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“I Want to Break Free”— German Locum Physicians Between Managerialism and Professionalism

Abstract: In the last decades, managerial instruments have gained importance to medical decisions and the logic of managerialism is juxtaposed with the logic of medical professionalism. Recent changes in the hospital employment structure raise the question of contradictory logics not only at the organizational but also at the individual level. Therefore, we investigate the rise of locum doctors which is a relatively new phenomenon in Germany. Our qualitative interview study with 21 locum tenens, permanently employed physicians, and chief physicians shows that locum physicians re-contextualize professional standards in hospitals. According to their self-perception, patient care stays at the center of their medical practice regardless of economic, bureaucratic, and hierarchical requirements as well as hospital-specific routines. We argue that the interrelationship between professionalism and managerialism exists not only within organizations but also on an individual level of locum doctors.

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Health care systems throughout the world are experiencing similar pressures, such as the need to decrease costs as the burden of treating disease and the aging of populations increases (Kikuzawa, Olafsdottir & Pescosolido, 2008). Almost all developed countries are seeking better and more efficient ways to deliver medical services (Glied & Smith, 2011). For this reason, health care systems are undergoing processes that reconfigure professional practice (Correia, 2017; Mechanic & McAlpine, 2010; Numerato, Salvatore, & Giovanni, 2012; Scott, Ruef, Mendel, & Caronna, 2000).

In Germany, recent health care reforms have led to major changes that affect hospitals' profits or losses because of the introduction of a remuneration system for medical procedures based on diagnosis-related groups (DRGs), irrespective of whether these are private, non-profit or public hospitals. The reorganization of organizational processes and structures (e.g. new incentive schemes, outsourcing activities) that accompanies these processes affects professional standards as well. These developments lead to changes in the hospital physicians' work context resulting in a deterioration of working conditions and a deprofessionalization regarding the strong focus on management issues (Dent, 2005; Hogwood, 2016; Mattei, Mitra, Vrangbaek, Neby, & Byrkjeflot, 2013; Rosta & Aasland, 2011). At the same time, we observe a shortage of doctors in German hospitals and an increasing acquisition

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of new forms of employment, the so-called self-employed doctors or independent contractors, i.e. self-employed doctors without employees (hereinafter referred to as locum physicians). In contrast to other countries (e.g., UK), these locum physicians are not simple medical replacements, but are highly sought-after professionals and have a high status since they are highly skilled and finished specialized training. The individual level and the employment status of physicians working in hospitals have been neglected in the discussion of (changing) professional behavior so far. However, the employment status, and in particular the attachment or detachment of physicians to a specific hospital may influence the extent to which they are affected by organizational restructuring, their scope for strategies to react to these changes, and the handling of complementary and competing logics of managerialism and professionalism. Using the example of German hospitals, we examine how reorganization in hospitals affects physicians' professional practice by considering the physician's employment status (dependent employee vs. self-employed) and analyze how locum physicians individually cope with conflicting and competing logics of managerialism and professionalism.

Drawing on a qualitative study of locum physicians, permanently employed physicians, and chief physicians in hospitals, we find that breaking free of organizational constraints and becoming self-employed as a locum physician can be an attempt at reprofessionalization. We contribute to the literature on professionals dealing with competing institutional logics in organizations by highlighting the individual behavior of physicians who become self-employed and are subsequently (re-)engaged as locum physicians in hospitals. As a result, the relationship between managerialism and professionalism has different dynamics at the organizational and individual level. In health care organizations, managerialism has so far led to a decline in professionalism. This is due to health care reforms which are perceived to strengthen managerial control and economic rationales—as opposed to professional autonomy—in decision making. At an individual level, managerialism leads to more professionalism since solo self-employed locum physicians concentrate on the basic values of their profession, their professional expertise, and client-centered autonomy to offer high-quality standards in order to remain in the market. In addition to studies with a focus on competing and changing institutional logics (Martin, Armstrong, Aveling, & Dixon-Woods, 2015; Thornton, Ocasio, & Lounsbury, 2012), our analysis provides insights into the role that the employment status in professional organizations plays in hampering or fostering the articulation of professional values in general.

In the next sections, we first briefly introduce hospitals as professional organizations and physicians as members of a profession. We rely on the theory of professions to describe the aligned changes of employment relationships in German hospitals. We then introduce our qualitative study and present the analysis of our data. In the discussion section, we develop conclusions and put forward implications for further research.

Conceptual framework

Analytical approaches towards professions, and related perspectives on changes in professional work, primarily concentrate at the organizational level or on groups of professionals. As the subsequent literature review will draw out, the analytical merit of these perspectives on changes in professional work needs to be complemented with an analysis of the integration of individual physicians into professional organizations, and, more specifically, with an analysis of the implications of the employment status on professional practice.

Hospitals as professional organizations

Conceptualizations of professional organizations point to the relevance of different organizational units and occupations within these organizations. Traditionally, the medical profession is the most powerful category of staff within the health care system (Seifert, 1992). This power mainly results from the key position of physicians in hospitals as professional bureaucracies (Mintzberg, 1979). Although professional organizations “vary in the robustness and the legitimacy of their claims to expertise and in their status” (Suddaby, Greenwood, & Wilderom, 2008, p. 990), the most important resource of these organizations is their knowledge expertise in relation to the strategic apex, the technostructure and the support staff. The strategic apex is the managing directors of hospitals. The technostructure comprises in particular analysts who standardize, control and optimize the processes in the organization (e.g. clerical support staff). In hospitals as a professional bureaucracy, the technostructure plays a subordinate role because the professionals organize their own treatment standards within the professional community. The so-called support staff—nurses and allied health staff in hospitals—are completely oriented towards the requirements of the operating core. In the operating core of professional bureaucracies, professionals like physicians must carry out the central work and are in a key position (see Figure 1). Professional organizations’ configuration tends to encourage the relatively autonomous and independent action of their workforce and rejects formal management controls to protect the professional autonomy (Abernethy & Stoelwinder, 1990). Consequently, the logic of medical professionalism is promoted. In contrast to Mintzberg’s (1979) other archetypes of organizations (e.g. simple structure, machine bureaucracy, adhocracy), the control mechanisms in professional organizations are based on the operating core, which in turn influences all other administrative components because of its professional autonomy and dominance.

Mintzberg’s organizational configuration is historically situated in the power relations and organizational structures of the 1970s. Therefore, it is challenged significantly by health care reforms in Germany in the last two decades which have profoundly affected hospitals as professional organizations. Especially the implementation of case-based compensation systems has led to increasing cost transparency for medical treatment procedures in Germany. DRGs also promote competition in the hospital sector because internal processes become standardized and thus more manageable. In view of this development, strategic aspects become more important for hospitals—a change that is reflected by the prevalence of profound reorganization measures with respect to processes and structures. In this model, the logic of business-like health care (Reay & Hinings, 2009; Szymczak & Bosk, 2012), which aims at increasing efficiency, dominates. Moreover, cost pressure resulting from greater competition leads to restructuring processes in hospitals (Ernst & Szczesny, 2005; Tiemann & Schreyögg, 2012). In sum, these developments strengthen the technostructure of hospitals (Llewellyn, 2001; O’Reilly & Reed, 2011) because the members of the technostructure now “serve to effect standardization in the organization” as Mintzberg (1979, p. 30) points out. In this context, new functional areas like case management, medical controlling, and quality management become relevant. Consequently, in Germany the dominance of the operating core has been weakened, the support staff has been reduced, and the strategic apex and technostructure occupy a larger space (see Figure 1).

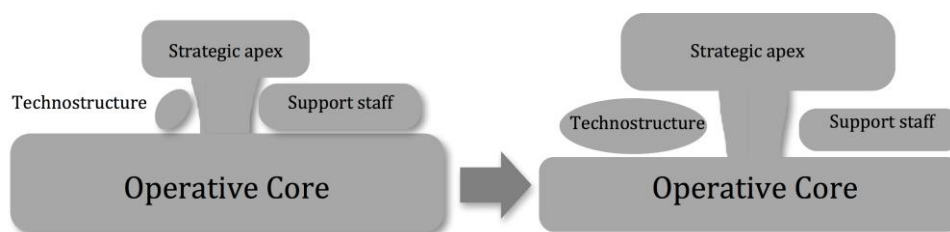


Figure 1. *Professional bureaucracy in transformation* (Mintzberg 1979, p. 355, modified by the authors).

The question that arises at this point is to what extent these changes in the organizational configuration affect the professional understanding of physicians.

Physicians as professionals

Physicians are the prototypical profession (Freidson, 1970). Professionalization, professionalism, and professions are considered in professional sociology from different theoretical perspectives. A prominent or even universally accepted theoretical position, which is able to illuminate the subject area occupation or profession in the modern society in all its facets, is not to be recognized at present, however. A general distinction can be made between the largely "theory-free" traits approach, the structure-functionalist, the symbolic-interactionist, the structure-theoretical, the power-theoretical, and the system-theoretical professional approach, which each emphasize different aspects of the development of professions and/or professional action. In our case, especially the traits approach of professions is helpful to understand the acting and status of physicians as well as shifts of professionalization and deprofessionalization (e.g., Brennan et al., 2002; Carr-Saunders, 1955; Cruess, Johnston, & Cruess, 2002; Goode, 1957; McClelland, 1985; Sox, 2007). According to this approach, professionals fulfill several characteristics among which professional autonomy, cooperative self-control and the commitment to a professional ethos play a decisive role. Professional autonomy results from the state conferring the right upon the medical profession to regulate those issues independently which form part of their professional expertise. Depending on the national context, professional legislation and self-control can extend to aspects such as the medical curriculum, the admission into the profession, the content and structure of specialist training and much more. The commitment to a professional ethos is documented from ancient times in Professional Codes of Ethics such as the Hippocratic Oath which exhibits the moral norms of professional communities.

Beyond the discussion of traits inherent to professions there have been influential attempts to capture the logic of professionalism in a theoretical model. Freidson (2001), for example, uses the notion of an ideal type to develop a comprehensive account to professionalism. Freidson distinguishes between three different forms of division of labor, which are conditioned by the logic of action to be found in each specific occupation. The three forms of division of labor are, on the one hand, the bureaucratic-managerial, the competition-based-consumerist, and the specialized-professional forms. This differentiation is based on different degrees and conditions of the control of the working conditions, the problem or task relation and the specific ways of working. According to the "third logic" of professionalism, the social sphere is ruled by highly qualified specialists who organize and control their business by themselves. Professionals are thought to act primarily to the benefit of others and, in this, provide the society with high-quality goods and services at reasonable prices.

Such supremacy of professionals is juxtaposed with the market logic in which consumers have the final power and the logic of rational-legal bureaucracy where production and distribution are controlled by the management of large organizations. According to Freidson (2001), monopoly, as well as the professional judgement and discretion, are intrinsic to professionalism. This stands in sharp contrast to managerialism with its emphasis on competition and efficiency through standardization. Freidson (2001) further argues that professions do not defend themselves well against managerialism implying and adjudging the power of management. However, Llewellyn (2001) analyzed how clinicians could acquire managerial expertise, or learn the discourse, and deploy it as a resource in a new medical management role (see also Thomas & Hewitt, 2011). Moreover, as depicted in Freidson's idea of a "third logic", the special kind of knowledge ascribed to professionals allows them to exercise discretionary judgment with respect to highly individual cases in clinical care. This, however, can collide with the requirement of cost-effectiveness and standardization which dominates the strategic apex respectively their managerial perspective on hospitals.

The major changes in hospitals outlined above can, therefore, be interpreted as a form of deprofessionalization within the medical profession, as doctors lose power due to the loss of autonomy through improved management control (Noordegraaf, 2006, 2016; Reed, 1996). In fact, hospital physicians are transformed into ordinary employees who have to commit themselves to organizational goals (Wilkesmann, 2016). In sum, physicians' professional behavior today is shaped by contradictory principles in professional organizations (Berki, 1985; Evetts, 2009). Thus, hybrid forms of professionalism risk to be blended with other logics to the extent that they lose their core elements (Martin et al., 2015, p. 394). Over 70 years ago, Parsons (1939) argued in a normative way that 'professional men' behave toward patients as altruistic servants, whereas "businessmen" mainly follow their self-interests. However, both behaviors are a result of institutional patterns and structures (Riska, 2010). Reay and Hinings (2009) discuss a rivalry of logics and a co-existence of governance structures that increase efficiency and medical professionalism, with a strong orientation to the physician-patient relationship guiding the services. In this context, the weakening of autonomous spaces appears to threaten professional work and harm professional values, especially if autonomous and committed professionals lose their ability to treat their patients as individual cases. More recent approaches, however, stress that the "rivalry picture" of professional and managerial logics should be abandoned for the benefit of an advanced model of professionalism which overcomes the idea of hybridity (Noordegraaf, 2015). Instead of being seen as a threat to professionalism, management and organization are then depicted as normal aspects of professional work. Exemplary empirical studies have also demonstrated how physicians mediate and co-create new organizational environments against the background of their traditional structured forms of power (Waring & Bishop, 2013). Other studies examined the identity work of medical professionals in managerial roles (McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015). The logics of professionalism and managerialism form, thus, the background for multifaceted social processes which culminate in hospitals as professional organizations. Recent studies point to the importance of the wider institutional context for the maintenance of professional values (Martin et al., 2015, p. 394). Consequently, hospitals as professional bureaucracies provide an appropriate example for a social sphere where the three logics of professionalism, market, and bureaucracy meet and often cannot be easily unified. However, it remains widely unclear how the situation affects hospital physicians' professional behavior at the individual level with respect to their daily clinical work.

Physicians' employment in German hospitals

Regarding the organizational integration of professionals, a change in the employment structure raises the question of contradictory logics not only at the organizational level but also at the individual level. Indeed, the attachment of physicians (as dependent employees), or their detachment (as independent contractors) from hospitals varies historically. In German hospitals, physicians usually work as employees and receive a fixed salary. However, before the introduction of the public health care system in Germany at the end of the nineteenth century, physicians predominantly worked as independent contractors and were not included in a hospital's organizational setting. Hospitals developed compensation structures to ensure the employed chief physicians an almost equal or higher income in comparison with their resident colleagues (Wilkesmann, 2016) because they were allowed to augment their relatively low income by treating and charging wealthy patients. However, the implementation of DRGs, along with new labor legislation adopted in 2004 owing to a decision by the European Court of Justice on new daily and weekly hour maximums, resulted in increased demands for medical personnel accompanied by the goal of decreasing fixed salary costs. As a result, physicians employed in German hospitals earn comparatively low wages in relation to their workload (Mitlacher & Welker, 2012). Furthermore, managerial steering instruments aim to involve chief physicians more closely in fulfilling organizational objectives, thus giving economic considerations increasing importance in daily medical practice. New contracts include budget targets as well as personal or departmental target agreements involving bonus–penalty schemes, and the pay-out of variable bonuses depends on the degree of goal achievement

In Germany, the increasing demand of medical personnel leads to (1) the recruitment of physicians from different countries all over the world, and (2) a growing number of locum physicians (Keller & Wilkesmann, 2014). The phenomenon of contingent and nonstandard employment in the hospital context is relatively new but can be observed in several countries, e.g. the US and the UK (Alonzo & Simon, 2008; De Ruyter, Kirkpatrick, Hoque, Lonsdale, & Malan, 2008; Hoque & Kirkpatrick, 2008; Hoque, Kirkpatrick, De Ruyter, & Lonsdale, 2008; Houseman, Kalleberg, & Erickcek, 2003; Kirkpatrick & Hoque, 2006; Simon & Alonzo, 2004). Houseman et al. (2003) analyzed agency work of nurses and showed that, in contrast to hospitals, agencies were able to recruit nurses and other hospital professionals by paying them more than hospitals did. Since 2007, German hospitals have been allowed to deduct costs for physicians who are not permanently employed and typically serve as temporary substitutes for permanently employed physicians. However, in contrast to other contingent workers, locum physicians are less affected by the disadvantages of atypical employment, since they are better compensated and not bound by directives as dependent employees are (Wilkesmann, 2016). Notably, the decision to become a locum physician is only an option if a physician has finished specialized training and obtains a Certificate of Completion in Specialist Training (Facharztanerkennung). There are about 4,000 to 5,000 locum physicians in Germany which is around 1% of all physicians in hospitals. Most of them are engaged in the field of anesthesiology because here is the highest need of hospitals since they keep the operating rooms running. Moreover, this unit has rather standardized processes promoting an easy engagement of temporary workers such as locum physicians. Self-employed physicians, who are (only) temporarily engaged in hospitals, are by law not bound to organizational constraints. Therefore, they can—in comparison to their permanently employed colleagues—in principle be considered as less dependent on organizational forms of control, and therefore may be better able to defend professional values in their everyday practice. The emergence and expansion of this new group of contingent workers in hospitals presents a challenge with regard to understanding and theorizing broader transformations in professional work and

the interplay of contradicting logics of professionalism and managerialism at the organizational and individual levels in light of changing employment structures.

