



ORIGINALS

Care management in Chile: perceptions and meanings from a managerial perspective

Gestión del cuidado en Chile: percepciones y significados desde una mirada gerencial

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ABSTRACT:

Introduction: Nurses in managerial positions play a key role within hospitals.

Objective: To explore the meanings that nurses in managerial roles attribute to the implications of care management within the Chilean hospital context.

Material and method: Qualitative research with an interpretative approach, employing an embedded case study design. Participants were purposively selected with inclusion criteria being nurse deputy directors of care management with over one year of experience in the role. Content analysis as described by Bardin was conducted, focusing on units of meaning (text decomposition) followed by category development (classification). NVivo® V14 software was used to optimize analysis. The study was positively reviewed by the Deontological Committee (Reference: CD 392022) and the Scientific Ethical Committee of SSVSA (Memo 062019).

Results: Three nurses were interviewed. One main category emerged: “Implications of the care management construct within the hospital structure,” which addressed the research purpose. From this, six subcategories surfaced, illustrating various ways care management is approached, the challenges faced, reflective processes, risks of “losing ground,” and how implementation can be measured through indicators and care standardization.

Conclusions: Chilean regulation on care management has left a significant mark on the hospital structure; however, it remains a fluid construct requiring greater professional, social, and legal recognition.

Keywords: Nursing Care; Health Management; Empowerment; Health Services Administration; Qualitative research.

RESUMEN:

Introducción: Las enfermeras en cargos gerenciales desempeñan un papel clave para los hospitales.

Objetivo: Develar los significados que le otorgan las enfermeras en cargos gerenciales a las implicancias de la gestión del cuidado en la estructura hospitalaria chilena.

Material y método: investigación cualitativa, enfoque interpretativo, diseño basado en estudio de caso, tipo embebido. La selección fue intencionada, teniendo como criterio de inclusión: enfermeras subdirectoras de gestión del cuidado con más de un año de experiencia en el cargo. Se realizó análisis de contenido descrito por Bardin obteniendo un análisis de las unidades de significado (descomposición del texto) con la posterior concreción de las categorías (clasificación). Para optimizar el análisis se utiliza programa N-Vivo® V14. Estudio evaluado positivamente por Comité Deontológico (Referencia: CD 392022) y Comité Ético Científico SSVSA (Memo 062019). **Resultados:** las entrevistadas fueron tres enfermeras. Se desprendió una gran categoría la cual se denominó “*Implicancias del constructo gestión del cuidado en la estructura hospitalaria*”, siendo la que responde al propósito de investigación. De esta, nacieron 6 subcategorías que mostraron de diversas formas como se aborda la gestión del cuidado, los desafíos, los procesos reflexivos y el riesgo de la “*pérdida de lo ganado*” hasta como se puede medir la implementación de este constructo a través de indicadores y estandarización de los cuidados.

Conclusiones: el ordenamiento chileno sobre la gestión del cuidado ha generado una huella importante en la estructura hospitalaria chilena, sin embargo, aún es considerado un constructo lábil que precisa mayor reconocimiento profesional, social y legal.

Palabras Claves: Atención de Enfermería; Gestión en Salud; Empoderamiento; Administración de los Servicios de Salud; Investigación cualitativa.

INTRODUCTION

Nurses holding managerial positions fulfill a critical role in healthcare institutions, as they must not only exhibit effective leadership to achieve organizational goals but also operationalize these objectives into clinical actions without losing sight of strategic vision and the values inherent to the organizational macrostructure^(1,2). These competencies endow nurse managers with substantial responsibilities, including resource management, coordination of care activities, planning and participation in evaluation processes, fostering teamwork, and implementing innovative practices to enhance healthcare delivery and nursing care^(1,3).

Given this context, it is essential that governments strengthen nursing governance and leadership structures at strategic institutional levels, promoting nursing inclusion in policymaking and decision-making processes, alongside increased investment through more contracts, positions, and improved salaries⁽⁴⁾.

