerning. Thus, the significant benefit of the standard means is that maintaining values is almost automatic. Through this pathway, consistently enacting, and therefore maintaining, core values in daily work is a streamlined process that involves framing daily project work as standard and delegating values work to a set of standard means that are specifically designed to enact core values.

However, daily project work in many organizations is still situated, or bound by context. What works in most situations may not work in all situations. Further, as demonstrated by Wright and colleagues (2021), in some contexts other values besides core values may be important and require enacting. This suggests that despite being effective for most project work, standard means may not be appropriate for all project work.

Consequently, while values work can be delegated to a set of standard means in many instances, standard means may not always adequately address all concerns associated with situated project work. Some concerns may not be adequately addressed through delegation to a standard set of means. In these situations, members may find themselves needing to engage in deliberate effort to enact important values. They may find they need to take a pathway that differs from delegating values work to standard means to engage in values work. I call this

second pathway *Performing Values Work Using Adjusted Means*. I describe it in detail in the next section.

## **5.2 Performing Values Work Using Adjusted Means**

I labeled the second pathway organizations can use to maintain important values *Performing Values Work Using Adjusted Means*. Rather than being streamlined or automatic, this pathway requires effort from members to evaluate desired ends associated with particular daily project work, and to craft the means necessary to achieve those desired ends. Maintaining values through this pathway can require negotiation, tradeoffs and sacrifices. Thus, values work following this pathway is not a streamlined process, it is an effortful process that requires work.

Consistent with the model in Figure 5.1, in following this pathway, organizational members are framing daily work projects as exceptions to the standard. This framing results in project work that is viewed as concerning. Concerning project work results in members effortfully enacting adjusted means to protect core values from threat or to accommodate the enactment of other important, but non-core values. I expand on this pathway in the following sections.

### **5.2.1 Framing Daily Project Work as an Exception**

Consistent with the *Delegating Values Work to Standard Means* pathway, the first important activity in the *Performing Values Work Using Adjusted Means* pathway involves framing daily project work. However, rather than framing daily project work as standard, daily projects are framed as exceptions to, or different from, the standard. As one of my participants described it, this daily project work is “unique” (P2, 320).

Framing daily project work as an exception to the standard involves members making concerns about a particular work project salient to each other. It is these concerns that

differentiate project work framed as an exception from project work framed as standard. In my study, for instance, one concern made salient was patients experiencing significant pain associated with their cancer. This salient concern resulted in members framing the case as an exception to the standard.

Like the *Delegating Values Work to Standard Means* pathway, framing in this pathway occurs when members are interacting and communicating about upcoming project work. It is often accomplished through the sayings of members that compare these projects to standard projects, and signal that these projects are exceptions to the standard. This comparison challenges perceptions of daily project work as non-concerning. Through framing daily project work as an exception to the standard, members can make sense of upcoming work as concerning.

### **5.2.2 Project Work Considered Concerning**

Project work considered concerning means that there is a concern associated with projects that members view as unwelcome or potentially harmful for values enactment. Consequently, members seek to address this concern. There are two types of concerns associated with concerning project work. Both are values-related. By this I mean these concerns relate to the means used to achieve core values, or they relate to which values are important to enact in a given work situation.

The first type of values-related concern in project work involves concerns related to the means for accomplishing desired ends (i.e., core values). By this I mean that because of a situated contingency associated with a specific project, standard means alone are perceived as insufficient for enacting core values. This concern, in other words, poses a threat to the enactment of core values using the standard means associated with the *Delegating Values Work to Standard Means* pathway.

An example of this type of concern in my data involved fast growing cancers. Because these cancers were changing shape rapidly, using the standard means of waiting seven days to begin treatment posed a threat to the core value of efficacy. This was because by waiting seven days, the cancer that the team planned to treat would be much smaller than the actual cancer in the patient's body. Thus, there was the threat that the team would not effectively kill all of the cancer in the patient's body during treatment. In this instance, the team had to effortfully change means to start treatment as soon as possible in order to maintain accurate measurements of the cancer before it could grow larger.

