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The Professional Work of *Hinge Objects*: Inter-Professional Coordination in Urban Drainage

Abstract: Recent developments in sustainable urban drainage have turned the area, formerly controlled by engineers, into a professional field encompassing engineers, landscape architects, and urban planners. Through interviews, fieldwork, and document analysis of three Danish cases of urban rainwater management, the article shows how these three different professions, in drawing upon the specific Danish concept of LAR (Local Diversion of Rainwater), compete with each other but also coordinate their work tasks. The article proposes the concept of *hinge object*, inspired by Star and Griesemer's boundary object and Abbott's work on hinges, to capture how LAR serves as a coordinating object among professions, but also among professions, the state, and universities.

Keywords: Urban drainage, engineers, landscape architects, Abbott, boundary object

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Recent changes in the field of urban rainwater management and drainage have led to an opening for new professionals in this field, which has previously been dominated by wastewater engineers. More rain as a result of climate change is challenging the existing rainwater infrastructure and in Denmark has resulted in a political awareness of the problem of urban rain and drainage. Together with an increased focus on the greening of cities and more urban nature, this opens the area to landscape architects and urban planners, who combine the draining of rain with building greener cities by draining rainwater on the surface. Different conventions of legitimate coordination are beginning to establish themselves in this field of sustainable urban rainwater management and drainage, but the three professions—engineering (mostly wastewater and environmental), landscape architecture, and urban planning—still compete to some extent over which new (or old) techniques should be used for draining urban rainwater.

In the international community of sustainable urban drainage, these techniques consist of, for instance, Sustainable Urban Drainage Systems (SUDS), Low Impact Development (LID), and Water Sensitive Urban Design (WSUD). In Denmark, the concept of LAR (translated into English as Local Diversion of Rainwater) is the most commonly used for specific rainwater drainage techniques that drain rainwater on the ground (through rain beds and so on) instead of leading it into the sewers, where it potentially floods the system. LAR is used widely by engineers, landscape architects, and urban planners. But there is a discussion among the different professions about what is covered by the concept, how it should be used, and what it provides a solution for. These discussions take place in professional, governmental, and research networks, which are constituted not only by professional actors, but also by

actors from universities, municipalities, and state agencies. To understand how inter-professional work is organized and arranged in this new, emerging field, I analyze how professionals define, discuss, and work with the concept of LAR. The definitions and discussions are professional, but they are also closely tied to political ideas about greener cities and to the research practices and agendas of university communities.

In this paper, I draw on Andrew Abbott´s sociology of professions (2001, 2005) and the sociological work on classification and boundary objects by Star and Griesemer (1989, also Bowker & Star 1999) to analyze LAR as an object that not only coordinates among professions, but also hinges professional groups and discussions on to the political and university field. Based on this analysis, I propose the concept of a *hinge object* to explain this dual way that LAR works in a professional ecology. A hinge object in my definition makes cooperation across multiple, different professional worlds possible while at the same time allowing for alliances on a different level, namely, among the different ecologies (in the language of Abbott): the professional, the political, and the university. The analysis of LAR draws on material gathered by following three different urban development projects in Denmark that deal with climate adaptation and urban rainwater management.

The paper will proceed with a background section, where I briefly contextualize the professional arena of urban rainwater management. Afterward, I elaborate on my theoretical framework and contribution in a theoretical section, which draws on Andrew Abbott's sociology of professions and Star and Griesemer's work on boundary objects. I then describe the data collected for the paper, my methods, and my research logic. In the following empirical sections, I analyze the way that different professions define and work with techniques for urban rainwater management. Lastly, the discussion will show how conceptualizing LAR as a hinge object captures an important aspect of inter-professional work in an emerging professional field: namely, the combination of cooperation and competition among professionals and the linking of this cooperation and competition to other non-professional actors and arenas.

Inter-professionality in urban rainwater management

For a long time in Western cities, ever since the late 19th century, urban wastewater has been channeled underground to the sewage system in pipes, at first directly to recipients (rivers, streams, oceans) and later to water treatment plants. Thus, the management of urban rainwater became was almost entirely the domain of wastewater engineers. But from the 1960s, '70s, and '80s, discussions began transnationally among engineers, biologists, and ecologists about the water quality of urban rainwater runoff (Karvonen, 2011, in Danish see documents from the Danish EPA, Miljøstyrelsen, 1979, 1981, 1990). This increased focus on water quality led to different new management techniques and ideas. Some of these new techniques are conceptualized as LID, SUDS or, in Denmark (around the 1990s), as LAR. In the United States, such techniques are influenced by landscape architects and ecologists, who thereby influence the area of urban rainwater management and drainage as a whole (Karvonen, 2011, p. 19). This presence of landscape architects in urban rainwater management happened later in Denmark, from the late 1990s into the 2000s, but today there is no question that managing urban rainwater is an "interdisciplinary" area of expertise (as described by the actors themselves).

This interdisciplinarity manifests in the way that actors describe professionals in the field: for example, landscape architects may be referred to as "landscape [architects] classic," which describes a certain kind of landscape architect, specifically one focused on aesthetics. In another instance, a professor referred to a landscape architect as a "technical landscape architect," as opposed to the classic landscape architects described above. Someone else called certain building consultants "architects

engineers," which meant that they were educated as architects but understood knew all the formalities and technicalities of building, whereas an engineer from the utility company was described as an "engineer engineer." In all these examples, the major dividing line is between the technical and the aesthetic/artistic. This is a typical distinction in the relationship between engineers and architects (see, for instance, Faulkner 2007). The blurring of this characteristic engineer-architect divide is the result of an area of expertise that is, at this moment, extremely interdisciplinary, and where organizing and delegating work tasks is still new and confusing for many, if not all, of the actors. It does not mean a dissolving of professions as a main organizing principle for delegating work tasks because strong ideas about the competences of engineers and architects (and the differences between them) still prevail in the field, and these ideas are backed by the organization of work, where engineers are assigned specific tasks and landscape architects others. Yet the interdisciplinarity indicates the possibility of new specializations forming.

This interdisciplinarity is closely tied to the location of rainwater in these new management techniques: having been managed in infrastructures underground, urban rain is now being managed (to some extent) on the surface. For almost 100 years, then, engineers had almost complete control over calculating, designing, and building sewage systems underground, but the surface of the city is an area where urban planners and (landscape) architects perform and, to a certain degree, control different work tasks. A traditional sewage project, where rainwater is led underground to a treatment plant, does not present complicated issues concerning pollution or installations in protected forest and nature, nor issues regarding waterborne diseases and epidemics. LAR projects, on the other hand, affect a whole new set of related areas: roads, forests, parks, and so on. Therefore, draining rainwater on the surface also means that new types of engineers are becoming involved, for example, road and environmental engineers.

In Denmark, the practice of managing urban water on the surface has been further strengthened by very heavy rains and cloudbursts in 2007, 2010, and 2011, which flooded large areas of the Danish capital, Copenhagen, and led to an increased political awareness of the limited capacity of the urban sewage systems. There is professional agreement around the fact that the current system is not equipped to handle the increased amounts of rain. Expanding the existing systems poses economic and technical obstacles in urban settings, where there is little room for larger pipes and a greater risk of flooding owing to large fortified areas. Therefore, urban rainwater is managed on the surface and LAR plays an important role in this new way of managing rain.

The field of urban rainwater management and drainage has, then, in the last 50 years developed from a largely mono-professional area to a field where different professions claim expertise. As described, this change has been driven by new environmental problems, but instead of leading to the forming of a new profession, these new tasks are being integrated into existing professions, especially those of engineering and landscape architecture, as Mieg and others have also shown in Switzerland (Mieg, de Sombre & Näf. 2013). In Denmark, the practice of managing water on the surface has also transformed the field from being dominated by one organization, the utility company, to involve more organizations and businesses, where the tasks and responsibilities are distributed in new ways. These novel ways of managing urban rainwater thus involve much more coordination among a wider set of organizational actors and professions.

Theoretical contribution: Towards professional hinge objects?

Following Andrew Abbott's sociology of professions (2001, 2005), I understand the professional system as an ecology linked with other ecologies. The concept of ecology signifies a changing relational professional space, where professions and professional organizations construct and constitute the boundaries for other professions. This puts the inter-professional struggles over *jurisdictions* at the centre of the sociological analysis (for other analysis of the professional jurisdiction, see, e.g., Fourcade, 2006; Suddaby & Viale, 2011). Jurisdictions are the link between professions and a particular task over which certain professions claim control. A central point in Abbott's sociology (2005) is that professional work and claim-making are linked to other arenas, the university, and political ecology, where similar battles for control take place. Professions are thus arenas shaped by jurisdictional battles within and between different professions, and jurisdictional struggles in the professional ecology are also fought within a broader ecological landscape.

In the university arena, the locations that actors try to control are called *settlements*. This term can refer to a body of more or less controlled knowledge or a special faculty and may involve, for instance, research practices (Abbott, 2005, p. 250). Another ecology is the political, where *bundles* (Abbott, 2005) correspond to jurisdictions and settlements as the areas in which political issues are transformed and where political actors try to exercise control. Examples of a political bundle might be social policy, deregulation, or climate adaptation.

An alliance between two or three of the different ecologies is called a *hinge* (Abbott, 2005). A hinge links specific groups of professionals, university researchers, and/or political actors, and offers different rewards in different ecologies. In the field of urban rainwater management, for instance, a hinge could be the Danish municipal climate adaptation plans and flooding maps, which work in the political ecology as a way to deal with the recent floods in Denmark, and which serve in a professional ecology as a roadmap to the locations where interventions should be made in relation to flooding. Forming a specific link between a profession and a political actor is one strategy that a profession can apply when fighting for jurisdictional closure in the professional ecology. Therefore, the struggles between professions often also are tied into links between ecologies. Another link between ecologies can be established when an ecology attempts to create an *avatar* of itself in another ecology (an example of this is when professions seek a place in the university by creating undergraduate disciplines, Abbott 2005, p. 265).

In the professional jurisdiction of urban rainwater management, LAR emerges through the work that professional actors do when they manage rain and urban drainage. It is a concept that different professions use and work with, but one that they also fight over. At the same time, university and political actors are involved, too, in these discussions and struggles. To understand the new inter-professional field of urban rainwater management, it is, therefore, crucial to grasp how professional actors work with and interpret LAR as a central concept in the professional work of urban drainage and rain management.

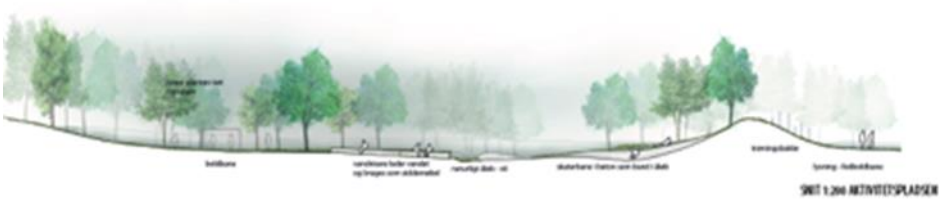
Abbott does not elaborate on what exactly a hinge between ecologies could look like, and the theory does not offer more precise language than the somewhat abstract concepts of hinge and avatar to grasp how different ecologies are linked together. Furthermore, the relations among different professional groups are not explicated other than as battles for autonomy and control. Faced with the field of urban rainwater management, where coordination among many different actors in many different organizational contexts is the norm rather than the exception, a more detailed language of coordination is needed. A conceptually coherent and nuanced language of coordination among different groups that has been used to understand professional cooperation in engineering, for instance (e.g., Bechky, 2003; Faulkner, 2007; Van de Poel, 2008), is the idea of a *boundary object* developed by Star and Griesemer (1989). A boundary object inhabits intersecting communities of practice and can not only adapt to local needs and local meanings in the different communities, but also

maintains a common identity across different locations (Star & Griesemer 1989, p. 393). In joint practices, the object is thus relatively unstructured, but highly structured when used in the different communities (Trompette & Vinck 2009). Thus, it is a coordination device not "engineered as such by any one individual or group, but rather emerged through the process of the work. As groups from different worlds work together, they create various sorts of boundary objects" (Star & Griesemer 1989, p. 408). The object is a way for actors from different communities of practice to coordinate in spite of their different points of view (Trompette & Vinck 2009).

A boundary object can take many forms, and in their work from 1989, Star and Griesemer distinguished among four different types of boundary objects: repositories, ideal types, coincident boundaries, and standardized forms. These types exemplify ways of coordinating work between locations and communities of practice. In the terminology of Star and Griesemer, the concept of LAR can be categorized as a boundary object because the different professions use it to coordinate among themselves but assign to it very different meanings and models (see also Van de Poel 2008 for a conceptualization of engineers' drawings and models as boundary objects). More specifically, LAR is an *ideal type* (in the Weberian sense of the word, where ideal refers to a coherent whole of typical traits of reality, not the actual, specific thing itself). A boundary object as an ideal type is an object such as a diagram or an atlas:

> Which in fact does not accurately describe the details of any one locality or thing. It is abstracted from all domains, and may be fairly vague. However, it is adaptable to a local site precisely because it is fairly vague; it serves as a means of communicating and cooperating symbolically—a "good enough" road map for all parties […] Ideal types arise with differences in degree of abstraction. They result in the deletion of local contingencies from the common object and have the advantage of adaptability. (Star & Griesemer 1989, p. 410)

LAR demonstrates this quality of abstractness and vagueness. It is a diagram (like the one shown in picture 1 below) that illustrates a cross-section of above and beneath the surface, shows different sorts of green plants and trees, and exhibits where and how the water will stay on the surface in the event of rain.



Picture 1. *LAR as an ideal type–boundary object. Part of the project description for climate adaptation project, The Climate City, GHB Landscape architects.*

This way of picturing LAR is common to landscape architects, urban planners, and engineers but lacks all the important details of their professional work (depth, width, length, material specifications, elevation levels, and so on) and therefore also all the local characteristics of the city. For this diagram to become specific enough, engineers would need to break it down into many much-smaller parts, both longitudinal-

and cross-sections, and into different diagrams with specific measures and description of materials attached to them. The landscape architects would have to make lists of specific plants to put in rain beds and diagrams of how they should be planted. In this way LAR as an ideal type coordinates between professional groups by being vague enough for different professions to adapt it to specific areas and work tasks.

Other studies have shown how boundary objects are not neutral or consensual but can exercise power (e.g., Huvila 2011). In the case of interdisciplinary professional work in urban rainwater management, what matters is that LAR not only coordinates among different communities of professional practice, but also is a contested concept at the heart of the jurisdictional struggles. In these struggles, LAR functions as a central *hinge* between the professional jurisdictional battles over the area of urban rainwater management and other ecologies such as the state and universities. To understand the specific role that LAR plays in the field of urban rainwater management, I therefore suggest that it is a *particular* kind of boundary object that not only coordinates between professions, but also serves as a hinge between the professional ecology and other ecologies. Therefore, I propose the term hinge object to capture this dual role of LAR.

Focusing on LAR also shows that the area of urban rainwater management is not a stable, monopolized jurisdiction, and that the idea of total control is in some ways misleading. This is because the whole point of the new way of managing urban rainwater is that it can do several things at once, which means that different professions benefit from it—and from the fact that other professions are involved.

Data and methods

The main data produced for this paper are interviews, documents, and meeting observations from three Danish urban rainwater management projects, which began in 2012 and are ongoing. All three are urban planning and rainwater management projects that manage water on the surface. Projects like these make good case studies for the coordination practices of different professions, since they involve engineers, urban planners, and landscape architects. The projects specific to my study are trying to solve the problem of heavier rain as a consequence of climate change by preventing flooding in instances of cloudbursts and extreme rain. They are located in three larger Danish cities and, at the time I conducted my interviews and observations, were at different stages of planning: One was 2/3 finished, with only 1/3 of the area waiting to be built. One was still in the drawing and calculation phase, and one had just been selected as a planning project and was about to be developed in more detail. In the three projects, I have talked with different people from the municipality, along with the utility company, and with consultants employed on the projects and from different professions (engineers, landscape architects, and urban planners). I also draw on interviews with other actors from other projects, and on interviews with key people in the field—from universities, consulting companies, and interest groups—who were not directly affiliated with the projects. I have conducted 31 interviews with 33 people, which took from 1 to 2.5 hours. The interviews were semi-structured and focused on work practices and the cooperation between different professions. I also draw on observations made during a brief one-month-long fieldwork in an engineering consultancy and at meetings.

The theoretical contribution from this paper is the suggestion of the concept of a *hinge object*, a supplementary concept to the original idea of a boundary object developed by Star and Griesemer (1989). This concept is developed through an abductive analysis of the empirical data (Timmermans & Tavory, 2012). Using this abductive approach, the analysis is informed theoretically, but the theory is not used either to verify, falsify, or modify the theory, as in the case of deduction. Instead, I have entered the field with an understanding of theories and developed my theoretical

repertoires throughout the research process, which has given me the ability to modify and extend existing theories in novel ways (in line with what is described by Timmermans and Tavory, 2012, p. 173). My analytical departure was to understand the inter-professional work and coordination that was practiced in the field of urban rainwater management, informed by the sociology of professions, especially Abbott's (1988, 2005). As I worked with the interview data and my fieldnotes, the concept of LAR emerged as an object that in important ways helped actors coordinate and compromise in their daily inter-professional work. This resonated with the idea of a boundary object (also part of my theoretical ideas about professional work) that makes possible cooperation across multiple, different professional worlds. Yet informed by my theoretical understanding of a professional ecology coexisting with other ecologies, I saw that LAR did more than coordinate among professions. It also made possible alliances on a different level, namely, between the different ecologies (in the language of Abbott). LAR functioned in the language of Abbott as a hinge between the different ecologies. Describing LAR as a hinge object is, therefore, an addition to the concept of boundary objects, a particular kind of boundary object that coordinates not only between the different professional worlds, but also across ecologies.

Everyday rain and cloudbursts: Engineers working with LAR

Historically, engineers have had a major impact on and control over the area of urban rainwater management. In Denmark, the Danish Society of Engineers has a committee, The Wastewater Committee (called in Danish, and from now on, SVK), which has been very influential in establishing standards and norms for practice in urban rainwater management. The members of SVK are academics, consultants, employees from the utility companies, manufacturers (e.g., of pipes), and also governmental actors. The only requirement for volunteering as a member is that you belong to the Danish Society of Engineers. SVK has historically influenced the Danish state and legislation by publishing documents on "good engineering practice." These documents have been adopted as Danish standards, not officially, but because all engineers use them and therefore risk being accused of not following good practice if they fail to comply with the recommendations (this actually occurred, when a municipality was convicted of not complying with best practice, based on the recommendation of SVK, in a case of flooding). When defining how urban rainwater management and LAR should be practiced, SVK therefore plays a major role. SVK is a professional committee, but since its members are also from both the political institutions and universities, it could be characterized as a *hinge organization* that link engineers and other ecologies in relation to urban rainwater management.

SVK has been central in developing the definition of LAR. LAR as a concept was invented in the 1990s by an engineer employed at the Technical University of Denmark and actively involved with SVK. Inspired by the Swedish approach to rainwater drainage and as a strategy for developing a research field, he coined the term LAR:

> Yes, well, in that period, we invented the name LAR … It was also the case at that time, when we produced our mathematical models, that they also needed a name. Everything needed some sort of name and abbreviation … so I said to Paul [his colleague at the university]: "We need to…now we need to make this a slogan that we can run with," and then I came up with the name LAR.

This naming of LAR can be characterized as a way to define a settlement in the university by inventing a "slogan" to show its importance as a research field. LAR,

then, was initially an attempt to create an area for research defined and controlled by academic engineers. The academic engineers working in this area wrote two important documents on LAR in the early 1990s: one published by the Environmental Agency and one by SVK. In both these documents, LAR is described as techniques for managing rainwater without leading water into the sewers. The idea of using LAR to create greener cities and better urban spaces is not mentioned.

The university actors' attempt to create a settlement of LAR in the university ecology was hinged on to the political ecology (The Environmental Agency) and the professional ecology (via SVK). This work was done by specific academics, who acted as avatars in the different ecologies, where they wrote about LAR and thereby exported the concept into the professional and political arenas.

After these two documents were published in 1992 and 1994, almost 20 years passed without either of the organizations mentioning LAR again. But in 2011, the same year that Copenhagen was flooded by cloudbursts, SVK published a second document on LAR, in which the dimensioning criteria from 1994 was updated. Here, LAR is described as having two functions: it is a drainage technology but can also be used as a tool for urban design.

> LAR installations in the form of newly built green areas in roads or buildings can be established for the benefit of the city and people. If LAR-installations are meant to be used in this way, even relatively small constructions can be very useful. But if they are meant as complete or partial replacement for sewers, they have to be able to protect against flooding, which requires big constructions. (SVK 2011, p. 2)

This idea of LAR as a tool for planning green and better urban spaces is new to SVK's 2011 definition of LAR. In the interval between SVK's first and second documents on LAR, landscape architects (as I will show later) were actively working to define LAR as a tool for planning greener and bluer cities. This definition is then adopted by the engineers in the 2011 document. The documents from SVK describe the formalized rules for designing LAR constructions and how much water they should handle. They are related to earlier documents from SVK on dimensioning draining systems and climate adaptation. LAR constructions thus are being standardized as a technical part (but only a part) of the drainage and sewage system related to measures for the different amounts of rain they should accommodate.