Data and methods

We engaged in a qualitative study to assess the impact of contradictory logics in hospitals not only at the organizational but at the individual level with a special focus on the view of locum physicians. More specifically, we investigate how locum physicians cope with conflicting and competing logics in German hospitals. In 2014, we conducted 21 semi-structured interviews: 13 interviews with locum physicians, five with permanently employed physicians, and three with organizational representatives who assign locum physicians. We aimed at triangulating to enhance credibility of the findings presented by examining multiple perspectives of the people concerned and by the quality of data (Miles, Huberman, & Saldana, 2014). In our sample we achieved informational redundancy and theoretical saturation (Saunders, Sim, Kingstone et al., 2018). In this sense, further interviews did not reveal additional information relevant to the research questions so that we decided not to acquire more interviewees. Moreover, we were constantly engaged in critically reflecting our findings and research process-oriented to the principles of falsification. As Crouch and McKenzie (2006) claim in case of a small sample size, we can confirm that all authors were immersed in the research field due to prior research which helped to create a diversified sample which covers relevant aspects with regard to the research questions. We gained access to the interviewees by directly and simultaneously contacting personally known gatekeepers, through calls in relevant newsgroups, and by using the snowballing technique. Snowball sampling is an established method for identifying and contacting hard to reach populations such as physicians. By choosing different ways of recruiting interviewees, we avoid the downsides of snowball sampling such as bias and dependency on the subjective choices of the first respondents (Faugier & Sargeant, 1997). The respondents were predominantly male and between 31 and 70 years old, and represented the following fields (in order of frequency): anesthesia, emergency medicine, critical care, internal medicine, psychiatry and psychotherapy, gynecology, surgery, and radiology. The interviewees have a working experience of 18 years on average.

The locum physicians in our sample indicated they had worked in five to 40 different hospitals. Ten male and three female locum physicians were interviewed which roughly equals to the overall gender distribution of locum physicians in Germany.

The interviews were conducted face-to-face and on the telephone by a core group of four interviewers. The interview guideline contained open questions on the interviewees' professional biographies, on the locum physicians' professional behavior and cooperation with core staff and superiors in hospitals as well as the physician-patient relationship and critical incidents.

All interviews were audio-recorded, transcribed, and anonymized. The length of the interviews was on average 49 minutes. The data were analyzed with the method of qualitative content analysis (Mayring, 2000), including a deductive application and an inductive development of codes. We started with a theoretical formulation of definitions, e.g. consequences of engaging locum physicians, and applied these codes to the interview transcripts. Likewise, we formulated inductive categories out of the material, e.g. reasons to become self-employed, to be able to code relevant narratives. We, then, explicated coding rules for the categories and identified examples. The transcripts were primarily encoded individually and the codes were subsequently compared and discussed in several team sessions. Correspondingly, the coding system was constantly checked and modified, inductively expanded, and revised. After the revision of categories and coding agenda, we applied the final code scheme

to all transcripts and interpreted the results. Rater influence was controlled by having at least three researchers participate in the data interpretation process and by team discussions of the match of encoded codes to jointly develop the code system.

Table 1. *Participant characteristics*

Participant characteristics	
Age	29-73 y; median: 50 y
Gender	14 male; 7 female
Working experience	2-35 y; median: 18 y
Function	13 locum physicians; 5 permanently employed physicians; 3 organizational representatives
Clinical specialty (physicians only)	Anesthesiology / A&E (8); Surgery (3); Neurology / Psychiatry (3); Internal Medicine (2); Urology (2); Gynecology / Obstetrics (2); Radiology (1)

Results

Managerialism resulting in deprofessionalization on organizational level

The interviews revealed that health care reforms and the resulting changes in hospitals affect the medical decisions of employed physicians in the operating core of the professional organization in manifold ways. Most importantly, the managerial staff of the technostructure and non-professional aspects such as budget constraints or profit criteria gained in influence and restricted the professional behavior of physicians. Changes at the organizational level and the dominance of the managerialism in hospitals have led locum physicians to perceive a deprofessionalization of their daily work when being permanently employed, which especially affected their professional autonomy, the quality of patient care, and public welfare. A permanently employed physician expressed this widely shared observation as follows:

In most German hospitals the administration is increasingly taking the reign. One has too little say, too little leeway. This is a form of disempowerment of physicians, which I cannot accept. (Permanently employed physician 20: 8).

The interviewees criticized the increasing market orientation in the hospital, noting the greater importance of decisions that rely on profit or commercial criteria. They emphasized that their medical autonomy had been eroded because economic incentives took precedence over medical requirements:

If you go to a doctor there is a difference between the fact of what a patient really needs and the fact of what the hospital management wants. Even the chief physician then exerts pressure because he has agreed to several targets in his or her contract. And of course, you see frustrated physicians everywhere, apart from all the working pressure and the permanent shortage of staff which prevails everywhere. (Locum physician 03: 29)

This quote also shows how chief physicians adhere to the new commercialized requirements and how they pass pressure down to their subordinates. In this respect, physicians in hospitals perceive that the organization and organizational representatives constrain their professional work, leading to work situations in which following professional standards is made more difficult:

We live today in a massive commercialized form of medicine.... What really frustrates is that really the only ones who have something to say in hospitals are the hospital managers. As a doctor, you should be allowed to act in line with professional values, but that's over.... In addition, an incredible time pressure is put on the physicians. (Locum physician 05: 27).

Against this background, physicians consider quitting their jobs as permanently employed physicians in hospitals and working as a locum physician as a way to break free from working conditions in hospitals that strengthen managerialism and restrict professional behavior in a way which challenges the physicians' professional autonomy, commitment to patients' well-being, and economic independence.

Locum physicians also choose this form of employment because, among other advantages, it offers better income opportunities. They invoice all hours worked, whereas physicians employed in a hospital often do unpaid overtime. In this sense, economic criteria do play a role in their decisions to become self-employed. Whereas the possible financial motivation of locum physicians resonated in the subtext matters of professional autonomy clearly dominated the interviews with both employed physicians and locum physicians. Consequently, working as a locum physician can be seen a means of medical reprofessionalization with regard to professional autonomy, status, and adherence to professional values.

Working with locum physicians, however, does also affect working conditions of permanently employed. One criticism referred to responsibilities for peripheral tasks, such as documentation, which may increase with the recruitment of locum physicians. Especially chief physicians also worried about the effort to teach locum physicians about standards and routines specific to a given hospital or department. On the other hand, as locum physicians are typically hired when permanent positions cannot be filled, they positively affect working conditions of permanent staff as they reduce overtime and work intensity in times of shortages of personnel. Apart from these questions of work intensity related to vacancies and their compensation with locum physicians, as we will discuss below, the deployment of external medical staff does also impact on the possibilities to defend professional standards.

Managerialism resulting in reprofessionalization on individual level

Shifting from being permanently employed in a hospital to being self-employed enabled locum physicians to uphold the main characteristics of professional work. Locum physician interviewees emphasized a higher degree of autonomy and better working conditions compared to employed physicians. They underlined that they can escape both exhausting working conditions as well as economic and hierarchical controls, as they are not formally integrated into hospital structures and chief physicians are not authorized to issue directives with regard to medical decisions.

I am totally committed to the patients. One could also say: I can order what I want, because I am not subject to any economic constraints of the hospital or anything else, but I'm practicing medicine really well and I do it for the patients. (Locum physician 01: 159)

In addition, the short-term nature of working as a locum physician for a specific hospital and hospitals' fear of accusations that they are avoiding social insurance contributions through pseudo self-employment (as, for example, by integrating self-employed physicians into organizational hierarchies and processes) provide locum physicians with freedom from orders and the ability to change workplaces if their autonomy is undermined or they observe malpractice.

[Being a locum physician] makes it easier to say 'I am not contributing to what is going on here, because I do not want to'. And then I go. This is why I am a locum physician. (Locum physician 01: 175)

Following their own self-perception, the employment status allows locum physicians maintaining their professional ethos by giving priority to professional criteria in carrying out their medical activities instead of capitulating to superiors' economically driven directives. This autonomy is particularly important for them regarding treatment decisions. Moreover, locum physicians have leeway to keep their knowledge up-to-date because they do not have to apply for an exemption in order to attend conferences or other forms of further training. In organizational settings, permanently employed physicians often depend on the goodwill of chief physicians when it comes to their professional development. The autonomy locum physicians enjoy in this respect means that they rather base their patient-oriented decisions on the latest scientific findings than on organizational routines or chief physicians' directives and, thus, strengthen the knowledge base of their professional work.

However, since locum physicians have to offer their manpower in the job market, they are exposed to market risks such as unpredictable demand and have to engage in marketing activities, including skill acquisition to keep their knowledge up-to-date:

So, all physicians need to improve their knowledge, but I have had the experience that one doesn't keep up to date when you're in practice. And at the clinic, you have to do that because you're expected to, but as an independent contractor you do that voluntarily, because when you have to defend your treatment as an independent contractor and have to explain, you have to improve your knowledge. Then you absolutely always have to have the latest news in your head, because only then you get the respect of your colleagues. Yes, one can quickly be out of the picture if you don't look at the further developments ... and if you don't regularly keep up to date. So that's a very, very important thing, especially for us. (Locum physician 02: 71)

This need to improve one's medical knowledge in order to compete in a market

of solo self-employed reflects the market situation of professionals who are evaluated by peers (in comparison to patients as layperson). Therefore, considering market logics, managerialism promotes medical professionalism since locum physicians have to provide up to date services to be in demand by the market. Thus, the locum physician's stronger focus on the latest scientific results about treatments, further training, and professional (not organizational) standards shows how market and professional logics dovetail at the individual level. In this respect, locum physicians perceive themselves as being able to combine the two logics as they act and decide autonomously. As a result, the tension between professionalism and managerialism which holds true at the organizational level is reconciled on the individual level by the locum physicians.

Reprofessionalization on organizational level through engaging locum physicians

Locum physicians not only show reprofessionalization at an individual level. Evidence also hints at instances of a reprofessionalization of medical behavior at an organizational level. As argued above, locum physicians claim to consolidate their medical decisions rather on the latest scientific findings and the basic principles of the profession instead of following organizational routines and directives of chief physicians. In this sense, they contribute their knowledge in cooperative work arrangements and thereby reorient reasoning and decision-making towards professional knowledge. In addition, permanently employed and locum physicians reported that locum physicians conduct informal training by sharing their manifold expertise with permanently employed physicians in hospitals. In this context, they distribute knowledge they have gained in numerous hospitals, where they learned about alternative medications or operation techniques, or point to malpractices that endanger patient care.

Sometimes, locum physicians even propose specific structural changes for the department they are working in. For example, engaging locum physicians in hospitals allows time and space for professional training of the permanently employed physicians to support the maintenance of their professional standards.

I tell the chief doctors: When I'm here, you can allow your subordinates to go on vacation, to accomplish training leave, and so on. In this sense, I'm here to improve the working conditions. (Locum physician 10: 37)

So, we had actually quite positive experiences because the benefit is that locum physicians are often specialists, and otherwise many colleagues are freshmen On one hand, locum physicians are of course novices in terms of organizational structures, but on the other hand you can learn a lot ... that's why I find it really positive. (Employed physician 01: 82)

In the end, we are thankful because locum physicians take much of the load off. (Employed physician 03: 262)

In sum, as solo self-employed workers, locum physicians hold a new, more autonomous position within the organization, promoting a reprofessionalization in hospitals. This is due to their changed employment status resulting in the need to keep the locum physician's knowledge up to date and supporting autonomous decisions by being not bound by organizational directives.

Discussion and Conclusions

Summary of findings

Against the background of profound health care reforms, this paper uses the example of locum physicians in German hospitals to analyze how reorganization in hospitals affects physicians' professional practice by considering the physician's employment status (permanently employed vs. self-employed) and analyze how locum physicians cope with conflicting and competing logics of managerialism and professionalism. We start from the assumption that the major changes in the hospital sector promote the accountability and control of professionals, resulting in pressure to conduct and adopt more 'business-like' practices (Carvalho, 2014). More specifically, physicians in hospitals perceive this development as decreasing the quality of their working conditions, and in particular their ability to exercise professional autonomy. The resulting combination of professional and managerial logics of medical work at the organizational level leads to unintended effects. Some physicians changed their employment status, they quit their hospital jobs and become self-employed as locum physicians. In other words, they had become solo self-employed to evade the rivalry of competing logics (Reay & Hinings, 2009) in hospitals and reprofessionalize their medical care through focusing on medical professionalism. They are then (re-)engaged in hospitals and affect organizational practices since they are not subject to management or bound by organizational directives. This finding aligns with the result of Jones and Green (2006) found in their case study on general practitioners in the UK with regard to a higher job satisfaction of locum physicians because their occupational status allows them to do so-called nice work. Adding to the research on hybrid manager-professionals' identity work (McGivern et al., 2015), locum physicians rather support the view of representing and protecting professionalism in hospitals through simultaneously using and integrating professionalism and managerialism at an individual level.

With the help of our research, the phenomenon of locum physicians can be more generally interpreted as an attempt of individuals to reprofessionalize health care by reestablishing professional practice—including the terms of updating professionals' scientific knowledge, autonomy in medical decisions, and economic privileges. Through self-employment they practice a specific form of hybrid professionalism (Noordegraaf, 2015), combining the logics of (self-)managerialism and (medical) professionalism. Consequently, the focus on this form of employment raises the question of the interrelationship between professionalism and managerialism not only on an organizational level but also on an individual level. The employment status is, thus, a key factor which contributes to a deeper understanding of the professional behavior of physicians working in the organizational context of hospitals.