The second type of values-related concern in daily project work involves the emergence of an important value that differs from core values. This type of concern occurs when a desired end that is different from achieving core values emerges as important but cannot be addressed through standard means. This type of concern suggests that in some instances, new means will be required to accomplish new, or different values while also maintaining core values. As an example in my research, while the team always strove to accomplish the core values of safety and efficacy in treatment planning, in some cases, patients requested specific treatment starting dates. In these instances, the desired end of meeting the customer's wishes, or the value of customer service, emerged as important. The team had to reconsider its means for treatment to both accommodate this new value while maintaining core values of safety and efficacy. There were several instances like this in my study data. Each of these instances involved considering how to accommodate a new value (e.g., customer service) that was important, but was not a core value of safety or efficacy.

In sum, two types of values-related problems in daily project work are associated with project work considered concerning. One problem is when use of the standard means threatens

the accomplishment of core values. The other is when other important values besides core values are important and cannot be accommodated using the standard means. For both types of problems, the consideration of daily project work as concerning arises through the framing of daily project work as an exception to the standard. Project work considered concerning shapes how members approach and plan for project work. It implies that because there are concerns, new means will be necessary to address the concerns and maintain core values or, in some instances, other important values as well.

Members problematize concerning project work against the standard means that are typically used to enact core values. This helps them to make sense of the standard means as incapable of providing a solution to the concerns associated with specific, concerning project work. This in turn opens space to consider doing things differently to maintain core values, or to accomplish additional important values.

### **5.2.3 Effortfully Enacting Adjusted Means**

Effortfully enacting adjusted means occurs when members take conscious and deliberate action to deviate from standard means to fit the specific needs of project work considered concerning. In the *Delegating Values Work to Standard Means* pathway, members can simply delegate project work to standard means to enact core values. In the *Performing Values Work Using Adjusted Means* pathway, project work is framed as an exception and is considered concerning. As a result, members must put additional consideration into how to address the concerns preventing them from enacting core values under threat or preventing them from accommodating additional values while also maintaining core values.

I use the label *effortfully* to help clearly distinguish this pathway from the *Delegating Values Work to Standard Means* pathway where values work can be performed, and core values

maintained, more habitually or automatically. Adjusting means takes effort. It may require negotiation among members. It can be costly in that members may have to adjust their own task work, make sacrifices or reprioritize other important work. When considering the emergence of different values as important, effort must also be taken to adjust means in a way that enacts the new value while minimizing threats to core values.

In my research, for example, adjusting means to accomplish the different value of compassion (i.e., assuaging suffering) for patients in significant pain required effort from team members. They had to suggest and often negotiate among each other new, accelerated treatment starting dates. They had to prioritize getting plans done for those patients before accomplishing other work. In many cases, they had to come in on their personal time to complete those plans. They also had to be aware of core values such as safety by flexing when they were able to review the draft plan as a team, or by changing dose levels of radiation to prevent potential overdoses to healthy structures when they simplified plans for pain relief. They could not simply streamline this work through delegation to a set of standard means.

Effortfully enacting adjusted means occurs when the standard means are problematic in addressing project work considered concerning. As described above, these concerns suggest that either the standard means will not be able to accomplish a core value, or other, additional values that are not core, have emerged as important and necessary for enactment. The outcomes of enacting effortfully adjusted means are temporarily adjusted, one-time changes to standard means. These one-time adjustments either protect the enactment of core values when standard means will not be sufficient or accommodate other important values in addition to core values.

Under the *Performing Values Work Using Adjusted Means* pathway, salient concerns are framed as exceptions, organizational members view exceptions as concerning and the standard

means as problematic. This prompts them to effortfully engage in enacting adjusted standard means to address the salient concern. These concerns represent threats to core values or suggest additional, but non-core values are important. Therefore, by engaging in effort to adjust standard means to solve concerning work, organizations are maintaining core values by protecting them from the concerns that threaten them. They are also enacting different values that emerge as important while maintaining core values.

In the setting I observed, my findings show there are two pathways organizations can take to consistently enact, or maintain, core values and other important values in concrete, daily work. These pathways are illustrated in Figure 5.1. The first pathway, called *Delegating Values Work to Standard Means*, involves delegating values enactment for daily project work framed as standard to standard means. Standard means allow organizations to consistently enact core values quickly, or almost automatically, in daily work without a great deal of deliberate effort from members. The second pathway, called *Performing Values Work Using Adjusted Means*, involves effortfully enacting adjusted means for daily project work framed as exceptions. These adjusted means allow organizations to protect core values when use of the standard means threatens their enactment, or to accommodate additional important values (identified and defined in Table 3.3) that cannot be accommodated under the standard means alone.