This professional standardization by SVK is a way to clearly define LAR in engineering terms by relating it to earlier professional standards. What is important for engineers is that LAR is one solution, but not the only one, for managing urban rainwater. For most engineers, LAR solutions are part of a larger system of different methods for managing urban rainwater. Pipes underground remain a component of these methods, and guiding water along the surface and away from certain areas, but not draining it locally (as is implied by LAR), is another method. One engineer from a private consultancy firm describes a LAR project he has been working on:

> That's more like everyday LAR. It's also there that you have to distinguish between LAR or climate adaptation. They're two different things … Because climate adaptation aims to handle these extreme events, either flooding from the sea or an extreme rain event. Whereas LAR is more about managing water locally, and there can be infrastructure advantages to it.

Several engineers talk about LAR as involving methods for handling the increased amounts of everyday rain but specify that other methods—for example, leading water on the surface directly to recipients—are needed for managing extreme events (such as the Copenhagen cloudbursts), which are also increasing. An engineer explains: "It [LAR] is a tool in the toolbox, in the same way that a sewage pipe is."

This is not a view of LAR that is shared by all professions. An engineering professor makes the following comments about landscape architects:

> I have great respect for them, but they have a hard time understanding the scale … No matter how much you put LAR or landscape-whatever into it, it won't solve the cloudburst problem. And if you want it out in the harbor, and there's a hill, then you must have a tunnel or a big pump. Otherwise it's impossible.

For engineers, LAR is a tool, but not the only one, to manage urban rain, and they emphasize that LAR is not the final solution. In the university ecology's fight over settlements, LAR is a central object in the area of rainwater, climate adaptation, and urban planning. In the university ecology and professional ecology, engineers and engineering professors are performing professional boundary work (Gieryn 1983, Liu 2015) in relation to landscape architects by clearly defining a line between, on the one hand, everyday rain, which can be managed with small LAR installations, and on the other, cloudbursts or extreme rain; in the view of the engineers, the more extreme forms *could* be handled with large and expensive LAR installations but should be managed with other cheaper and less comprehensive methods (methods belonging to the engineering toolbox). LAR installations—or "landscape-whatever," as it is called by the engineering professor—do not solve the cloudbursts problem; only engineering installations like a tunnel or a big pump can do that.

Boundary work is done by engineers by assigning specific tasks to their own profession, but also by clearly defining tasks for others. One professor says: "I will not comment on which plants should be in a rain bed. But they [landscape architects] must also respect that an average rainfall is 3 mm, but the big ones are also coming, and we need to know what happens when they come." So, landscape architects can handle everyday rain in rain beds and decide on the plants that go in there, but they cannot prevent flooding. That is an engineering job.

"Pipes on the surface": The critique from landscape architects

In Denmark, academic landscape architects were the first to describe managing water on the surface as a way to combine drainage, flood protection, urban planning, and city greening. This approach emerged from the research project 2BG, dating from 2007, which was funded by the Danish government. At the time, the concept was not called LAR, but *landscape-based drainage*. It is worth noting that the official institution representing landscape architects is neither very strongly organized nor institutionalized and, in contrast to SVK, enjoys no strong links to the political system and the universities. Landscape architects therefore have competed for control over the area of urban rainwater management by way of projects and networks. The research project 2BG, which ran from 2007 to 2011, was central in establishing the link between drainage and a greener city. As such, the vision of the academic landscape architects was linked—both economically and normatively – with the political ecology. Later, 2BG was replaced by 19K, a network of 19 municipalities wherein the coordination between utilities and municipalities became the focus, also led by academic landscape architects. From this network grew the new network Water in Cities (Vand i byer, ViB in Danish), a very large partnership and innovation network consisting of universities, utility companies, public authorities, and private companies. Water in Cities was also partly initiated and, in the beginning, partly run, by an academic landscape architect. The network started in 2010 and is still operating today with 201 participants (knowledge institutions, public institutions, utility companies, manufacturers and contractors, consultants, and interest groups). The

network has been very influential in promoting its mission, which is "to create climate robust and sustainable cities by value-creating water management" (from the website vandibyer.dk). LAR provides a central method for implementing the mission of this network. Thus, this work by the academic landscape architects can be seen as a way to establish alliances with political institutions in the field.

At some point, the landscape architects adopted the engineering term LAR, possibly as a way to coordinate with engineers who are employed in municipalities and utilities to handle urban rainwater. But in contrast to engineers, landscape architects typically believe it is possible to create LAR installations that can handle all rainwater in cities, as well as cloudbursts. Landscape architects maintain that this has always formed part of their area of expertise (in contrast with how an engineer framed the landscape architects' relationship to LAR, claiming that they saw an opportunity to expand their area of expertise to urban planning). When a professor of landscape architecture talks about LAR and the differences in rainfall, she emphasizes that it needs to handle everyday rain but can also handle extreme rain.

> The idea is that it handles all rainwater and not just once in a decade or the cloudbursts. So, it's an alternative to a sewer. Or it can work together with the sewers, but the idea is more that it's an imitation of nature, while [the other solutions]—they're more that you just transport water on the surface along some newly profiled roads … But it's really just the same idea as conventional sewage … They [engineers] have raised the sewage system to the surface.

This is a way of critiquing (some of the) engineers' approach to LAR as just another method of building sewers. For the landscape architects, this approach misses the point of LAR, which is tied to the whole water network in the city and to the possibility of creating a greener and more biodiverse city. LAR, then, for the landscape architects, is about a more "natural" approach to water and the water life cycle, which LAR imitates.

A common critique of projects in the field of urban rainwater management is that what is built is just "pipes on the surface," or involves only raising the sewage system to the surface, as described in the quote above. This could be characterized as a critique of the engineering approach to LAR. What matters to landscape architects, then, is that LAR should do something more and something different for the city than what traditional wastewater projects can achieve. It should create more green areas and more biodiversity. Therefore, it is not enough for LAR installations to manage rainwater. Something more should come out of these projects, and that "more"—greener areas, more trees, greater biodiversity—is a job for landscape architects.

LAR as city branding: Urban planning and the political ecology

The profession of urban planning has a history, in Denmark and many other European countries (Frank et al. 2014), of being interdisciplinary. Established at the beginning of the 19th century and consisting mostly of engineers and architects, the occupation today has developed into an even more interdisciplinary field, where sociologists, geographers, and political scientists all carry out the work of urban planners. The professional association struggled in Denmark in the 1960s and '70s to establish an educational qualification, and still struggles to maintain some sort of control over the area of city planning. Compared with engineering and landscape architecture, the profession of urban planning is much less stable and cohesive. In Denmark, although a strong tradition of comprehensive planning practice exists, planning nonetheless is embedded in architecture, engineering, and surveying pro-

grams (Frank et al. 2014, p. 38). There is still to be found, however, an official association of urban planning, along with different professional networks of urban planners, and in this sense, the field exhibits the traits of professional control.

Compared with the two other professions, urban planning is much more closely related to politics. This has probably always been the case with the profession, which, from the beginning, has been tied to the wish of cities and municipalities to control and regulate the area of the city. Urban planning as a profession has not detached from these strong political and official goals, and in Denmark, urban planners are almost entirely employed by the municipalities. Therefore, the way that urban planners think of, work with, and practice LAR is tied in many respects to the political ecology. Urban planners thus contribute to shaping the conditions under which landscape architects and engineers can enter into political alliances.

The cloudbursts in 2011, which left several streets in Copenhagen under water, became a turning point in the public debate about rain and climate. In the field of urban rainwater management, this event is referred to frequently as the point in time when politicians became aware of the problem and were ready to act upon it (mostly in bigger Danish cities, and especially in Copenhagen). The municipality of Copenhagen responded directly to the 2011 cloudbursts by publishing a "cloudburst plan," in which surface-based solutions should form a central part of the protective measures.

> In case of cloudburst, the water can be drained both over- and underground. Solutions on the surface are both easier and cheaper to create. At the same time, we can have new blue and green breathing spaces and recreational areas by combining surface-based solutions with plants and trees. Therefore, they will be preferred in those parts of the city where there's room for it. (The Cloudburst Plan of the Municipality of Copenhagen 2012, p. 2)

In urban planning and the political ecology, LAR is a way to green the city in a sustainable manner for the benefit of the people, as well as a way to optimize the city resources that are being invested in infrastructure. These investments also function to brand the city. Several actors talk about presenting rainwater projects at conferences and exhibitions, both in Denmark but also internationally. An urban planner talks about a municipal climate adaptation project with a comprehensive rainwater management plan: "I know that when the municipality is out and marketing itself abroad, then that's thing they're impressed with—the comprehensive plan". Talking about presenting climate adaptation projects at international conferences, another planner emphasizes the Danish approach to urban rainwater management:

> There are also larger cities in Europe that are working with climate adaptation, but they are working with it in separate sectors. I think it's very Danish to make connections all the time … so that the added value comes in and you get the urban development layer … to connect urban development and climate adaptation.

The work of urban planners is closely tied to the political ecology, where LAR is a concept that helps brand the city as green and sustainable and optimizes the city resources to create greener urban spaces.

LAR as a hinge object

The network mentioned earlier, Water in Cities, functions as a means of coordination among the different actors and organizations involved in urban rainwater management in Denmark. Here, LAR has a prominent place in the methods discussed and used for rainwater management. Therefore, even though the different professions

and university disciplines do not completely agree on what LAR is, LAR is good enough for coordinating among the different communities of practice. "The shared vision is big and the same", an engineer says about LAR and Water in Cities. In this context, LAR can be seen as a boundary object: a diagram that shows how water is drained and contained on the surface in relation to green areas, trees, and plants. This is the shared vision: that urban rainwater management can lead to greener cities and added urban value. There are still professional conflicts regarding the specific use of LAR, but these are minor. LAR is thus a means for professional actors to coordinate in spite of their different points of view (Trompette & Vinck 2009).

In this way, a willingness to focus not on the differences but on the shared ideas means that one of the prominent features of the field is a widespread consensus regarding both solutions and those things that still need to be studied and explored, together with the willingness of different professions to cooperate. A specific illustration of this collaborative process, where engineers and landscape architects work together, is the design of a LAR installation (a "rain garden") in one of the projects studied. The lead road engineer describes the design process as a long and thorough debate between engineers and architects about materials, water flows, and road traffic safety.

> Well, they [architects] see things differently. And maybe they're more concerned with what color a tile should be, whereas I'm thinking: "Well, we need a curb, so let's use granite, because we know it will hold". They're looking at, "Is it going to look good and beautiful?". And I'm thinking, "But the other way is working!" Yet it would be boring if everything was made the way engineers want it, right? … So, it helps to have the [landscape] architects on board.

When dealing with LAR in practice instead of in professional, jurisdictional closure, where one profession exercises its authority over another, professionals engage in processes of different, smaller compromises. In this case, the result is a material chosen by landscape architects because of its aesthetic value, but arranged in a way that satisfied the engineers' ideas of road safety and maintenance (literally, the tiles around the garden are tilted 90 degrees to make the curb more robust). This episode illustrates a general idea often described in the interviews, namely, the importance of engaging in close and respectful cooperation among professions when working with LAR. There is an agreement among actors that projects cannot be successful (or even realized) if they do not involve engineers, landscape architects, and urban planners who are committed and willing to do things differently than they normally would. One could see this as a sign of an inter-professional jurisdiction forming, one that is still very fragile but emerging among the professions of engineering, landscape architecture, and urban planning. This does not mean, however, that discussions and jurisdictional battles disappear. Professions still attempt to maintain and mark dividing lines, but without definite jurisdictional closure.

As the paper has shown, both discussions and battles are taking place among professions, and these professional battles are linked to the university and political ecology. An engineering professor says: "It's not the vision that there's something wrong with. But when it comes down to the concrete things, there's something that I can't vouch for professionally." Engineers, and especially university researchers, are doing boundary work to control their area of expertise in this new, interdisciplinary field by drawing upon the strong alliance among the engineering profession, university researchers, and the political institutions in SVK, which functions as an institutionalized hinge among the three ecologies. Here, the university actors are fighting the battle for control over the settlement of urban rainwater management and LAR. This battle is linked to the professional ecology via SVK, where the dimensioning of LAR installations is standardized as one group of methods for managing urban rain.

But why, might we wonder, do the engineers, who already control so much of this area, bother to fight the landscape architects, who are poorly organized and have already adopted the concept of LAR, which the engineers created and to some extent control? The reason might be found in the strong link between the landscape architects' version of LAR and the political versions current in larger Danish municipalities, which focuses strongly on greening the city and adding value to investments in infrastructure. This has forced engineers to engage in conversation about LAR and the green city.

A boundary object emerges through the process of work between different groups, with LAR being a particular kind of boundary object. It is created and maintained as part of jurisdictional struggles over professional control and, at the same time, links these struggles to political ideas about greener cities and to the research practices and agendas of university communities. Expanding on Abbott's idea of hinges, LAR can in this way be thought of as a *hinge object*, which makes coordination (and competition) between specific professional groups possible—and which links these groups to other ecologies.

Conclusion

The area of urban rainwater management in Denmark has changed from a largely mono-professional area of expertise, controlled by engineers, to a field where new professions also claim expertise, namely, landscape architects and urban planners. The case of LAR shows that in Danish sustainable urban drainage, there is not a clearly defined professional monopoly on the area. LAR is used by engineers, landscape architects, and urban planners, but these professionals work with and conceptualize LAR in different ways: urban planners use LAR for city branding and for optimizing the city's investment in infrastructure; engineers standardize LAR via their powerful professional organization and define it as a concept used for managing everyday rain; and for landscape architects, LAR is a model for urban development that tries to build on a natural water cycle and wherein green values are highly prioritized.

The concept of LAR is both part of a general professional coordination in this new area of expertise and part of the competition over control of this same area. As such, LAR is a boundary object that coordinates between different professions while also hinging the professional ecology with that of the state and university. I have therefore proposed the concept of hinge object to capture the way that LAR makes coordination (and competition) possible between specific professional groups, and also links these groups to other ecologies. In the case of LAR, what we see perhaps is the forming of an inter-professional jurisdiction cantered on sustainable urban drainage.

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Interdisciplinary Promises and Hierarchical Ambiguities in a Danish Hospital Context

Abstract: The public health sector in welfare states is increasingly subject to organisational changes, particularly in hospitals, as organisations comprise coalitions of various (healthcare) professionals. In this context, due to interprofessional competition, knowledge claims play an important role in achieving jurisdictional control. In this paper, we investigate the manifestations of and health professionals' reactions to competing institutional discourses. Through qualitative interviews with hospital management, middle managers, and staff employees at three hospitals in Denmark, we demonstrate how managerial attempts to control tenacious professional bureaucracies are exercised through both bureaucratic forms of control and cultural-ideological modes of control with an introduction of new discourses of interprofessional teamwork. The findings suggest that hospitals seek not only to contain ambiguity through bureaucratic features of control, but also to cultivate it when seeking to strengthen cooperation between professions. Thereby, ambiguity itself becomes a mechanism for management.

Keywords: Autonomy, control, ambiguity, interprofessional education, jurisdiction, professionalism, power, critical management studies, discourse, public hospitals

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The public health sector is increasingly subject to organisational changes. Among these is the application of Lean manufacturing principles to public health sector activities that focus on cutting out waste whilst continuing to ensure quality, which has been rapidly diffusing into the sector with claims of "providing a much-needed rethink of traditional ways of working and stimulating performance improvements" (McCann, Hassard, Granter & Hyde 2015, p. 1557). However, along with Lean, we see an emerging form of managerial practice which Kunda (1992, p. 11) defines as normative control and "the attempt to elicit and direct the required efforts of members by controlling the underlying experience, thoughts, and feelings that guide their actions". One such discourse that promises to separate power differences among employees and increase their awareness of each other's workplace contributions is Interprofessional Education. This discourse is touted in internationally acclaimed reports (WHO, 2010; Frenk et al., 2010) as the solution to future healthcare challenges such as diminishing resources, an ageing population and workforce, and advancements in medicine that enable people with complex healthcare problems to live longer, requiring more care. The ability to collaborate is thus increasingly considered

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a basic competency for healthcare professionals, and Inter Professional Education has become a core curricular component in many health professions' international education programmes where it is introduced as an effective evidence-based method for establishing continuity of patient care (Gittell, Godfrey, & Thistlethwaite, 2013; Jørgensen, Jeppesen, & Hotzman, 2010).

Inter Professional Education was developed in Canada. Behind the concept is the desire for a democratic professional practice based on the understanding that a pressing problem in healthcare is that health professionals cannot or will not cooperate (Axelsson & Axelsson, 2009). D'Amour and Oandasan (2005) provide the following definition of interprofessional learning and cooperation: "interprofessionality is defined as the development of cohesive practice between professionals from different disciplines," and "interprofessionality requires a paradigm shift, since interprofessional practice has unique characteristics in terms of values, codes of conduct, and ways of working" (p. 9). The intention is therefore to address the power dynamics among healthcare professionals and equalise the statuses among them.

What is not clear in the literature on this topic in general, however, is precisely who collaborates with whom, or how exactly collaboration is defined. Moreover, this normative form of control of healthcare professionals is intended for public hospitals, which are generally bureaucratic organisations with many layers of hierarchical professional knowledge distribution and the formalisation and standardisation of work processes, and which are ultimately accountable to democratically elected politicians (Mintzberg, 1989). Hospital professionals are faced with the dilemma of developing standardised practices in order to reduce ambiguity (Baker & Denis, 2011) while at the same being confronted with real human beings. They have historically resisted new ways of organising work that challenges their dominance and autonomy (Flynn, 1999; Freidson, 1994; Harrison & Ahmad, 2000; Mintzberg, 1989). The focus on healthcare professionals as both objects of control and exercisers of control was coined by Friedman (1986, p. 121) when stating:

> There is always a fundamental tension between the need to gain cooperation or consent from those who do the work, and the need to force them to do things they do not wish to do, or to be treated in a way which is against their own interests, in order that the goals of those "in control" of the labour process be achieved.

The inherent ambiguity in the hierarchical relations and managerial answers to this challenge is the focus of this paper. Rather than considering control in hierarchical relations as merely a matter of subjugation, in this paper control is analysed as a complex and ambiguous dynamic depending on (a sense of) employee autonomy to succeed.

In the study of professions, a classic twist is typically seen with regard to the question of whether knowledge or power is fundamental (Abbott, 1988, 2005; Brante, 2010; Evetts, 2003; Harrits, 2014; Saks, 2010). In this article, the methodological and analytical strategy is to study hospital professions at the point of overlap between power and knowledge within organisations that seem to have constructed a combination of bureaucratic and normative or cultural-ideological frameworks (Kärreman & Alvesson, 2004, p. 151), thus potentially generating highly ambiguous norms about work. Our research question is as follows:

What are the manifestations of and reactions to competing institutional discourses in hospitals when healthcare professionals seeking to achieve jurisdictional control are faced with both bureaucratic and cultural-ideological forms of control at the same time?

Theoretical background

The managerial work of bringing these "tenacious" professional bureaucracies under

more comprehensive control (Bode, Lange & Märker, 2016, p.1) involves different types of standardisation, such as standardised work methodologies, division of labour, formal HRM procedures, etc. and to simultaneously offer the bureaucracies increased autonomy at work by introducing Interprofessional Education. In order to address these issues, we consider it fruitful to draw on critical management studies and their research into new forms of management in a context of organizational complexity (Alvesson & Willmot 1992, 2003). Organisational complexity means that there is not necessarily any established form of consensus, consistency, or clarity in the culture of the organisation. The focus on ambiguity enables us to determine what is shared in the organisation, and what is not. According to Alvesson (1993), ambiguity is a condition that can be empirically developed by focusing on: 1) what counts as knowledge (about how the work is best organised and performed); 2) how managers and employees make sense of this knowledge; and 3) what the knowledge should produce. Alvesson's point is that this ambiguity leads to an interpretive space: "the ambiguity of knowledge and the work ... means that "knowledge", "expertise" and "solving problems" to a large degree become matters of beliefs, impressions and negotiations of meaning" (Alvesson, 2001, p. 870). Alvesson and Willmott (2002) argue that company leadership seeks to achieve organisational control in different ways "through the self-positioning of employees within managerially inspired discourses" (p. 620). However, according to the authors, this can never be fully achieved, since the meaning of such attempts is negotiated by employees with "other elements of life history forged by a capacity to accomplish life projects out of various sources of influence and inspiration" (Alvesson & Willmott, 2002, p. 628). This suggests the importance of focusing on how people are continuously "engaged in forming, repairing, maintaining, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness" (Alvesson & Sveningsson, 2003, p. 1165).