Moreover, when re-entering hospitals as self-employed individuals, locum physicians disturb organizational structures. Standing out of hospital hierarchies, they explicitly promote professional values, such as the scientific foundation and cooperative self-control, allow the organization to make more time for further training of the permanent staff, point to malpractices, and bring in new professional knowledge. In this sense, locum physicians reprofessionalize medical decisions in German hospitals on both the individual and the organizational level.

Conceptual contributions

Through these findings, we contribute to theory by showing how individuals find strategies to manage the rivalry between the competing logics of managerialism and professionalism through leaving the standard form of occupation. Hybrid professionalism (Noordegraaf, 2015) in the sense of an interrelationship between professionalism and managerialism not only exists on an organizational level but also on an individual level. The example of locum physicians reveals that they also have to combine different logics to remain in the market. Interestingly, the relationships between

managerialism and professionalism at the organizational and individual levels were profoundly different: While the introduction of managerialism into hospitals as professional organizations was more controversial, combining managerialism and professionalism at the individual level of solo self-employed was perceived as a way to uphold professional standards and to reprofessionalize. As permanently employed physicians in hospitals, they had to follow the directives of chief physicians and make decisions based on economic criteria. Thus, the engagement of locum physicians in hospitals was perceived as a reprofessionalization on the organizational level since these experts align their medical decisions to professional standards and are able to decide autonomously and without being compelled to follow directions of chief physicians and organizational routines.

Adding to Mintzberg's professional bureaucracy, we can say that the boundaries of these organizations became permeable. In this context, it is not only the organization framing (and redefining) professionalism (Muzio & Kirkpatrick, 2011) but also the physicians who mirror these processes and not only passively adopt but also actively change them. Thus, changes in professional organizations like hospitals not necessarily lead to deprofessionalization since there are obvious chances to reprofessionalize the operative core.

Limitations and future research

Our findings are based on a qualitative study of the effects of changing working conditions in hospitals on the professional behavior of physicians. While we gained valuable insights into a previously under-researched topic, these insights are limited to a highly specific sample. Additionally, we have to take into account the special situation of a labor shortage, which implies lower risk to becoming self-employed as it is unlikely that they get unemployed and focusing on professionalism while being engaged in hospitals. Changes in demand for locum physicians might also negatively affect their capabilities of negotiating favorable and autonomous positions which allow them to defend professional values. Another study limitation results from sampling effects: Due to self-selection effects our sample might have included particularly those locum physicians who uphold high professional standards and not those individuals who are mainly driven by financial incentives to quit regular employment in a hospital.

Future studies should attempt to integrate the perspectives of other professionals in health care, such as nurses, and the patient perspective to gather a comprehensive understanding of locum physicians' professional role in the hospital. In light of an increasing need for multi-professional teamwork (e.g. Gadolin & Wikström 2016) and interprofessional cooperation (Körner et al. 2015) and a trend towards joint education of the health care professions, future research should particularly address how locum physicians can be adequately integrated in interprofessional teams to ensure high-quality patient care. This also raises questions regarding further qualification of the non-physician health care within the German health care system which suffers from a shortage of physicians.

It would also be interesting to observe whether the job of locum physicians will develop as an alternative career path to the classic hospital physician or established physician. Furthermore, a quantitative validation of the results would be worthwhile. Further perspectives would emanate from a replication of our study in other countries to estimate the impact of employment status on hybrid professionalism.

Last but not least, it would be worth looking at a comparison between different countries that both work under DRG conditions and engage Locum physicians.

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The Complexities of Boundaries, Task Claims, and Professional Identity in Teamwork—from Dentists' Perspective

Abstract: This article concerns how dentists in a Swedish dental care organisation conceptualized work division when teamwork was requested by the senior manager and their boundary work in relation to dental auxiliaries. Data were drawn from semi-structured interviews with the dentists. The dentists' made claims to tasks based on legislation and their wanting to focus on tasks that required their expertise. Dental auxiliaries may be reluctant to take on new tasks and become more involved in patient care, which indicates that they have some influence in the work division. Nevertheless, the dentists retained control as their invitation for dental auxiliaries in patient care was based on certain conditions. The dentists' claim to certain tasks may have strengthened their identity as experts and reinforced boundaries between themselves and dental auxiliaries.

Keywords: Boundary work, dental care, identity work, interprofessional teamwork, resistance, power

WHO emphasizes that interprofessional teams are an effective use of health workers because teamwork requires them to operate within the full scope of their profession. This way of working is recommended to meet population needs and to improve cost-effectiveness, quality and access to health services (WHO, 2016). In Sweden and in other countries, government and organisational policies identify teamwork as an effective use of healthcare resources.

Previous studies have shown various professional reactions to the campaign for teamwork. On the one hand, it cannot be taken for granted that professionals will work together without disagreement. The request for teamwork may entail that professionals perceive that certain professional boundaries are under threat, which will lead to boundary work (Fournier, 2000; Liberati, Gorli & Scaratti, 2016; Powell & Davies, 2012; Sanders & Harrison, 2008) that aims to protect and maintain boundaries around tasks (Fournier, 2000). On the other hand, professionals can promote teamwork and cross boundaries. Consequently, individuals from various professions can work closely together in a relationship that is characterized by the intention to do good work rather than by competition (Allen, 1997; Apesoa-Varano, 2013; Carmel, 2006).

In this paper, I focus on how dentists conceptualized work division in a Swedish public dental service (PDS) where teamwork was requested by the senior manager to increase the efficiency of the service. This required dental hygienists and dental

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nurses to be more involved in patient care and to perform tasks that are usually performed by dentists. The focus is on how the dentists' idea of work division had an influence on the boundaries between them and dental auxiliaries and on their professional identity.

Struggle over tasks and the construction of professional boundaries are considered significant in the understanding of the work division in workplaces (Salhani & Coulter, 2009). Classic professionals, such as physicians and dentists, are generally assumed to have more influence on the work division due to their autonomy in patient care and a stronger scientific position than other, more subordinate professions (Brante, 2013; Freidson, 1994). However, subordinates may have some control over work division as they can resist undertaking tasks that are otherwise performed by those in a higher hierarchical position (Apesoa-Varano, 2013; Nancarrow & Bortwick, 2005).

The construction of boundaries is also related to professionals' identity as the construction of identities concerns the differentiation between oneself and others. Identities are significant in what happens at workplaces as they have implications for individuals' behaviour. In organisations, individuals do identity work to create and to maintain a sense of distinctness and a positively valued view of themselves (Alvesson & Willmott, 2002; Alvesson & Sveningsson, 2010). Professionals' ambition to focus on certain tasks and remove less prestigious tasks is one way to maintain or reinforce a positive professional identity. However, individuals who adopt a specific identity may find it difficult to be flexible, which can hinder work being performed in the best ways (Alvesson, 2013).

Boundary work regarding tasks and identities are thus intertwined and have implications for the work division at workplaces. The aim of this paper is to examine the complexities of dentists' boundaries between themselves and dental auxiliaries. In the following sections, I describe the paper's approach as applied to professions and boundary work and to the dental context. Thereafter, I present how the data was collected and analyzed. In the empirical section, I will show dentists' boundary work concerning tasks and identities. To conclude, these kinds of boundary work and implications of these on the work division and the care of patients in dental care will be discussed.

Professions and semi-professions

What constitutes a profession is a debated matter (Brante, 2011). For the purpose of this article, I use the definition of professions as science-based occupations, which implies that professionals integrate scientific principles and findings into a practice, and apply the formally organized theoretical knowledge of a field. Further, lengthy, specialized academic education is necessary to practise, and professionals are required to apply for a licence from the state upon graduation. Professions are characterized as occupations that allow a high degree of autonomy in the daily work. This implies that professionals have a mandate to make choices and decisions about what work they will do as well as how it should be performed and evaluated (Brante, 2013; Freidson, 1994). This general description of a profession is comparable with that of the classic professions (Brante, 2013), such as medicine and dentistry (Adams, 2003; Freidson, 1994; Trathen & Gallagher, 2009). Professionals' work is believed to be of significance for the well-being of individuals and of society. Professionals are supposed to be committed to doing good for others and to be ethical, but they can also strive to achieve their own interests, such as having control over certain tasks (Freidson, 1994).

Classic professions originated in the nineteenth century. The development of the welfare state and higher education in the twentieth century led to an expansion of semi-professions, which include for example nurses, dental hygienists, and social workers. When higher education programmes for these occupations were integrated

into universities, their practices became more science-based (Brante, 2013). The prefix *semi* implies that these occupations do not fully encompass the same characteristics of the classic professions. Important differences for this paper are that (1) a semi-profession's knowledge and authority are subordinate to another profession, which means that the profession is not the primary asset point for the highest knowledge in a field; (2) semi-professions have less autonomy in relation to other professions; and (3) they have been less successful in "closing" their field of work (Brante, 2013). In dental care, dental hygienists were established in subordinate roles in relationship to dentists, which involves a narrower range of tasks that they are permitted to perform when caring for patients (Adams, 2003). Dental nurses were established as assistants to dentists and have less formal education than dental hygienists.

Professional boundary work

Boundary work concerns professions' claim of jurisdiction, that is, the right to perform certain tasks and have control over an area of work (Abbott, 1988). Another term is a professions' scope of practice (Macdonald, 1995). Professions' boundary work is described as the construction of demarcations that establish a professions' control over the scope of practice as a basis for authority and exclusivity (Fournier, 2000). It concerns constructions of differentiation between a group and others with the goals of the expansion or monopolization of authority or expertise as well as autonomy over professional work (Gieryn, 1983).

A professions' jurisdictional claims involve three parts: "claims to classify a problem, to reason about it, and to take action to it: in more formal terms, to diagnose, to infer, and to treat" (Abbott, 1988, p. 40). In healthcare this means that practitioners use their knowledge to evaluate a patient's problem, make a diagnosis and perform treatment. The individuals who make the diagnosis are not necessarily those who perform the treatment; physicians can delegate parts of treatment to subordinates. Professions can make claims on who should see patients first, evaluate their problems, make the diagnosis and determine treatment, and perform treatments. Subordinated professions may want to expand their scope of practice with the aim of greater autonomy, independence and social status (Adams, 2004). In interprofessional competition, the degree of abstraction of a profession's knowledge will have an effect on its possibility to sustain its jurisdiction: "abstraction enables survival" (Abbott, 1988, p. 30).

Boundary work can take place at three types of arenas: the legal system, which can grant formal professional control over tasks; the public media, where professions can build images with the aim to put pressure on the legal system; and the workplace, where boundaries can be blurred and distorted (Abbott, 1988). The focus of this paper is on boundary work at workplaces. At this level, formalized work descriptions do not always matter, and consequently, boundaries between professional jurisdictions can be eroded (Abbott, 1988). Instead, work division in workplaces is established through negotiations of who should do what, when, how and why (Abbott, 1988; Allen, 1997; Powell & Davies, 2012; Svensson, 1996). Work division should be seen as a process of social interaction in which individuals are "engaged in attempting to define, establish, maintain, and renew the tasks they perform" (Freidson, 1994, p. 58).

The room for negotiation in healthcare is limited because the work division is regulated by laws and prescripts that establish the kinds of tasks that professions are permitted to undertake. The state can confer on a profession legal control over a work field through a license to practice (Freidson, 1994; Macdonald, 1995), as is the case with physicians and dentists. However, despite the strength of legal regulations, laws or a licence to practice, a profession may not have total control over certain tasks. Some tasks can be performed by more than one occupation, which opens up

for negotiations in healthcare organisations (Allen, 1997; Svensson, 1996). Professionals can try to expand their scope of practice by taking on more specialized and prestigious tasks, but they can also defend the status quo and resist undertaking new tasks (Nancarrow & Borthwick, 2005; Powell & Davies, 2012). Boundary work can also concern the blurring and crossing of professional boundaries, which in healthcare could result in nurses taking on tasks that fall outside their jurisdiction (Allen, 1997).

In negotiations, professionals can use laws and regulations, which are formal and strong power resources, in order to control the work division (Freidson, 1994). They can also use educational resources, such as degrees, authorization and specialist skills that are needed to perform tasks properly, and treatment responsibility (Freidson, 1986). Professionals can further legitimize their work by emphasizing how it contributes to organisational efficiency and the patient-centred nature of their practices (Sanders & Harrison, 2008).

Professionals' influence on work division

Professions have different possibilities to maintain or to expand their boundaries (Fournier, 2000). Traditionally, male-dominated classic professions, such as dentistry, have had more influence on the work division than female-dominated subordinated professions, such as dental hygienists (Adams, 2003). In workplaces, dominant professionals such as physicians and dentists have influence on work division due to their autonomy in patient care and stronger scientific position (Freidson, 1994; Lipsky, 1980; Hunter & Segrott, 2014; Powell & Davies, 2012), and they are said to control the division of labour (Freidson, 1994; Brante, 2013). Healthcare professionals have the autonomy to decide the content of their work and how it should be performed, as each patient should be treated on individual terms and a special kind of expertise is required to do the work adequately (Freidson, 1994).

Professionals in a dominant position depend on subordinates to conduct daily tasks (Abbott, 1988; Lipsky, 1980). However, they may not want to assign every task to subordinates, but only those that they do not want to perform themselves, such as routine work (Abbott, 1988). These kinds of tasks have been labeled “dirty work” (Hughes & Coser, 1994). As a consequence, professionals in a dominant position will retain tasks they find desirable to perform. Furthermore, when tasks are assigned to subordinates, professionals in a more powerful position tend to control their work (Nancarrow & Borthwick, 2005). No evidence supports the notion that physicians have lost important parts of their monopoly on giving orders to others and supervising others' work. Thus, they continue to be in a dominant position (Freidson, 1994).

Nevertheless, physicians and dentists cannot take for granted that subordinates will take on the tasks assigned to them. Subordinates can refuse to do the tasks they are offered (Lipsky, 1980; Nancarrow & Borthwick, 2005). In other words, professionals, like physicians, can exercise degrees of control over patient care. However, nurses and other subordinate groups have some control as well, as they can thwart orders from physicians (Apesoa-Varano, 2013). Nevertheless, the resistance of subordinates has been interpreted as not based on power. A study concerning the request for interprofessional teams in a healthcare setting showed that nurses' resistance to expand their professional boundaries stemmed from professional and individual weakness and fear, as well as a perceived lack of competence to undertake tasks not usually performed by them on patients (Powell & Davies, 2012).

Identity work

Individuals' claim to tasks can also be explained from an identity perspective. The concept of identity concerns the questions “who am I?” and “what do I stand for?”

(Sveningsson & Alvesson, 2003), which involves what is appropriate, desirable and valued at work for an individual (Alvesson & Willmott, 2002). Identities are not fixed and stable, but rather something that must be worked on. Boundary work is a central part of the construction of identities as identity work involves the creation of a sense of a distinct identity by defining oneself as different to someone else (Alvesson & Willmott, 2002). Identity work may be triggered by everyday forms of stress and strain, for example, complex or problematic social situations (Alvesson, Ashcraft & Thomas, 2008). Requests for teamwork that lead to conflicts about tasks and individuals questioning their roles can lead to situations where individuals' professional identity has to be worked on (Hunter & Segrott, 2014). Undergraduate education plays a role in the development of healthcare professionals' identities by the process of socialization into professional values and norms. This implies that they enter a workplace with ideas of how to perform their work (Freidson, 1994). Individuals from different occupations develop different values about their work that will form competitions for tasks. For health professionals, this can concern what constitutes evidence, safe practice, high-quality patient care, correct patient treatment, and who should carry these out (Powell & Davies, 2012).