In recent years, the establishment of nursing management roles has increased due to the integration of quality evaluation systems in healthcare, which justifies the inclusion of nurses in strategic positions, emphasizing their role as a key organizational success factor⁽⁵⁾. According to the 2020 State of the World's Nursing report, 70% of countries have a Chief Nurse position within public health governance^(6,7). However, the International Council of Nurses reported fewer countries with nurses in adequate authority positions or nursing development programs⁽⁸⁾. In the Americas, 79% of member states have a Chief Nursing Officer, with 46% possessing nursing leadership programs^(7,8).

In Chile, nurses gained access to strategic leadership roles in hospitals following their recognition as autonomous Care Managers in the Health Code in 1997⁽⁹⁾. This paved

the way for the Health Authority and Management structures from the early 2000s, establishing the role of professional nursing in Chile. Furthermore, the Health Services Regulations and Administrative Technical Standard No. 19 of the Ministry of Health defined the organizational and functional foundations for Care Management Units within public hospitals, under a Nursing Deputy Directorate⁽⁹⁻¹²⁾.

These developments have legitimized and legally recognized nursing as an autonomous profession with access to strategic leadership positions. However, there is insufficient evidence regarding the implications of this regulatory framework within hospital structures. Thus, this study aims to explore, from the perspective of the nurses themselves, the meanings generated by incorporating this construct into hospital structures and the changes this has brought to hospital service practices.

MATERIAL AND METHOD

Paradigm and Design

A qualitative study was conducted⁽¹³⁾, aimed at inductively interpreting and understanding the meanings of the phenomenon under study: the construct of care management and its impact on Chilean hospital structures. The interpretative paradigm framed the research, focusing on individual consciousness and participant subjectivity, viewing their worldview as a socially emergent process where assumptions and meanings are intersubjectively shared⁽¹⁴⁾. An embedded case study design was employed, characterized as an exploration of a bounded system over time and depth, through information collected from diverse but context-rich sources⁽¹⁵⁻¹⁷⁾. This design adopts a holistic perspective linking empirical data throughout the investigation and is embedded or multiple in nature, since inferences and interpretations derive from a single group—hospital nurse deputy directors^(16,17).

Participant Selection

Participants were purposively sampled for accessibility, ease, speed, and low cost^(18,19). Inclusion criteria included: (i) nurses holding managerial positions in Chilean hospital structures (Nursing Deputy Directorate and/or Care Management Deputy Directorate) and (ii) at least one year in the role.

Initial contact with nurses holding managerial roles in public hospitals across Chile yielded one response. The first participant then referred two more nurses in similar positions from other regions, culminating in a total of three informants.

Data Collection

Semi-structured qualitative interviews were conducted due to their non-directive, flexible nature, allowing expanded discourse⁽¹³⁾. The interviews began with general semi-structured questions derived from the study's theoretical framework and evolved according to interaction flow. Conducted via Zoom® due to geographic dispersion, interviews lasted between 30 and 60 minutes. Participants received information about the study's objectives, methodology, and participation process beforehand. Informed consent was sent by email for prior review and signed before interviews commenced.

Audio and video recordings were made, transcribed verbatim, and transcripts were returned to participants for verification, receiving no objections.

Qualitative Analysis

Content analysis was conducted following Bardin's approach⁽²⁰⁾, defined as "a set of communication analysis techniques aimed at obtaining (quantitative or qualitative) indicators by systematic and objective description of message content, enabling inferences related to production/reception conditions (social context)."

Coding followed a systematic process: first, units of meaning (text decomposition) and category construction (classification) were identified using units of record to ensure complementarity. Categories were inductively built from the coding, followed by analogical and progressive classification. Analysis evolved into a bidirectional, circular process, integrating units of meaning and theory deductively and inductively. NVivo® V14 software was utilized to facilitate coding and code matrix generation, enhancing phenomenon comprehension.