According to Abbott (1988), the authority in a profession's knowledge is dependent on achieving successful jurisdiction demands. This process is determined in a power struggle, where the number and quality of knowledge resources in the profession and its individual members is crucial. Thus, when the member of top management in the following sections speaks of the correct "culture" as the one that is defined by the doctor group, the relative value of the other professional groups in the hospital is made clear. From Alvesson's perspective, this means that hospital employees are steered through the management's indirect articulations of professional affiliations.

Context and setting

Since the beginning of the 2000s, many Lean initiatives, both large and small, have been carried out at Danish hospitals (Arlbjørn, Nørby, Norlyk, Wiborg & Holm, 2008, p. 149), and many hospitals continue to work based on Lean principles.

Lean is a management philosophy and methodology that was developed in Toyota's factories in Japan in the 1960s, which revolutionized the manufacture of physical goods. In a healthcare context, mainstream prescriptive discourses suggest that Lean "provides a much-needed rethink of traditional ways of working and stimulating radical performance improvements" (McCann et al., 2015).

The Danish version of Interprofessional Education also aims to fundamentally change organisational thinking and values when stating that "interprofessional education can reduce the number of complications, admission time, conflicts between health professionals, number of admissions and mortality rates" (Jørgensen et al., 2010). The Danish players behind Interprofessional Education emphasize the initial evidence that it has a positive impact on clinical quality, patient safety, and patient satisfaction, as well as on employee satisfaction (Zwarenstein, Goldman & Reeves, 2009).

Method and analysis strategy

In order to identify potential competing institutional discourses , we conducted semi-structured qualitative interviews with a total of 14 health professionals at 3 large Danish public hospitals: hospital A, with 12,000 employees; B, with 2,700 employees; and C, with 3,000 employees. The hospitals were chosen based on their explicit use of the new socio-ideological tool of Interprofessional Education. The respondents were selected opportunistically and were primarily middle managers thus they had considerable responsibility for managing people and processes. All were on or close to the front line of patient care, and were thus both managers and part of "the managed." They were able to provide rich information on how organizational changes had been translated into daily practice. All respondents had many years of experience in the hospital sector. They were assured anonymity prior to participating in the project. Therefore, in the analyses, we have given them fictional initials and removed the locations of the hospitals.

The interviews lasted approximately one hour each, were conducted by the two authors, and took place mainly in the hospital, though some were conducted via Skype. In one case, we interviewed two respondents simultaneously. All interviews were recorded and transcribed.

Drawing on the initial theoretical perspectives of critical management scholars alongside Abbott, as described above, we focused in the interviews on the discursive possibilities available across two professional groups, nurses and physicians, when they (re)construct their professional selves in relation to the management discourses introduced. These discursive possibilities are important elements in management since knowledge defines the knower: what one is able to do (or is expected to be able to do) frames who one "is" (Alvesson & Wilmott, 2002). Therefore, we asked about each respondent's experience with the specific tools used, and how the respondent created meaning with these tools with regard to his or her own understanding of how professional work in healthcare is best carried out—by whom and why. We were not able to observe the practices. Instead, we drew on Nicolini's (2009) method to articulate and represent practice by "interviewing to the double," a technique that requires the respondents to imagine they have a double who will have to show up for their jobs the next day. The respondent is then asked to provide the necessary detailed instructions for the work to be done. These narratives are, according to Nicolini, often morally connoted and idealized in character. We systematically analysed the transcripts with a focus on what orients the conduct of health professionals and the normative and moral dimensions of practice in an era of Inter Professional Education: which inclusion and exclusion mechanisms were constructed? What was constructed as obvious versus surprising? How did this affect the legitimate modes of professionalism and action? By comparing these questions, a complex picture emerged of the ambiguous representations of management forms of control, making it possible to develop themes that fell broadly into three main categories: 1) normative forms of control; 2) achieving control by jurisdiction demands; and 3) the interplay between control forms. These themes form the subsections in the findings and highlight how ambiguity predominated as a central feature of the hospital culture.

Findings

Normative forms of control

All three hospitals have many years of experience with Lean as a method for standardizing workflows. As a lead doctor in a department at hospital B says, "Here, we put in a lot of effort to plan some programmes, guidelines, and procedures to get something to flow better. There are guidelines for almost everything; there is a long

tradition for it." To "get something to flow better" can be interpreted as an attempt by management to reduce ambiguity, as "the practices of quantification, standardization and classification ... work to reduce ambiguities" (Best, 2012, p. 91). All the respondents, from all three hospitals, mentioned that they are regularly introduced to new management tools. One of our interviewees, Michael, is currently part of the top management at hospital A but also has top management experience from hospital B. We asked him how the management has decided to handle the different tools. Michael explained that they are careful not to implement new management tools blindly, but instead to consider what makes sense for the individual department.

> Michael: The dangerous thing is to make a big campaign and say, "Now we are doing Inter Professional Education projects," and then afterwards we do Lean projects, and then suddenly there are "patient-responsible doctor" projects, and then suddenly, on top of everything, there are cutbacks, and then none of it matters. [We do it] in such a way, so that it's a tool we can cope with and handle, that our own consultants can use when they are out in situations in the hospital where it makes sense. Because there are some departments where Inter Professional Education is the answer.... There are other departments where it's Lean that's needed. And in other departments it's sometimes a direct order that is needed; elsewhere, it can be education.

As indicated by the phrase "there are cut-backs," in Denmark, the hospital sector as a whole is highly politically managed and subject to regular demands for savings. Michael links Inter Professional Education, Lean, "responsible doctor," "direct orders," and "education," thus designating them as management tools that do not necessarily need to be implemented all over the hospital. Moreover, to him, such projects cannot be realized in times of cutbacks. They only gain footing in certain situations, and they need to "make sense." Notably, he sees "Inter Professional Education" as something other than "education." We therefore asked Michael what problem Inter Professional Education is supposed to solve.

> Michael: Some of the departments where I think Inter Professional Education could be something you should consider are where there is a poor working environment, places where there is low patient satisfaction or places where you have to work across departments.

When Michael explains how Inter Professional Education can be fruitful in departments with poor working environments, this may reflect the WHO document, which positions Inter Professional Education as a vehicle for making trainees "collaborative practice ready" (WHO, 2010, p. 12) and suggests that poor working environments are due to the staff not collaborating enough. To Michael, Inter Professional Education can also help with low patient satisfaction or increase cross-department collaboration. He does not, however, indicate how Interprofessional Education does these things or whether it should be implemented at the undergraduate, postgraduate, or practice level, which creates the possibility for many different interpretations amongst the health professionals about what the primary purpose of it is, and how it should be implemented in practice. By not being explicit as to how exactly it creates collaborative practice-ready health professionals and happy patients, ambiguity is compounded rather than reduced. We, therefore, asked what he as part of the top management based his decision on when deciding to introduce Inter Professional Education in the departments.

> Michael: I think it's very, very important that there is a genuine interest amongst all professional groups, not least amongst the doctors, to want this. If those doctors who set the tone don't have a genuine interest in this and really go for it, then you can really work with it, but you don't get the full effect out of it.... So, if there

> isn't a culture with a genuine interest and desire for this, then you can make schedules on the walls from here to Christmas; it doesn't change anything.... The places I've seen where it really flourished and has really done something, it's been in the passionate group, if you can say it like that, where there have been some leading doctors who have dragged the culture with them.

All professionals should be able to see an interest in strengthening cooperation, which signals attempts to control exercised through promises of autonomy. Not all professionals have an equal say in the matter, however, which generates ambiguous norms about work. According to Michael, it is ultimately the doctor group that decides whether the tool becomes a part of daily practice or not, since the doctor group "sets the tone." This corresponds to the experience of Marie, a staff nurse serving on the staff of Hospital A, when she provided insight into the top management's strategy for the introduction of tools:

> Marie: The philosophy has been, "We cannot get everyone onboard." So, there are a few islands around the hospital where it's being used…. At these big hospitals, you make a lot out of testing the water, since there is a high level of autonomy…. It's a bit difficult to be one of the few…. If it seriously has to become a new culture, the physician management has to be involved…. You have to be careful not to present a framework that is too fixed, because already then, they get annoyed…. It's something like giving people free reign but at the same time controlling it slightly from above.

It is quite clear who holds decision-making power and how management relates to this, thus maintaining hierarchical differences. Thus, health professionals are confronted with both classic bureaucratic and normative involvement-based forms of control at once: "Do not present a framework that is too fixed' AND 'control it from above".

Achieving control by jurisdiction demands

As we initially described, contemporary bureaucracies are typically organised through routines and standardisations for exercising control and handling ambiguities. However, the above quotes show that such strategies do not always work in this context, where the doctor profession has, according to the top management, won the right to determine what the "correct" culture is considered to be. Abbott (1988) explains how full jurisdiction is based on professionals' complex knowledge, which gives them the power to define and solve particular issues. Professionals strive for complete, legitimate control of work and knowledge areas as well as the opportunity to defend and expand these areas. In this hospital context, there is also the issue of what Abbott calls subordination as jurisdiction, which is when a given professional area (in this case, the nursing profession) is subordinate to another (the doctor profession). This subordination requires a certain "symbolic order" that includes "the use of honorifics, the wearing of uniforms and other symbols of authority, and countless similar behaviors" (Abbott 1988, p. 72-73). Here, this interprofessional relationship is clarified by the nursing group working with tools that deal with cooperation and respect for each other's professional areas, while the dominant professions are not necessarily invested in engaging with them.

In hospital B, two years ago, the top management chose to introduce Interprofessional Education as a true top-down decision. In the implementation phase, each department could decide how they would work with the tools, as Martin, physician and department head, explained.

> Martin: It was good that the hospital decided to work with Interprofessional Education because it meant that it was forced down in the organization and that's

> good.... Every department was instructed to work with things in a way that made sense to them.... First, we [the department's management] did something with interdisciplinary conversations and conferences. Because at that time you talked about patient involvement; it was a little in fashion. And then we decided to introduce the ward rounds involving patients.... We don't put it out there for discussion, because it's a concept that is developed, and if it doesn't work after three months, then we'll drop it again.

In this quote, we see that Martin has a broad definition of Interprofessional Education, including "interdisciplinary conversations," "patient involvement," "ward rounds," and "conferences." At the same time, he sees much of it as a fad, as in, "it was a little in fashion." Thus, Martin represents practice as a place with many changing discourses regarding what the right way to act as a health professional is. At the same time, however, it is important for Martin that the concepts introduced have been developed to be well received at the ward level. Later in our conversation with Martin, from highlighting the positive aspects of the top-down implementation of the tool, pivoted to emphasizing autonomy as crucial to his wellbeing.

> Martin: I hate all that top-down management. My managers do not involve themselves in what we do. They trust us. And that's the kind of support you should have. So, if any problems arise, they have to give support. Because they shouldn't manage; they don't know what happens in practice.

Martin's representations of hospital practice help identify what slips out, does not fit, or gets lost in translation in top management's attempts to handle ambiguity (Best, 2012). The risk of using a top-down management strategy to avoid ambiguity in the organization, by giving specific and exhaustive instructions in the use of collaboration tools, is that such precision may lead to a lack of flexibility, which will annoy someone like Martin. On the other hand, a strategy with intentional ambiguity—based on letting the individual hospital department decide what they understand by interprofessional practice—enables a more flexible use of the tools and will please someone like Martin. In both cases, however, the ambiguity continues.
Alvesson points to the use of consultants as a strategy management uses to increase legitimacy when something new is to be introduced. As expressed in Martin's remark below, the health professionals have extensive experience with both internal and external consultants in their work of bringing these "tenacious" professional bureaucracies under more comprehensive control, as when exposing them to projects with new types of tools. However, for Martin, it does not seem that this increases legitimacy.

> Martin: Most of them [projects with tools] are old wine in new bottles, and typically there's a 35-year-old consultant with high heels and clever expressions. Then you just get incredibly tired of it, because you know you have to go back and do a mountain of work.

Again, he emphasizes that these types of tools are superfluous rather than actually helping the hospital carry out work when under pressure. Another head of department, Patricia, from hospital A, expressed the same understanding.

> Patricia: I can also have a tendency to think that it's a bit of hot air. But it is a little more systematic and allows the patients to be involved in some advice. And then something about how you design outpatient clinics… but really it doesn't affect my daily practice.... It was launched by the former centre director. Often, they have a strategy, and then they throw a few million [Danish kroner] at it.

According to this lead doctor, several of the tools are "hot air" and do not really

affect daily workflow. Martin expressed it thus: "It's not a given that interdisciplinary cooperation makes it better. [It only works] if rules are introduced about what it is you have to contribute. It's about us knowing what each other's subject areas are and that we don't cross them." He continued:

> Martin: Including patients and relatives in every consideration requires a big professional identity…. But there is not so much professional identity amongst the nurses, even though they are actually the group that is around the patients the most.... You only become good with the interdisciplinary side if you are good in your own profession. Because otherwise, it will be a kind of porridge, where nobody is good anymore because everyone distances themselves from responsibility.

From the nurses' perspective, Interprofessional Education helps to increase the individual's professional identity, since it forces professionals to think about what their role is in the everyday work around the patient. Lisa, an expert nurse who serves on the staff at hospital B and is a trained facilitator, also explained that, in her experience, not all professionals see the point of interdisciplinary cooperation. Even though almost every single patient meets several professionals during their admission, Lisa believes that the worker's medical specialty is crucial to whether they experience the tool as relevant.

> Lisa: My experience is that it doesn't seem important to talk to each other across specialties.... It is typically easier to sell it [the tool] within specialties, where there is a great need for interdisciplinary cooperation.

With this, Lisa indicates that it is not necessary to know what every other staff member does across all specialties. She points out that interdisciplinarity can be an ambiguous concept that is not clearly defined by management when they introduce tools for individual departments. This point was also reflected in our conversation with Hans, department head at hospital C, who explained that he had chosen to work on the patient-involving rounds in his department.

> Interviewer: And you maintain professional competencies even though it's Interprofessional Education? And let the doctor lead the ward even though there may be a nurse who has been on a course about it?
> Hans: We're not Interprofessional Education pioneers. We do it because it's a ward. It's the doctor who leads the meeting no matter what, and that shouldn't be changed. Each time you put something up for assessment in an organization, you're getting out a can of petrol and a match—and it happens every time—that it then has to be discussed. But this is not an interdisciplinary meeting. It is the doctor's meeting with the patient where we invite others (professional groups) because we think it is interdisciplinary.

Hans represents practice as a place where it is the doctor who is responsible for the ward, even though it is practised in new ways, where those in other professions are invited when necessary. To him, interdisciplinary cooperation is not about professional borders being diluted, but rather that mono-professionalism must be strengthened, thus reinforcing professional stereotypes and the hierarchy of professions (Hindhede & Larsen, 2018). Morality and values are articulated by the profession that has jurisdiction: the doctor group. In Hans's understanding, the more mono-professional the department's function, the better the interprofessional cooperation becomes. The ambiguity from management with regard to what Interprofessional Education is good for is an invitation for the employees to contribute to an interpretation exercise. In this way, the introduction of the tool is very efficient for purposes

of management: by presenting it as something that individual employees can themselves interpret, management creates an opportunity for employees to arrive at the understanding that best fits their professional identity without a great deal of opposition. In this way, the doctor interprets Interprofessional Education as supporting the cementing of mono-professionalism as the best way to achieve good interprofessional work, and the nurse—who, according to the doctor group, does not have a strong professional identity—feels respected by the tool for his or her own area of responsibility, which is defined by the doctor profession.

The interplay between control forms

In all three hospitals, the version of leanness that is used is known as "performance goal management": a tool with a focus on regional performance goals, where data about the centre and clinic levels is found. Employees must follow up on these regional performance goals, but they are allowed to supplement the regional goals with their own goals that the local management perceives as relevant. "Whiteboard meetings" enable a department's staff to meet once a week in front of a whiteboard and discuss the goals the department has set for itself. These can concern anything, such as the continuity of care across clinics, the patient-involving ward, screening for bed sores, doctor-contact agreements, or wellbeing. An administering senior doctor at hospital C, Tom, described the morning meetings in the operating hall as being the situation where Interprofessional Education was practised. However, based on his explanation of the content, it is not clear how the professions were collaborating.

> Tom: Twenty minutes can easily be spent in the operating hall for the morning meeting, and if we don't reach the last patient, then they are a costly twenty minutes; I've pointed this out several times. Many things can be talked about, but the important thing is the production and target numbers. We have to achieve 2,100 operations. Graphs are used, and "Where are we this month and where should we be?" The target numbers are incredibly important and they occur again and again. I have regular meetings where we talk about how we best fill the beds.... The challenge with something having to be measured constantly is that things are changing all the time. Often the goal is not the goal anymore. And those goals can easily restrict us. Some goals we can't reach, which is why we use delaying tactics, just to be able to say that now the goal has been achieved, for example, with the contact person arrangement. There must be a name, but you are not always a function but just a title.

The goals move and change, and rather than the employees being restricted by these standardizations, they choose to interpret them so that they fit into their daily practice. A tool such as Interprofessional Education is also billed as a way to measure work and to increase productivity. For this study, we asked the respondents for their perceptions of these measuring tools. It appeared that the doctor profession emphasized different elements than the nursing profession. First, we present some statements from the doctors. The top management member of hospital A, Michael, talked about the Interprofessional Education tool and its measurability.

> Michael: I don't know anything about the model. And it's not about me having to understand everything in detail in order to believe it, but I'm sceptical about it. It has to be much more solid and tested elsewhere before I think we need to spend time on making before and after measurements on a large scale.

Thus, Michael does not experience the performance indicators as transparent. He questions the tool's measurement criteria. When we asked Mona, a chief surgeon from hospital B, if they use the measurable parts of Interprofessional Education in her department, she explained:

> Mona: The Interprofessional Education COMPASS tool can measure, but we don't use it. We don't have time, so a luxury like being able to measure things, unless it's hardcore data, we don't have time for it. We are working flat out and can't do the everyday things.... But when we did patient-involving rounds, we measured it. With before and after measurements. Otherwise, you can't know whether it works.

Here, measurability is not questioned in the same way. Mona indicates that she is able to code the ambiguity convincingly by turning some of the work of measuring into a luxury. Thus, a distinction is drawn between the measurement of hardcore data and the type of data that the tools generate. As the day-to-day manager of the department, she helps define what is important to measure and what is less important, which matches the regional policy that, for both department and hospital, measurements must be made on some parameters, while other parameters are voluntary. Here, Mona indicates that there is no reason to measure something for which the department is not required to provide an accounting. Thus, she makes use of a specific vocabulary of motives with her staff group regarding what is and what is not important in their work.

Common to the doctor profession and represented by the statements above is the notion that there are right and wrong ways to measure and that there must be evidence for something to be recognized as useful. At the same time, a distinction is drawn between those measurements involving hard data and more uncertain qualitative and ambiguous measurement methods. The doctor group has jurisdiction to interpret what is the "right" knowledge about how to best measure a given output. As can be seen, the polyvalence of the ambiguous measurement methods is difficult to control and can give rise to creative misunderstandings that reduce control for those who have decided that performance goal management should be introduced.

More nuanced representations of practice and how the work is best organized and performed were expressed amongst those in the nursing profession. Here, bureaucratic forms of control such as measurability was not seen as a criterion for the tool to be useful. Instead, the focus was on the process. We interviewed a lead nurse, Anna, who is part of the overall interdisciplinary management team in a department at hospital C, regarding her attitude towards Interprofessional Education. She explained that her interest was in how to plan the organization of work in hospital departments so that they function as well as possible: "I am busy with the staff seeing each other's competencies. That takes some time. Over time, my need to know why I do what I do has increased—and to get some theory about it. So, that's why I took the facilitator education." An instance of how she saw others' competencies was the morning meetings in the operating hall, the same place Tom had described. Anna explained further when asked about the importance of measurability for Interprofessional Education.

> Anna: No… the project was hugely successful, and everyone felt that it had been a lot of fun and a lot of new things happened, but we scored low. So, we've discovered that it is more important to be in the process and not necessarily to have a goal…. It was because the surgeons were tired of the project. They thought that it had been a disturbance, so they scored it low. But the nurses scored it high; they thought it was great.
> Interviewer: Then what did you do about it?
> Anna: Well, we can see that they work well together.
> Interviewer: Can Interprofessional Education increase productivity?
> Anna: Yes, it does, absolutely. Because everyone is much more aware of each other's roles and you are quicker getting started. And it increases the quality of what they are doing. In relation to safe surgery, we actually score the highest in the country, and that is after we have run Interprofessional Education. But just

> the exercise of working with some performance goals, then especially the doctors react by saying, "Yes, but what do other studies say?" etcetera.

According to Anna, a sign of a successful interprofessional practice is that "everyone is much more aware of each other's roles" and that "you are quicker getting started." She expresses norms of "working well together," although it is not quite clear how this is done.