To achieve a positively valued view of themselves, individuals tend to describe themselves in more positive terms in comparison with others (Alvesson & Willmott, 2002). In an organisational context, this can mean that individuals attribute themselves positive qualities and credit themselves with contributing to positive outcomes and efforts at work but blame others for shortcomings (Alvesson & Sveningsson, 2010). Professionals can also blame those who they perceive as not doing work in accordance with appropriate norms and values (Frank, 2003). Further, professionals may strive to focus on identity-confirming tasks to maintain or reinforce a positive identity. However, the adoption of a specific identity may lead to inhibition regarding the tasks that must be done if they not fall in line with the identity. As a consequence, patient care can be affected in healthcare organisations (Alvesson, 2013).

The dental context

In Swedish dental care, dentists work with dental hygienists and dental nurses. Dentists complete a longer higher education and possess the widest range of qualifications among dental professionals. They are educated to examine, diagnose, prevent, and treat dental and oral diseases in all dental areas. Some tasks in regard to patients are legally restricted to dentists, who have high degree of autonomy with deciding how to treat a patient. Dentists have to complete a 5-year higher education programme to acquire the necessary theoretical knowledge and practical skills. After graduation, they must apply for a licence awarded by the Swedish National Board of Health and Welfare in order to practise. Due to these characteristics of dentistry, it is classified as a classic profession (Adams, 2003; Freidson, 1994; Trathen & Gallagher, 2009). Dental hygienist training involves a 2- or 3-year higher education programme, while dental nurse training is 1.5 to 2 years long and part of the vocational higher education system. After graduation, dental hygienists are also required to apply for a licence.

Dental teamwork implies that dentists work with “other people with lesser training who are able to carry out delegated tasks not requiring the full range of the dentists' skill and experience” (Harris & Haycox, 2001, p. 354). Teamwork is recommended in a Swedish government report to maximize efficiency in dental care and to increase the availability of dental care for patients. It is recommended that dental hygienists promote oral health, perform preventive procedures and examine patients to a higher degree to relieve the pressure on dentists. Although dental nurses usually assist dentists, they should also perform some work on patients, such as certain preventive procedures (National Board of Health and Welfare, 2011).

Previous studies have shown that dentists agree that dental hygienists can do more examinations and treatments on patients which are usually performed by dentists (Abelsen & Olsen, 2008; Kravitz & Treasure, 2007). Dentists see the benefits of letting dental hygienists carry out preventative treatments, as this allows them to focus on more complex treatments (Nilchian, Rodd & Robinson, 2009). However, dentists can also be unwilling to assign tasks to dental hygienists (Abelsen & Olsen, 2008). In a Swedish study, it was shown that dentists demarcated boundaries in relation to dental auxiliaries by emphasizing their treatment responsibility, specialist knowledge, and autonomy in determining what tasks to perform and how to perform them. However, it was also shown that dentists blurred the boundaries by discussing patient treatments with dental auxiliaries (Franzén, 2012). Studies on dental hygienists have shown that, despite expressing a positive attitude towards an extended scope of practice (Abelsen & Olsen, 2008; Reinders, Krijnen, Onclin, van der Schans & Stegenga, 2017), not all of them want to work in a team with a dentist if it is the dentist who solely decides how the work should be carried out (Candell & Engström, 2009). For dental nurses, encouragement from dentists to take an active and shared role in patient care can be seen as rewarding (Gibson, Freeman & Ekins, 1999). Moreover, dental nurses may want more “hands-on” involvement with patients (Macleavy, 2013).

Thus it is not self-evident how tasks can be divided between dentists and dental auxiliaries. This study is a further investigation of the boundaries between dentists and dental auxiliaries in regard to how dentists in a Swedish dental care organisation conceptualized work division and how their ideas were met by dental auxiliaries. Moreover, it also concerns dentists' identity in relation to their claims to tasks.

Methods

The empirical material of this article is based on a study on the development of teamwork in a Swedish public dental service organisation, which I carried out in 2016. In this organisation, the senior manager initiated a course for dentists to develop teamwork and become team leaders. The course started in 2009 and thereafter was held annually until 2016. It lasted for three days: two days initially and one day six months later. At the second meeting, the dentists' experiences of developing teamwork at their workplaces were discussed. As part of the study, dentists who attended the course were interviewed. The issue of professional boundary work in local workplaces emerged as important during the data analysis; therefore, it became the focus of this article.

Six dentists were interviewed; four women and two men. These dentists were self-selecting, as they had previously answered a web questionnaire that was sent from the organisational strategist in spring 2016 as part of an evaluation of the course. The questionnaire was sent to 26 of the approximately 100 dentists who attended the course and still worked in the organisation. A total of 19 dentists answered the questionnaire, of whom eight were willing to be interviewed. They were contacted by email in September 2016. One of the dentists did not respond, while another one no longer worked in the organisation.

The interviews were carried out by me in October 2016 by telephone. Each lasted for approximately 30 minutes and was recorded digitally and transcribed verbatim. The interviews were semi-structured with open-ended questions concerning the dentists' perception of the course, ideas about work division, and possibilities to realize their ideas at their workplaces. Although the interviews lasted only about 30 minutes, the dentists were able to give much information as the questions concerned well-defined themes. Additionally, telephone interviews tend to be shorter than those conducted face-to-face, but less quantity of data may not imply less quality of data (Irvine, 2011).

For the analysis, I read the transcripts several times. In the reading, it became

clear that some of the dentists' statements about the work division between themselves and the dental auxiliaries were relevant for the issue of boundary work and categories around this issue emerged. In addition, statements that belonged in the categories were identified. The identification of the categories was based on both the empirical data and my knowledge of boundary work. As the issue of boundary work became the focus of the analysis, I returned to the literature on boundary work for inspiration in the subsequent analysis. The result of this reading was that I came across boundary work as a part of identity work, which resulted in the modification of the first framework of categories. This process means that I used an abductive approach, which involves movement back and forth between the data and the reading of literature on relevant theories in the analysis (Graneheim, Lindgren & Lundman, 2017).

Six dentists were interviewed; this may be seen as a small number, which implies that this article has an explorative character. The interviews contained interesting accounts of the dentists' idea of work division and allowed for an illustration of boundary work performed by professionals in relation to subordinates. The results are presented in the following section.

Results

Four themes emerged showing the dentists' perspective of work division and how these perspectives influenced the boundaries between themselves and dental auxiliaries and their professional identity.

Dentists as gatekeepers and trail blazers

All the dentists emphasized they were willing to involve dental auxiliaries in the care of patients. However, dentists focused primarily on the role of dental nurses as their role would likely be more affected than that of dental hygienists'. Dental hygienists work on their own with patients within their scope of practice. Dental nurses can be employed to primarily assist dentists, sterilize instruments, and work in the reception. The dentists pointed out that they were willing to let dental nurses take part in the examination of patients, realised through asking patients about their medical history, diet, and use of fluoride. One dentist explained how tasks could be divided in the examination of a patient:

When it is an examination, they [dental nurses] take in the patient [to the treating room] and start asking questions about the patient's diet and oral hygiene and whether they use fluoride and such things. Then I come in, take a look in the mouth and evaluate which X-rays needed to be taken and then I go out and they take the X-rays. Thereafter, I come back, look at the X-rays, examine the patient, and explain the oral health status; and then finally, the dental nurse polishes the patient's teeth. So, there is some division of work. (Dentist D)

Dental nurses may also be involved in the treatment of a patient. Dentists remarked that dental nurses could, for example, take impressions, provide permanent and temporary fillings, provide local anesthesia, and perform preventive procedures. However, the tasks that dental nurses and dental hygienists are allowed to perform are restricted by national regulations. The dentists seemed to be aware of these restrictions and did not blur the professional boundaries by assigning tasks to nurses that they are not allowed to perform. Nevertheless, one dentist pointed out:

If you look at how dental nurses are constrained by the National Board of Health and Welfare, it is not really very much. They can do a lot. (Dentist B)

Another dentist emphasized that dental hygienists should only perform tasks that are within their scope of practice and not those that are restricted to dentists:

The dental hygienist wanted to drill, and I did not think that the dental hygienist should do that. (Dentist A)

Dentists explained that the assignment of tasks to dental nurses means that dentists can rid themselves of routine tasks and focus on more complicated patient treatments. One dentist described the opportunity to focus on tasks that were regarded as being at the core of dentists' competences as an important reason to involve dental nurses in patient care:

It is hard to do everything myself, and it is nice when the dental nurses can be helpful in the treatments so I can focus on the diagnostic. I should certainly delegate injections more; that is something I feel would be good to get rid of.

Interviewer: What benefits can you see from that?

It will save me time. I can plan the treatment and spend time on things that I should do – medical records, and go through them and, well, do therapy plans and prepare a little for the treatment. (Dentist E)

Thus, dentists maintain a boundary between themselves and dental hygienists based on differences in their competency and in the regulations that stipulate how tasks should be divided in dental care. They did not let dental auxiliaries cross boundaries and work contrary to legal regulations.

Dentists as supervisors

It was evident that dentists had reservations about assigning certain tasks to dental auxiliaries before being certain of their competency. The differences in the dentists' knowledge skills compared to those of the dental auxiliaries could lead to the former not allowing dental nurses and dental hygienists to work without supervision unless they were satisfied with the level of competency. Some of the dentists related the importance of being sure that dental nurses and dental hygienists are qualified to perform the tasks assigned to them and of having control over the treatments that were performed by the others. One dentist spoke of a conflict with dental hygienists who wanted to perform a task that the dentists did not think they should:

There was a dispute about the matrix band [around the tooth that should be restored]. They [dental hygienists] wanted to try first themselves, but I thought they were not really ready for that. They had tried, but the contact with the adjacent teeth had been poor. So, then I wanted to be in control for a little longer. (Dentist A)

Another dentist explained that as long as you have control over dental nurses' work there are no problems assigning tasks to them:

I have control over everything that happens – what happens in the room. My dental nurses do not do anything that I do not check afterward. So, it does not feel like I can miss anything. (Dentist C)

Dentists further explained that controlling dental nurses' work was important to determine quality work, and to ensure they work in accordance with the dentist's view of how it should be performed. This criterion should be met before giving dental nurses some degree of autonomy.

It is about trust. Even if I know that they are capable, I do not know if they do

things my way. I cannot sign notes in a medical record and stand behind a job when I do not know if it was performed in a proper way. First, I want to see how they work. If I have seen that they can, then I let it go. Then I have no problems. (Dentist F)

Another point of emphasis was the importance of working with the same dental nurses to ascertain their competence and thus have confidence in their abilities.

It is very important. I always work with the same two dental nurses. I know what they can [do]. I have taught them, and we trust in each other, so it is the best way. (Dentist C)

In other words, dentists constructed boundaries based on the view that they need to control the work of dental auxiliaries to be sure that they did good work. They also emphasized that they were in a position that gives them the right to evaluate the quality of the tasks performed by the others.

Dentists met with resistance

All of the dentists remarked that they wanted to assign tasks to dental nurses as it was an efficient way of working. They explained that it reduced patient queues, which increased the availability of dental care and prevented aggregated oral health for the patients. For example, two dentists explained:

We have long queues, and we work much quicker when we work in teams in examinations. So it is very efficient. (Dentist E)

It is to be efficient. We have too many patients in relation to the staffing level at the clinic. We have long queues, so the benefit for patients is that they can get an appointment earlier, and at the same time the finances [at the clinic] will be better. (Dentist D)

Another reason to assign tasks to dental auxiliaries was to eliminate unwanted tasks. In return, as one dentist said, dentists could focus on tasks they saw as more fun to take on. This dentist had experienced at another dental clinic how the work division led to time for more treatments that were in line with the dentists' interest, which was appreciated:

It was me, one dental hygienist and two dental nurses, so I could work more in teams. When it came to fillings and examinations, we did that in teams. This meant I gained time for root fillings and prosthodontics, which I found more fun to do. (Dentist A)

Another motivating factor for dentists to assign unwanted tasks was to gain competence development by focusing on complicated tasks:

The biggest opportunity is that I will get more time for complicated patients, and then I will get competence development. You always think of yourself first. I am afraid it is so. I think that if I will be successful, I will be motivated to do it. (Dentist B)

However, all the dentists except Dentist F disclosed that they could not assign tasks to the extent that they wanted due to resistance from dental auxiliaries. For example, some dentists said that though dental hygienists were accustomed to working on their own with patients, some of them were not prepared to perform tasks other than usual. Dentist B explained that dental hygienists and dental nurses may prefer to work as

usual and be “more traditional”. For instance, dental hygienists may prefer to perform preventive dental care and dental nurses may primarily want to assist dentists. Similarly, another dentist pointed out that dental nurses may prefer to assist dentists and may not be willing to work on patients. Reasons for this may be not wanting to work alone and not seeing themselves competent enough:

Dental nurses who work in teams must have the competence. They must be able to perform fillings and they must be willing to work on their own, [but] not everyone wants to do that. Maybe [they] just want to assist. There are individuals like that. (Dentist C)

According to one dentist, dental nurses may be afraid of taking on new tasks and may feel forced into doing so:

You notice that there is no interest; they do not dare to examine [a patient]. Many do not dare and do not really want to, but they do not say anything. But if you talk one-to-one with them after you have worked in a team, they are relieved that it is over. (Dentist A)

Similarly, dental auxiliaries' unwillingness to undertake more tasks may be due their self-confidence in taking responsibility. One dentist pointed out:

It is rather mostly the personality. [They may ask themselves.] How secure [do] I feel about myself? How much [do] I like to try something new in my life? (Dentist D)

The lack of interest among some dental nurses in undertaking new tasks was further interpreted as a fear of being given heavier workload:

Many of the dental nurses did not think that teamwork was as fun as we [dentists] thought. They did not want to do more than necessary, so to say. (Dentist E)

The good and the bad

To achieve desired work division, dentists related that they were willing to educate dental nurses to develop their competence, and as a consequence, increase their self-confidence. All the dentists informed that they willingly educated dental nurses by explaining how to perform tasks on patients or by guiding them in their clinical training. One dentist outlined how dental nurses could be educated:

I have initiated an education for dental nurses and educated [them]. We have been through X-rays, temporary crowns, impressions and so on. After every learning component, I sit and evaluate and talk with them about what has been good and how they can try to learn from each other. (Dentist B)

However, some dentists found a number of dental nurses not wanting their advices or wanting to develop their competence, which was described as frustrating:

I made a schedule to train them. I have tried during treatments of patients to perform tasks together [with dental nurses] so they can see that they really can [do it] and that it is not as difficult as they thought. We tried to do it in different ways so it should be fun and that one feels important – that you do something more than before. Sometimes, we succeed and sometimes it feels like [the nurses think] “we don't want to”. (Dentist D)

I want to guide. I want to educate. I want to explain. I want to show. Some dental

nurses want to listen, but others do not. (Dentist F)

I offered to sit and show them [the dental nurses] how to do it, but no, they did not want to work in teams. (Dentist E)

Thus, dentists blamed some dental auxiliaries for being unwilling to develop their skills and, consequently, not being competent or self-confident enough to undertake new tasks. In contrast, dentists credited themselves for being willing to educate dental nurses and contribute towards developing teamwork in the workplaces.