Ethical Considerations

The study complied with Chilean human research legislation and was approved by the Scientific Ethical Committee of SSVSA (Memo 062019) and the Deontological Committee of the educational institution endorsing the research (Reference: CD 392022). The study upheld criteria of rigor, relevance, credibility, and epistemological adequacy, ensuring consistency⁽²¹⁾.

RESULTS

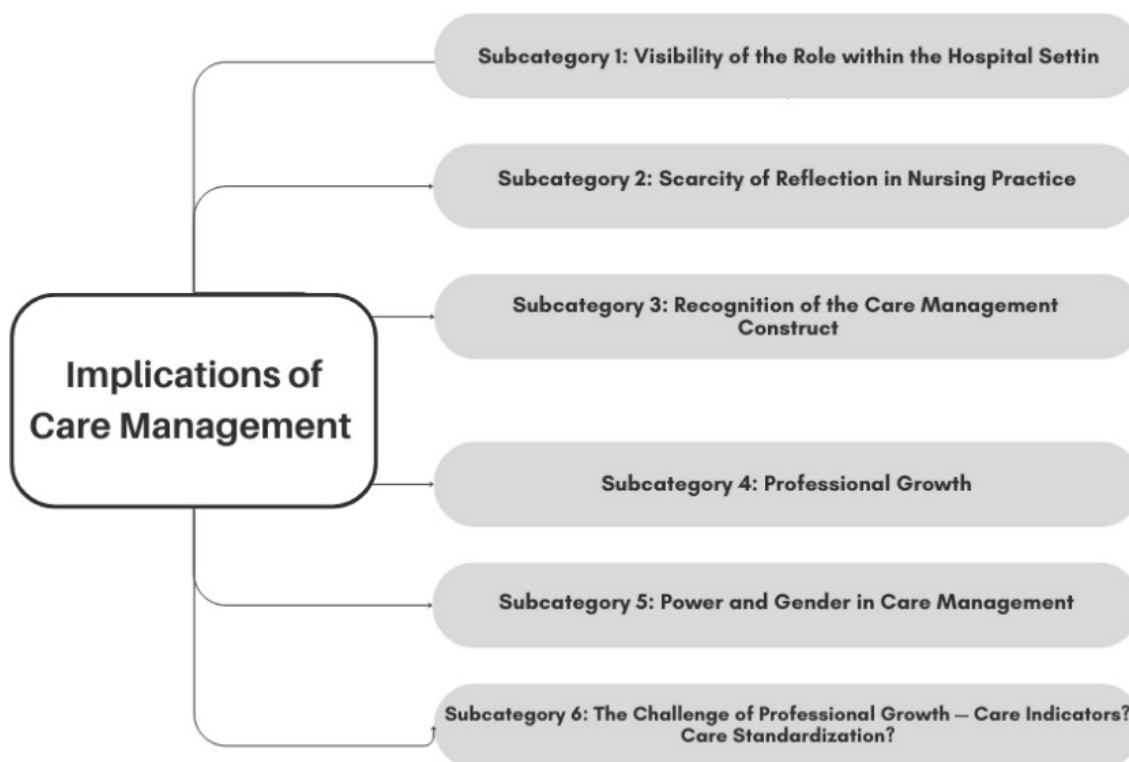
Participant Description

All three participants were women aged 37 to 53, with professional trajectories spanning 15 to 34 years. Each held deputy nursing director or care management deputy director roles in public Chilean hospitals for over two years. Geographically, one worked in a type-2 hospital in the northern macrozone, one in a type-1 hospital in the central macrozone, and one in a type-1 hospital in the southern macrozone. Two held master's degrees, and all had more than two postgraduate qualifications related to health management or administration.

Categories and Units of Meaning

The primary category identified was "Implications of the care management construct within the hospital structure," encompassing the strategic and operational scope of care management implementation in Chilean hospitals from the perspective of nurses in managerial roles⁽²²⁾. Six subcategories emerged (Figure 1).