Conclusion and discussion

In this article, we have investigated the ambiguities involved in organizational cultures of three Danish public hospitals. They are dominated by a logic of technical rationality and the accompanying efforts to standardize, quantify, and formalize as much of daily hospital practice as possible. This is displayed in a continuing introduction of management tools such as leanness, and more recently, Interprofessional Education as a new discourse and form of control. This combination of tools and concepts is deemed critical to the optimal functioning of healthcare systems as it is believed to improve efficiency, patient safety, and patient satisfaction, as well as to reduce healthcare costs and generally lead to improved health outcomes.

The condition of ambiguity in the hospitals was constructed by focusing on both what counts as knowledge about how the work is best organized and performed along with how managers at various levels of the organizations make sense of this knowledge. Finally, we have focused on the various representations of to what this knowledge should produce. Rather than operating with predefined normative positions, such as the victimised employees and more powerful managers, we asked about both the costs and the benefits of ambiguity for both managers and employees.

We found that the groups of doctors and nurses are both committed to interprofessional practice as a fruitful way of organizing work, although in one of the three hospitals, it was implemented as a top-down order. The respondents also agreed that Interprofessional Education was accepted due to being a "developed concept." Finally, in both groups, there were normative understandings of this tool as improving patient-centredness. However, although Interprofessional Education claims to be measurable, neither doctors nor nurses had positive experiences with that part of the tool; thus, in times of performance management, this was not translated into a positive attribute of the tool. Reflecting the findings of Carpenter and Dickinson (2011), in our study, professional stereotypes were in fact reinforced through Interprofessional Education activities, as both nurses and doctors emphasized that the strengthening of mono-professionalism was the goal of their collaborative practice, which thus affected how they translated the concept to practice. For nurses, though, the focus on mono-professionalism was considered helpful, as the tool led to them being recognized as a group of people whose voices are heard in interprofessional teamwork.

Our analyses also show how a gap occurs between the social production of knowledge about interdisciplinary cooperation in terms of measurable tools and the social experience of interprofessionality and cooperation around the patient amongst the different professional groups in the hospitals. This gap creates an interpretive space for both understanding and action. We found an interplay between three forms of control: 1) a technocratic form of control circling around the use of bureaucracy and performance measures (Kärreman & Alvesson, 2004, p. 171); 2) with an element of jurisdiction control where it is the doctor profession that has the power to define the "right" knowledge and thus decide whether a tool that measures more ambiguous things such as wellbeing and collaboration will be implemented; and 3) a layer of socio-ideological control that addresses norms of values of collaboration and attempts to eliminate power, hierarchies, conflict, and their manifold consequences.

Although we used the "interview to the double" technique to get normative representations of practice, we still have little information about what Interprofessional Education looks like and in what ways it is used. In the description of wards where workers from different professions are invited to go along with the doctor on rounds, it was not clear who did what. Another example was the morning meetings in the operating hall, which were represented as Interprofessional Education in practice no direct indications were provided of who collaborated with whom. We found that seeking to democratize how tools such as Interprofessional Education can be implemented can encourage more ambiguous management, in spite of political pressure to standardize and measure practice and outputs. In our study, democratizing the tools led to their being mobilized in ambiguous ways, to the extent that the notion of collaborative practice was rendered somewhat meaningless. Ambiguity thus had the social role of increasing the complexity of the management practices of the hospitals.

As many other scholars have mentioned (e.g., Kroezen et al., 2013), there exists a long sociological tradition of considering the effects of existing professional hierarchies, suggesting that professionals use demarcating strategies that divide rather than connect, and that institutional and organizational structures limit the ease with which collaborative practices can be implemented. One can pose the critique that with Interprofessional Education, education is considered the "solution" to problems that are in fact structural, organizational, and institutional matters. The history of health professionals delivering care together indicates that they hold different levels of legitimacy and thus differential scientific authority to define and lead best practices. Thus, enabling contact among them has not solved the problem of providing collaborative care.

A number of researchers have pointed out that there are particular difficulties associated with measuring the results of often broad political and social goals and formulating relevant indicators for these (Lee, Rainey & Chun., 2009; Orr & Vince, 2009; Pratchett & Wingfield, 1996). Some of the arguments are that much of the work that is carried out in the public sector, in comparison to the private sector, is characterized by being less visible, less intentional, and more contradictory, which, according to Noordegraaf and Amba (2003), is due to changing political agendas and disagreement about which knowledge is the "right" kind, as well as unclear goal–method relationships. Typically, a paradox occurs because the handling of the problems is subject to an ambiguity that gives rise to an interpretative space. In this interpretative space, strict series of measurements do not work, since the set conditions and prerequisites cannot be fulfilled. Therefore, it does not make sense to measure, for example, interprofessionality.

The fact that ambiguity persists and even thrives in this kind of organizational context indicates that we must avoid overly simplistic assumptions about bureaucracy and that we must acknowledge the less rational side of these institutions (Best, 2012; Davies & McGoey, 2012). The persistence of ambiguity—and its potential role as a kind of interpretative lubricant in an uncertain world—suggests that we should direct more attention to shifts and holes in these meaning-forming processes. Ambiguity invites us to consider what is lost in translation and to discover what other possibilities are getting away in these moments of miscommunication and reinterpretation (Best, 2012). At the same time, if ambiguities are not only impossible to eliminate but can actually be a source of authority through the power to interpret and define the "right knowledge," we can no longer expect bureaucracies such as public hospitals to be pure ambiguity-reducing machines. Instead, it would not be surprising to find a more managerially ambivalent attitude towards institutional ambiguity, as Best (2012) found at the IMF and the World Bank, and which it would also be unsurprising to find in hospitals, ministries, companies, and universities. In this way, ambiguity becomes a useful, but unpredictable, strategic tool in institutional struggles.

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Interprofessional Education: Students´ Learning of Joint Patient Care

Abstract: This study examines how patient care is developed in meetings between students of occupational therapy, physiotherapy, nursing and medicine who are allowed to shape their own interprofessional collaboration. We conduct a thematic interpretative analysis of audio recordings and observations from the meetings and informal talks with the students. The analysis draws on traditions in sociocultural learning theory that deal with interaction on something in common between actors with different knowledge bases and the consequences of this interaction. The analysis showed that the students developed collaboration in patient care by sharing, assessing and determining professional knowledge of patients' health conditions collectively. In conclusion, we argue that the students learned to use a multiprofessional knowledge base in the design of patient treatment when they were given responsibility to create the collaboration themselves. This demonstrates that students can be encouraged to independently develop professional collaboration in patient care within interprofessional education.

Keywords: Interprofessional education, collaboration, student meetings, community of practice, joint enterprise, boundary crossing, fieldwork

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In the late 1970s, interprofessional teamwork arose as a global healthcare trend (WHO, 1988). This trend was based on an understanding that health workers with different professional skills work more efficiently in interprofessional teams than individually (WHO, 1988). The World Health Organization (WHO) has since followed up the trend and encouraged interprofessional education (IPE) in the education of health professionals (WHO, 2010). Interprofessional education takes place when students from two or more professions learn about, from and with each other (WHO, 2010). The objective of IPE is for students to learn how to collaborate effectively in interprofessional teams when they start employment and thus help to optimize healthcare (CAIPE, 2017; WHO, 2010).

A recent synthesis of systematic reviews shows that IPE has a positive effect on students (Reeves, Palaganas & Zierler, 2017). The students' attitudes to each other improve and they acquire knowledge and skills in collaboration (Fox et al., 2018; Reeves et al., 2016), especially when participation is voluntary (Reeves et al., 2016). Further, when IPE is facilitated in realistic contexts, it leads to particularly good learning outcomes (Fain & Kennell, 2016; Reeves et al., 2016). The review articles show that students enjoy interacting in authentic learning situations (Granheim, Shaw & Mansah, 2017) and that this improves their communication and cooperation skills (Granheim et al., 2017; Kent & Keating, 2015).

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However, these positive findings mainly rest on learners' self-reported experience (Granheim et al., 2017; Kent & Keating, 2015; Reeves et al., 2016, 2017). For this reason, more observational studies are needed to show how students learn in IPE (Kent & Keating, 2015; Morgan, Pullon & McKinlay, 2015; Olson & Bialocerkowski, 2014; Reeves et al., 2017). Interprofessional collaboration is complex; we, therefore, need knowledge of what actually takes place in this form of collaboration (Kent & Keating, 2015; Morgan et al., 2015). For example, observational studies have shown that a favourable physical environment and time for the informal talk are important for joint knowledge generation, goals, and decisions (Morgan et al., 2015). Students who are allowed to adopt their own professional role in role-play have a particularly positive view of interprofessional collaboration (van Soeren et al., 2011) and demonstrate complex collaborative skills in direct patient care (Turrentine et al., 2016).

In this article, we explore how students of occupational therapy, physiotherapy, nursing and medicine who are allowed to shape their own interprofessional collaboration learn such collaboration in patient care. In order to gain insight into the students' learning processes, we used ethnographic methods in the data collection and drew on Lave & Wenger's (1991) sociocultural learning theory and the concept of community of practice to explore how basic interaction and collaboration processes can take place. The concept of community of practice is regularly used to describe work in practice in health and social care (Hean, Craddock & O'Halloran, 2009) and to support IPE interventions (Hean et al., 2009, 2018). However, the concept has seldom been used in exploring how learning in IPE takes place (Hean et al., 2009, 2018), which is precisely the goal of our study.

One general assumption in sociocultural learning theory is that learning is achieved through social processes (Hean et al., 2009; Wenger, 1998) which mediate cognition and motivation on the individual level (Schoor, Narciss & Körndle, 2015). A further assumption is that the pursuit of common goals is fundamental to human interaction and can lead to the establishment of communities of practice (Lave & Wenger, 1991; Wenger, 1998). A community of practice evolves when the participants jointly develop and learn its three constituent components, namely *mutual engagement*, *joint enterprise* and *shared repertoire* (Wenger, 1998). The goal is achieved through the shared development and learning of the three components.

In our study, we limit our research to how one of the three components constituting a community of practice, namely joint enterprise, is developed and learned in students' group meetings. Joint enterprise refers to the activities participants implement and commit to in order to achieve a common goal (Wenger, 1998). The goal of interprofessional collaboration is that different professions should share responsibility for problem solving and decisions in patient care (CAIPE, 2017). In order to realize such collaboration, the professions must draw on each other's knowledge by performing work that is not confined to the limits of their own profession. Joint enterprise in interprofessional collaboration can, therefore, be understood as crossing professional boundaries. In order to observe and describe the development of such work among students, we use the concepts of boundary crossing and boundary object from sociocultural learning theory. These concepts indicate sociocultural differences between specialized practices and suggest how links between the practices can still be established (Akkerman & Bakker, 2011). We analyzed the data using the practical iterative framework for qualitative data analysis (Srivastava & Hopwood, 2009). The research question underpinning our study is: How do the students realize the goal of interprofessional collaboration in patient care in group meetings and what do they achieve through their actions?

Based on our observations of the students' group meetings and students' reflections on the activity during these meetings, we aim to describe and explain how the students themselves take on an active role in organizing their collaboration on patient care in the meetings and what consequences the students' actions have on patient care.

Theoretical framework

According to the sociocultural learning perspective, goal achievement and learning take place through ongoing negotiations about what creates meaning between people, or between people and objects, culture or history (Lave & Wenger, 1991; Wenger, 1998). In pursuit of the goal, people connect what they already know to what they do not yet know (Wenger, 1998). Because different people have different knowledge and skills, it is natural that there should be disagreement and unequal power between people. Learning thus takes place informally and in any context and can create, maintain and change social practices. However, contemporary society rests on a foundation of professional practices. These require specific types of knowledge of the participants, thus creating boundaries for membership. At the same time, societal productivity requires collaboration between different professions to avoid fragmentation and promote development (Akkerman & Bakker, 2011; Wenger, 1998). This implies that people must cross boundaries, that is, create environments to negotiate and combine different expert knowledge to develop new and more complex knowledge (Akkerman & Bakker, 2011; Wenger, 1998). However, boundary crossing does not mean that people adopt each other's basic professional perspectives. In order to cross over into another professional perspective, professionals must have something to collaborate on. The interconnection, therefore, takes place by means of *boundary objects*, that is, various entities that bridge gaps between different professional perspectives (Akkerman & Bakker, 2011; Wenger, 1998). The consequence of the interconnection is that all professions cross their knowledge boundaries and develop knowledge of the object on a multiprofessional basis.

As already mentioned, we focus solely on the development of the component of joint enterprise in the group meetings initiated by the students, that is, the activities students develop and take responsibility for, in order to achieve the goal of interprofessional collaboration on patient care in their meetings. The students represent different professional practices at the start of their practice period, where they are expected to draw on each other's professional knowledge in designing interprofessional patient care. In order to explore how the students reached the goal of interprofessional collaboration on patient care, we used the concept of *boundary crossing.*

In the present article, our premise is that students are goal-oriented individuals who negotiate meaningful activities in order to cooperate interprofessionally during their practice period. We define students' group meetings as *sites of knowing* (Nicolini, 2011), illuminating a point in time and space where we can observe knowledge being developed. We focus our attention on identifying the actions the students implement and take responsibility for in order to collaborate on goal achievement.

The disadvantage of exploring IPE using sociocultural learning theory is that the individual's psychological processes and needs in the learning process receive less attention (Hean et al., 2009; Schoor et al., 2015). Further, illegitimate use of power by participants is interpreted as harmless disagreement and informal aspects of learning arrangements are romanticized (Schoor et al., 2015). Both researchers and consumers of research must be aware of this.

Methodology

In a sociocultural learning perspective, human actions are understood as social and knowledge-based practices in which meanings are continuously created and recreated (Lave & Wenger, 1991; Wenger, 1998). Based on our understanding of learning and our research question, the students' interaction to find out how to realize interprofessional collaboration was seen to be relevant as a data source. We were therefore inspired by ethnographic methods of data collection and developed process data on student interaction and collaboration through observation of their activity and informal talks with the student groups. We then developed process knowledge about

the students' interaction and collaboration through a repeated movement back and forth between the process data and theory to find answers to our research question.

The interprofessional intervention under study

In our study, we investigated students participating in an interprofessional educational intervention facilitated by a university in collaboration with three municipal health services. Fifth-year students of medicine and third-year students of occupational therapy, physiotherapy, and nursing volunteered to participate and were organized into four groups that contained one student from three of the four professions, and five groups that included one student from each of the four professions. The students had not previously collaborated during their studies. Each student group was given joint and independent responsibility for pre-selected patients. The students were asked to work out themselves how to collaborate interprofessionally on patient care on the basis of their particular knowledge and skills at the start of the practice period. The students did not receive any specific training, guidelines or learning outcomes before the practice period to aid their collaboration. Each student group had a two-week practice period between February 2014 and February 2015.

A member of the staff of the local health services served as an interprofessional coordinator. The coordinator introduced the students to the health services, arranged up to two meetings with the student group during the period, answered questions from students on interprofessional issues and facilitated the final discussion. There was also a representative of each of the students' professions to answer specific profession-oriented questions from students. The students also had to report to and collaborate with the health services.

Data collection

The first and second authors generated data from different types of student activity throughout the practice period. The fourth author observed two student group meetings. The authors noted down their observations during or shortly after each student activity. Their notes emphasized in-depth descriptions of what they perceived to be the focus of the students, the content and form of student interaction and any patterns revealed. The students' interprofessional meetings and the first author's informal talks with the student groups after the meetings were audio recorded.

Ethics

The research project was approved by the Norwegian Centre for Research Data (NSD) in July 2013 (Approval No. 34895) and by the Regional Committee for Medical and Health Research Ethics in September 2014 (Approval No. 2014/1659).

Analytical strategy

The data for the thematic content analysis in this article are field notes and audio recordings from twenty-six interprofessional student meetings in six student groups and twelve informal talks between the first author and the six groups. Three of the groups completed the placement in a geriatric rehabilitation ward and the other three groups in a short-term nursing home. Two meetings in each student group were transcribed. The other meetings were listened to several times and compared with the transcriptions and further compared with the observations recorded in the field notes from the meetings. We specifically searched for how the students took an active role in organizing their collaboration on patient care in the meetings and what consequences the students' actions had on patient care. In the analysis, we moved back

and forth between data and theory by following the principles of the iterative questions from "A Practical Iterative Framework for Qualitative Data Analysis" (Srivastava & Hopwood, 2009). The framework guide researchers to ask themselves what the data is telling them and what they want to know. Through the repetitive back and forth movement between data and theory, one main theme and three sub-themes emerged in the data. The main theme was the patients' health condition and treatment and the sub-themes were: a) sharing professional perspectives on patient care b) collective assessment of the information shared, and c) joint decisions on patient care. Typical examples of the content of each sub-theme were condensed. The students' reflections on discussions of patients' health condition and treatment in the group meetings in the informal talks with the first author were then listened to several times and compared with the sub-themes and related expressions were condensed. We found that the students collaborated closely on patient care in their interprofessional meetings by developing a multiprofessional knowledge base for patient care. All four authors were involved in the interpretation of the data

Findings

We observed that a typical feature of the interaction in the student groups was that the students spontaneously and immediately stated that they wanted to give the patients care and treatment as an interprofessional group and planned to discuss what to do with the patients as soon as they received information about them. In this way, the students placed the unique situation of the patients in the centre of their shared professional attention and agreed to include each other in the decisions about the patients' care from the start. As one nursing student in group four explained to author A.C.G. in the corridor on the first day of placement:

> We have to get some information about the patients first to know what to collaborate on. We're not going to collaborate just for its own sake, that would be pointless.

After the first group meeting, meetings became the most frequent and regular form of interprofessional interaction in the student groups throughout the practice period. Our analysis shows that the main theme of the students' discussions in the meetings was the patients' situation and treatment. In this context, the students focused on three main areas: a) sharing professional perspectives on patient care b) collective assessment of the information shared, and c) joint decisions on patient care on the basis of the knowledge developed collectively. We describe below how these three focus areas were manifested and how each focus area taught the students to interact with each other in order to reach the goal of working together as an interprofessional group in their meetings.

Sharing professional perspectives

We observed that the sharing of professional perspectives in the meetings was typically achieved by the students spontaneously telling fellow students what they had learned about a patient by reading information, listening to an oral report, talking to the staff on the ward or other people, and observing the patient themselves. They also made sure that all students were given time to share their information before the meetings ended. This was achieved by taking turns and allowing one student to finish sharing before another took over, and by listening to each other. In the example below from day eight of placement, the students in group five talk about how they experienced the sharing of professional knowledge in their meetings:

> "We listened to each other," said the nursing student. "We wanted to know everything from everyone, so there were four times as much information as there usually is," continued the physiotherapy student. "And we also explained why we do things the way we do," added the occupational therapy student.

Students in all groups reported discovering that they gained more comprehensive and coherent knowledge of patients' health and treatment when they shared knowledge than they could have acquired alone. In the quotation below from the third day of the practice period, the physiotherapy student in group two gives an example of this learning effect:

> The physiotherapy student looked at the nurse student and said, "For example, you've focused on the patient's nutrition and dental status. That's not the first thing I think about. What I think is that the patient is sitting still a lot and it's making him lethargic. In this way, we remind each other that there are several things involved and we avoid having one of us fix one thing while the other one fixes another thing. You can see that things are actually connected and fluid in a patient."

In addition, the students realized that they reached decisions on patients' complete needs for care and treatment more rapidly than they could have done individually. The physiotherapy student in the example above also recognized this effect when continuing her explanation:

> By sharing different situations, different roles, different expectations, you get a more complete view of the patient and so you understand faster what the patient's situation is really all about.

We also observed how students explained the meaning of professional terminology to each other in the meetings. Some students spontaneously altered their language by replacing difficult terminology with everyday words, sometimes when fellow students asked for explanations. In the example below from day two of the practice period, the medical student in group two spontaneously explained "status praesens", a term used in Norway, to other students:

> I thought, but I want to hear what you think about it, I'd do a complete check of status praesens. That means the nerves in the brain, sensitivity of the face, heart, lungs, stomach and all the pulses.

Students in all groups reported finding that they had to explain professional knowledge to fellow students or ask them for explanations. The example below from day seven is part of a reflection among students in group five about terminology:

> "A physiotherapist knows a lot about movements and analysis and can say where the problem lies, whether it's in a muscle or anywhere else. But it's often been a challenge to understand what you actually said and meant. There are so many words and expressions when you describe a patient's functioning," said the medical student, looking at the physiotherapy student. "Yes, we have a slightly different language and it's been challenging to change it into a language that you all understand," replied the physiotherapy student.

Through sharing professional perspectives on patient situations by encouraging turn-taking, being friendly and interested in communicating and listening, and explaining any professional observations, examinations, assessments, and terminology, the students orientated themselves across professional boundaries and showed how a potential multiprofessional knowledge base was the basis for their practical work with

patients.