Discussion

The need for interprofessional teams in healthcare worldwide is emphasized on both political and organisational levels. However, it may not be clear how professionals conceptualize teamwork and how their ideas of teamwork influence the boundaries between themselves and the subordinates. Based on the dentists' idea of the best way to divide the work, this paper explored dentists' boundary work in relation to dental auxiliaries in an organisation where teamwork was required by the senior manager to increase efficiency. The focus was on dentists' boundaries that concerned both their claims to tasks and the construction of a professional identity, as these kinds of boundaries are intertwined (Alvesson, 2013).

All the dentists in this study emphasized that they support working in teams as it gives them an opportunity to focus on the tasks that they prefer to do when caring for patients. Further, dentists constructed boundaries around tasks which only dentists are permitted to do and which require their specialized knowledge and skills. The work division was justified by referring to dental work regulations: dentists clearly emphasized that they did not let dental hygienists and dental nurses cross the regulated lines and blur the boundaries. Regulations are formal and strong power resources to be used by professionals in negotiations to support their interests (Freidson, 1986). However, the dentists' claims to tasks can also be seen in the light of the power of professionals' abstract, academic knowledge to exclude subordinates from doing tasks (Abbott, 1988). During undergraduate education, dentists learn abstract knowledge and technical skills that give them the right to perform certain tasks that can be perceived as the core of dentists' practice, which the dentists in this study sought to defend.

Dentists emphasized the importance of supervising tasks carried out by dental nurses after the tasks had been assigned. They pointed out their treatment responsibility, which is another power resource that professionals can utilize (Freidson, 1986). The dentists' accounts indicated that they saw themselves not only as responsible professionals who must ensure safe and high-quality dental care but also as professionals in a position that gives them the right to decide which tasks dental auxiliaries should do. Moreover, it confers upon them the right to assume the role of supervisors. The dentists' accounts fall in line with the assumption that professionals like dentists are in a position to have more influence over work division than subordinates (Brante, 2013; Freidson, 1994). Consequently, this study did not indicate that dentists have lost a dominant professional position. Furthermore, the focus on more specialized tasks, which dentists can do when dental auxiliaries are carrying out other tasks on patients, can be seen as securing a professional position (Van Bochove et al., 2018).

However, in line with previous studies (Apesoa-Varano, 2013; Lipsky, 1980; Nancarrow & Borthwick, 2005), this study showed that it should not be taken for granted that subordinates will accept the tasks that they are assigned. The dentists in this study were met with both willingness and resistance by dental auxiliaries. In particular, they discussed dental nurses who were unwilling to be more involved in patient care. According to the dentists, the resistance from the dental nurses stemmed

from several reasons, such as the fear of not being competent enough to undertake treatment tasks. It is unsurprising that dental nurses may be insecure about new tasks, as mistakes can have severe consequences for patients. Nurses in medical care can be reluctant to assume new tasks due to concerns about potential side-effects for patients, especially with treatments they are not used to performing (Powell & Davies, 2012). Consequently, as shown in previous studies, this study demonstrated that even if professionals have the power to decide about the division of work, subordinates may have some influence. Boundary work not only concerns professionals' and subordinates' aspirations to expand their scope of practice, but also the defence of the status quo or resistance to new tasks (Nancarrow & Borthwick, 2005; Powell & Davies, 2012).

The dentists credited themselves with being in favour of teamwork to increase the availability of dental care for patients and to help dental nurses in their skill development. However, they placed blame on dental auxiliaries who did not want to take on new tasks or develop more skills. In other words, dentists credited themselves for positive efforts at work and blamed others for shortcomings, which is a common way to achieve a positively valued identity (Alvesson & Sveningsson, 2010). Furthermore, the dentists' eagerness to concentrate on certain tasks can be interpreted as a way to focus on identity-confirming tasks in order to maintain or reinforce a positive professional identity, such as experts. However, the desire to maintain an identity may be at the expense of smooth work division (Alvesson, 2013), as the work has to be done by someone. Taking good care of patients did not seem to be a lesser priority than the dentists' personal interests regarding work division. One reason may be that professionals' identity construction begins during their undergraduate education through socialization into professional norms and values that emphasizes the ethical aspects of work to do good for others (Freidson, 1994), such as for patients.

A limitation of this study is that it only concerns the dentists' idea of teamwork and how they experienced dental auxiliaries' responses to the invitation to take part in patient care. The dentists' understanding of the others' position may differ from the others' view on how patients should be treated and by whom. Therefore, further research is needed to gain more knowledge of the views of dental hygienists and dental nurses on dentists' ideas of work division. There is also need for further research on work division and dental professionals' boundary work in practice.

Although this study concerns dental care, it may also be of interest in other contexts. Individuals within a classic profession are supposed to control the work division, but subordinates may assert some influence through resisting undertaking new tasks. However, as this study shows, within healthcare differences still remain in the power dynamic between professionals and subordinates. Dentists still have a high degree of autonomy in patient care and their invitation for dental auxiliaries to become more involved in patient care was based on the dentists' conditions. One must also take into account differences between contexts that may occur when conducting further research into how professionals conceptualize interprofessional teamwork.

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Martin Whiting, Stephen A. May and Mike Saks

Social Closure and Veterinary Professionalization in Britain: A Self-Interested or Public Interested Endeavour?

Abstract: The professionalization of veterinary medicine in Britain has been little studied by sociologists, although as a classic instance of an occupation that has achieved exclusionary social closure it merits examination from a neo-Weberian perspective. Therefore, this paper explores how it has attained this position through state action in an historical and contemporary context using neo-Weberianism as a theoretical lens. In charting the different stages and forms of professional regulation in veterinary medicine, group self-interest is identified as a central driver, following the neo-Weberian idiom. However, contrary to the position adopted by some neo-Weberians, the professionalization process is seen as being more complex than simply being interest-based, with the public interest being upheld. As such, through the case of veterinary medicine, it is claimed professional self-interests and the public interest can be co-terminous and mutually achieve a dynamic equilibrium. They do not have to form part of a zero-sum game.

Keywords: Neo-Weberianism, professionalization, public interest, self-interests, social closure, veterinary medicine

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This article provides a macro-level discussion of veterinary professionalization in Britain. Although this has been interestingly addressed in other countries (e.g. Elvbakken, 2017; Kjæmpenes, 2018), the professionalization of veterinary medicine in Britain, focused on non-human animals, has been largely neglected by sociologists, with very few exceptions (e.g. Carr-Saunders & Wilson 1933; Hobson-West & Timmons, 2015). This is surprising as it was one of the first professions to gain formal government recognition in this country—and has latterly become a classic self-regulated profession like law and human medicine (see e.g. Burrage, 2006; Saks, 2015). This paper examines the various stages of the state-sponsored professionalization of veterinary medicine in an historical and contemporary setting. The research question here is that of the balance between the self-interests of veterinarians and the public interest in this process. Although the analysis in this short article can only be indicative, it hopefully provides some theoretical and empirical illumination on this issue.

It is argued from a neo-Weberian perspective that a central driving force, amongst others, has been the collective self-interests of veterinarians. It is claimed here, though, that—in a manner that has implications for the wider study of the sociology of professions – the development of veterinary medicine as a profession is complex and can also be seen to have served the public interest as an important part of its legitimation. In considering the altruism of professional groups, many neo-Weberian

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sociologists have suggested that the pursuit of self-interests necessarily runs counter to the public interest (e.g. Elliott, 1972; Perucci, 1973). However, following Saks (1995) and based on the study of the professionalization of veterinary medicine, it is stressed that this may not always be the case; in other words, professional self-interest and the public interest need not be in tension and, even when they are, can be helpfully pursued in tandem.

The early theoretical context: Taxonomy and its critics

Early approaches to understanding professionalization were based on the taxonomic approach highlighting the uniquely positive characteristics separating professions from other occupations (Cogan, 1995). The trait variant of this approach listed attributes, such as esoteric knowledge and high educational levels, in defining professions, which were used to justify the attainment of professional standing (Millerson, 1964). Critically, in this context, professional altruism—in which professional groups subordinate their self-interests to the public interest—was heavily emphasized (e.g. Greenwood, 1957). This was accentuated in the more theoretically sophisticated functionalist approach which explained professionalization largely in terms of the public interest. Here it was argued that a functional trade-off occurs; high socio-economic privileges were given to professions in return for ethical, non-exploitative control of knowledge of great importance to society (e.g. Goode, 1960). This is developed further by Wilensky (1964) who argued from the study of eighteen occupational groups in the United States that there was a “natural history” of professionalization. Such development begins with training schools increasingly associated with universities and the creation of professional associations and ends with rules eliminating internal competition and formal codes of ethics.

The taxonomic approach, however, has been criticized for being ethnocentric and ahistorical (Johnson, 2016). As Abbott (1988) observed in his critique of Wilensky’s “natural history” of professionalization, the regular sequence he outlined may empirically fit some American professions, but not organization-based occupations like the clergy and some British professional groups. In addition, such assumptions as unidirectionality, independent professional development and the homogeneity of professions can be challenged in a world made up of stakeholders with conflicting power and interests. The self-fulfilling sugar-coated image of professions that trait and functionalist contributors conveyed was also attacked. Indeed, Roth (1974) felt they were deceived by professions whose dominance they legitimated. More generally in the 1960s/70s, counter cultural critiques came from disparagers of professionally-inspired scientific progress (Roszak, 1995). Given the coalescence of the taxonomic approach and the public-facing ideologies of professions, such sociological contributors reflexively shored up the professional establishment (Saks, 1995)—unless employing the concept of a profession as an ideal type to judge reality (e.g. Parsons, 1949).

The resonance of such theorizing with professional ideologies was apparent across a range of such groups in the Anglo-American context—not least in relation to the service ideal central to most professional codes (Saks, 1995). In veterinary medicine in Britain, on which this paper is focused, a commitment to the public interest has remained embedded in its accountability through government, including in promoting the wellbeing of domestic companion and farmed animals. This has undergone several iterations historically driven by various social, economic, scientific and technological shifts (Woods, 2013), but is currently stated on the website of the professional body as follows:

As the Royal College of Veterinary Surgeons (RCVS), our role is to safeguard the health and welfare of animals committed to veterinary care through the regulation of the educational, ethical and clinical standards of veterinary surgeons and

veterinary nurses, thereby protecting the interests of those dependent on animals, and assuring public health. We also act as an impartial source of informed opinion on relevant veterinary matters. (RCVS, 2012a)

This is reinforced by the Code of Professional Conduct (RCVS, 2012b) which outlines the acceptable boundaries of professional behaviour in terms of the “public interest”. There are many ways that the veterinary profession could be seen to have served the broader public interest—from fostering a safe and stable food supply to the control of infectious diseases (Woods, 2011). The public affected here span from human food consumers to farmers wanting efficient animal health care and companion animal owners seeking welfare enhancement for their pets (Whiting, 2016). However, as previously noted, a major flaw of taxonomic work is that professions like veterinary medicine were usually assumed, rather than demonstrated, to perform this role, in accord with their professional ideologies. We argue here that this issue is better addressed through the currently more fashionable neo-Weberian approach.

The neo-Weberian approach and the veterinary profession

As suggested above, professionalization may also be linked with the interplay of group as well as societal interests in veterinary and other professional fields. This may make a neo-Weberian approach more applicable. The neo-Weberian perspective on professionalization is based on groups gaining exclusionary social closure in a competitive marketplace, underpinned by the state (Saks, 2010). This is seen to result from professions exercising their interests in obtaining and maintaining monopolistic legal regulatory mechanisms excluding outsiders—leading to increased income, status and power. Here the outcome hinges on occupations convincing key state officials of the merits of supporting such closure in terms of public protection and other factors. While there are many forms of direct/indirect exclusionary social closure, it is typically based on market control, in which conditions are regulated in their favour, facilitating collective social mobility as exemplified by the case of medicine in Britain (Parry & Parry, 1976). As Parkin (1971) observes, social closure is founded on self-maintained, exclusive registers of qualified practitioners—entry to which is gained by obtaining specified credentials controlled by the profession.

The advantages of the neo-Weberian perspective over the taxonomic approach based on defining a profession in terms of exclusionary social closure are manifold. As Saks (2012) notes, it strips away in-built assumptions enabling the relationship between professions and society to be examined other than by the reflexive benevolence of trait and functionalist writers. It also enables a more systematic empirical analysis of the nature and role of professional groups without the strait jacket of taxonomy. This is not to say that a neo-Weberian approach is without problems in application. These include a frequent lack of empirical rigour in implementation and making overly denigratory claims about professions—in which the unsubstantiated positivity of taxonomic writers has been supplanted by unsupported negativity. However, these issues relate more to the operationalization of the framework than a fundamental flaw in approach in a fast-changing socio-political context (Saks, 2016).

This also applies to the way the state has been conceptualized in neo-Weberian work on the professions. As Adams and Saks (2018) note, although some neo-Weberians have a more subtle view of its operation, it is often presented as a black box passively influenced by self-seeking professional groups, in which state decision-making is not typically examined. As with other aspects of its application, neo-Weberianism centred on the abstracted notion of exclusionary social closure must be differentiated from Max Weber’s own work (e.g. Weber 1968), which offers a more incisive and complex analysis of the values, interests and ideals of actors in policy formation, including those linked to the state as a bureaucratic body strongly dependent on expert advice. This is illustrated by Saks and Adams (2019) in examining

the passing of the 1858 Medical Act in the House of Commons in Britain that effected the social closure of the medical profession.

The concept of state-sanctioned social closure in the market certainly applies to veterinarians in Britain too. Veterinary medicine has won direct market control of almost all veterinary services, and is a self-governing profession. Moreover, its Codes of Professional Conduct underline the unequal power distribution between veterinarians and consumers, and the ability of the profession to offer services that professionals believe are in the clients' interest. MacDonald (1985) says the highest level of state-underwritten exclusionary social closure in Britain occurs with an Act of Parliament, within which the title to and/or membership of the professional occupation are described. Protection of work domains is gained by statutory governance, and services may only be provided by those on the register. This final stage is considered to be the ultimate step in social closure found only in professions of greatest significance to the public interest. This is precisely what veterinary medicine has achieved through its legal monopoly power to treat animals, powers which extend beyond those of medicine in treating human beings (Whiting, 2016).

The history of how the veterinary profession gained these powers in Britain through professionalization will now be documented from a neo-Weberian perspective—using published research that often draws on archival material, including parliamentary records. In so doing, we can penetrate further into the “black box” of state-profession relations. In charting the history that follows, particular attention will be paid to considering the role of the collective interests of veterinarians in bringing about such change. There are many different definitions of “interests” at a group level. As Saks (1995) has documented within a neo-Weberian framework, a number of attempts to operationalize this as an empirically contestable concept are flawed. For example, the positivist approach, linked to the earlier taxonomic analysis of professions, holds that interests equate to subjectively expressed preferences. However, this rules out, amongst other things, groups mistaking their interests and the influence of other sources of power (Lukes, 2005). To sidestep this difficulty, the paper defines group interests in terms of the balance of objectively assessed benefits, as opposed to costs, of an action or policy in terms of income, status and power in specific socio-historical circumstances.