Figure 1. Framework of the Main Category and Subcategories of the Care Management Construct According to Deputy Director Nurses



Source: Authors' elaboration

Subcategory 1: Visibility of the Nursing Managerial Role

Participants highlighted the ongoing challenge of making the nursing managerial role visible across operational, clinical, managerial, and strategic levels. Concepts such as empowerment, cohesion, and nursing indicators were emphasized as relevant supports for hospital leadership teams to reinforce nursing's role:

"The contribution of nursing itself is highly relevant; one is an essential support within the leadership team, because bed management and resource administration center on the nurse" (EG14).

"I believe empowering nursing further... realizing its potential to create new, truly empowered leaders who embody Florence Nightingale's essence—those who understand what it truly means to be a nurse" (EG9).

The notion of autonomy was noted as poorly understood both among nurses and healthcare teams, limiting role visibility. Autonomy was associated with understanding nursing as art, science, discipline, and profession:

"Doctors think autonomy means 'I do whatever I want,' which is a misunderstanding. Autonomy relates to satisfying needs derived from illness, so there is an issue... of comprehension or a failure to publicly demonstrate what care management truly means in practice" (EG14).

Subcategory 2: Scarcity of Reflection in Nursing Practice

Participants related this to limited time for nurse managers to reflect on disciplinary practice and how it translates operationally, as most time is consumed by contingency management unrelated to nursing care:

*“I think the weakness is that we are so consumed by **putting out fires**¹ that planning often can’t be controlled, not due to poor planning, but because time is swallowed by numerous hospital emergencies” (EG9).*

“Time eats you up; you end up extinguishing many fires with little time left to think, discuss, or plan” (EG14).

Subcategory 3: Recognition of the Care Management Construct

This subcategory refers to the extent care management is acknowledged by nurses, healthcare teams, and society. A dichotomy was evident, with recognition sometimes clear, other times not. Participants stressed the importance of theoretical preparation, clinical/administrative competence, and economic recognition, which directly influence professional self-esteem:

“I feel a good care manager must be competent and knowledgeable of her discipline. This is a tremendous contribution to the leadership team, with a more human outlook. Still, I feel the terrain in our country is not yet firm; more effort is needed to explain and make others, especially physicians, understand” (EG14).

“Someone told me that after reviewing various deputy directorates and hospital entities, people know and recognize us now—I think we have achieved that” (EG10).

Subcategory 4: Professional Growth

Implementation of nursing deputy directorates was associated with professional development primarily through leadership. Participants connected leadership with knowledge necessary for managerial roles, peer support, learning from mistakes, and passion for nursing in diverse areas. They emphasized the importance of cultivating new leaders and passing the baton to maintain and strengthen nursing’s strategic leadership, acknowledging the persistent fear that these achievements may be challenged or lost:

“I have felt well-supported by experienced colleagues in large hospitals, as one always seeks support, especially when creating new units, like our ICU” (EG10).

“I say, ‘We can do it too.’ Just because we’re not from Europe doesn’t mean we can’t; we are Latin Americans with grit, intellect, and passion” (EG9).

“Keep forming motivated leaders with new ways to manage care” (EG14).

¹ “Putting out fires” (apagar incendios): a term used in Chile to refer to focusing exclusively on urgent matters, while neglecting important tasks or systematic work necessary for informed decision-making.

Subcategory 5: Power and Gender in Care Management

This refers to the hard-won right to managerial roles, which remains socially and legally fragile. Participants noted that acquired power can create distance from other disciplines, especially medicine, due to the still-patriarchal biomedical model in Chile's health system. They emphasized gender as a factor, whereby women are often relegated to operational roles and excluded from strategic decision-making, fighting to generate these spaces:

"I have felt that although public hospitals have mostly implemented care management, medical colleges often resist" (EG14).

"I think it has had an impact... but there is still a need to break part of the culture produced by this biomedical model, where the physician is the team leader" (EG9).

"Often gender issues intersect here, with men generally in these roles, and since nursing is predominantly female, these machista models persist" (EG9).

"Women are sometimes excluded from certain operational decisions; one must constantly insist on inclusion, not out of ego, but because I believe in this discourse" (EG14).