Collective assessment

We observed that a typical aspect of the students' collective assessment of the knowledge sharing in the meetings was that they spontaneously responded to the information they received from the others. In the quotation below from day three of the practice period, the nursing student in group four explained that interprofessional collaboration is about assessing and exchanging opinions on the information received from one's own professional perspective:

> I'd say that you need to listen to what the others have done and what they think and try to see it from a nursing perspective. Let's say that the occupational therapy student and the medical student are discussing mobilization. Then you have to join in the discussion from a nursing perspective.

We also observed that the students began to jointly assess shared knowledge through polite requests, spontaneity and friendly encouragement in asking questions or discussing or supplementing the information provided. They then received friendly and helpful responses. In this way, they attempted to find out about a patient's situation by gaining insight into the details and depth of the information. This enhanced insight might place the information in a different context from the one originally communicated. The example below is from day two of the practice period. The medical student and the occupational therapy student in group six were reporting their observations from morning care of one of the patients. The nursing student's question places the shared information in a new context and leads to a discussion about possible treatment:

> "He did fine," said the medical student. "Yes! It was easy for him to climb out of bed and stand upright," continued the occupational therapy student. "How was his dizziness?" asked the nursing student. "He didn't show any dizziness," answered the medical student. "Did you ask him about it?" asked the nursing student. "No, we didn't," answered the medical and occupational therapy students in one voice. There was a short pause. "He used a walker and then he walked steadily. He could stand, but he had to hold on to things. He's probably afraid of falling," said the medical student calmly. "I'm sure it'll be good for him to practice walking. Maybe there are steps here we can use for practice," said the occupational therapy student.

The discussions between the students continued until no one had any more to say. The students also spoke in a friendly tone when they disagreed. The example below is from a meeting on day six in group three, and shows how the students handled disagreement:

> "I'm not sure about the quality of his morning care if he had to do it by himself; I've only been with him once," the nursing student said. "As long as he has access to what he needs, he manages it quite well, I think, if it's just basic morning care," the occupational therapy student answered. "Here, it's quite obvious that you as an occupational therapist focus on what he can manage, while I focus on what help he needs. I'm not sure about his fine motor skills in his right hand. What's more, he's not allowed to use his left arm. What quality will there be?" the nursing student said eagerly and looked at the occupational therapy student. "Yes, that's the question," the occupational therapy student replied. "That's good then, isn't it? You focus on the help he needs, the weaknesses, while you focus on what he can do without help," said the medical student, looking from one to the other and they all start laughing.

The students in all groups stated that discussing the patients' situation in detail from different professional perspectives gave them insight into other students' perspectives and greater awareness of their own. In the quotation below from the end of the practice period, the occupational therapy student used the example above to explain about the learning that took place in the discussion with the nursing student:

> It's like that example of taking a shower we had before. My lens included resources, limitations and functioning, while the nursing student was looking more at quality. And it's a bit like that in the training we're having now, when we talk together every day we discuss what each one of us has seen. Then my occupational therapy lens gets a new dimension, because it's not just a matter of functioning, resources and limitations.

By collectively assessing a patient's situation, that is, responding to the information shared in a friendly and interested manner, the students negotiated and combined knowledge across professional boundaries and developed new and more complex knowledge about the patients.

Joint decisions

We noticed that students' joint decisions about patient activities typically consisted of a spontaneous clarification of what each of them could do for the patients. In the quotation below from day eight of the practice period, the medical student in group three explained that interprofessional collaboration was about reaching joint conclusions about the work to be done on the basis of the information that all the students had shared and discussed:

> It's important to form your own thoughts and opinion about the patient's situation, discuss these with the others, be open for their input, and jointly reach a conclusion on causes and actions. We should use all the knowledge we have and listen to each other; six eyes and three brains instead of just one.

A further observation was that the students reached joint decisions on assessment and treatment by individually suggesting activities that they themselves, fellow students or several students together could do in relation to parts or the whole of a patient's situation; the other students would then give their opinion on the suggestions. Sometimes the students decided to take a broad view and make an assessment including all the students' perspectives on behalf of the group. On other occasions, they decided to approach the patient's situation on the basis of the perspective of a single student. In the example below from the eighth day of the practice period, the students in group one decided to use two students' perspectives as the basis for their action:

> The medical student had observed the patient during his morning care and felt that his cognitive impairment had deteriorated. He offered to speak to the ward doctor to find out whether the patient should undergo new tests. "I don't think there's been any cognitive change since before the weekend. For example, he could easily remember what he'd done the day before," said the physiotherapy student. "But the patient is worse in your assessment today?" the nursing student asked the medical student. "Yes, that's my impression today," replied the medical student. "I think our impression is different from yours because we've had a lot of contact with the patient during his training and so on. You haven't spent as much time in real situations with the patient as we have," said the occupational therapy student to the medical student, referring to herself and the physiotherapy student. The conversation continued about observations of the patient and the

> physiotherapy student assessed that the patient was still at an early stage of rehabilitation. After a while, the medical student agreed that the students could wait and see how the patient's cognitive state developed and continue the training as planned.

The students stated that they came to realize that patient treatment quality depended on the fact that they all ensured that decision-making processes had a broad knowledge base. On day seven of the practice period, when group six were reflecting on what they had learned, two students said:

> "You're responsible for your own field, other students don't always suggest what needs to be done, so then you have to suggest it yourself," said the physiotherapy student. "And if you don't know what the others can do, you don't know what's the most sensible solution," said the medical student.

By taking joint decisions about their work with the patients, which involved making and evaluating suggestions for care and treatment across professions, the students translated the multiprofessional knowledge arising from their discussions into care actions.

The students received spontaneous support from the interprofessional coordinator, the ward staff and the management of the health services for spending time to get together and talk; there were no objections to their meetings, they were given meeting rooms and the patients received adequate care while the meetings were taking place.

Discussion

We base our analysis on the notion that a community of practice is constituted by a number of individuals pursuing a common goal and developing mutual engagement, joint enterprise and shared repertoire (Wenger, 1998). By specifically focusing on the dimension of joint enterprise, we were able to reveal that the students had a common goal for their collaboration in the groups and that they realized the goal in a way that concurred with the type of joint enterprise that Wenger (1998) describes as necessary for the development of a community of practice. We answered our research question How do the students realize the goal of interprofessional collaboration in patient care in group meetings and what do they achieve by their actions? by describing and explaining how the students took an active role in exploring and exploiting their different professional perspectives on patient care and learned to collaborate on patient care based on multiprofessional knowledge when allowed to shape collaboration in the student groups themselves. Our findings support previous findings showing that students develop collaborative knowledge and skills by participating in IPE (Fox et al., 2018; Reeves et al., 2017), particularly when IPE is facilitated in realistic contexts (Fain & Kennell, 2016; Reeves et al., 2016).

Joint enterprise is a collective process in which the participants define a goal, negotiate how to pursue the goal and commit themselves to contribute to the achievement of the goal (Wenger, 1998). With the help of the concept of joint enterprise (Wenger, 1998), our data revealed that on the very first day of meeting each other the students declared a common goal of succeeding in collaborating on patient care, in accordance with their mandate for the practice period. By supplementing the concept of joint enterprise with the concepts of boundary object and boundary crossing, our data also revealed that the students defined the patients' health situation as their area of focus and conducted and committed themselves to a continuous multiprofessional dialogue on patients' health situation to achieve the goal of the placement.

The students developed patient care as joint enterprise by immediately deciding

to collaborate on patient care as a common goal. In this way, they explicitly stated that they collectively made the goal of the educational intervention the goal of the group for the practice period. After this, in order to realize the collaboration, the students figured out what to do to achieve the goal. The students agreed that the patients' health situation was the centre of their joint attention and that they had to discuss this in order to collaborate on patient care. In this way, the students made the patients' health situation into what they would collaborate on and through which they would communicate their different professional knowledge to each other. In a sociocultural learning perspective, the patient's health situation could be understood as a boundary object, that is, a relevant interaction focus that all students are interested in and can relate to without having the same profession and without needing to adopt each other's professional perspectives.

Following this, the students decided to arrange an initial group meeting because they as professionals had different focus areas and ideas about the work they could do with patients. In this way, the students spontaneously established a specific setting in time and space for the multiprofessional exchange of knowledge about the patients' health and treatment. According to Morgan et al. (2015), time and space for dialogue are necessary to enable interprofessional groups to create and maintain interprofessional goals, knowledge, and decisions in patient care. By deciding to meet to talk about patient situations, the students laid the foundation for boundary crossing. The students thus drew a parallel between interprofessional collaboration on patient care and the exchange of professional knowledge of a patients' situation to jointly ascertain what the situation of the patient actually was. The students' early decision to hold interprofessional meetings to discuss patients may have enhanced their self-esteem and prioritization of further meetings since they learned that such discussions helped them consider patients' assistance needs from different professional perspectives and develop a multiprofessional informed basis for patient care.

Our interpretation is that the interprofessional discussions started because the groups were given independent responsibility for jointly providing real healthcare to preselected patients and because each student had responsibility for the care provided by his or her own profession. The students, therefore, needed to gain insight into other students' assessments and opinions and to present their own in order to provide comprehensive patient care. By regularly discussing the patients' situation, they developed knowledge that enabled them to provide care individually and as an interprofessional group. The students thus deepened their understanding of the importance of combining knowledge and assessments of a patient's condition across professions. They came to realize the significance of interprofessional dialogue for patient care and they continued to interact in the same way throughout the period. Previous research has also shown that students develop and improve their skills in communication and interaction when participating in IPE that facilitates the practice of cooperation in authentic situations (Granheim et al., 2017; Kent & Keating, 2015; Turrentine et al., 2016). From a sociocultural learning perspective, this can be understood as meaning that the students, as meaning-creating and goal-seeking individuals, linked their prior knowledge with the knowledge they developed in the interaction, thus creating new knowledge and new ideas about what was good patient care and good collaboration.

The rationale of interprofessional health education is that students should learn to practice effective interprofessional collaboration to provide optimal healthcare to patients (WHO, 1988; WHO, 2010). Here, collaboration means joint problem solving and decision making in patient care (CAIPE, 2017). Therefore, a prerequisite for the development of interprofessional collaboration is that the participants define joint patient care as a common goal and draw on each other's resources to achieve the goal. In order to benefit from each other's professional resources, students must be given the opportunity to exercise their own profession in their training. Previous research has shown that it is important for students to exercise their profession in IPE (van Soeren et al., 2011). The students in our study utilized each other's

knowledge and assessment capabilities and developed multiprofessional knowledge in patient care when given independent responsibility for providing care as a group, while each student also had individual responsibility for providing treatment from his or her own profession. The students achieved the common goal by making the patients' health situation the object of joint attention and by crossing professional boundaries in their dialogues on the patients' situation with each other and themselves. Wenger (1998) argues that joint enterprise must be negotiated and learned by the participants. In our view, the discussions developed by the students enabled them to learn to relate and integrate their professions in the group process. The students did this by setting aside time to share, discuss and clarify knowledge, assessments and actions with each other by moving back and forth between professional perspectives and they continued to set aside time for this throughout their practice period. In this way, the students could adjust their individual professional competencies and responsibilities for the care provided to conform to the group thinking. At the same time, they learned the importance of interprofessional collaboration for the optimization of the healthcare provided to their patients. The findings reveal that the students' natural meaning-forming process was exploited by organizing them in interprofessional groups and giving them independent responsibility for providing relevant healthcare to their patients. A further important factor was the support provided by the coordinator, the ward staff and the management of the health services for their choice of spending time on regular discussions. The students' natural negotiation and learning process led to the development of a deep understanding of each other's and their common competence and responsibility to reach the goal of the group. Our findings are also consistent with previous findings in IPE, showing that students not only enjoy, but also improve their communication and collaboration skills, in authentic learning situations (Fain & Kennell, 2016; Granheim et al., 2017; Kent & Keating, 2015; Reeves et al., 2016; Turrentine et al., 2016), especially when participation is voluntary (Reeves et al., 2016) and when they can practice their profession (van Soeren et al., 2011).

We have based our process research on Wenger's (1998) concept of joint enterprise, supported by the concepts of boundary object and boundary crossing, and shown that students in a self-organized interprofessional learning situation are able to collaborate on patient care when they have this as their objective and set aside time to discuss patients with each other. We have also shown how an interprofessional educational intervention can rely on students' prior knowledge on entering IPE and support students' natural learning processes throughout the placement. Our findings contribute new knowledge of what students learn and how they learn, by showing that their joint enterprise and its depth could be observed and articulated among the students as it was being developed in their groups. Our findings also provide new knowledge of how the components of the educational intervention influenced the development of joint enterprise in the student groups. These components were as follows: a predefined mandate, voluntary participation, interprofessional groups containing one student from each profession, final-year students, exercise of one's own profession, clinical practice, independent responsibility for developing collaboration, independent responsibility for patients, availability of resource persons such as an interprofessional coordinator and a contact person for each profession, a two-week time frame, municipal health services as field of practice and support to the students in trying out forms of collaboration. The components may be transferable to other educational interventions. We have not found our description of student learning of joint enterprise in other research on interprofessional education.

Limitations

The students volunteered to participate and were positive and motivated to engage in interprofessional collaboration even before the practice period started. This may have led to a bias in our findings, as voluntary participation in IPE has a particularly

positive effect on student learning (Reeves et al., 2016). Some students also expressed a feeling of exclusivity due to the research focus on them. Some students reported achieving deeper reflection on student activity through the informal talks with the researcher during the practice period. Further, the students' collaboration was encouraged by the interprofessional coordinator, the ward staff and the management of the health services during the period. This general positive attitude towards the students from the various actors involved may have strengthened the students' motivation to collaborate in the groups.

Nevertheless, the students developed their collaboration on patient care on the basis of their prior knowledge and skills and ongoing negotiations of meaning with each other and the information and personnel involved. The goal stated and realized by the students in their meetings may, therefore, be seen as their own negotiated response to their particular situation.

In this article, we have limited ourselves to exploring students' collaboration in and reflection on their self-organized interprofessional meetings. This limitation means that we have excluded any impact that other joint student activities might have had on the students' learning and the realization of their common goal in the meetings, and vice versa.

Conclusion and implication

The students developed close collaboration on patient care through the regular discussions they arranged when allowed to shape the collaboration and the learning themselves in group meetings. We believe that the students realized the goal of interprofessional collaboration in patient care by having the opportunity to regularly spend time exploring and exploiting their different professional perspectives on patient care in the student groups in addition to their continuous dialogue with the patients and staff. In this way, they learned about, from and with each other and above all more about the patients. In their discussions in the groups, the students developed a broad knowledge base about the patients and they included more aspects of the patient's health situation in the treatment than an individual student would have achieved.

We interpret the students' development of close collaboration as a result of their prior knowledge and natural quest for meaning in relation to the goal of the placement, and the responsibility and trust given to them at the start of the practice period. In order for interprofessional collaboration to work, it is crucial that the participants are capable of relating and integrating each other's professional perspectives in the group. Interprofessional education must, therefore, provide learning arrangements that support students' initiative to develop a multiprofessional knowledge base in patient care. The learning arrangement we studied relied on the students' prior knowledge and supported their natural learning process when negotiating and implementing activities for joint patient care. Lave and Wenger's (1991) sociocultural learning theory and the concept of joint enterprise (Wenger, 1998) enabled us to focus on the actual activities the students initiated on patient care to reach the goal of interprofessional collaboration. Further, the concepts of boundary crossing and boundary objects enabled us to observe and describe what the discussions required of the students to be able to collaborate on patient care across professions and the consequences of the discussions, that is, that the students could continuously base their initiatives, assessments, and adjustments in patient care on a multiprofessional picture of the patient situation.

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Helena Flam

Civil Society and Professions: US Civic and Politicized Lawyering

Abstract: It is important to include civil society in the purview of the sociology of professions because many professionals and professions interact not just with the state and the market but also with civil society actors. Moreover, members of professions engage in civic action and political activism not just as citizens or single professionals but also as the (founding or regular) members of their professional associations. They also establish think-tanks, research and counseling centres, consortia, and on occasion even citizen initiatives or social movements. Professional life can be explored more comprehensively when these professional interactions and activities are included in the analysis. The text provides a standard definition of professions, argues for considering professions' role in civil society, defines civil society, and draws on US research on civic and political lawyering to buttress its arguments. Some examples from other professions are also offered.

Keywords: Neutrality, professional work, professional organizations, civic and political involvement, civil society, cause lawyers, civic and politicized lawyering

This text proposes a widened perspective on professions. This perspective investigates which issues and contemporary contexts mobilize professionals and professions. It calls for asking why and how they engage with, and position themselves on these issues in their professional capacity. Furthermore, this perspective raises the question of whether and how professionals and professions seek to bring others within and beyond their profession to position themselves on these issues, thereby possibly creating new lines of cooperation and conflict within the profession but also within the civil society and perhaps in relation to the state and the market. It also posits that another question worthy of pursuit is whether such mobilized professionals and professions generate issue-related specialized knowledge, offer new role models of professional conduct, and create both novel work opportunities and issue-related networks.

A profession is often defined as an occupational group whose members claim (even if they do not have) a jurisdictional monopoly on the development and application of systematic, occupationally relevant, scientific knowledge, which it treats as its area of expertise, informing its work standards, procedures, and practices. A profession strives to impose and maintain controls on the selection, education, and certification of new members. When successful, it manages to establish institutions charged with defining and implementing professional knowledge as well as codes of conduct obligatory for its members, and it can claim successes in asserting its institutional and ethical autonomy (Freidson 2001; Pfadenhauer 2003). Professions enjoy high social esteem and relatively high income, providing that the state, the market, and the other competing professions permit this.

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To buttress the argument that professions should not be investigated merely along these lines—that is, should not be reduced to their status as occupations chiefly concerned with gaining or defending a (jurisdictional) monopoly of a specialized body of knowledge, educational and training systems, professional ethics codes, working practices, and career paths—this text will draw mainly on the US material pertaining to lawyers.

From the perspective advocated here the question of why and how issue-related professional mobilization results in establishing a variety of professional organizations become an interesting object of study. In contrast, a well-known sociologist of professions, Freidson (2001, p. 133-149), turns to professional associations mainly to contextualize professionalization processes within a four-fold professions-state typology. Similarly, Sciulli (2009, p. 219-343) focuses on professions and professionalization processes from a historical perspective and in this context ascribes a pivotal role to the professional bodies and their leaders, but neither investigates these bodies and their leaders nor other, issue-related, forms of professional mobilization (see endnote 1). Judging by *The Routledge Companion to Professions and Professionalism* (Dent et al., 2016) and a recent—award-winning—overview of theories of the profession (Saks, 2016), professions' issue-related organizational mobilization receives little attention.

As the examples provided further down will illustrate, professionals and professions devoted to or mobilized by specific issues may not just adopt specific work forms but also become involved in (initiating) specialized educational programs; research, professional service or advocacy centres; consortia; and even in establishing citizen initiatives or social movements. Those pushing for social change come to live—depending on the issues and causes they promote—in antagonistic or symbiotic relationships with the state, the market and their institutions, other professional organizations, advocacy groups, and the constituencies these say they represent. They may do so through their occupational practices, but also as members of their voluntary associations, consortia and the like. If they feel confined by local and national communities, they may also pursue their aims in the transnational sphere, even exclusively so (see Dezalay & Garth, 2010 on lawyers, and Avenell, 2017 on biologists).

Although the main part of this text discusses professional initiatives pursued in public interest understood as greater equality, human rights, and environmental protection, neoliberal economists placing freedom from restraint and public choice over public good can serve as a contrary example (Harvey, 2005; Ptak, 2007; see also Conclusion). This is to say, professionals, professions and their professional organizational initiatives are often far from neutral, but instead value-oriented and positioned on the issues of the day (Cohen, 1983). Once we allow this possibility, research can address the causes and organizational expressions of the emerging, possibly diverging, substantive views on various issues adopted within and by single professions.

Advocating a research agenda that focuses on the initiatives and activities of professionals inhabiting or interacting with the organizations of the civil society calls for defining the concept of civil society. The concept was revived in the 1970s to draw attention to the history and consequences of the suppression of nearly all types of non-state individual or group initiatives in the totalitarian systems in general and in the Soviet bloc in particular (Arato, 1981/1982). It was also re-introduced to highlight the presence of the non-state and non-market types of initiatives, organizations and institutions in Western societies (Keane, 1988). Applied to the Western societies, the concept drew attention to the fact that, apart from the capitalist enterprises and government institutions, such entities as households, friendly and professional societies, social movements, religious institutions, independent communication media, cultural institutions, foundations, non-government political parties, etc., populate modern societies (Keane, 1988, p.19-20). British and US research on the civil society

has focused on its various theoretical conceptualizations, historical trajectories hindering or facilitating the development of civil societies in various national and continental contexts, and on the changing positioning of the civil society mainly in relation to the state but also to the market. Despite its great diversity, initially, the main concern was, on the one hand, with the oppressive or civilizing and disciplining powers of the state and capitalism, and, on the other hand, with the emancipatory potential and activities of civil society. The emergence of civil society predominantly in the Central European countries of the Soviet bloc gave this research field a new impetus in the 1980s (Ekiert, 1991; Feher & Heller, 1987; Pelczynski, 1988; Skilling, 1989). Revolts and upheavals on various continents led to the adoption of comparative perspectives and concept modifications (Kamali, 1998; Wagner, 2006), while the breakdown of the Soviet regime raised the questions about the post-Soviet civil societies.