### **5.3 Revisiting My Research Questions**

I began this study asking how organizations can consistently enact important but abstract values through daily work performance and how they can accommodate multiple values that may be important in situated contexts associated with daily work? In response to the first question, in the setting I observed I found that that in many instances of daily organizational work, core values can be enacted consistently, and therefore maintained, with minimal effort by delegating



values work to standard means. These standard means are used when daily project work is framed as standard and considered non-concerning. As discussed above, standard means are formed through past experiences, industry guidelines or ongoing routines that consistently make possible the enactment of core values. They have established track records of enacting core values in organizations and are therefore trusted by organizational members to accomplish core values when enacted. Because of this, they require little additional deliberation or consideration from team members.

However, because daily project work is often dynamic and situated, in some situations core values can be threatened through use of standard means. In these situations, members frame their daily project work as exceptions to the standard and consider this work to be concerning. Members make sense of the standard means for this concerning work as being unable to enact important core values. In these instances, because of an exceptional, situated concern, the standard means acts as a barrier to core values enactment, rather than as a facilitator of core values enactment in daily project work.

Concerning daily project work prompts members to make one-time, effortful adjustments to standard means to resolve the concern and protect core values from threat. In using these two pathways, organizations can consistently enact and protect, and therefore maintain, important core values in situated, daily, concrete work.

In response to my second question about how organizations accommodate multiple values that may be important in situated contexts, I find that while organizations hold core values that are prioritized in work, they also hold other important values that they desire to enact when required in situated work. Like threats to core values, these additional values are also enacted through effortfully adjusted means. These adjusted means are used when work is framed as an

exception to the standard and considered concerning because other values, beyond core values, are important but cannot be enacted through standard means. Adjusted means offer the space to accommodate additional values while also maintaining core values.

My study's two identified pathways, *Delegating Values Work to Standard Means* and *Performing Values Work Using Adjusted Means* offer important insight into how organizations can engage in values work to maintain core values in daily, situated work. They also offer insight into how organizations can, in practice, accomplish a variety of different values that are important, depending on the context of the work situation. The identification of both pathways offers important conclusions and implications for ongoing values work research and for organizations. These conclusions are next discussed.

#### **5.4 Conclusions from Findings**

My findings offer three important conclusions that have implications for future research into values work and maintaining values in organizations. Specifically, my findings highlight the importance of the practices of framing, delegating and effortfully adjusting in maintaining values in daily organizational work. Each of these findings, and their implications, are addressed in the next sections.

The first conclusion from my research is that the practice of framing work as either standard or an exception is very important for values work inside of organizations. This is because framing is the key point of divergence in values work. Framing determines which pathway organizations will take in values work. How work is framed shapes whether organizations will enact core values through delegating, or protect core values and, in some cases accommodate different values through effortfully enacting adjusted means.

One implication of this finding is that power and status may be important parts of values work. Organizations may hold enduring core values that extend beyond the influence of any one actor. However, my findings suggest that actors with the ability to effectively frame can shape which additional values organizations enact in situated contexts. Framers also have the power to ignore or not act upon values that are important to some stakeholders but not others. In my findings, for example, the doctors were the actors who framed work as standard or exceptional. They framed customer requests for start dates as exceptional. This triggered effortfully adjusting to enact the value of customer service. Had any of these doctors not valued customer service, they might not have framed the work as exceptional. They might have instead delegated it to standard means for the enactment of safety and quality. This would have left the values associated with patient desires, in this case customer service, out of organizational values work.

The implication of this finding is that in daily organizational work, members who are in the position to frame work as standard or problematic carry a great deal of power in shaping how values are enacted in the daily work of organizations. They are the ones who can determine which concerns that crop up in situated daily work require effortful adjustment to protect core values or accommodate different values. They also determine which concerns will remain unaddressed.