Subcategory 6: The Challenge of Professional Growth: Care Indicators and Standardization

Participants viewed the challenge of creating discipline-specific tools to measure or demonstrate nursing work, such as care indicators. Systematic implementation would positively impact healthcare management. While some indicators exist sensitive to nursing, none are entirely nursing-specific. Participants emphasized the need for a model that clearly and systematically measures nursing care. Measurement would reveal not only managerial roles but also nurses' clinical management roles. Chile currently lacks such tools, mainly due to lack of dedicated time to develop them. Participants expressed this need without specifying particular indicators:

"There has been significant error prevention, which has improved the quality of care and reduced hospital stays. Previously, many infections or errors could not be corrected, but now... improvement is substantial" (EG10).

"I believe we are still behind; currently, there is no nationwide balanced scorecard capturing care..." (EG14).

"We need to advance, but many indicators exist. Sometimes indicators don't have to be sophisticated to address care management; simple yet powerful ones exist" (EG9).

"[...] so it's hard for us—we have the knowledge, we have the mindset to do it—but we struggle to find the time. Ideally, there would be a team dedicated to that

purpose, instead of us being overwhelmed with multiple responsibilities, like a “Circo de chamorro”², ending up doing a thousand things at once.” (EG9)

Regarding care standardization, participants viewed it as an aspiration, since no tools currently normalize nursing language or care linked to unmet needs. While patient categorization implementation is important, it does not cover the full spectrum of nursing care, mostly reflecting accreditation-related actions:

“Care has been standardized through risk-dependency categorization, allowing visualization of patient types and delivery of necessary care with appropriate personnel and equipment in critical, intermediate, or basic care patients” (EG10).

“I believe this must emanate from a centralized organization so we can all work uniformly” (EG14).

“I dream of a nationwide nursing process where, regardless of institution (public or private), nursing admission and discharge (nursing epicrisis) are uniform, customizable with logos but fundamentally one, with cross-institutional nursing processes” (EG9).

DISCUSSION

The findings reveal reflections that construct an image of how care management has been interpreted in Chilean hospital structures from the perspective of key informants—nurses in managerial roles. Discourses reflect ongoing defense of gains (professional autonomy interpreted as care management), power struggles (especially with the medical profession), continuous demonstration of care management’s importance via non-nursing-specific indicators, and persistent self-reflection on what it means to be a nurse in a managerial capacity. Despite feminist advances, it remains difficult for women, particularly nurses, to attain power positions in health institutions, a condition that persists over time⁽²³⁻²⁵⁾.

Foucault⁽²⁶⁾ and Gastaldo⁽²⁷⁾ conceptualize power in nursing as the positive influence exerted on work teams⁽²⁵⁻²⁸⁾. For Foucault, this power is directly linked to nursing knowledge, which, from a critical perspective, is considered silenced, subordinated, and overshadowed by biomedical knowledge—deemed superior and hegemonic—thus subordinating nursing⁽²⁹⁻³¹⁾. This is evident in nurses’ emphasis on difficulties gaining recognition, especially from physicians, and the ongoing “struggle” to differentiate nursing knowledge from medical knowledge, both essential for improving health outcomes.

Analyzing how nurses empower themselves amid these challenges is crucial. Studies indicate nurses in health care are insufficiently empowered due to hierarchical “doctor-nurse” relations favoring medical authority, exacerbated by gender biases and social norms perpetuating inequalities such as negative comments, harassment, and wage gaps⁽³²⁻³⁸⁾. This is reflected in the discourse on nurse empowerment in strategic

² Circo de chamorro: Term used in Chile to describe a situation in which all tasks within a setting are carried out by a single person. The expression refers to the Chilean film *El gran circo de Chamorro* (1965), in which the main character takes on all roles in the circus—from selling tickets and seating the audience to performing in the show, among others.

institutional levels, where participation is often limited to technical and operational consultations, excluding political or strategic decision-making.

MacMillan and Perron⁽³²⁾ report that strong medical dominance in health organization management not only invisibilizes nurses but also negates their participation in health policy - a reality confirmed by multiple studies^(23,39-42).