This brief account highlights that civil society is often associated with aspirations to freedom, civic and political engagement, solidarity and humanity, and contrasted with the state and the market. In the present text, a more sceptical position, more akin to that adopted by Foucault is taken (Dean & Villadsen, 2016; Freidson, 2001; Furedi, 2006; Villadsen, 2016). Briefly put, one should not idealize civil society for it is definitely not a sole site of virtuous ethics or truth production (Dean & Villadsen, 2016, p.3). It is ambivalent: it serves as a pillar of the social order and is a source of insurrection. It harbours peace- and violence-espousing individuals, initiatives, associations and organizations (Villadsen, 2016). At the same time, it also harbours solidarity and self-interest, cooperation and competition, tolerance and intolerance, lofty ideals of equality and freedom, and national chauvinism and racism.

Although Foucault warned against idealizing civil society, he did not theorize about it (Dean & Villadsen, 2016; Villadsen, 2016). His focus on disciplining, pastoral and bio-political institutions narrowed his vision to diverse controlled populations defined as either "deviant" or "normal". It was only later in his life that he came to cautiously acknowledge the emancipatory potential of the "bottom-up" counter-discourses emerging from the civil society. However, most of his life, contrary to his own civic and political engagements, Foucault believed counter-discourses mainly fed into the dominant discourses (see endnote 2).

It is the unadorned image of the civil society that is proposed here. This is premised on the idea that it is worthwhile to engage in research exploring under which conditions and how professionals, professions, professional bodies, and various professional associations and initiatives—whether status quo-solidifying, reformist or revolutionary—inhabit and relate to the equally richly "ambivalent" civil society and thereby to the state and the market.

The professional activities that dwell in or engage with the key issues and actors of the civil society deserve to be studied in their own right because they offer a more comprehensive view of professional life. The research agenda proposed here draws attention to i) the (actual or potential) capacity of these to act the part of a social force seeking to influence societal decisions and developments and ii) poses the question of why and how professionals, professions, and their associations and initiatives position themselves on various issues. The premise adopted here is that this is not so much or not exclusively because of their professional knowledge, problem-definitions, general professional values or a profession's professed obligation to activism (Brint & Levi, 2002; Burns & Stöhr, 2011; Dagi, 1988; Freidson, 2001, p.197-222; Foucault, 1965, 1975) or their interactions with the state, the market and other professions. Instead, it is argued here, the burning issues of the time mobilize and some of them emerge from civil society (see below and compare to Furedi, 2006).

This research agenda does not treat professions a priori as arbitrators or mediators of values and norms (Parsons, 1939, 1968). They are not defined here as the third power "upgrading" society and its organizations by spreading superior knowledge as well as the principles of meritocracy, collegiality, transparency, fiduciary responsibility, and so on (Sciulli, 2009; Freidson, 2001). Neither are they a priori defined

as authors and administrators of disciplinary measures (Goffman, 1991, Foucault, 1975) nor as promoters of pastoral care or bio-politics (Foucault in Goldstein, 1984; Dean & Villadsen 2016). Nor finally does this research agenda attribute to all professional initiatives and organizations the capacity and the will to strive for (the left-liberal) "public good" and generate "insurrectionary knowledge" just because they are part and parcel of the civil society (Foucault in Villadsen, 2016, p. 7). Instead, it calls for considering professionals and professions as well as their organizational offshoots as capable, in principle, of arbitration and mediation, disciplining or engaging in pastoral care or bio-politics and upgrading as well as generating status quo-supporting, progressive or transgressive-insurrectional ideas.

Although I advocate a pluralistic image of professions as well as contextualizing their activities, in what follows, my focus will be on a "free" profession—in this case, that of the US lawyers, especially those who take interest in the controversial issues of their time mostly from an emancipatory perspective. This makes them more likely than their peers to cross the lines circumscribing proper professional knowledge and codes of conduct. They act within a pluralistic, democratic state (Freidson, 2001, p. 139; Schmitter, 1974).

Civic and politicized lawyering

The sociology of professions and sociology of law have generated only modest knowledge about lawyers and their civic or political engagements, not to mention anti-state discourses or stands (but see Shapiro, 2002). In the sociology of law (Banakar & Travers, 2005; Banakar, 2009), the scant British, Scandinavian and US research on lawyers has paid much empirical attention to the least prestigious and worst paid end of the profession—criminal lawyers—and their relationship to their clients (for exceptions, see Dezalay & Garth, 2010; Lange, 2005; Pierce, 1995, 2012; Paterson & Teubner, 2005; Scheffer, Hannken-Illjes & Kozin, 2010; Shapiro, 2002) (see endnote 3).

An interdisciplinary survey of literature shows that an American duo, Sarat and Scheingold—a law professor and a political scientist—wrote their own volume and edited several collected volumes on what they labeled *cause* and *transgressive* lawyers who consistently take on controversial issues, such as labour rights, racism, poverty, environment, gender equality, sexual violence, refugee rights, etc., often at considerable risk to their income, professional reputation, and professional career.

The text that follows will lean heavily on their edited volumes to illustrate some of the points made earlier. Also relevant, although not drawn upon here, is a French-US cooperation, involving Karpik and Halliday (2011), and Halliday, Karpik and Feeley (2007)—a French sociologist, a law professor with a degree also in sociology, and a political policy analyst—which resulted in a comprehensive edited volume focusing on the contribution of the legal profession to establishing and defending liberal democracies (see endnote 4). In France, a historian, Liora Israel (2009), edited a special issue of a journal focusing on professionals and their public engagement. Finally, early in 2018 a lawyer-organized symposium entitled, "The Use of Law by Social Movements and Civil Society", with around 100 participants, took place in Brussels to investigate the interface between social movements and lawyers, law, and judicial case reviews. These examples demonstrate that when exploring the various aspects of lawyers' professional life, adopting a broad perspective including their civic and political engagements makes good sense.

Sarat and Scheingold (1998, 2006) offer rich material about US lawyers and their civic and political engagements. They seek to define and to elaborate the contrast between the "conventional" legal profession and cause lawyers, investigating how cause lawyers attenuate and re-shape boundaries between professional and political fields of action, despite their being subject to professional, legal and political constraints.

Before I turn to cause and transgressive US lawyers, let me note that they, although certainly numerous, constitute a minority among lawyers. Conventional lawyers represent citizens or members of the civil society vis-à-vis one another or in relation to the state or business. They work for a fee (the US differs from many European countries in that it features numerous big corporations specializing solely in providing legal services to others, see Pierce, 1995; Shapiro, 2002).

Another group of lawyers plays an important role in state administration or in the judiciary. These are public officials or government employees who are salaried. So-called "corporate lawyers" are employed by private enterprises to keep abreast of new legal developments, monitor compliance with laws and regulations, but they are also employed to discover and use loopholes in laws and to represent their firm in court and other institutional contexts when necessary. US lawyers may be employed by particularly venal, corrupt or discriminating firms and be put under pressure to follow their dictates, but such firms do not exhaust the job universe (Pierce, 1995, 2012; Shapiro, 2002). US lawyers have, comparatively speaking, a great deal of leeway in setting up their own professional associations and organizations. These provide them with additional employment opportunities. US lawyers are also free to work for non-governmental and not-for-profit organizations. This implies that civil society constitutes their fourth type of employment opportunity. It is an empirical question, which cannot be pursued here whether lawyers in other liberal democracies are distributed between similar employment sectors, how these weigh in relationship to each other and what roles can be played within and between them, and whether lawyers are similarly free and willing to pursue civic and political causes.

In effect, lawyers are found playing multiple roles within and in relationship to civil society. In their professional capacity as lawyers they may mediate, discipline, administer bio-politics in relationship to their various clients. They might also represent (conservative or transgressive) causes in courts. In addition, in their professional capacity, they might act as the consultants, founders, or employees of civil society organizations related or unrelated to their own profession. Finally, as members of their professional associations or initiatives, they might be called upon to engage with specific issues, other civil society organizations or initiatives.

Work forms, client referrals, and finances

Political activism/transgressive lawyering affects the work form itself. Lawyers' collectives, feminist or minority firms rely on recruitment practices excluding co-workers and clients not compatible with their aims. They strive for a more democratic relationship with their clients. Some have equal pay and equal work as an ideal, and seek to politicize, de-commodify and socialize legal practice (Sarat & Scheingold, 1998, p. 7-8). In the US activists pursue work with "public interest" law offices (funded by the state or foundations) or subsidized university-affiliated or neighbourhood "law clinics" servicing discriminated or poor population groups.

Sources of referrals tell whether a firm has a civic society as its important reference point. Such referrals may come from minority communities, churches, advocacy organizations, think-tanks, foundations, networks of like-minded lawyers or public service agencies to name a few (e.g. Kilwein, 1998, p. 189). Similarly, civic and political activism can be surmised by the sources of financing. Law firms are financed by client fees, but in the case of cause lawyers also – alone or in combination—by state funds, obligatory court/settlement fees, minority communities, churches, voluntary lawyers' or special cause associations, advocacy organizations, consortia, and foundations. These sources of funding bring the point home that civic or political activism of law firms is often predicated on its symbiotic relationship with the civil society. Cause and transgressive lawyers are also concerned with how they can lower the financial burden of their unprivileged clients: for example, they take on some "regular" cases to be able to balance their books when they offer pro

bono services or introduce income-based fees to their poorer clients.

Substantive focus

To distinguish conventional from transgressive lawyering for the US Scheingold and Bloom (1998, p. 213) proposed a lawyering continuum. At its opposite poles, we find pro bono work and radical-critical, transgressive legal work as illustrated by Figure 1:

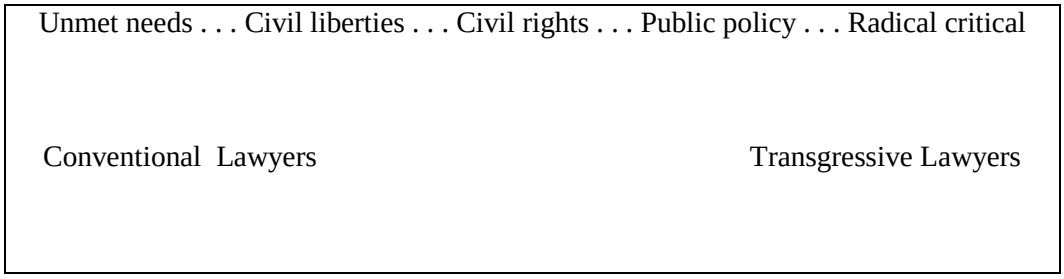

Figure 1. *Lawyering continuum.*

In their view, nearly all law firms provide occasional pro-bono service following professional ideals. Even corporate law firms, seeking prestige, encourage their employees to do a bit of pro bono work. However, pro bono work per se is not transgressive since it only alleviates individual needs. In the US, civil liberties and civil rights cases cannot be seen as transgressive as defending or expanding liberties and rights is part and parcel of honouring the Bill of Rights. Such cases are *raison d'être* for such professional organizations as the American Civil Liberties Union, but even some conventional law firms occasionally take on such cases. Only when these challenge the established power structures and vested interests, can one speak of transgressive lawyering. Similarly, policy contestation is only transgressive when it challenges the power holders to achieve "public good" and mobilizes citizens or establishes advocacy groups, crossing the boundaries of conventional lawyering. Truly transgressive lawyers wish to transform their societies and join hands with social movements pursuing radical change (Scheingold & Bloom, 1998, p. 215). Usually such lawyers become involved in specific areas of law to achieve racial justice, assert feminist or minority rights or they engage in monitoring and challenging the state and the corporations, often at a considerable financial risk to their firms (McCann & Dudas, 2006; Menkel-Meadow, 1998, p. 42-43, 50; Sarat & Scheingold, 1998, p. 9; Trubek & Kransberger 1998;; Scheingold, 1998, p. 128; Sarat & Scheingold, 2006).

Mobilization forms: "legal activism" and "political activism"

Lawyers can still be said to respect the boundaries of conventional lawyering when they mobilize for specific issues within a (regime-loyal) official lawyer organization, lobby governments or try to influence advisory or decision-making committees. In the US, this is the case when they initiate educational public campaigns, advise social movements or set up neutral consortia, research and counseling centres or Think Tanks. (Menkel-Meadow, 1998, p.42-43,50; Sarat & Scheingold, 1998; Trubek & Kransberger, 1998; Scheingold, 1998, p.128; Sarat & Scheingold 2006). Individual lawyers may pursue several of these courses of action, without disrespecting the boundaries of *legal activism*.

Political activism transgresses the boundaries of legal activism since it entails leaving the confines of the office, the court, and the bar as well as the conventional

"extra-effort" or "ethical" lawyering. It stands for involvement in political strategizing, outsider mobilizing and participation in civil disobedience actions. It also entails setting up consortia, research and counseling centres, legal defence leagues or Think Tanks with an explicit political agenda (see History and Forms lower down). For example, both equity and animal rights cause lawyers have relied on litigation and became personally involved in political strategizing, lobbying, networking, organizing public campaigns, demonstrations and voter support, and pushing for and drafting specific changes in legislation as multi-pronged means of achieving their ends—winning the case and improving specific laws or their implementation (McCann & Silverstein, 1998, p. 269,275,282; for Ralph Nader's citizen and lawyer organizing, see Meili, 2006, p. 124-127).

Civic engagement and political activism also take the form of establishing status quo-contesting organizations manned by the members of the same profession with the aim of pursuing transgressive, controversial and risky causes. This form of professional activism also enriches and expands civil society. It may imply partaking in proscribed actions and outsider mobilizing, backed by the coordinated members of their voluntary association:

> The American Civil Liberties Union was founded to raise First Amendment defenses for social protestors and pacifists during World War I and was among the first legal organizations to employ "nonlegal" means in the form of grassroots organizing and demonstrations to raise public consciousness about issues and to create "test" cases for litigation purposes. (Menkel-Meadow, 1998, p.43; on civil disobedience, see also Scheingold, 1998, p.125, 130,138)

Similarly, the National Lawyers Guild (NLG) is a progressive public interest association of lawyers, law students, paralegals, jailhouse lawyers, etc. It was founded in 1937 to protest the exclusionary membership practices and conservative outlook of the American Bar Association. The NLG was the first US bar association to admit minorities and did not bend under the pressures to hunt communists and homosexuals during the McCarthy Era. Its current preamble states that it is dedicated to economic and political change, and it defines human rights as more important than property interests (Kilwein, 1998, p.195; Scheingold, 1998, p.119, 130, 139-141). Up until the 1980s, in a reform-oriented political climate, it was able to consolidate left-wing lawyers. In the ensuing conservative-repressive era, its consolidating powers began to wane and vary by location.

History and forms of professional engagements

Research on the history of a profession's civic and political engagements should become a research area in its own right (see Sarat & Scheingold, 1998, 2006). A historical perspective highlights how changes in the context of professional action influence the forms these engagements take. The present sketch pinpoints that in the US the political spectrum moved from the left to the right by the 1980s, making it much more difficult to engage in cause or transgressive lawyering. During this time, research and advisory councils or legal defence or law research centres gave way to networks and consortia. Their very names trumpet their political intent, speaking of political activism in pursuit of civil rights, equality, environmental and consumer protection, civic and minority rights. In the 1980s, in contrast, profession-led counter-initiatives to cause and transgressive lawyering entered the centre stage.

Starting with the late 1960s, when the political context allowed for many successful law reforms, lawyers and law students set up firms and organizations on special issues:

> The success of many of the new "public interest" law firms [funded by the state]

> led to the founding of a variety of new organizations, some associated with particular issues like environmentalism (e.g., Natural Resources Defense Council), free speech and consumer rights, and others with the growing development of "identity" politics (for instance, the Mexican American Legal Defense Fund, Women´s Legal Defense Fund, the National Women`s Law Center, and Lambda Defense Fund), most often patterned on the highly successful National Association for the Advancement of Colored People Legal Defense Fund (now the LDF). (Menkel-Meadow, 1998, p.43)

Once law reforms and impact litigation advancing redistributive, identity or public interest politics became less likely in the conservative-repressive 1980s and 1990s:

> Many organizations have banded together in either loose consortiums (e.g., the Alliance for Justice in Washington and Women´s Way in Philadelphia) for funding, lobbying and legal strategy development or more formal consortium for multi-issue public interest work (e.g., the former Center for Law and Social Policy and the Institute for Public Representation in Georgetown). (Menkel-Meadow, 1998, p.43; see also Scheingold, 1998, p.119,133-134)

Since the 1980s cause lawyers have more often pursued regular court cases on behalf of groups affected by poverty and/or intersectional discrimination (combining "race", gender, age, sexual orientation, etc.). They have focused on client empowerment at micro-sites of power—such as the family, the workplace, schools, social and medical services—thus accepting less popular and less profitable legal activities. Yet specific types of rights-activism continued on issues such as same-sex marriage, disabilities, Native American rights, environmental justice, living wages and AIDS prevention (McCann & Dudas, 2006, p.54). Some cause lawyers have heeded the shift of funds to human rights and have become involved with a number of (T)NGOs to pursue old and new causes from this perspective. Non-profit human rights organizations mushroomed financed by well-known foundations (e.g. Ford Foundation) and citizen donations. For lawyers, Amnesty International, the US Human Rights Network, Women´s Institute for Leadership Development for Human Rights (WILD), the Indian Law Resource Center, and the Center for Constitutional Rights have become both a source of employment and referrals (McCann & Dudas, 2006, p.54).

In a parallel development beginning in the 1980s, conservative counter-mobilization became noticeable among lawyers who organized themselves in the Manhattan Institute, the Pacific Legal Foundation and the Federalist Society (McCann & Dudas, 2006, p.48-50). Conservative cause lawyers (just as conservative churches and fundamentalist evangelical groups) imitated organizational and discursive strategies of their leftist, identity ascertaining, and public interest lawyers. They relied on the language of rights. They declared to defend American values when advocating, law and order, property rights, limited government, the abolition of tort law, right to life, tobacco products, handguns, etc., and established lawyer-staffed Moral Majority Legal Defense Foundation and the Center for Law and Religious Freedom (den Dulk, 2006).

Tensions between lawyers and civil society

At best, lawyers' political activism can spearhead or keep alive an issue, even in the absence of a social movement or citizen initiatives. When a movement emerges, politicized lawyers and lawyers´ organizations can help create a collective, empowering sense of grievance and entitlement to rights, put issues and claims in legal terms, and advise about alternative or complementary strategies (McCann & Dudas, 2006). They can also provide support in confrontations and negotiations with the opponent, use litigation to dramatize abuses while allocating blame, win media attention for

the issue, and, if there are such, execute legal outcomes thus increasing a sense of overall empowerment. However, politicized lawyers and their organizations can pre-empt, deflect or marginalize citizen initiatives or social movements while acting on their own vision of what is or should be a good society. This was the case with the National Association for the Advancement of the Colored People (NAACP) Legal Defense and Education Fund, Inc. As an elite lawyers´ organization, it commanded considerable resources which enabled it to gain much legal and public attention for the issues on which it set priority. NAACP was a movement of lawyers who believed in law, courts and the legal pursuit of rights as the only or main means of achieving social change. An exemplary, it inspired a plethora of similar lawyers' organizations on various—environmental, gay and lesbian, poverty and other—issues. After 1961 it acted under the leadership of a new director who had managed the successful legal campaign which resulted in a de-segregation (known as the "Brown") court decision. NAACP vehemently rejected direct action, seeing it as an illegitimate attack on the rule of law and as detrimental to the pioneering legal campaign it waged against racism, segregation and for equality. In contrast, the Civic Rights Movement and the lawyer who led Student Nonviolent Coordinating Committee (SNCC), after experiencing for several years how old and new legal rights were being disregarded and violated in the South, had no more trust in the legal procedure (Hilbink, 2006, p.60-62). In the 1960s, at the height of the Civil Rights Movement NAACP caused a great deal of anger and resentment among civil rights activists when it openly condemned direct action at a time when the letter of law was daily and massively violated by the very authorities which were supposed to implement it (for a similar constellation, see Levitsky, 2006, p.145,155).

Conclusion

This text showed how every day and more sporadic activities of professionals have been studied to include those shaped by their involvement with key social issues of the day. Specifically for the *cause* and *transgressive* lawyers, it pinpointed that the engagement with the issues of the day has shaped their everyday work: its forms, recruitment and litigation strategies, and financing sources. Sarat and Scheingold's edited volumes also demonstrated that US lawyers concerned with controversial issues of the day have employed a variety of innovative—collegial, associational, citizen—and institution-building—strategies to be able to generate new specialized knowledge, offer services to the unprivileged groups or mobilize others within and beyond their profession on the issue thereby pitting them against the state or the vested interest. The concerns and strategies of lawyers pulled them into the very midst of civil society and its actors. Their organizing and campaigning, when successful, shifted the substantive concerns and the boundaries not just of their own profession, but—correspondingly—also of the civil society, the state, and the market.