This finding opens pathways for future research on values work. This includes seeking better understanding of how organizations provide actors with opportunities to frame work to enact values. In my study, daily huddles were the mechanism that allowed actors to frame their work for the rest of the collective. One question for future work is how do organizations that do not engage in daily huddles frame their work for members to understand and act upon? If there is

no opportunity for framing, do organizations only enact core values through a streamlined process rather than considering other values through effortfully adjusting?

A related question involves better understanding of the impact that the actor doing the framing has on members' motivation to engage in values work. In my study, framing was a highly structured process. It was the high-status doctors doing the framing for the rest of the team at each daily huddle. And for the most part, others were eager to act upon this framing. What happens in organizations with less hierarchy? Do members vie or compete for the chance to frame values work in ways they desire? Are some actors more likely to be listened to and taken seriously when framing work for values enactment than others? Future research may focus on the framing process in other organizations with less hierarchy, such as a team of multidisciplinary research professionals of equal status where many members have the opportunity to vie for framing rights.

A second conclusion from my study findings is that delegating most values work to a standard procedure, or to standard means is a significant component of maintaining values in daily organizational work. This finding is important because it illustrates that values work does not require a great deal of ongoing reflection, interpretation or consideration that can cost organizations time and productivity. Through the *Delegating Values Work to Standard Means* pathway, important core values can be maintained, as Dewey would suggest, almost automatically (Anderson, 2023).

Yet this does surface other important questions for future consideration. One obvious question would be, is there a limit to the number of core values that a standard set of means can maintain? In my study, there were two core values that were strongly held by team members. These seemed to be almost automatically accomplished through delegation to standard means.

However, other organizations may hold many core values (Bourne et al., 2019). Are these all accomplished through delegation to standard means? As the number of core values grows, is more effortful adjustment required in situated daily project work simply to ensure they are maintained? Conversely, as more effort is required to maintain certain core values, will these values cease to be core over time? Will they yield to values that are enacted consistently and easily through a more streamlined process such as delegation to standard means (Noordegraaf, 2015)?

My findings reflect an organization holding only a small set of core values that could be consistently enacted through delegation to standard means. Meanwhile, other important values were situationally enacted through effortfully enacting adjusted means. Future work may explore how organizations that hold multiple core values maintain them all consistently through a delegation to standard means. Or, does the need for more effortful adjustment grow as the number of core values held by an organization grows?

A third important conclusion from my study findings is that performing values work using adjusted means is a critical mechanism for values enactment in daily, concrete work. It allows organizations to effectively protect, and thus maintain, core values in situations where they cannot be enacted under standard means. It is also the mechanism that allows multiple values (beyond a small set of core values) to be accomplished in daily work.

However, as the label suggests, performing values work using adjusted means is not automatic or necessarily easy. It requires negotiation, sacrifice and has a cost. In other words, it requires *effort* from organizational members who must work together to adjust. In my study for example, the cost of effortful adjustment was that for some staff, important work had to be put on

the backburner for later. Others frequently had to come in off hours to accommodate adjustments made to treatment starting dates.

Because of the effort required for adjusting to maintain values or enact different values, it is possible that this is the spot in my two identified pathways where values-related conflict (Jehn, 1994) among members may occur. Members may be asked to expend effort to adjust work in situations they do not agree to be problematic. They may also push back at being asked to expend extra effort to adjust their work in order to enact values.

I went into my study framing it as a conflict study. I knew I was observing a multi-disciplinary team comprised of a variety of different medical professionals. I expected to see team members in huddles engaging in conflict about desired outcomes and means for patient treatment that were driven by the different values held by the different professionals on the planning team. I was curious as to how the team would work through these values-related conflicts. However, as mentioned in the findings section, I observed almost no conflict. When a work situation was framed as an exception and viewed as concerning, the entire team had a sense of the importance of adjusting to resolve the situated problem. They willingly put in the effort to enacting adjusted means when needed.

As mentioned above, this observation could have been the result of power dynamics. Despite holding different values, the team might have been striving to accommodate the requests of the higher-status doctors. But it could also have been because of this team's history of working together for a long time in a field (the medical field) with a strong set of institutionalized values revolving around quality and safety. These values span across the boundaries of each individual medical profession and are entrenched in medical professionals. Consequently, despite physicians, nurses, social workers, therapists, dosimetrists and physicists all belonging to

different individual professions, they are all members of professions residing under the umbrella of a medical field that strongly values safety and quality. For this reason, there may have been less values diversity, and consequently less values-related conflict associated with effortfully adjusting than I originally anticipated.