Despite this unfavorable sociohistorical context, nursing's role must be reaffirmed, empowering nurses at all levels, recognizing that empowered nurses improve care quality and use their power to advocate for patients and families^(32,33,43).

Research shows nurse managers who understand and recognize their power and autonomy significantly improve organizational processes, becoming indispensable and essential in hospital structures for developing profession-specific improvement plans^(33,44). Participants highlighted the need for discipline-specific processes such as nursing indicators. Although many indirect care-related indicators exist, none are nursing-specific. This "need-desire" analyzed through a Foucauldian lens suggests the development of unique nursing knowledge and consequent power, legitimized by clinical nurses, which constitutes power to be possessed and exercised. This knowledge and power translate into agency, enabling nurse managers to enact change and exercise autonomy^(45,46). Hence, nurses' interest in developing indicators and standardization reflects a desire to strengthen agency recognized through these tools, as echoed in their statements.

While findings invite reflection on care management's implications in Chilean hospital structures, limited informant numbers prevented saturation. Nevertheless, results provide insight into how nurses in power interpret their role and influence, underscoring the need to strengthen exercised agency.

CONCLUSIONS

This study interpreted nurse managers' conception of care management and its implications for hospital service structure and function in Chile. Analysis was framed through power and agency within the discipline, recognizing the need to expand perspectives and advance a new paradigm of power and agency in nursing management roles. Overcoming sociohistorical subordination and invisibility relative to other disciplines requires concrete strategies such as developing nursing-specific indicators and advancing care standardization. Promoting disciplinary and clinical research from diverse epistemological approaches is also essential, as knowledge generation will reinforce nurses' agency and power across professional practice levels.

REFERENCES

1. González-García A, Pinto-Carral A, Pérez-González S, Marqués-Sánchez P. Nurse managers' competencies: A scoping review. *J Nurs Manag*. 2021;29(6):1410-1419. DOI: <https://doi.org/10.1111/jonm.13380>
2. Ansah MA, Paarima Y, Barnes T. Exploring the management competencies of nurse managers in the Greater Accra Region, Ghana. *International Journal of Africa Nursing Sciences*. 2020; (13). DOI: <https://doi.org/10.1016/j.ijans.2020.100248>.