This is contrasted with the wider “public interest”, an even more slippery concept that Rosenau (1968) believes should be simply viewed as an ideological datum to be examined in political debates. Following Saks (1995) again, in operationalizing this notion more objectively, we must avoid defining it in unnecessarily constraining unitary terms that do not allow conflict with other interests, as well as in terms of the rather too simplistic preponderance accounts based on the “greatest good of the greatest number” that prejudice the rights of minority groups. Recognizing the public interest is a normative concept, it is argued that it can best be viewed as centred on outcomes according with the common values prevalent in a given place and time. Thus, over the past two or three centuries in Britain, the public interest may be seen as any action or policy advancing the particular configuration of three key principles of the liberal-democratic state—freedom, justice and the overall welfare. This definition also means that decisions made by government itself are open to scrutiny. In this framework the pursuit of group self-interests may or may not ally with the public interest, which opens up to empirical consideration the analysis of the professionalization of veterinary medicine. This is now discussed in each of the four watershed moments that have defined its development.

The attainment of a Royal Charter for veterinary medicine by 1844

The initial stage of the professionalization of veterinary medicine saw the establishment of a Royal Charter in 1844 that acted as a crucial stepping stone for the attainment of statutory regulation towards the end of the nineteenth century in Britain from a neo-Weberian perspective. Here it should be remembered that many occupations

have had great difficulty in obtaining social closure. This included medicine itself for which several bills were put forward to Parliament before the 1858 Medical Act was passed (Waddington, 1984). The process is therefore complex, amplified by the need to battle with a range of protagonists in order to eventually gain a legal monopoly (Macdonald, 1985).

This was very true of the veterinary profession, which had to struggle to gain its Royal Charter on the path to social closure against a number of competing groups, as well as deal with the internal strife that threatened to derail its ambitions (Whiting, 2016). This underlines that understanding exclusionary social closure is not just about a particular occupation progressively carving out its unique identity and work domain, as suggested by Wilensky (1964). It is also a struggle which is both intra- and extra-professional that often leads to compromise and incorporation in a socio-political climate where regular shifts occur in such areas as the value placed on animals, technological capability and the political orientation of the state.

As Whiting (2016) documents, the origins of the veterinary profession in Britain began with the founding of the Veterinary College in London in 1791 (Cotchin, 1990) which was later to become, under Royal Charter, the Royal Veterinary College (RVC)—followed by the establishment of further schools in Edinburgh and elsewhere (Pattison, 1984). Although it is debatable whether the farriers or their employers had the first vision of a veterinary profession, the Odiham Society accelerated this process. The Society was founded in 1783 to encourage agriculture and industry and shortly afterwards extended its remit to enhancing the scientific study of anatomy, diseases and cure of animals—especially horses, cows and sheep.

The early evolution of the veterinary profession alongside medicine was far from being one of linear growth and progressive development as sometimes depicted—not least as their paths socially, culturally and epistemologically fractured over the period 1815 to 1835 (Woods, 2017). In the first half of the nineteenth century as veterinarians sought an independent route to that of human medicine, those qualifying from the now Chartered Royal Veterinary College competed for professional standing against graduates from Edinburgh, as well as outsiders calling themselves animal doctors, farriers, and cow leeches (Woods & Matthews, 2010). The initial education arrangements were followed by growing university involvement, particularly from the first half of the twentieth century onwards. This battle in the marketplace between two sets of College-trained and untrained people treating animals ultimately led to the formation of an independent professional body, and the start of the social closure of the profession, which was finally completed in 1966.

In this respect, Whiting (2016) relates that the market for the public to choose who could treat their animals was open in the early nineteenth century. There were no specific regulations or laws regarding claims of medicinal powers over animals. Treatments of any sort could be administered by anyone without evidence of competence or information on associated harms. The public had to gamble their trust on the person they paid for successful outcomes based on their judgements about value for money and quality assurance. However, 1844 saw the start of a dramatic increase in professional regulation of veterinarians with the Royal Charter, which was pivotal in gaining statutory protection of the title of Veterinary Surgeon in 1881 (Pattison, 1984). Although several factors were involved in a shifting marketplace of reform and a variety of outcomes were possible in achieving wider professional goals (Woods & Matthews, 2010), the history of social closure of the veterinary profession at this time demonstrates how veterinarians fought for their rights to engage in commercial veterinary activities to enhance their interests in terms of income, status and power. At the same time, though, the government could be seen to be navigating a path aimed at protecting the public interest, in face of claims by the emerging profession that its competitors were “ignorant” and “incompetent”.

Perforce, the first Royal Charter for the veterinary profession was granted in 1844. Royal Charters tend to be reserved for organizations and regulatory bodies that are specifically held to work in the public interest. In order to gain a Royal Charter,

granted by the reigning monarch under the authority of the Privy Council, an organization must demonstrate pre-eminence, stability and permanence in their particular field. Other historic examples of Royal Charters are found in professional regulatory bodies such as the Royal College of Physicians (1518) and the Law Society (1845).

As Hall (1994) recounts, the route to obtaining a Royal Charter to establish the self-regulating Royal College of Veterinary Surgeons (RCVS) was not straight forward. By the early nineteenth century those qualifying from the Veterinary College in London were at best described as of low standard, following the decision of the Principal to reduce training from three years to three months. By the 1830s, members and friends of the emerging profession were starting to criticize the quality of more recent College-trained veterinarians in *The Veterinarian* and *The Lancet*. Some saw the need to uphold standards at the same time as distinguishing themselves as an educated elite.

This move for a Royal Charter to shift power away from the “autocratic and anachronistic” order of the Veterinary College in London was also encouraged by attempts by surgeons and apothecaries to unify training in medicine (Hall, 1994; Whiting, 2016). Petitioning began in 1839 for a Charter to protect the public from “illiterate and uneducated” practitioners and give veterinarians the same privileges and exemptions of other parallel occupational bodies. A long series of letters, meetings and dinners eventually led to the successful submission for a Royal Charter for the profession. This Charter united those qualifying from veterinary schools in gaining initial professional standing, with the RCVS granted a Coat of Arms with the appropriate motto *Vis Unita Fortior* (United, our strength is greater) (Porter, 1994).

This unity of veterinarians was vital in reaching this key staging post in the professionalization process which advanced their collective interests. But no sooner had the RCVS been established, the veterinary schools in London and Edinburgh were in disagreement (Whiting, 2016). The RCVS had limited powers at this point; it did not control education at the various schools, although it set its own membership examination—a tradition continuing as the “one portal” examination for non-degree-holding members of the profession until the 1948 Act. This examination allowed membership of the RCVS, granting insider standing in the profession.

However, as Porter (1994) observes, there were no provisions in the Charter to limit the practice of outsiders, and it was not unlawful for them to style themselves as veterinary surgeons—the professional name used in Britain that describes those labelled as veterinarians in most other countries. Nevertheless, for all its weaknesses and the bitter rivalry between London and Edinburgh, the 1844 Royal Charter was the start of the exclusionary social closure of the profession. The privileges of being a profession were associated with MRCVS standing, which was to be embellished further with the first Veterinary Surgeons Act in 1881 that represented the next watershed in proceedings in Britain.

The social closure of the profession through the 1881 Veterinary Surgeons Act

Before the 1881 Act there were many references in Hansard to veterinarians following the first use of this term in the mid-seventeenth century, particularly in providing advice to government. But, as Whiting (2016) observes, what was missing—despite the Royal Charter—was a defining criterion of what constituted a veterinarian. This did not appear until the first bill was introduced through the House of Lords in 1866. This controversially set its objective to limit the title “veterinary surgeon” to only those who had obtained the diploma in veterinary medicine from the RVC in London. In the Commons debate, though, it was proposed that the title of veterinary surgeon be linked with members of the RCVS more generally, rather than simply practitioners qualified from the RVC. The proposed bill was cited as a means to promote and improve the veterinary education system, which had at the time done a great deal to resolve the problem of cattle plague.

There was a strong public interest in having only those who were properly qualified in identifying themselves as a trusted source of information. Although only one voice amongst many, Mr Newdegate illustrates this well when he stated in the debate:

No obstacle had interposed more constantly, or tended more directly to defeat this attempt [to raise the standard of education] than the fact that the education after it was completed brought with it no distinction, so that the uneducated as well as the educated appeared before the public with equal claims so far as appearances were concerned, as many as chose, however unqualified, adopting the denomination of veterinary surgeons. (Hansard, 1866)

In terms of the public interest, though, other Members of Parliament felt that veterinary science was still too young to warrant protection of title and the regulatory structure was not sufficiently well established in terms of the knowledge base, especially given the problematic leadership of the RVC in London in the award of diplomas. The 1866 bill was therefore withdrawn.

However, parliamentary debate continued about the standing of the MRCVS. Further power was granted to the RCVS in 1878, when refining the wording of the Contagious Diseases of Cattle Bill which included the term “veterinary surgeons”. During a lengthy discussion, it was decided that rather than leaving the qualifying criterion of an inspector as a graduate from the various schools, all veterinary surgeons should be members of the RCVS (Hansard, 1878). The first legislation to protect the title of veterinary surgeon was finally passed in 1881 through the Veterinary Surgeons Act which was strongly linked to raising the standing of the veterinary profession (Pattison, 1984). As such, it advanced the interests of veterinary surgeons in driving up their income, status and power, while increasing the number of trained veterinarians to help address the supply issues surrounding the Contagious Diseases (Animals) Act 1866.

This 1881 Act therefore promoted the public interest, as well as professional self-interests, by enhancing the general welfare. The public interest aspects of professionalization were reinforced by the recognition that many other persons were practising who were “utterly unfitted” to do so and were inflicting an “immense amount” of cruelty on animals, while the educational standards of veterinarians were rising. Although this did not yet fully protect their domain of work—others could still perform work on animals, but could not claim to be veterinarians or be paid for their labours—it did enable the public helpfully to distinguish between formally qualified and unqualified veterinarians in a de facto form of closure in neo-Weberian terms. At the same time, the public could still choose to receive animal treatment from non-veterinarians, even if only insiders were allowed to say they were qualified in veterinary medicine.

The establishment of full exclusionary social closure by 1966

This brings us on to the third watershed stage of development leading to the full exclusionary social closure of the profession in Britain. The main contours of a further dynamic, turbulent and complex period of professionalization facilitated by the wider socio-political context are set out below. As Pattison (1984) relates, the 85 years following the 1881 Act saw ten further major amendments or new Acts relating to veterinarians. These resulted in the full social closure of the veterinary profession in both title and deed by 1966.

Throughout this period, the public could continue to diagnose, treat and advise on the health and welfare of animals. However, minor legislative limitations were gradually imposed that restricted who may undertake certain actions as “veterinary surgeons”. For example, the Veterinary Surgeons (Amendment) Act 1900 refined when the term “veterinary” could be legitimately used, by preventing its employment

by outsiders in conducting operations, giving advice and/or attending animals. Although the RCVS could still not prohibit non-veterinarians from practising, they did encourage all qualified veterinarians to place themselves under its regulatory structure. The RCVS also gained the power to regulate veterinary businesses, as well as individual members. This allowed it to discipline and bring action against businesses illegitimately undertaking acts of veterinary surgery or claiming to do so. However, this power was short lived, as it was rescinded in the Veterinary Surgeons Act of 1948.

From 1948 onwards, as Whiting (2016) observes, the RCVS could only regulate individual members of the profession, and not their employers nor any businesses that may undertake veterinary surgery. The 1948 Act also began the process of social closure of veterinary actions. This included all operations and treatment, except minor procedures. In addition, like the 1881 Act before it, the 1948 Act opened up a second supplementary register of “veterinary practitioners” held at the RCVS containing the names of people “grand parented” into the veterinary profession who had been practising for at least seven out of ten years previously. Those who were on the Supplementary Register were given the same rights as veterinarians, such as prescribing rights. However, it was formally possible to refuse entry to the Supplementary Register, if ascribing rights to the individual practitioner would be prejudicial to the public interest.

Any member of either register who was disciplined or refused entry was able to appeal, albeit with a shift from the Judiciary Committee of the Privy Council to the High Court until the 1966 Act. Prior to the 1966 Act, the Minister for Agriculture, Food and Fisheries could also delegate powers of veterinary surgery to any practitioner in a charity, if there were not enough qualified veterinary surgeons to treat the number of animals owned by people of diminished means. This meant that the process of gaining social closure through the state was again dovetailed with both the interests of the profession and to some degree those of the wider public.

As documented by Hobson-West and Timmons (2015), the fully-fledged social closure of the veterinary profession finally occurred in 1966, with the latest iteration of the Veterinary Surgeons Act. Whiting (2016) notes that this prevented further new admissions to the Supplementary Veterinary Register as only those with qualifying degrees and diplomas could become members of the RCVS. Nonetheless, practitioners already on the Supplementary Veterinary Register were allowed to continue to practise as full members.

All forms of diagnosis, advice and treatment of animals therefore became exclusively the remit of members of the RCVS and no veterinary actions could lawfully be undertaken by the public alone. There were exemptions relating to husbandry practices concerning agricultural animals and research undertaken on animals. The veterinarian could also empower certain people to undertake acts of veterinary surgery—for instance, a veterinary nurse, a veterinary student, a doctor or a dentist. This delegated power, though, was always under the direction of the veterinarian, whether involving simple direction or continuous supervision, with one exception—farm workers could undertake minor surgery themselves, as long as they did not enter body cavities. Crucially, the 1966 Act closed down the ability of outsiders to undertake acts of veterinary surgery, unless delegated by a veterinarian. The general public was henceforth dependent upon the monopoly power held by the veterinary profession.

This was very significant because the monopoly gained over work as well as title gave the profession a stronger form of exclusionary social closure than that gained by the medical profession in Britain—even at the height of that profession’s self-regulatory powers (Hobson-West & Timmons, 2015). As Whiting (2016) relates, this was achieved following ideological skirmishes through much of the first half of the twentieth century with the People’s Dispensary for Sick Animals (PDSA) en route to the passing of the 1966 Act. In this period the PDSA and certain other animal charities came close to developing an alternative veterinary occupation for the poor

so that small domestic animals in their care could be helped, most of which was lawful. However, this was a fundamental challenge to the group interests of veterinarians in ensuring a good livelihood, when times were often financially tight, especially in poorer parts of the country. Given the scale of the threat, this led veterinary surgeons to engage their non-veterinary adversaries in vitriolic debate, in which the latter were labelled as “quacks” and “charlatans”, who were “parasites of the misinformed and gullible” (Wall, 1926).

In view of the generally lesser state of knowledge of those working under the umbrella of the PDSA (Gardiner, 2010) and the rise of university degrees in veterinary medicine with a greater amount of scientific content, further development of the RCVS-led veterinary profession could be seen as in the public interest. Even organizations like the Royal Society for the Prevention of Cruelty to Animals (RSPCA) threw their weight behind restricting animal care to the qualified on general welfare grounds. This was backed by the Ministry of Agriculture and Fisheries (MAFF) and the Department of Agriculture for Scotland (1945) Report of the Committee on Veterinary Practice by Unregistered Persons which stated that, for all their experience, the increasing numbers of unqualified practitioners had inadequate training, far short of veterinary students. It was therefore concluded that the practice of unqualified persons should be ended.