Future work may explore the effort required to enact adjustments to standard means in more values diverse fields. Koppman and colleagues (2022), for example, studied occupational differences in a multidisciplinary team of professionals in the advertising field that included graphic designers, copy writers, agency administrators, sales staff, and strategists. Exploring the effort required in more professionally diverse groups (such as the one these authors studied) to come to shared agreement on core values, and to enact adjustments when those values are threatened, or when other values become important may be an important addition to this study. It may shed more insight into how values are maintained in values-diverse organizations. It may also shed insight into how organizations resolve conflict among members of different professions related to on-going values work.

In sum, there were three important conclusions resulting from my findings. The first was that framing represents the point of divergence where organizations shift from automatically enacting core values through delegation to standard means to effortfully enacting adjusted means to protect core values from threat or accommodate other important values. As a critical activity, the actors doing the framing hold considerable sway, or influence in determining the direction of values work within organizations. The second conclusion is that the practice of delegating allows core values to be enacted with little deliberation from members. It allows for the automatic and consistent enactment of values in daily work. The third conclusion is that effortfully enacting adjusted means is the mechanism that allows organizations to protect core values from threat and

to accommodate different values as they emerge as important. These three practices, framing, delegating, and effortfully enacting adjustments comprise the critical practices driving the values work of maintaining core values in the daily, concrete work of organizations. However, there are still many questions to be answered about these three key practices and future research is required. Additionally, my study has limitations that may impact the generalizability of these findings. These limitations are addressed next.

## **5.5 Limitations**

Like other process studies my research has limitations (Gehman et al., 2013). One possible limitation is that my study, like Gehman and colleagues before me, brings up questions about the appropriate way to study performance or values work. I had considerable access to organizational members. I was able to collect a great deal of data through interviews and observations of planning huddles. Through these methods I could understand the unfolding of the treatment planning process over time. I could also clearly see how values were a critical component of this planning process.

Yet treatment planning was one process involved in the totality of this organization's work. Because of IRB restrictions, I could not see actors engaging directly with patients. Consequently, it is possible that I missed seeing other important organizational values being performed through the daily work of actors as they engaged directly with patients. This is an important concern because it suggests there may be values work occurring in the daily work of this organization for which I was unable to account.

However, despite this important concern, I was specifically interested in the collaborative process involved in members engaging in values work together, as they collectively engaged in daily work. While observing patient interactions would have been helpful, those are largely



individual performances enacted by one provider towards one patient. Daily huddles, by contrast, represented the only time in each workday where members of this organization were grouped together to formally plan and make care-related decisions. Thus, I was able to observe the one time each day where this organization engaged in collaborative decision making that resulted in values enactment. Further, through interviews, I was able to confirm that the planning work individuals did outside of daily huddles reflected the decisions made inside of huddles. This suggests that the activities these planners performed individually that I did not observe were outcomes of decisions made in daily huddles that I did observe. For these reasons I am confident that I captured the values work the team put into the collective activity of treatment planning.

Tracking entire patient cases represented a second methodological limitation in my study. Due to travel concerns associated with researching at an organization located three states away from where I lived, I was only onsite one week at a time over the course of seven months. This meant that I was unable to see the plans for the patients who were introduced in huddle while I was there when they were reviewed five days later. Likewise, the draft plans I did see reviewed two days prior to scheduled start were for patients that I did not see introduced during huddles the prior week. Therefore, other than some patient cases in which the start was accelerated to three days or fewer, I was rarely able to track entire individual cases from start to finish.

This is important because it is possible that I missed small, but crucial details associated with patient cases. For example, I have no data with standard cases getting delayed, or becoming problematic for the team. I have little understanding of how the team engaged in troubleshooting issues that arose with standard cases. It is possible that I missed important values work associated with cases that took place mid-planning. That said, beyond the standard review of draft plans two-days prior to a patient's treatment starting date, there was no huddle agenda item

for trouble-shooting issues mid-planning. It is possible that tracking cases from start to finish through huddle observations would not have made any difference at all in my findings.