3. Chase L. Nurse Manager Competencies. JONA: The Journal of Nursing Administration. 1994. 24(4S). URL: https://journals.lww.com/jonajournal/citation/1994/04011/nurse_manager_competencies.9.aspx
4. International Council of Nurses. International Nurses Day 2024 Report. Ginebra. Disponible en: https://www.icn.ch/sites/default/files/2023-07/ICN_IND_2023_Report_SP.pdf
5. Warshawsky NE, Caramanica L, Cramer E. Organizational Support for Nurse Manager Role Transition and Onboarding: Strategies for Success. J Nurs Adm. 2020;50(5):254-260. DOI: <https://doi.org/10.1097/nna.0000000000000880>
6. World Health Organization. State of the world's nursing 2020. Geneva: WHO; 2020. Available from: <https://apps.who.int/iris/bitstream/handle/10665/331675/9789240003392-spa.pdf>
7. Pan American Health Organization (PAHO). The strategic importance of national investment in nursing professionals in the Americas region. OPS; 2022. Available from: https://iris.paho.org/bitstream/handle/10665.2/56055/OPSHSSHR220012_spa.pdf?sequence=1&isAllowed=y
8. International Council of Nurses. Government chief nursing officer (GCNO) positions. Ginebra: ICN; 2020. Available from: https://www.icn.ch/system/files/documents/2020-01/ICN%20briefing_GCNO_ENG.pdf
9. Milos P, Larrain A. Care management in Chile: from function to structure. Cienc. enferm. 2013; 19(2): 7-10. <http://dx.doi.org/10.4067/S0717-95532013000200001>
10. Ministerio de Salud. Reglamento Orgánico de los Establecimientos de Salud de Menor Complejidad y Establecimientos de Autogestión en Red, Decreto N°38. 2005. Disponible en: <http://www.leychile.cl/Navegar?idNorma=247591>
11. Ministry of health. Reglamento Orgánico de los Servicios de Salud N° 140. 2004. Disponible en: <http://www.bcn.cl/leyes/pdf/actualizado/237231.pdf>
12. Ministry of health. Norma Técnica Administrativa N°19. 2007. Disponible en: http://www.minsal.cl/juridico/RESOLUCION_1127_07.doc
13. Taylor SJ, Bodgan R. Introduction to qualitative research methods. 1ª Ed. Barcelona: Ed. Paidós; 1992.
14. Guba E, Lincoln Y. Competing Paradigms in Qualitative Research: Handbook of Qualitative Research. 1st ed. California, USA: SAGE. 1994.
15. Do Prado M, De Souza M, Monticelli M, Cometto MC, Gómez P. Qualitative Research in Nursing: Methodology and Didactics. 1ª Ed. Washington DC. Ed. PALTEX; 2013.
16. Yin RK. Case study research: Design and methods. 4a. ed. Thousands Oaks, CA; Sage. 2009.
17. Urra E, Núñez R, Retamal C, Jure L. Case study approaches in nursing RESEARCH Cienc. Enferm. 2014;20(1). DOI: <http://dx.doi.org/10.4067/S0717-95532014000100012>.
18. Martínez-Salgado C. Sampling in qualitative research: Basic principles and some controversies. Ciência & Saúde Coletiva, 2012. 17(3):613-619,. URL: <https://www.scielo.br/j/csc/a/VgFnXGmqhGHNMBsv4h76tyg/?format=pdf&lang=es>
19. Berndt AE. Sampling Methods. Journal of Human Lactation. 2020;36(2):224-226. DOI:10.1177/0890334420906850
20. Bardin L. Content analysis. 3a Ed. Madrid – España. Ed. Akal.2002
21. Macia Soler ML. Qualitative Research. 1ª Ed. Barcelona – España. Ed. Elsevier. 2015