However, the shortage of veterinary surgeons at this time muddied the water in meeting public need in terms of the overall welfare (Holmes & MacClean, 1926). Questions could also be raised about other aspects of the public interest—justice in relation to access to veterinary medicine and the freedom of people to choose who attended to their animals in what remained of an open market. Whether the public were in a position to make an informed choice, though, was a moot point since, as Whiting (2016) comments, the PDSA technicians often misleadingly looked and behaved like veterinary surgeons. Their presence in a competitive marketplace also reduced the number of more fully trained veterinary surgeons coming through. The MAFF Committee, though, felt that the ring could be held given post-war shortages by putting more highly skilled but unqualified people through an exam regulated by the RCVS and under the guidance of qualified veterinarians.

The 1966 Veterinary Surgeons Act and beyond

The final watershed period in the development of the veterinary profession in Britain was the 1966 Act and its aftermath. The previously outlined limitations of the social closure legislation provided a forward path through the 1948 Act and led increasingly to the restriction of veterinary practice to only those who were qualified in the public interest. The position of full exclusionary closure was sealed with the passing of the 1966 Act, when “grand parenting” also ended following the growth in numbers of qualified veterinary surgeons. This Act defines veterinary surgery and medicine as including the diagnoses of diseases in, and injuries to, animals; the giving of advice based on such diagnoses; the medical or surgical treatment of animals; and the performance of surgical operations on animals (Hobson-West & Timmons 2015).

As Whiting (2016) notes, three registers were prescribed—those for qualified veterinarians and members of the RCVS, the Supplementary Veterinary Register of unqualified practitioners, and a temporary register of those under limited licence, including foreign qualified veterinarians, from countries without mutual recognition of qualifications, who were allowed to practice in Britain under the supervision of a MRCVS. The Act also established a statutory Disciplinary Committee, with set rules and procedures, overseen by the Privy Council, with a judicial facility for appeals. There followed significant debates in the House of Lords about the composition of the RCVS Council and the number of members necessary for the self-regulating profession—not least in light of developments in the parallel sphere of medicine. In this latter respect, it was decided that most members of the Council should be practising veterinarians.

Much has remained constant in terms of professional regulation in Britain since the 1966 Act. However, since that time government views have changed about the viability of self-regulating professions. This has particularly applied to medicine in the wake of the mass serial killing general practitioner Dr Harold Shipman and other medical scandals over the past twenty or thirty years (Roche, 2018). Accordingly, successive governments of different political colour have attempted to increase the role of state regulation and to modernize professions. Medicine, for example, has seen the recent introduction of regular appraisals, periodic re-accreditation by peers, more independent adjudication of complaints, greater lay representation on an ever more streamlined General Medical Council (GMC), and a meta-regulator overseeing its operation (Saks, 2014).

This has triggered responses from the veterinary profession, albeit on a more limited scale. In 2013, for instance, a Legislative Reform Order (LRO) was passed that changed the composition of the Disciplinary Committee so that it was no longer constituted from members of the RCVS Council, but was independent, with a higher proportion of lay input. This separated the legislative branch (standard setting) from the judiciary branch (disciplinary), as reflected in contemporary health and care professions. A further LRO in 2018 reduced the composition of RCVS Council from a comparatively large 42-strong body, predominantly elected by the profession and nominated by veterinary schools, to a smaller Council of 24, including thirteen elected veterinarians, six appointed lay members, three veterinary school appointees and two appointed associate members (veterinary nurses), with the Chief Veterinary Officer attending as an observer.

The relative lag in reforming veterinary medicine in the direction of what has become known in human medicine as “regulated self-regulation” (Chamberlain, 2015), with the only reforms that have occurred being led by the RCVS itself, has been explained in various ways. Hobson-West & Timmons (2015) put forward three possible reasons, with some caveats. The first is the declining role of farming in the economy leading to a shift of focus in veterinary work towards companion animals, which is less central to protecting human health. The second is the lack of a Nationalized Health Service for animals as most veterinarians do not work in state bureaucracies, but in the private sector—where there have been relatively few large-scale scandals involving non-human animals. The third is the lower moral status of animals and animal health, as compared to human beings. Allied to this, veterinary medicine is a much smaller profession than that of human medicine—with some 24,000 practitioners, as compared to close to 200,000 doctors, overseen by a Council currently presiding over graduates of only seven veterinary schools in Britain.

It could be argued that the limited change in the regulation of the veterinary profession since the 1966 Act is not in the public interest, in light of the extensive reform of medicine and other health and social care professions, which some have argued renders the 1966 Veterinary Surgeons Act no longer fit for purpose (Fox, 2012). However, the relative lack of reform of veterinary medicine cannot wholly be laid at the door of the veterinary profession, parts of which have been pushing for thoroughgoing change. The government must also bear some responsibility. Currently, it has lost its veterinary focus with Brexit and other political distractions—including the economic recession following the financial crash in 2008 (Saluja, 2011). But even before this, the government department responsible for veterinary regulation, the Department for Environment, Food and Rural Affairs, was unenthusiastic about reforming the 1966 Act. This was ostensibly because of “the lack of parliamentary time”, despite the support of legislators (Hobson-West & Timmons, 2015).

The loss of momentum in an age of more generic professional modernization therefore may have largely been because it was a low government priority, exacerbated by internal differences in the veterinary profession on the aims of any new legislation (Vet Record, 2009). The relatively slow present regulatory development of veterinary medicine may be in the interests of much of the profession in terms of the balance of costs and benefits. This is accentuated by the impact that regulatory

reform has had on the parallel power and status, if not the income, of medical doctors—notwithstanding the restratification of hospital specialist and general practitioners (Saks, 2015).

Conclusion

Having conducted a helicopter analysis of the professionalization of veterinary medicine in Britain from a neo-Weberian perspective, other competing contemporary macro theories of professionalization should be noted—in particular Marxism and Foucauldianism—which have also been widely applied to health care, not least in Britain (e.g. Navarro 1978; Nettleton 1992). However, as Saks (2016) relates, these can be overly rigid in their approach to the relationship between professions and the state—and therefore may not fit as well with the examination of the veterinary case. In the former instance, Marxist contributors tend tautologically to view the state as primarily operating in the interests of the capitalist class, or fragments thereof. This gives less flexibility in interpretation than in a neo-Weberian analysis. Meanwhile Foucauldians, aside from frequently being less rigorous in their use of empirical data (Jones & Porter, 1994), tend analytically to conflate the state and professions in the concept of governmentality, which is seen to pervade modern societies. This makes it more difficult systematically to examine the interrelationship between the two in the process of professionalization in veterinary medicine and other occupational groups.

It is argued here that, while there may well be aspects of co-production in the veterinary field, these cannot be assumed and need to be more closely empirically investigated. This may be best undertaken from a neo-Weberian viewpoint. An exemplary analysis of the intricate relationship between the profession and the state from this perspective in Sweden has been undertaken by Hellberg (1990). In her classic sociological account she underlines how veterinarians have assumed different roles over time both generally and in their interrelationship with the state. As such, they historically had very different knowledge, practice and client groups, as well as shifting relationships with the state. Initially, veterinarians in Sweden directly served the state through the military, before becoming more involved in animal husbandry for farmers and local authorities with the agricultural revolution, and later gravitated to small animal care for domestic pet owners alongside animal production.

In the parallel British case, where similar shifts occurred (Saks, 2016)—notwithstanding differences between veterinary medicine in Britain and on the continent (Carr-Saunders and Wilson, 1933)—the veterinary profession also had distinctive roles, relations and authority with the state over time, including in relation to state sponsorship. This is illustrated in the contemporary health arena where the state has intervened in response to illnesses like BSE and e-coli that can spread from animals to people (Hobson-West and Timmons, 2015)—despite having earlier removed animal considerations from human public health programmes after the mid-twentieth century (Hardy, 2003). This underscores the complexity of the more open neo-Weberian analysis of the development of exclusionary social closure and the professionalization of veterinary medicine in Britain. Although more detailed work is required in each of the various stages involved, the self-interests of the veterinary profession, or at least significant parts of it, seem usually—if not always—to have gone hand in hand with the public interest. This concept therefore has been more than a legitimacy ideology.

It is also an important methodological wake-up call for the sociology of the professions given the tendency of neo-Weberians simply to juxtapose the two notions in a zero-sum game. There are some exceptions to the rule (e.g., Halliday, 1987), but it is vital that interests and the public interest are satisfactorily conceptualized and operationalized in any analysis of professionalization if their interrelated role in facilitating professional exclusionary social closure is to be properly understood (Saks,

1995). Otherwise contributors to the critical neo-Weberian approach will fall into a similar trap to proponents of the earlier more deferential taxonomic perspective—in reaching preordained views about the operation of professional groups, without appropriately considering empirical evidence. In this respect, more detailed neo-Weberian sociological research is certainly needed on the fascinating and much neglected case of veterinary professionalization in Britain, which has been outlined in this paper.

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Positioning Each Other: A Metasynthesis of Pharmacist-Physician Collaboration

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Abstract

Interprofessional collaboration between different professions within health care is essential to optimize patient outcomes. Community pharmacists (CPs) and general practitioners (GPs) are two professions who are encouraged to increase their collaboration. In this metasynthesis we use a meta-ethnographic approach to examine the interpersonal aspects of this collaboration, as perceived by the professionals themselves. The metasynthesis firstly suggests that CPs and GPs have differing storylines about the cooperation between them. Secondly, CPs seem to position their profession in relation to the GPs, whereas GPs do not rely on the CPs to define their professional position. A successful collaboration between the two professions requires the CPs to reposition themselves through adopting a proactive approach towards the GPs. This proactive approach should comprise the delivery of specific clinical advice, as well as taking responsibility for this advice. In this way, they can build a more coinciding storyline of the joint agenda of improved patient care.

Keywords

Interprofessional collaboration, community pharmacists, general practitioners, meta-ethnography, positioning theory

Introduction

Medication errors constitutes a substantial burden to patients, leading to unnecessary and avoidable illness and injury (World Health Organization (WHO), 2016). Medication errors also have great economic consequences, with an associated cost of nearly one percent of the total global health expenditure (WHO, 2017). The WHO states that one factor which may influence medication errors is poor communication between health care professionals (WHO, 2016), and advocates interprofessional education (IPE) and interprofessional collaborative practice, as this can improve patient safety and patient outcomes, and reduce health costs (WHO, 2010).

Already in 1998, a joint statement from the International Pharmaceutical Federation and the World Medical Association underscored the importance of the working relationship between pharmacists and physicians, and its consequences for patients, concluding that the patient will be best served when pharmacists and physicians collaborate (WHO, 1998). Collaboration between pharmacists and physicians in primary care is shown to improve patient outcomes and reduce health costs (Hwang, Gums & Gums, 2017). Despite this, collaboration is limited. Research has identified a variety of factors influencing the collaboration between pharmacists and physicians (Bardet, Vo, Bedouch & Allenet, 2015; Bollen, Harrison, Aslani & Haastregt, 2018; Doucette, Nevins & McDonough, 2005). However, there is no agreement on how to classify these factors, thus different classification systems and models exist (Bardet et al., 2015). One of the most widely used models is “The collaborative working relationship model” (CWR) (McDonough & Doucette, 2001). In this model the influential factors are classified as individual characteristics, contextual characteristics and exchange characteristics. Exchange characteristics describes the personal interactions between pharmacists and physicians, and these elements are found to be especially important influential drivers of collaboration (Doucette et al., 2005; Zillich, McDonough, Carter & Doucette, 2004). The importance of the exchange characteristics is supported by a meta-model by Bardet et al. (2015), which concludes that trust and interdependence are the two core elements of collaboration between pharmacists and physicians. While the importance of interpersonal factors is underscored in the above-mentioned articles, these factors are rarely addressed exclusively and in depth.

Our aim is to address this limitation by exclusively exploring the interpersonal aspects of the collaboration between community pharmacists (CPs)¹ and general practitioners (GPs) through performing a metasynthesis. The aim of a metasynthesis is to systematically interpret findings from previous qualitative research with the purpose of developing new explanations and fresh insights (Walsh & Downe, 2005). In our metasynthesis, we will use positioning theory (Harré & Langenhove, 1999b) as a theoretical framework to bring forward novel interpretations and insights.

Theoretical framework

Positioning theory focuses on interpersonal interactions and the attribution of positions among interactants. It can be applied to understand the interactions between people both at an individual level and at a group level, where people serve as group representatives (Harré & Langenhove, 1999a). The term “intergroup positioning” involves both the positioning of oneself or others at an individual level based upon group membership, and the positioning of oneself or others at a group level. To distinguish oneself and one’s group from others, one uses linguistic devices such as “us” and “them”, or specific group names (Tan & Moghaddam, 1999), in our study CPs and GPs. A central element in positioning theory is the mutually determining triad consisting of speech acts, positions and storylines. A speech act is the act of making an utterance, and in our study the speech act is understood as the utterance about collaboration between CPs and GPs that the participants gave in the original research this metasynthesis draws on. A position comprises certain personal attributes, rights, duties and responsibilities, which are negotiable and the result of a dynamic relation between the participants in a social episode. A storyline is the conversational history according to which a social episode evolves and positions arise (Harré & Langenhove, 1999b). When people participate in a social episode, they co-construct a storyline where each participant is given by others or claim for themselves, a position. Positioning can in other words be either interactive, which means that people position each other, or reflexive, which means that one positions oneself. In either case, positioning is not necessarily intentional (Davies & Harré, 1999). In our metasynthesis, this theoretical framework offered a lens through which to study the CPs’ and GPs’ perceptions of their collaboration, with a focus on how they positioned themselves and one another.

Method

Research design

Metasyntheses can be done in different ways, and we chose to use the method of meta-ethnography (Noblit & Hare, 1988) based on its systematic and stepwise procedure, consisting of seven steps (Box 1). To clarify the contents of each of the seven steps, we used the interpretations of Atkins et al. (2008).

Box 1

The seven steps of meta-ethnography (in bold) (Noblit & Hare 1988) as applied in our study informed by the interpretations of Atkins et al. (2008). The steps are a description of the research process, yet they should not be seen as isolated steps or a linear process, but rather as an iterative process where some of the steps were performed simultaneously.

1. **Getting started:** Determining a research question that could be informed by qualitative research.
2. **Deciding what is relevant to the initial interest:** Deciding which primary studies to include in the synthesis. This involves defining the focus of the synthesis (deciding how broad or narrow the scope of the synthesis should be), locating relevant studies (developing a search strategy, choosing databases and performing the search) and selecting studies for inclusion (deciding on inclusion -and exclusion criteria, screening and quality appraising the studies).
3. **Reading the studies:** Repeated reading of the studies to get as familiar as possible with the contents and details of the studies. Extracting emerging themes and concepts, as well as study characteristics, such as context, methods and type of participants.
4. **Determining how the studies are related:** Making a grid of key themes and concepts in each of the primary studies. Juxtaposing them and deciding how they are related. Making an initial assumption about the relationship between the studies regarding if they relate reciprocally (similar findings) or refutationally (conflicting findings) or both, and if they build a line of argument (explore different aspects that together can create a new interpretation).
5. **Translating the studies into one another** (in our study reciprocally): Comparing the themes and concepts in one primary study with the next, and the synthesis of these two studies with the next and so on.
6. **Synthesizing translations:** Creating a third-order interpretation/line-of-argument synthesis.
7. **Expressing the synthesis:** Reporting the outcomes of the synthesis in a form that is accessible to the intended audience, for example other researchers or health care professionals.