Consistent with both Gehman et al., (2013), as well as Chan and Hedden (2023), I filled this gap in observing cases from start to finish by using interviews. For example, I might observe a case introduced on a Thursday that the team determined needed to start the next Monday, a day I would not be onsite. To compensate for this, I would spend extra time interviewing planning staff to get an understanding of how they would adjust their work to accommodate that specific case. This combination of observation and interviewing allowed me to gain a complete understanding of the treatment planning process from start to finish.

Data collection represented a third methodological challenge. Because of IRB and healthcare industry privacy regulations, I could not record huddles. I had to capture huddle information through detailed field notes. Nor was I able to go back and review huddle transcripts or film to search for small, but critically important details. My observational data was based entirely on what I was able to record by hand in the fast-paced huddle environment. This of course, raises concerns that I was unable to accurately capture everything occurring in huddles, and that my reflection of what was occurring in daily huddles was heavily biased towards what I chose to pay attention to and record. I accounted for this by using interviews to ask participants about critical components of huddles, which I subsequently focused on in later observations. I also used interviews for member checking. I regularly asked participants during field interviews if what I observed during huddles was accurate, and, in their opinions, important. Finally, I engaged in a number of Zoom observations of huddles. In many of these I focused specifically on small parts of the huddles I sought to better understand in more accurate detail. Through these

methods, I am confident I was able to accurately capture data regarding the key huddle activities that impacted daily values work in this organization.

A final potential limitation of my study was the fact that I was only able to observe at one organization. This suggests that there are boundary conditions associated with my study which was conducted in a specific medical setting for one organization. Many of these are addressed above in the section on my findings' conclusions, where I call on research to be conducted in a variety of other contexts. A single site was appropriate for my study. The goal of my study was not to test a particular theory, but to refine and gain deeper understanding of a phenomenon through offering new insights not available in prior literature (Tsoukas, 2009). Though members shared strong, entrenched values at my study site, this was still a case of values being performed in a pluralistic organization. These are organizations characterized by knowledge-based work processes, diffuse power, dynamic daily work settings, and multiple objectives (Denis et al., 2007). My findings are general enough to apply to other pluralistic organizations such as other medical organizations, education organizations, professional organizations such as consulting firms or advertising and law firms (Wright et al., 2021). Future research may apply the model developed in this study to these other values-based settings.

In sum, my study had potential limitations. I was unable to observe team members engaged in their own daily individual work with patients. I was typically unable to track individual cases from start to finish through observation. I could not record what I was observing through any method other than field notes. My findings were based on observations at a single organization. However, using a variety of tactics, I was able to overcome these challenges in creating a model explaining how values are maintained in organizations. This model adds new

understanding to how multiple values are maintained, through performance, in organizations. In my final section, I discuss this contribution and offer concluding remarks.

## **5.6 Contributions and Conclusion**

In conclusion, my study sought to answer the questions of how organizations consistently enact important but abstract values through daily work performance and how organizations accommodate multiple values that may be important in situated contexts associated with daily work. I addressed these questions through a seven-month ethnographic study of the daily huddles of the members at a radiation oncology cancer center. During these huddles, members from a variety of different medical professions collaborated to develop radiation treatment plans for each cancer patient they treated. I found that there were two pathways this organization used to consistently enact and maintain values in daily work. The first I labeled *Delegating Values Work to Standard Means*. This pathway allowed members to enact core values in daily work almost automatically, or with very little ongoing deliberation, by delegating values enactment to a set of standard means. The second pathway was labeled *Performing Values Work Using Adjusted Means*. This pathway allowed members to protect core values in situated work contexts where those values were threatened. It also allowed them to incorporate, or accommodate different values that were important, but not necessarily core values, in situations where those values emerged as important. They did this through effortfully enacting adjusted means on a one-time basis to address concerns associated with individual patients.