As the text showed, sometimes the civil society actors appreciate the advice and strategies advocated by lawyers on an issue, even when these re-interpret or circumvent it to come close to the desired results, while in other cases they react with criticism or even moral outrage at what they perceive as presumptuous and wrong-headed interpretations of the issue and the appropriate ways to tackle it. It also referred to conservative civil society organizations learning from the strategies of the cause or transgressive lawyers how to organize their counter-mobilization. All this could be shown for the US lawyers, but what about other professions and locations?

To realize that professional idealistic engagement is not an isolated phenomenon one only needs to call to mind Médecins Sans Frontières (1971, see MSF.org), and its imitators from other professions, such as Reporters without Borders (1985, see rsf.org), Lawyers without Borders (2000, see lawyerswithoutborders.org), Engineers without Borders (2002, see ewb-international.com), Chemists without Borders (2004,

see chemistswithoutborders.org), Sociologists without Borders (2011, see sociologossinfronteras.org), or Biologists without Borders (2015, see biologistswithoutborders.org). Single professionals, groups within a profession, and professional bodies set up transnational non-government organizations (TNGOs) to offer their services to those dramatically deprived of access to fundamental natural resources, basic information and specialized knowledge or affected by deep poverty, illnesses and abuses of their rights.

Brint and Levy (2002) provide an overview of US professional organizations and academic disciplines associations, including the American Chemical Society, the American Institute of Architects, the American Society of Mechanical Engineers, the American Historical Association and the Modern Language Association and their fluctuating civic engagements between 1979/1900-1995. Dagi (1988, p.53-55) lists some policy areas seemingly distant from the key concerns of the medical profession in which it has become involved, carried by the medical paradigms implying or calling for activism: Physicians for Social Responsibility (founded in Boston in 1961) oppose nuclear proliferation, while the medical profession has much to say about occupational health, food inspection, and environmental protection.

Neoliberal economists have pushed for their scientific agenda far beyond the confines of their scientific discipline and their respective nation-states. They not only engaged in teaching or publishing or departmental takeovers to promote the idea that individual freedom can only be achieved under the conditions of the free market, but they also developed a four-pronged strategy for gaining academic and political elite support for these ideas. They established the Mont Pelerin Society (1947) as well as many Think Tanks, research centres, business foundations, roundtables, initiatives and lobbies to further develop, discuss and propagate their views (Harvey, 2005, p. 43-44; Ptak, 2007, p.75-86). In this manner, they contributed to the right-wing turn of the civil society and politics in the closing decades of the past century.

In the introduction, I proposed that engaging with issues of the day can lead to the expansion of professional knowledge. For about 100 years, neoliberal economists have been deeply concerned about defending individual freedom against the state, whether in planned or market economies. They developed their scientific arguments and then moved to inhabit the elite regions of the civil society and politics to implement their visions.

The case of the US chapter of the Sociologists without Borders (SWB) illustrates the opposite movement. The SWB, established as an NGO-chapter in Madrid, Spain in 2001, is concerned with global justice and focuses on human rights violations. It also seeks to reduce power and resource asymmetries between the global North and the global South. Once a SWB's chapter was established in the early 2000s, the question of how sociologists can contribute emerged. In contrast to doctors or engineers, it is not self-evident how their expertise on human rights violations or inequality and gender or racialized discrimination can counteract these (Golash-Boza, 2012). They, therefore, set up a journal entitled, "Societies without Borders", a Human Rights section within the American Sociological Association and also an international Think Tank. Moreover, awards went to scholars who advanced research on SWB-related questions. The key point here is that what started as a concern about human rights and global North-South power asymmetries, resulted in setting up an NGO-chapter. Its initiators then engaged in many professional activities with the purpose of generating new specialized knowledge about what sociologists without borders could do and societies without borders could stand for. As this case signals (see also Henriksen & Seabrooke, 2015), civil society constitutes a fourth source of worldviews and ethics, apart from the state, the market, and the professions. Not the least for this reason, as sociologists of professions we should become cognizant of it and its various entanglements with professions and their manifold pursuits.

A research agenda exploring professions and their organizational initiatives could disclose the ways in which professions contribute (or fail to contribute) to the general welfare and democratic life and thus fill the research gap Parsons created according

to his critics when theorizing about the integrative-mediating role of professions in society (see overview in Sciulli, 2005, p. 916-918). It would also hark back to the research programs of historians of professions who were centrally concerned with their positioning in the power struggles between the state and the citizenry over time (see the diverse contributions in Burrage & Torstendahl 1990).

Finally, such a research agenda would dovetail with research on civil society which investigates, for instance, the extent to which and the ways in which civil society organizations, in this case, professional bodies and associations, manage to aid in (or hinder) liberating citizens from the clutches of their (absolutist, totalitarian or authoritarian) states and, not to be forgotten, capitalist forces or out-of-date value and normative constraints. It would call for investigating how professionals and their organizations expand (or curtail) citizen and minority rights in liberal democracies and develop critical (rather than supportive) discourses and activities directed at the governance regimes (alternatively: disciplinary regimes). Such regimes purport to define a given phenomenon as a problem necessitating a solution, bestow authority on and define the formal relationships between the actors to be involved in problem-solving, and specify the objects and the subjects (read: population groups) which the governance regime is to monitor, regulate, care for and, if necessary and possible, discipline (see Burns & Stöhr, 2011; Foucault, 1965; Freidson, 2001, p.182-196; Furedi 2006; Goldstein, 1984, p.181-183). Various citizen initiatives, professions that are to be regulated as well as professional associations claiming expertise in the regulatory area are often found among the critics of such governance regimes, and some manage to modify them and be included among the regulatory actors. Under what conditions they develop a critical stand and manage to assert it, and what happens with this critical stand once they are included among the regulatory actors are all research questions worthy of pursuit.

Endnotes

1. Sciulli's several books feature "civil society" in the title. Sciulli's long-term focus was on private business corporations which, leaning among others on the US courts, he treats as intermediary associations and thus as civil society actors. Sciulli also saw professions divorced from the state and their corporate bodies as intermediary associations. He investigated, among others, how courts and professions made private business corporations more ethical. Apart from private business corporations and professional bodies, his "civil society" is an empty house (Sciulli, 2009, p. 236-2241, 261,266-269, 271).

2. Foucault apparently came to believe that a market society makes for more tolerance and thus more individual freedom than a state-centered society (Dean & Villadsen, 2016, p.158-161).

3. A recent comparative book presents a dynamic ('law-in-action') ethnography of criminal defense in three states (Scheffer, Hannken-Illjes & Kozin 2010). Research on the assertion of state and class power in law and the criminal court cases dates back to the 1980s (McBarnet, 1981) despite repeated calls for such studies (Abel 1980; Banakar & Travers, 2005; Banakar, 2009). Rare innovative research investigates the resistance of judges to the state attempts to dictate judgments (Milburn, 2015; but see Halliday, Karpik & Feeley, 2007). A new line of investigation asks about emotions management in court as a way of upholding professional neutrality (Bergman Blix & Wettergren, 2014; Roach Anleu, Bergman Blix & Mack, 2015; Flower, 2018).

4. Karpik and Halliday (2011) focus on France, Germany, Great Britain, and the US. Halliday, Karpik, and Feeley (2007) include case studies from various continents. Their main thesis is that when lawyers, judges and civil servants practicing law build

an alliance (comprising the "legal complex"), they are capable of winning their battles for the constitutional and civic freedoms. Strong civil society mobilization which shapes and reinforces lawyers' efforts is not focal in their research (Karpik, 2007, p.481-485).

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All Roads Lead to Rome: Discretionary Reasoning on Medically Objective Injuries at the Norwegian Labour and Welfare Offices

Abstract: Discretion may challenge the formal principle of justice as it may involve unequal treatment of the same type of case. This article explores the discretionary reasoning exhibited by the frontline workers at different Norwegian Labour and Welfare offices (NAV) towards the same fictitious case. Frontline workers participate in a focus group where they are presented with a vignette concerning the case of a user with medically objective findings, that is, a severe head injury. The analysis focuses on the reasoning of the frontline workers before they come up with a suggestion as to how to proceed with the case. The findings demonstrate that while different avenues are pursued in the reasoning of the focus groups, the same conclusion is reached as to the treatment of the case. The article argues that the institutional logic which guides the frontline workers actions infers the reasoning process through a "norm of action" that states how it ought to be done.

Keywords: Discretion, institutional logic, frontline workers, unequal treatment, return-to-work

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The formal principle of justice demands comparable consistency in judgements across time, space and persons (Molander 2016, p. 32). The manner in which discretion is exercised is a core interest in research on frontline workers and their practices, as it is concerned with the translation of policy to practice (Caswell, Larsen, van Berkel & Kupka, 2017; Lipsky, 1980). Frontline workers may have significant capacity for discretion within the confines of available resources and regulations due to the complex nature of their work (Lipsky, 1980). Room for discretion allows for flexibility; however, it may also lead to unequal treatment or arbitrary judgements (Lipsky, 1980; Larsson & Jacobsson, 2013; Molander, Grimen & Eriksen, 2012; Nothdurfter, 2016).

Discretion as a concept can be divided into the structural: a snpace in which the social actors have the possibility to judge, decide and act according to their own judgement, and epistemic: the cognitive activity of reasoning and judging under conditions of indeterminacy (Molander & Grimen, 2010, p. 214; Wallander & Molander, 2014). Christie (2016) argues that discretion is both a threat and a pre-requesite for equal treatment, as the categorization of cases as "the same case" already implies the use of discretion. Casewell et al., (2017, p. 192) argue that the risk of arbitrariness in the frontline workers' discretion is real, as indicated by the variation

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in frontline workers' practices. Variation in the practices of frontline workers may be due to inconsistency in the ways in which discretion is structured as a result of the background and contextual pressures under which frontline workers operate (Casewell et al., 2017, p. 191).

Frontline workers at NAV make decisions about how to help users return to work. Earlier research on frontline workers at NAV indicates that they have considerable discretionary space for making decisions (Hansen & Natland, 2016; Solvang, 2017), which implies there may be a risk of unequal treatment. Heum (2014, p. 21-23) uses examples to problematize discretion used at NAV, suggesting that this is a potential source for arbitrariness. The likelihood of arbitrariness in frontline workers' discretion increases with the discrepancy between policy goals, and frontline workers' perceptions of the difficulties and challenges that face their clients' (Nothdurfter, 2016, p. 434). In other words, arbitrariness in frontline workers' use of discretion depends on the users' willingness (or potential) to conform to the goals of the frontline workers.

There are potentially two ways in which to explore the principle of equal treatment. First, Røysum (2013) argues that consistency may be attributed to a stronger standardization of measures, limiting frontline workers' reflections and the possibility of them individualizing measures. In order to explore whether consistency is attributed to standardization, one needs to employ several vignette cases. In Denmark, Møller (2016) found that frontline workers used discretion differently based on stereotypes of users. Through applying three versions of a vignette, where one invoked a positive stereotype (a user with objective medical findings), one with negative stereotypes (a user with a "diffuse illness") and a neutral stereotype, the study found that the extent to which frontline workers aligned with the wishes of the user was influenced by whether the vignette presented a positive or negative stereotype.

Second, discretion may be affected by personal background (e.g. education) and organizational context. Terum and Jessen (2015) found that frontline workers at NAV had operationalized their tasks in a way which limited the influence of the user and thus limited the potential for arbitrary decisions. However, frontline workers with a background in social work tended to involve the users to a greater extent than those with other educational backgrounds or training. Fossestøl, Breit, and Borg (2016) found that there was variation among the local NAV offices in how they approached users. Some tended to use a professional social work approach characterized by individualizing measures, while others applied a bureaucratic approach that focused on judicial rights. Thus, the same case may be treated differently depending on both the frontline worker and the local office.

This article focuses on one vignette presented at eight different local NAV offices to explore the discretionary reasoning of frontline workers. As a single vignette is employed, the article aims to investigate whether the same case is treated differently at the various offices. The next section presents the theoretical foundations of the study, followed by the method, an analysis of the data, discussion and conclusion.

Epistemic Discretion and Institutionalism

The concept of discretion may be divided into epistemic and structural. While both these dimensions focus on discretion, they are concerned with different aspects of this. The structural dimension explores the space in which social actors have the possibility of using discretion, while the epistemic dimension focuses on the cognitive aspect of reasoning (Wallander & Molander, 2014). This article uses the epistemic dimension in order to explore frontline workers' discretionary reasoning. Epistemic discretion refers to how social actors reason and make judgements in accordance with the aims and goals set forth by the delegating authority (Wallander & Molander, 2014, p. 3). There are three components to epistemic discretion, based on

Toulmin's (1958) general model of argumentation: a description of a situation, a "norm of action" and a course of action (Wallander & Molander 2014, p. 3). The epistemic dimension operationalizes discretion as for the reasoning that takes place during a process from the description of a situation to deciding on a course of action, inferred by the "norm of action". The epistemic dimension of discretion guides our attention towards the norm of action (how things ought to be done).

In order to explore the underlying rationale of the frontline workers reasoning, a theory of institutional logic is applied. Institutional logic is a set of presumptions and perceptions that guide the actions of the social actors who are embedded in a field (Thornton, Ocasio & Lounsbury 2012, p. 114). As such, institutional logic provides these social actors with identities, goals, and schemas for focusing attention, accessing knowledge and guiding decision-making processes (Thornton et al., p. 91-95). Through triggering identities, goals, and schemas, institutional logic guides what the social actors "ought to do" by setting legitimate rationales for reasoning and decision-making. In other words, institutional logic constitutes an important influence on the norm of action which in turn influences the perception of a "description of a situation" and impacts on the reasoning which takes place in order to reach a "course of action".

Through guiding social actors in the field, institutional logic provides an institutional framework that influences the "norm of action", which in turn guides the reasoning of frontline workers. Institutional logic legitimates certain rationales above others through reliance on institutionalized knowledge on which frontline workers reflect when making decisions. As certain aspects are taken for granted, it is probable that these aspects do not receive due attention since humans have limited cognitive resources allocated to information processing (Thornton et al., 2012, p. 88-89). However, this does not mean that frontline workers' decisions are determined by institutional logic, but rather guided by it.

The current study shows that norms of action are based on the discretionary reasoning that takes place between the description of a situation and course of action. However, frontline workers use certain measures to increase the information available and thus add to the description of a situation. For example, if a frontline worker uses a measure aimed at evaluating the user's medical problems, a course of action will not in itself lead to that user accessing work, but rather add to the case information; this is then further considered upon as part of the process of reaching the final goal of returning the user to the labour market.

Material and Method

To study the structuring principles for teacher In order to explore the reasoning among frontline workers employed at different offices, eight focus groups at local NAV offices were conducted. The data are comprised of these focus group discussions about the vignette case and took place in 2015. The participating offices ranged in size from ten to 180 employees with 27 focus group participants in total. The moderator of each focus group was either myself or another researcher with a background in social sciences.

Recruiting the informants entailed first obtaining permission from the central directorate and the regional administration to contact local offices. The selection of local offices was based on data received from two rehabilitation hospitals, indicating which local offices had had recent experience with a user with similar injuries and symptoms to the one described in the vignette. However, it was not stipulated that the focus group participants had to have had experience with such cases.

Table 1 shows that no single profession is present in all the focus groups, the most prevalent being social workers who are present in five out of the eight focus groups.

Table 1. *Background information on the focus groups and background of participants*

Office	Participants	Municipal size	Office Size	Background
1	3	City District, 48000 inhabitants	53 Employees	1xSociology 1xPolitical Science 1xSocial Worker
2	5	Suburban municipality, 60000 inhabitants	40 Employees	1xLaw 1xSociology 1xUpper Secondary Education 1xEconomy and Administration 1xSocial Worker
3	4	Rural municipality. 10000 Inhabitants	10 Employees	1xEconomy and administration 1xUpper Secondary Education 2xSocial Worker
4	5	City, 80000 inhabitants	180 Employees	1xHealth Sciences 1xTeacher 2xSocial Worker 1xSociology
5	2	Rural municipality, 13000 inhabitants	28 Employees	2xLaw
6	3	City in Rural district, 30000 Inhabitants	65 Employees	1xNurse 1xUpper Secondary education 1xCriminology
7	3	City, 50000 inhabitants	80 Employees	1xSocial Worker 1xSociology 1xHealth Sciences
8	2	City District, 45000 inhabitants	70 Employees	1xHealth Sciences 1xUpper Secondary Education

The aim of the focus group was to promote discussion among frontline workers in order to access strategies, reasoning and approaches that aligned with their real practice. Following Morgan's (2012, 2010) approach, the focus groups were regarded as two overlapping phases: "sharing and comparing" and "categorising and conceptualising" (Morgan, 2012, p. 169). The first phase allows the focus group participants to share and relate to each other's experiences and knowledge, while the second phase generates abstract knowledge on the subject matter (Morgan, 2010). The focus group participants were invited to discuss amongst themselves how they would approach the case, and explain the rationale behind said approach. This setting allowed for an exploration of frontline workers' shared understandings, which constitutes a "NAV-approved way" of reasoning.

The interview guide was organized around five main questions: 1) How do you

approach a person such as the one described in the vignette? 2) Can you reflect on your approach to the character in the vignette? 3) What are your limitations in helping them? 4) What do you think is their biggest problem? 5) Would they be eligible for a Work Assessment Allowance (WAA), and why is that? The follow-up questions focused on giving the frontline workers the opportunity to further reflect on their answers.

The vignette case (see appendix A) revolved around a 34-year-old carpenter with a wife and two young children, who had an accident that resulted in a traumatic brain injury caused by cerebral haemorrhage. The symptoms included paralysis in the left extremities, which was the main cause for rehabilitation in this case. In addition, he had severely limited balance, as well as minor symptoms such as headaches, slight depression and a lack of energy, and lacked the motivation to return to work. His general practitioner (GP) had declared him 100 percent disabled pro tem. In addition, the vignette described the recommendation from health personnel that further rehabilitation would be advantageous. The accident was set 12 months prior to the focus group session, the point at which frontline workers are required to stop sick-leave benefits and approach the crossroads of either disability benefit or the WAA. The WAA is a benefit given to users whose work capacity is being tested and evaluated in order to determine if they are capable of work or require a permanent disability pension. Constructing the vignette was a collaborative effort between myself, researchers with medical training, and a panel of representatives from various user associations. Several of the frontline workers indicated that the vignette amply mimicked information they usually received about a case.

The design of the vignette aimed to stimulate discussion among the frontline workers by using the vagueness connected with head trauma and the difficulty of forming a prognosis. Vagueness helps to capture interpretations and thus the principles on which frontline workers reason; however, it may also encourage diverging views in the different interviews through shifts in focus (Morrison, Stettler & Anderson, 2004).

The data collected were transcribed verbatim and thematically coded using NVivo 11. During coding, particular attention was paid to the reasoning the frontline workers used when talking about the vignette. The coding of the data followed each group's reflections on the measures suggested as a course of action for the character in the vignette. This reasoning is explored in the next section.

Analysis

The analysis focused on exploring the epistemic aspect of discretion and the reasoning that takes place in the focus group interviews. Some of the focus groups had limited discussion about social measures (supporting the family); however, these measures were considered in relation to the municipality's available resources. The analysis showed that frontline workers discussed three types of measures: medical measures (measures recommended by health personnel), evaluative measures (measures aimed at testing the functionality of the user in a work-related setting) and return-to-work (RTW) measures (measures aimed at returning the user to ordinary paid employment). This is an iterative process, where frontline workers continuously went back and forth between suggesting evaluation measures and considering RTW measures and expanding the description of a situation. However, the reasoning related to these different measures is analysed separately in order to have a stringent and clear analysis.

The medically objective findings of the user depicted in the vignette may have given the case the appearance of simplicity because there was little discussion about the user not qualifying for WAA. In all the focus groups, the initial focus was on whether the medical information determined if the user was eligible for WAA: all

focus groups concluded he was. However, even if the medical findings are objective, the diagnosis does not provide a clear prognosis. Thus, the analysis focused on the frontline workers' reasoning about the application of measures.

The frontline workers' discussions on the evaluative measures and the RTW measures overlapped to some degree. This overlap is probably because the goals of these measures tend to focus on work participation. Several evaluation measures that were considered test a user's capacity to work, similar to the RTW measures. An RTW measure that did not lead to work was often perceived as an evaluation measure since it gave the frontline workers additional information expanding on the description of a situation, which then initiated a new reasoning process.

The frontline workers, in general, viewed the measures as part of a whole. One frontline worker, when asked about how they would approach the case, expressed this as a "cogwheel sort of thinking, where you combine treatment with evaluation and RTW measures" (Male frontline worker, background in law, Office 5). This "cogwheel sort of thinking" relies on the combination of several measures:

> [We] need to find ways to combine [measures]. We try to back him up. Off course he will have his [medical] treatment. Nevertheless, how to combine it all? (Female frontline worker, background in nursing, Office 6)

The anamnesis outlined in the vignette contained too little information on the prognosis and potential of the person in question, according to the frontline workers. They explained that such a lack of information is common so the first step for them would be evaluating the resources and obstacles facing the user for retaining their job or finding a new one.