22. Ma H, Chihava TN, Fu J, Zhang S, Lei L, Tan J, Lin L, Luo Y. Competencies of military nurse managers: A scoping review and unifying framework. *J Nurs Manag.* 2020 Sep;28(6):1166-1176. DOI: <https://doi.org/10.1111/jonm.13068>
23. Paynton T. "The Informal Power of Nurses for Promoting Patient Care", *OJIN: The Online Journal of Issues in Nursing.* 2008;14 (1). DOI: <https://doi.org/10.3912/OJIN.Vol14No1PPT01>
24. Rutz A, Buss M. The political empowerment of nurses in hospital practice. *Index Enferm.* 2015; 24(1-2): 20-24. URL: http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1132-12962015000100005&lng=es
25. Katriina P, Sari V, Anja R, Christina S, Paula A, Tarja S. Nursing power as viewed by nursing professionals. *Scand J Caring Sci.* 2013;27(3):580-8. DOI: 10.1111/j.1471-6712.2012.01069.x
26. Foucault, M. *Microfísica do poder.* 9. ed. Rio de Janeiro. 1990.
27. Gastaldo D, Holmes, D. Foucault & Nursing: a history of the present. *Nursing Inquiry.* 1999; 6 (4): 231-240. DOI: <https://doi.org/10.1046/j.1440-1800.1999.00042.x>
28. Landman C. Sociopolitical role of nurses linked to leadership and professional autonomy. 2021; 32(2):103-107. DOI: <https://dx.doi.org/10.4321/S1132-12962015000100005>
29. Amezcua M. Foucault and nurses: gauging the power every day. *Index Enferm.* 2009; 18(2): 77-79. URL: http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1132-12962009000200001&lng=en
30. Foucault M. *Discipline and Punish.* 2ª Ed. Argentina. 2013.
31. Foucault M. *Aesthetics, Ethics, and Hermeneutics.* Ed. PAIDOS.
32. McMillan K, Perron, A. Nurses' engagement with power, voice and politics amidst restructuring efforts. *Nursing Inquiry.* 2020; 27(3), e12345. DOI: <https://doi.org/10.1111/nin.12345>
33. George KC, Lyman B, Pilarte Alcantara A, Stephenson M. Women's power in hospital-based nursing: A critical qualitative study. *J Adv Nurs.* 2023;79(2):798-810. DOI: <https://doi.org/10.1111/jan.15550>
34. Fewster-Thuente L, Velsor-Friedrich B. Interdisciplinary collaboration for healthcare professionals. *Nursing Administration Quarterly.* 2008; 32(1), 40–48. <https://doi.org.bibliotecadigital.uv.cl/10.1097/01.naq.00003>
35. Hay, K. Disrupting gender norms in health systems: Making the case for change. *The Lancet.* 2019; 393(10190), 2535–2549. [https://doi.org.bibliotecadigital.uv.cl/10.1016/s0140-6736\(19\)30648-8](https://doi.org.bibliotecadigital.uv.cl/10.1016/s0140-6736(19)30648-8)
36. Galvin L, Parlier B, Martino E, Scott R, Buys E. Gender bias in nurse evaluations of residents in obstetrics and gynecology. *Obstetrics & Gynecology.* 2015; 126(Supplement 4), 7 S–12 S. <https://doi.org.bibliotecadigital.uv.cl/10.1097/aog.0000000>
37. Kahsay W, Negarandeh R, Dehghan N, Hasanpour M. Sexual harassment against female nurses: A systematic review. *BMC Nursing.* 2020; 19(1), 58. <https://doi.org.bibliotecadigital.uv.cl/10.1186/s12912-020-00450-w>
38. Muench, U., Sindelar, J., Busch, S. H., & Buerhaus, P. I. Salary differences between male and female registered nurses in the United States. *Journal of the American Medical Association,* 2015; 313(12), 1265. <https://doi.org.bibliotecadigital.uv.cl/10.1001/jama.2015.1487>
39. Elrod, PD, Tippett, DD. The "valley of death" of change. *Revista de Gestión del Cambio Organizacional,* 15, 273–291. <https://doi.org.bibliotecadigital.uv.cl/10.1108/095348102104>

40. Fulop L, Mark A. Relational leadership, decision-making, and contextual disorder in health care. *Liderazgo*. 2013; 9 (2), 254–277. <https://doi-org.bibliotecadigital.uv.cl/10.1177/1742715012468>
41. Rankin J, Campbell M. *Managing to nurse: Inside Canada's health care reform*. Toronto, ON 2006; University of Toronto Press
42. Fletcher K. Beyond Dualism: Leading the Way Out of Oppression. *Foro de Enfermería*. 2006; 41 (2), 50–59. <https://doi-org.bibliotecadigital.uv.cl/10.1111/j.1744-6198.2006.00039.x>
43. Smith Y, Cleveland K, Kleman C. "Understanding Nurses' Experiences and Contributions to Governing Boards" *OJIN: The Online Journal of Issues in Nursing*. 2021; 27 (1). DOI: <https://www.doi.org/10.3912/OJIN.Vol27No01PPT32>
44. Lyman B, Parchment J, George K. Diversity, equity, and inclusion: crucial for organizational learning and health equity. *Nurse Leader*. 2022. 20 (2), 193 – 196. <https://doi-org.bibliotecadigital.uv.cl/10.1016/j.mnl.2021.10.012>
45. Belvedresi R. Women's history and female agency: some epistemological considerations. *Epistemología E Historia De La Ciencia*. 2028; 3(1), 5-17. URL: <https://revistas.unc.edu.ar/index.php/afjor/article/view/19865>
46. Caro P, Román H, Armijo L. Women in senior mining positions in Chile. Agency and gender tensions. *Convergencia. Revista de Ciencias Sociales*. 2021; 28: 1-29. URL: <https://www.redalyc.org/articulo.oa?id=10565827003>