My primary contribution to the emerging stream of values work literature is the identification of three practices that, when performed in organizations, allow them to maintain several different values in situated, daily work. These practices are framing, delegating and effortfully enacting adjusted means. Framing is important because it allows organizations to

consider different work situations and determine which values are critical for enactment depending on the context of that work situation. Delegating is important because it allows members to effortlessly handoff values enactment to an established set of practices, or standard means, that they trust will consistently enact core values in daily work. Effortfully enacting adjusted means is important because it is the mechanism that allows for adjustment of standard means to protect and maintain core values when they are threatened by situated concerns. Effortfully enacting adjusted means is also the mechanism that allows members to thoughtfully make one-time changes to standard means to incorporate or accommodate other important but non-core values in situations where those values emerge as important. Together, these three practices represent a new contribution to values work and values practice literature which, heretofore, has yet to address how several different values can be maintained through performance in organizations.

My findings also contribute to the larger stream of literature on values in organizations. While this literature consistently articulates the importance of maintaining values in organizations (Bao et al., 2012; Noordegraaf, 2015), it focuses on the cognitive perceptions of values held by members (Bourne & Jenkins, 2013). This literature tells us that organizational members feel values are maintained in organizations when they are regularly espoused (Bourne et al., 2019) or when members observe influential leaders role modeling important values (Cha & Edmondson, 2006). However, this literature has yet to identify ways values can be maintained through daily work performance. My work adds to this literature by identifying key practices including framing, delegating and effortfully enacting adjusted means that organizational members engage in daily to maintain important values. In doing so, my study offers a more

comprehensive understanding of the values work that goes on inside of organizations to maintain important, shared organizational values through daily performance.

## APPENDIX A – INTERVIEW GUIDANCE

### Interview Questions

Study: Working through professional values conflicts

Principal Investigator: Jeff Larson

#### Informed consent related questions

1. Confirm that the participant has reviewed the informed consent document, which was emailed to them in advance of the interview.
  2. Reminder: "*Your participation in this study is voluntary and may be discontinued at any time. You may also refuse to answer any question.*"
  3. Explain: "*Please refrain from providing any confidential or private information about yourself, another individual, or your organization.*"
  4. Give the participant the opportunity to ask any questions or voice any concerns. Address these.
  5. Ask: "*Do you consent to participate in this research study?*"
    - If "no," thank them for their time and end the session.
    - If "yes," ask, "*Do you consent to having your interview audio recorded?*"
      - If "no," begin interview without audio recording
      - If "yes," begin audio recording and will start the interview.
- 
1. (Warm up) Tell me about your job, your organization and your experience with this unit: How long have you been here? Can you describe what a typical day is like?
  2. What is your role in these patient safety huddles/rounds/meetings (note – generally referred to as huddles from this point forward)?
  3. Describe these team huddles. What are they like? Who is involved? Walk me through a typical huddle. What happens? What are some outcomes that come to mind?
  4. What do you find most rewarding about them? Most challenging?
  5. Tell me a story about a great huddle. What happened? Who was involved? What were the outcomes? How did you arrive at that outcome?
  6. Tell me a story about an exceptionally challenging huddle? What happened? Who was involved? What were the outcomes? How did you arrive at that outcome? Were there any ramifications from this huddle on future huddles?
  7. In these huddles, what are the most important and difficult decisions you encounter? How do you handle them?
  8. Tell me a story about a time when there was argument or disagreement in these huddles. What was it about? Who was involved? Was resolution reached? How? Did the argument impact future huddles? How?
  9. What do you value most/least about these huddles?
  10. Can you tell me a story about a huddle that exemplified X (value identified in question 9) and a story of a huddle where X (value) was lacking?
  11. What is the ideal huddle environment? Team? When you have experienced an ideal huddle experience, what did that entail?
  12. Think about your best/most effective huddle team members – what values did you think they had? Why? How did they express these values - Can you tell me a story about what they did that was effective?

## APPENDIX B – INFORMED CONSENT



### MANAGEMENT AND ORGANIZATIONS

McClelland Hall  
1130 E Helen Street  
Tucson, AZ 85721  
520-621-1058

#### **Informed verbal consent to participate in observation and interview research.**

**Study Title:** Working through professional values conflicts.

**Principal Investigator:** Jeff Larson, University of Arizona

**This is a consent form for research participation.** It contains important information about this study and what to expect if you decide to participate. Please consider the information carefully. Feel free to discuss the study with your colleagues and to ask questions before making your decision whether or not to participate.