Course of Action: Medical Measures

Initially, the frontline workers' focused on the medical information provided in the vignette, and identified that the user met the regulatory demand of 50% reduced work capacity, so that he would "know where the next pay-check is coming from" (Female frontline worker, background in social work, Office 7). However, as the frontline workers are not health experts they are dependent on medical information and advice from health personnel.

After identifying the user's eligibility for benefit, the frontline workers mapped the user's resources and hindrances as a starting point for their reasoning in order to arrive at a course of action. The course of action, they contended, should focus on returning the user to the labour market: "You should work with the body you have" (Female frontline worker, background at the National insurance, Office 3).

One frontline worker stated "there is almost no limit when it comes to what you can spend in order for a person to gradually re-integrate into the labour market" (Female frontline worker, Sociology education, Office 7). The statement comes after the frontline worker listed the measures available to them to return a user to the labour market. The listing of possible measures may be perceived as creating the discretionary space in which frontline workers can reason—the structural dimension of discretion. While this is beyond the scope of this article, the statement underlines an important assumption among many of the frontline workers; that they have access to measures that allow them to re-integrate almost any user into the labour market given ample time.

> We see that he has the potential for a long work life, and it is easier to get a job when you are 34, even if the person requires a lot of facilitation at the work place. (Female frontline worker, sociology education, Office 7)

The frontline workers viewed the person portrayed in the vignette as a priority who

needs access to ample resources from them. This reasoning is based on the "priority list of NAV" as well as the underlying notion that younger people are easier to return to the labour market despite hindrances, and that they have a longer expected time in the labour market.

The character in the vignette was viewed by most of the frontline workers as being in need of medical treatment before focusing on work.

> It doesn't seem like he is ready for anything work-related, at least yet. (Female frontline worker, Work sociology education, Office 1)

Frontline workers have access to limited medical measures that focus on a return to work as illustrated by this frontline worker:

> We have some measures that are specifically related to medical treatment—psychologists and physical therapists with closer follow-up. We try to use it as often as we have the means. (Female Frontline worker, Sociologist, Office 4)

The initial evaluation consisted of gathering medical documentation in order to clarify the prognosis, as well as talking to the user in order to access his own experience of his situation. "None of us know how much improvement there will be [of the vignette person]" (Female Frontline worker, background in nursing, office 6). The frontline workers reasoned that there was potential for improvement through continued rehabilitation, following the medical advice in the vignette.

> I never focus on the 100 per cent disabled for work before I have done an evaluation … and gone through the possibilities for continued training together with the rehabilitation unit, since rehabilitation continues for a long time, including follow-up. (Female frontline worker, background in social work, Office 7)

> The GP has to be on our team, tell us what is possible. I am very interested in why the GP thinks he is a 100 percent disabled for work […] Still, our focus has to be on returning him to the labour market! (Female frontline worker, background in social work, Office 3 and Male frontline worker, background in economy and administration, Office 3)

Both of these quotes point to the frontline workers' somewhat ambivalent relationship with the medical information received from health personnel. The first quote points out that the frontline worker wishes to attempt to activate the user. The second quote indicates two aspects about which frontline workers reason; first, the frontline workers' perception of the GPs as important for the goal of returning users to work, and their perception of GPs.

One of the frontline workers was vocal in her reliance on health personnel being able to choose the right medical measure for the character in the vignette:

> It is important to not just sit and read the medical information, but to be in dialogue [with the user and medical personnel]. We cannot just sit and make up everything ourselves! We need contact with specialized health personnel. (Female frontline worker, background in nursing, Office 8)

This sentiment can be found, although less explicitly, in the other focus groups, exemplifying the frontline workers' reliance on communication with health personnel to make an informed choice regarding medical measures.

When asked questions relating to the medical information contained in the vignette, several of the frontline workers pointed out that one of the reasons for the focus on the reduced work capacity is due to GPs' lack of knowledge of the measures

that frontline workers have access to.

> It is a shame that the GPs do not know all the measures we have. When we ask for a statement from the GP about the user, they often think that the user needs to go straight back to work, which is a high threshold, but we have many low-threshold measures also. (Female frontline worker, background in law, Office 2)

Frontline workers' creative institutional work towards GPs for creating common grounds for cooperation is further explored in Håvold, Harsløf and Andreassen (2018).

Course of Action: Evaluative Measure

In all the focus groups, the frontline workers clearly stated that they needed more information than was provided in the vignette to make an informed decision on the user's prognosis and the possibility of returning to work.

> We need to ask the employer and those that treat him: How is it going? Does it work? Or doesn't it work? Compare this to the user's wishes. What is realistic is what becomes important. (Female frontline worker, background in the National Insurance, Office 6)

The key function of the evaluative measures is to gather more information on which to base the discretionary judgement. The frontline workers often used the term "mapping" when evaluating the user. The intention, according to the frontline workers, was to identify the user's opportunities and limitations in order to choose the correct facilitating measure(s) for a RTW process.

> What is the plan for treatment? At the same time, our focus is what is needed to get a person back to work; we need to map [his resources]. (Male frontline worker, background in economy and administration, Office 3)

Initially in this phase, the frontline workers aimed to map the formal and informal resources available to them. Formal resources include education, work-experience and medical documents about the diagnosis and prognosis, while the informal relate to social aspects, such as family and other social networks, psychological aspects, interests and aspirations.

> That is what the early mapping is all about, figuring out if he should be left alone [to continue medical treatment]? The medical treatment may be enough for now … but we can talk to him about that [i.e., work] as soon as it is appropriate. We should have it as a subject, incrementally move the dialogue towards work, but it is too early now. (Female frontline worker, background as schoolteacher, Office 4)

As we can see, this frontline worker makes a point about the user currently having health issues that are too severe and therefore possibly being "left alone" to focus on regaining his health. Two main ideas underline the frontline worker's reasoning here: that the user is not in adequate health to return to work, and that the user should in the future return to work.

> What is his current condition, and what is his prognosis? Is he still being treated? We should do a WCA if it has not been done already by [another focus group member] and have a conversation with the user to map [his resources]. So when they are granted WAA they are put in suitable measures ASAP. (Female frontline

worker, background in National Insurance, Office 8)

The frontline workers reported that a reoccurring problem was that the information received from the health sector focused mainly on the limitations of the user. Therefore, when evaluating the user the focus was on identifying the user's strengths. In the process for users with injuries such as those outlined in the vignette, a WCA was an important tool for guiding the user towards the correct benefits and for engaging the user in a return-to-work process.

> [This is what] the WCA is supposed to help us figure out. What kind of work experience does he have? How can he continue to use this experience in another type of work? (Female frontline worker, background in nursing, Office 8)

In evaluating the user, the frontline workers initially created an overview of the resources and hindrances of the user based on available information. In the aftermath of the initial evaluation, more evaluative measures create a more detailed picture of the resources available to the user.

> First we need to find some more … well here [pointing at the vignette] it says a lot about limitations … so I would find his competences and work experience and such in order to build on that. (Female frontline worker, background in social work, Office 4)

In approaching the vignette, the frontline workers said that evaluative measures were important for finding the correct way to reintegrate the user into the labour market. The frontline workers wanted more knowledge on how the person functions, meaning what he could and could not do. In so doing, the different offices used a range of different measures.

> I'm not thinking about work right now, but about mastery of skills, and when the mastery of a skill comes along, then you can focus on the other things around [the vignette]. (Female frontline officer, background in social work, Office 7)

> You can test his work capacity right … to see if he can actually do the job with his physical and psychological problems. (Female frontline worker, background in social work, Office 2)

> We should focus on the employer, since it's possible that he shouldn't work as a carpenter, but maybe get a bit more education to do more administrative work. (Male frontline worker, background in economy and administration, Office 3).

One frontline worker suggested adopting an evaluative course of action to test the user so that he might re-evaluate his own career. This reasoning relates to the frontline workers' perception that the person may be unwilling to consider a different career, despite the physical effects of his injuries.

> I would try testing him out somewhere, almost put it as a term that he is required to do some sort of trial at working. Then he would go to that competence centre which we often refer people to, because they have a practical work test, and they will often advise individuals to try another career after such a test. (Female frontline worker, Political science education, Office 1)

One frontline worker explained that they could not sit and wait for 12 months, the length of time that the user is entitled to health benefits, to do a WCA. The assess-

ment should be done as soon as possible to see if the user requires several and complex measures. They reasoned that in the multitude of measures they had available, some measures would help them recognise whether the user required assistance from them. If this assistance was not required, frontline workers could gain important information for evaluating the user's probability of re-integration into the labour market, or, whether they needed to start focusing on re-education at an early stage (Female frontline worker, background in nursing, Office 8).

In some cases, the frontline workers used the evaluative measures to keep the user active. One frontline worker reasoned:

> If his physical and psychological health has improved, we should do more vocational rehabilitation. Because it is dis-favourable to be idle and inactive for too long. Then you slide further away from working life and the road back will be so much longer. So it is very important to follow-up this person very closely. (Female frontline worker, background as a schoolteacher, Office 4)

The foundation of the rationale in this quote seems to be that a lack of activity on the part of the character in the vignette would cause a relapse and hinder further improvement, both physically and mentally in relation to returning to the labour market. According to another frontline worker, the character was likely to get back into the labour market:

> He would get information that when you get the WAA, as a user you are required to be active to assess your work capacity and to get back to work. A few times, there is no work capacity left, and you need to apply for permanent disability benefit, but that is a long process of assessing the user. I would think that he would get better when he gets therapy from the psychologist and his motivation to work would get better. We would keep the subject of work "warm" and talk about his possibilities. (Female frontline worker, background at the National Insurance, Office 8)

The requirement for activity in the above quote shows the duality of the evaluation measures, where the primary goal is to evaluate and motivate the user, while at the same time keeping the subject of work "warm". As the frontline worker reasons, the evaluative measure keeps the user closer to the labour market and provides frontline workers with information on the user's progress.

Course of Action: RTW Measure

All the measures aim at returning the user to the labour market, but in this section the analysis focuses exclusively on the measures aimed at the final leg of the return-to-work process, meaning the active measures to reintegrate the user into the workforce. The choice of RTW measures depends on the assessment of the user's work capacity, which can be tricky.

> We are supposed to evaluate according to any job they can do, but it still cannot be any job. You have to take into consideration what kind of background a person has, and the illness and what it does to the work capacity … and then the person's wishes and interests, so it's very complex when you try to evaluate a person, but we need to be realistic. (Office 4, Sociology)

> It's a dilemma—making each user responsible and … user involvement right … when should we do it, especially since we think it is important that everyone is accountable. Still we should see that in some cases the user is not capable of doing it … hum … so … it is always a dilemma. (Office 5, Law)

These two quotes exemplify the difficult balancing act, which the frontline workers are faced with when attempting to find the correct RTW measures to implement.

> The primary target for the frontline workers is the employer of the user, focusing on different measures available to help facilitate a continuation of the user's current employment. A good example from the data is when one frontline worker states, "We need to talk to the employer about which possibilities they have put measures in place to facilitate [for the vignettes injuries]" (Male frontline worker, background in economy and administration, Office 3).

Since all the focus groups focused initially on the return of the user to the same employer, this indicates strongly that this is a type of default reasoning. One focus group explained why this was best for all parties. Further, they reasoned, "problems with balance, headaches, bad memory … I doubt he can continue as a carpenter" (Female frontline worker, background at the National Insurance, Office 3). One of the arguments for returning the user to the same employer as the best course of action was that brain injury and side effects, such as depression, would make it harder for the user to create new relationships in a completely new work environment (Female frontline worker, background in nursing, Office 6).

If the user did not want to go back to the same employer, even in a different job, or the employer did not have the possibility (or economic means) to facilitate the user, one would have to approach the user about a return to work in a different career. In order for the user to get a different job, most of the frontline workers focused on short-term courses as the way to do this.

> It used to be called re-education [short-term courses], it is important that we have that conversation with the user at an early point in the process, and figure out what his needs are so that he can start a [re-education] process, not sit around waiting for 12 months to pass. (Male frontline worker, background in law, Office 5)

When considering longer courses, the frontline workers were generally more reluctant to implement these.

> Granting a benefit for him to study may backfire. He [the character from the vignette] may function well while studying, but may not function in a new job. [...] It is important that you grant a new career opportunity, not a study in itself. (Male frontline worker, carpenter and social work background, Office 1)

> What is the purpose of the education? Often new education does not increase the work capacity at all, so in general we are very strict at granting such a measure. There has to be a purpose! (Male frontline worker, background in nursing, Office 7)

The frontline workers considered a three-year bachelor's degree as too demanding on resources for the user particularly with the injuries he had: "I would not grant a bachelor degree!" (Female frontline worker, Background in Nursing, Office 8). Several of the frontline workers explained that due to the user's head injury and the lack of prognosis from the doctor, they were unwilling to offer a three-year degree course to a user with cognitive impairment either at this or at a later time.

> If it is a three-year bachelor in a subject, which requires a lot of concentration, then we will wait and see, because he has very bad cognitive function. It also

> depends on his motivation for study, since he is depressed as well. Will he manage to complete such an education...? Since he has work experience, maybe the best course of action is to get him back to the labour market, and then perhaps start talking about more education. In this case, I believe it is too early to talk about education. (Female frontline worker, background in economy, Office 2)

The RTW measures are cooperative by nature, and the frontline workers explained that it is imperative for the final leg of the process at NAV that they have a good relationship with the employer, if reduced work capacity is identified.

> We need to check if there are possibilities for [the user] finding another job. Normally we use an external re-integration company to help us with long-term measures. He should test out working, just to see what he actually can do, and afterwards we try him out at a local business.... Nevertheless, we see he has reduced work capacity, so we could refund the employer part of the wage, since he does not meet the requirements for a permanent disability pension. This requires having a good relationship with the employer, so we need to focus on that relationship. All the time! (Female frontline worker, background in nursing, Office 6)

Several of the frontline workers suggested wage subsidies as a possible means for helping the character in the vignette to reintegrate into the labour market. Wage subsidies pay part of a user's salary due to reduced work capacity. However, as several of the frontline workers indicated, there is a resource issue regarding both the number of frontline workers and cash available in the system, indicating a limitation in the structural discretionary room available. According to the frontline workers, the lack of resources meant that they could not sufficiently follow up employers and employees, therefore limiting the total number of wage subsidies an office could support.

Discussion

According to Christie (2016), discretion may be perceived as both a threat and a prerequisite for discretion. The Frontline workers at NAV have considerable discretionary space when making decisions (Solvang 2017, Hansen & Natland, 2016). Regarding the process of returning the user to the labour market, the frontline workers accepted the medical recommendations concerning treatment. The focus groups differed in their views on these recommendations; some groups wanted to do a work capacity assessment before they made a choice, while others accepted the medical recommendations without much reflection. The focus groups that first wanted to do a work capacity assessment were also those that claimed GPs lacked knowledge about return to work measures and the labour market. While both office one and seven decided that the character in the vignette was not ready for work, they nevertheless wanted to carry out a work capacity assessment. On the other hand, office three wanted to evaluate the user for work as early as possible, possibly indicating a different understanding of the vignette or a stronger adherence to the principle of work as beneficial to health despite hindrances.

The frontline workers' reasoning around the evaluative measures focused on gaining enough information to make a decision about the user's prognosis and the probability of his returning to the labour market. The evaluative measure thus expands on the "description of a situation" in order to better inform the frontline workers decision on a "course of action". The evaluative measures involved complex assessments of the user's competences and wishes that were deemed realistic and purposeful by the frontline workers. In the data, all eight focus groups wanted to map

the user's resources, and then to deal with obstacles to prevent him slipping further away from the labour market. However the groups' perceptions of how to achieve this goal differed, as office seven wanted to use therapy (i.e. a psychologist), and office four preferred vocational rehabilitation. The medical and the evaluative measures seemed to be aimed at creating a more comprehensive description of the situation, which, as Christie (2016) points out, suggests that it is the description of the situation inherent in the vignette that is being reasoned on by the focus groups.

The RTW measures revolve around three main subjects, options for returning to the current employer, options for embarking on a new career path through re-education and options for integration into work through wage subsidies. Re-education, beyond short-term courses, was rejected by most offices. Two offices indicated that they may consider a longer education or training course at a later date, providing that there is a clear purpose for the course and it is likely to lead employment. Wage-subsidies were discussed, however, these measures require the availability of sufficient financial resources in the NAV system, and depend on the user showing gradual improvements in his work capacity. Several of the frontline workers pointed out that at this stage of the process, more of their attention turned towards the user's employer, as cooperation and a good relationship was imperative for successful re-integration into the labour market. In addition, the emphasis on the possibility of wage-subsidies at some offices as a RTW measure bears witness to the importance of cultivating a relationship with the employer. The process of reasoning seems to operate iteratively between the evaluation and the RTW measures, expanding on the 'description of a situation' to make a more informed decision on the correct RTW measures to implement. If successful, the RTW measure returns the worker to the labour market (or permanent disability benefit), and the frontline worker may close the case.

All the offices decided that the most prudent course of action would be to attempt to return the user to his current employer. Much of their argument was based on the user's cognitive limitations, which according to frontline workers would make a change in the environment difficult for him. While the different focus groups came up with alternative solutions as described in the previous paragraph, the similarity in the perceived best course of action for returning a user to the labour market may indicate a strong norm of action, and thus an institutional logic.

Returning users to the labour market is the stated goal of NAV, and while the frontline workers discussed the user's injuries in the vignette case, they appeared to believe that the user will at one point return to work. The frontline workers statements bear witness to this goal as it frames their rationale. The "norm of action" which seems to underline their rationale is that work is beneficial, even to those with disabilities.

Following Christie (2016), it would be advantageous to do further research on the discretionary reasoning among frontline workers at NAV by exploring the initial understanding of the vignette further. This study had limited potential for exploring this initial understanding due to the focus group design; this restricted the time spent on discussions pertaining to the original vignette.

Conclusion

The similarities in the courses of action suggested by the focus groups highlight a possible limitation in discretionary reasoning of frontline workers, and thus a potential problem for the principle of justice. In other words, do frontline workers practice discretion, or do they simply comply with policy demands? The stated goal of NAV is to return users to work, with which the focus groups clearly comply; however, the variation in the frontline workers' approach to gaining more information and expanding the description of a situation indicates discretionary reasoning that takes

into account the contextual influences. The variation in approaches could be due to the different initial categorization of the vignette, leading to somewhat different descriptions of the situation. This indicates that the norm of action influences not only the course of action, but the description of a situation as well.

The reasoning process expressed by the frontline workers at NAV has some similarities to how they perceive the information contained in the vignette. The initial response was to build motivation for work, as suggested by not wanting to rush the user back into work, but rather to use the available measures to evaluate his potential, and thus expand on the information in the description of the situation. The frontline workers did not suggest permanent disability benefit and suggested that returning to the current employer was the best course of action. The similarities among the frontline workers in the data suggest that they are guided by an institutional logic which follows the principle that work is beneficial to health despite hindrances.

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Appendix 1. Vignette (translated by author)

Rehabilitation Hospital

Admitted: xxx Printed: xxx (3-week rehabilitation stay)

Doctor: xxx xxx
Diagnose: H82 Dizziness syndrome in diseases classified elsewhere
F07.2 Post-traumatic brain syndrome
F33 Recurrent depressive disorder

Patient:
Male, 34, married, 2 children (2 and 4 years). Carpenter with a certificate, 12 years of experience, currently on sick leave. Wife on 50% leave without pay and serves as support and caregiver at home.

Admitted due to treatment of previously diagnosed balance problems due to an accident 12 months ago with traumatic brain injury and paralysis in left extremities. A hip and multiple rib fractures well healed. Light / moderate depression diagnosed after injury.

Recovered function in left extremity, some impaired strength and problems with

everyday functions due to lack of dexterity in the hands. Intensive care treatment, primary rehabilitation carried out at University Hospital. Recommended further rehabilitation for dizziness and dexterity in specialized rehabilitation hospitals. Currently on the waiting list. Offered placement after 5 weeks. Conversation therapy due to depression conducted by a psychologist. Throughout the stay experienced balance problems, as well as problems with dexterity. He complains of not remembering and strong headaches in addition to lack of energy to help at home and with the children. He expresses a strong desire to have enough energy to play with the children. CT of head—unchanged. Neuropsychological testing identified a limited cognitive failure with limited memory retention. He describes the wife as a good support.

At Discharge:
Both balance and dexterity improved after training. Physiotherapist and occupational therapist recommends follow-up and training. Neuropsychologist further recommends cognitive therapy for memory problems. Medical treatment for headaches as needed. Lacks motivation to work. GP states that his lack of work capacity is currently at a 100%.