#### **Why is this study being done?**

You are invited to voluntarily take part in the above-titled research project. The study is intended to generate insights that may inform health care leaders, the public, or health care employees about ways to improve the health care system by exploring how different professionals such as physicians, mid-level providers, nurses, social workers, ancillary techs and others work through potential conflict in practice and reach agreement about daily work objectives when working together on multidisciplinary safety care planning teams or huddles.

#### **What will happen if I take part in this study?**

If you agree to participate in this study, I will observe you and other team members during patient safety meetings/huddles. I will be taking handwritten notes on general themes of conversations, general directions of dialogue and general sentiments of dialogue. I will also be capturing, through long-hand notes, actual snippets and details of specific conversations. These meetings will not be audio-recorded, nor will any identifying information such as names of participants or organizations be captured in the handwritten observational field notes.

You will also be invited to be interviewed by the researcher at a time that is convenient for you. At a minimum, you will be invited to complete one interview, about one hour in length. At the conclusion of that interview, the researcher may follow up requesting an additional brief interview. You will be free to discontinue participation in these interviews at any time. All interviews will be audio-recorded and transcribed. If you choose not to have your interview recorded, you may still participate in this study.

Identifying information, including your name and the name of your organization, will be removed from transcripts and replaced with pseudonyms or unique identification numbers. Your name and the name of your organization will never be used in any report or publication of this research study. In other words, your *responses will be de-identified*.

#### **How many people will take part in this study?**



I anticipate no more than 300 individuals will participate in the study. All participants must be at least 18 years of age or older.

**Can I stop being in the study?**

Yes, your participation is completely voluntary. You may refuse to participate in this study. If you decide to opt-in, you may withdraw from the study at any time. You may also refuse to answer any questions that may be asked at any time in any interview. Should you choose to no longer be a part of the study, you can simply contact the principal investigator (Jeff Larson, [jefflarson@email.arizona.edu](mailto:jefflarson@email.arizona.edu)). There will be no penalty to you.

**What risks or benefits can I expect from being in the study?**

The risks associated with participation in this study are minimal. While there are no direct benefits from participating in this study, you may learn more about findings regarding reaching agreement and working through conflict in health care units. If you are interested in learning about the results of the study, you can contact the principal investigator Jeff Larson, [jefflarson@arizona.edu](mailto:jefflarson@arizona.edu) to request a summary report. The report of the results will be sent via email upon study completion.

Will I be paid for taking part in this study?

You will receive *no* compensation for participating in this study.

**Will my study-related information be kept confidential?**

Your study-related information will be kept confidential. Any personal identifiers will be *removed* from transcripts made from the interviews or notes taken through observation. The audio recordings of interviews will be kept in secure data storage and deleted after a period of five years. I will use a unique participant identification number to match responses across the transcripts if you participate in multiple interviews. Personal information will be stored in a secure, pass-word protected electronic file. I will delete your personal information (e.g., name and email address) from our database, thereby severing all links between your identity and the study data after a period of no longer than five years. No one except study researchers will have access to your data or the interview transcripts. Additionally, I will use pseudonyms and participant identification numbers in reports and publications from this study. Neither you nor your organization will ever be identified in any report from this study.

**Who can answer my questions about the study?**

For questions, concerns, or complaints about the study you may contact the principal investigator Jeff Larson, [jefflarson@arizona.edu](mailto:jefflarson@arizona.edu).

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact the Human Subjects Protection Program at 520-626-6721 or online at <http://rgw.arizona.edu/compliance/human-subjects-protection-program>.

An Institutional Review Board responsible for human subjects research at The University of Arizona reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

**Providing verbal consent**

I have read this form, and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study.

I am not giving up any legal rights by agreeing to this form. If I would like a copy of this form, or decide to consent at a later point, I will contact principal investigator Jeff Larson, [jefflarson@arizona.edu](mailto:jefflarson@arizona.edu)).

Do you consent to participate in this study?

- Yes, I consent to participate.
- No, I do not consent to participate

Do you consent to having your interview audio recorded

- Yes, I consent to audio recording.
- No, I do not consent to audio recording.

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