To ensure transparency, we reported our meta-ethnography in accordance with the recommendations in the eMERGe reporting guidance (France et al., 2019), to the extent that this guide was relevant to our exploratory study.

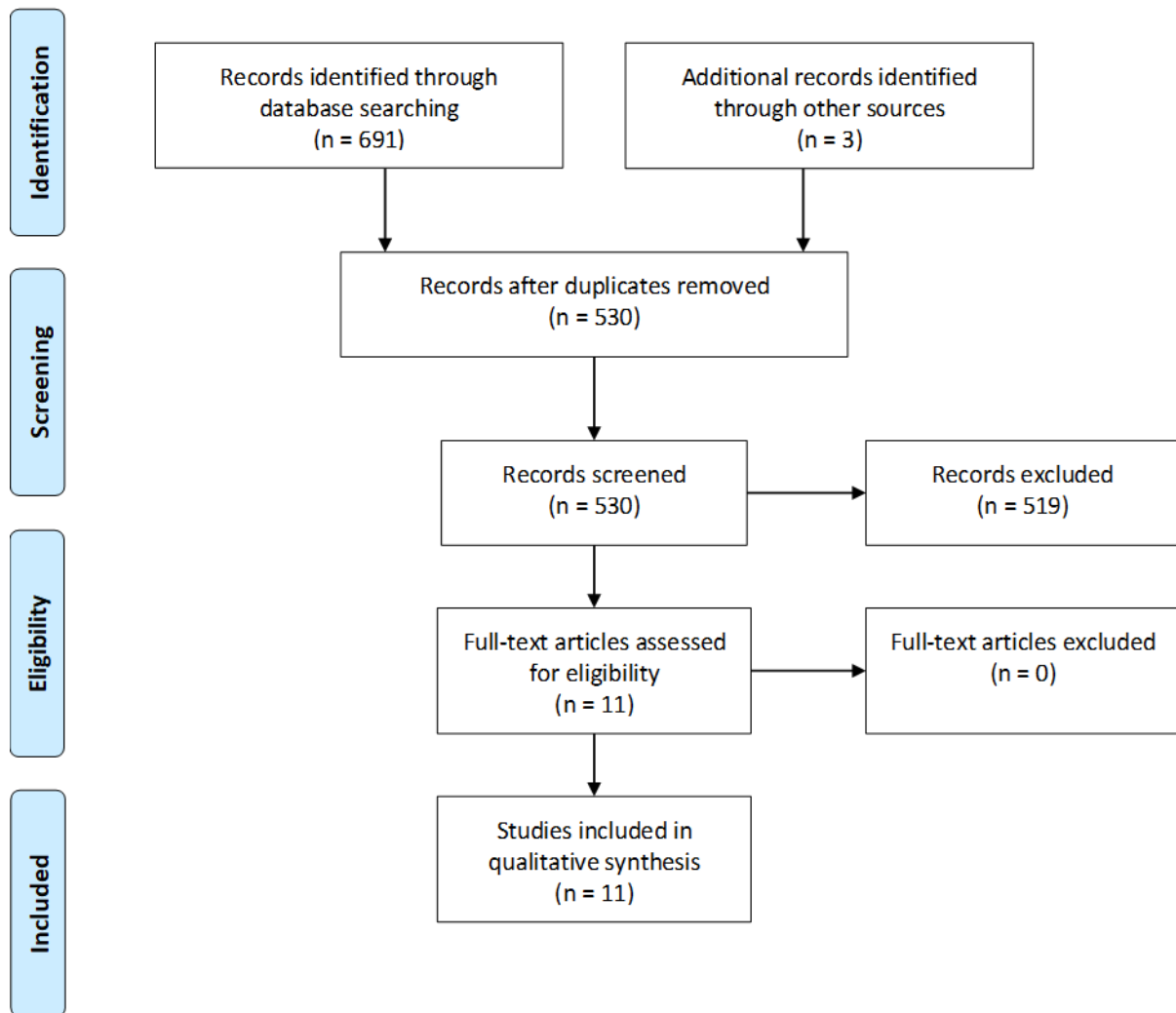
Data collection

Based on our study purpose, we made a search strategy with the aim of identifying qualitative studies about the collaboration between CPs and GPs which also elucidated interpersonal aspects of collaboration. Preparation of the search strategy, selection of bibliographic databases and the systematic database search was done in collaboration with an experienced academic librarian from within the medical field. We searched the electronic databases Embase, Medline, PsycInfo, ISI Web of Science and SweMed+, using the search strategy presented in Appendix 1. In addition, we performed citation snowballing and additional free searching using search words such as pharmacist, general practitioner and interprofessional collaboration. The outcome of our search is presented in Figure 1.

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Figure 1

PRISMA Flow diagram (Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The PRISMA group, 2009)



Our primary studies (Table 1) comprised empirical data from 397 individuals from seven countries.

Table 1
Characteristics of the included primary studies

Study	Country	Data collection	Sample	Aim
Bradley, Ashcroft & Noyce (2012)	England	In-depth semi-structured interviews	31 CPs 27 GPs	To present a new model of collaboration derived from interviews with GPs and CPs involved in service provision that required some form of collaboration
Dey, De Vries & Bosnic-Anticevich (2011)	Australia	Semi-structured interviews	18 CPs 7 GPs	To gain deeper understanding of the expectations, experiences and perceptions of Australian GPs and CPs around collaboration in chronic illness (asthma) management in the primary care setting
Gregory & Austin (2016)	Canada	Semi-structured telephone interviews	11 pharmacists 8 family physicians	To characterize the cognitive model of trust that exists between pharmacists and family physicians working in

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Study	Country	Data collection	Sample	Aim
				collaborative primary care settings
Löfler et al. (2017)	Germany	In-depth narrative interviews and focus groups	10 CPs 15 GPs	Investigating CPs' and GPs' views on barriers to interprofessional collaboration in the German health care system
Paulino et al. (2010)	Portugal	Semi-structured interviews and focus groups	31 CPs 6 pharmacy leaders 2 medical leaders 12 physicians (mix of GPs and hospital physicians) 21 patients	To explore the opinions and experiences of a range of stakeholders on interprofessional working relationships between CPs and physicians
Rathbone, Mansoor, Krass, Hamrosi & Aslani (2016)	Australia	Focus groups	23 CPs 22 GPs	To propose a model of interprofessional collaboration between CPs and GPs within the context of identifying and improving medication non-

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Study	Country	Data collection	Sample	Aim
				adherence in primary care
Rieck (2014)	Australia	Semi-structured interviews	22 CPs 22 GPs	To explore the perceptions and attitudes of CPs and GPs regarding the CP-GP relationship and its impact on CP-GP collaboration in chronic disease management in primary healthcare
Rubio-Valera et al. (2012)	Spain	Semi-structured interviews	19 CPs 18 GPs	To identify and analyze factors affecting GP-CP collaboration
Snyder et al. (2010)	USA	Semi-structured interviews	5 CPs 5 physicians	To describe the professional exchanges that occurred between CPs and physicians engaged in successful collaborative working relationships

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Study	Country	Data collection	Sample	Aim
Van, Mitchell & Krass (2011)	Australia	Semi-structured interviews, face-to-face and telephone	15 CPs 15 GPs	To investigate the nature and extent of interactions between GPs and CPs and the factors that influence these interactions in the context of professional pharmacy services
Weissenborn, Haefeli, Peters-Klimm & Seidling (2017)	Germany	In-depth semi-structured interviews and focus groups	19 CPs 13 GPs	To assess CPs' and GPs' perceptions of interprofessional communication with regard to content and methods of communication as a basis to subsequently develop best-practice recommendations for information exchange

CP: community pharmacist, GP: general practitioner

Searching for qualitative studies can be challenging since qualitative research is not always indexed correctly in electronic databases, and the terms used in the titles are sometimes not a direct reflection of the topic (Evans, 2002). Despite our attempt to identify all relevant studies, we are aware of the possibility that additional studies suitable for inclusion in our synthesis may exist. However, the selection of studies was sufficient for our purposes, as it has provided an overview of significant research in the field. Also, while including more

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studies into our synthesis might add additional findings, a large number of included studies is not a goal in itself in metasyntheses, as one can easily lose track and end up with a superficial analysis (Campbell et al., 2011).

The first and last author screened all titles and abstracts independently, and potentially relevant articles were discussed, read in full text and appraised according to the following inclusion criteria: empirical qualitative studies, written in English or a Scandinavian language, published between 2010 and 2017, about collaboration between community pharmacists and physicians in primary care, and containing findings regarding interpersonal aspects of collaboration. Studies concerning pharmacists integrated in a primary health care team or located in a physician's practice were excluded. This due to the likelihood of these settings influencing the interpersonal relationships in different ways than the typical primary care setting, where CPs and GPs most often work physically isolated from each other. The eleven studies which met our inclusion criteria were quality appraised by the first and last author, using the Critical Appraisal Skills Programme (CASP) checklist (2017) for qualitative research.

Data analysis and synthesis

The primary studies were read thoroughly and independently in full text by the first and last author to get an overview and identify key themes and concepts in each study as well as study characteristics such as context, types of participants and study design. Data was extracted by the first author in collaboration with the last author. Only findings regarding interpersonal aspects of collaboration were extracted, while findings regarding factors such as practice setting, infrastructure, systems of reimbursement, data sharing, time constraints and practitioner demographics were excluded, as these factors were outside of our scope. We made the decision to extract findings only from the results section of the articles. This choice was discussed thoroughly in advance, and decided upon due to the fact that the discussion section often contains information based upon other sources than the study findings, for example research done by others, and authors' personal opinions. We attempted to only extract concepts developed by authors of the primary studies, but participant quotes may also have been extracted due to a low level of interpretation in many of the primary studies, and hence difficulties in distinguishing participant quotes from author interpretations. An exception is the participants quotes that are presented in our results section, these were selected deliberately to serve as illustrations to our findings. The further analysis of the studies will be described in the following and is illustrated in Appendix 2.

Inspired by Atkins et al. (2008), we first used thematic analysis to identify thematic categories and organize the key themes and concepts in each study into these categories.

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During this step of the analysis, we tried to preserve the terminology used by the original authors. To get an overview across all studies and to determine how the studies were related, we structured the eleven studies and the identified 13 thematic categories into a grid. Appendix 3 shows an excerpt from the grid for one of the thematic categories, labeled “shopkeepers”.

Data within the different categories then formed the basis for the translation of the primary studies into one another. We found that the focus and themes of the included primary studies were sufficiently similar for a reciprocal translation² to be made. The original categories were revised and reconfigured as the analysis progressed through discussions on how they were related; some were merged, some were split up and new categories and subcategories were agreed upon. The concepts of the different primary studies were compared by translating the data within each category from one study into the next, and then translating this synthesis into the next study and so on, while at the same time keeping our minds open for emerging new categories. We also attempted to examine if different contexts, such as country, had an influence on the findings. Our translations were finally synthesized into three main categories.

Based on our translations, we then created our third order interpretations by applying positioning theory to identify different positions that the CPs and GPs assigned to themselves and each other through reflexive and interactive positioning. These positions further served as a basis to identify the CPs’ and GPs’ main storylines. Throughout the analytical process, findings and categories were discussed with the second author. The outcome of this metasynthesis is presented as a line-of-argument synthesis in the form of storylines in the results section, and further elaborated on through the framework of positioning theory in the discussion section.

Results

We found coherence across the different countries in the way pharmacists and physicians perceived their challenges related to collaboration. All of the studies used individual interviews or focus groups or a combination of these, and included both pharmacists and physicians, with a small predominance of pharmacists. One study also included pharmacy and medical leaders and patients. The studies varied regarding the level of collaboration that existed between the participating pharmacists and physicians. Some were involved in a highly collaborative working relationship, but the majority were not.

There were two sets of stories that asserted themselves in the results of the primary studies included in our synthesis: stories about limited collaboration and stories about successful collaboration. In the following, we will present the dominant storylines and positions in these two sets of stories.

The stories of limited collaboration

Most of the CP and GP participants described the collaboration between the two professions as limited. However, the two professions described the lack of collaboration using different storylines. Within their respective storylines, the CPs and GPs also took on different positions, and positioned the other profession in different ways.

The CPs' storyline

This storyline was concerned with a desire to deliver improved patient care through engaging in interprofessional collaboration with the GPs, while experiencing the GPs as not very forthcoming. Most of the CPs in the included primary studies seemed to hold the opinion that both the GPs, the patients and they themselves would benefit from an interprofessional collaboration (Dey, de Vries & Bosnic-Anticevich, 2011; Paulino et al., 2010). However, there were many accounts of them feeling disrespected, underappreciated and underevaluated by the GPs (Dey et al., 2011; Gregory & Austin, 2016; Löffler et al., 2017; Paulino et al., 2010; Rieck, 2014; Snyder et al., 2010; Van, Mitchell & Krass, 2011; Weissenborn, Haefeli, Peters-Klimm & Seidling, 2017):

I trust them to do their job—it's frustrating, okay, sometimes it feels almost like patronizing?—when you know they don't trust your recommendation just because they think, well, you're [air quotes] "just a pharmacist". (CP) (Gregory & Austin, 2016, p. 241)

Some CPs specified that they had knowledge that was additional and complementary to that of the GPs (Gregory & Austin, 2016; Paulino et al., 2010; Snyder et al., 2010). They generally positioned themselves as clinically competent to contribute in patient care by solving drug related problems (Bradley, Ashcroft & Noyce, 2012; Gregory & Austin, 2016; Löffler et al., 2017; Paulino et al., 2010; Snyder et al., 2010), and wished for stronger support from the GPs (Bradley et al., 2012; Dey et al., 2011; Gregory & Austin, 2016; Löffler et al., 2017; Weissenborn et al., 2017). Yet, they ultimately positioned the GPs as the ones responsible for the patients' outcome, and seemed reluctant to take on this level of responsibility themselves (Bradley et al., 2012; Paulino et al., 2010):

I'd rather not have the responsibility on my head... I'd like [the GPs] to be the ones who explain, initiate the whole service, and I can just be there as an addition... (CP) (Bradley et al., 2012, p. 43)

The CPs positioned themselves as dependent on the GPs to be able to contribute, and hereby placed themselves in the position as the "noble" profession who were looking to improve the treatment of patients through interprofessional collaboration, while being rejected by the GPs (Snyder et al., 2010). Nevertheless, there was one account of CPs

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positioning themselves as passive, recognizing that they were also partly to blame for the limited collaboration with the GPs (Paulino et al., 2010).

The CPs generally positioned the GPs as highly competent, respected and trustworthy (Gregory & Austin, 2016; Rieck, 2014):

Well, of course, why wouldn't you trust them? They're doctors, right, so they've proven themselves already. (CP) (Gregory & Austin, 2016, p. 240)

Gregory and Austin (2016) point out that the GPs do not need to *earn* the CPs' trust; it is conferred on them implicitly through their status and title as GPs. This implicit trust was also evident in three of the other primary articles (Bradley et al., 2012; Snyder et al., 2010; Van et al., 2011), and also shone through a large proportion of the material, where the focus was on what could improve the GPs' opinions about the CPs, and not the other way around (Rathbone, Mansoor, Krass, Hamrosi & Aslani, 2016; Rieck, 2014; Rubio-Valera et al., 2012). Nevertheless, the GPs were not only featured in positive terms. They were also positioned by the CPs as territorial and as a profession with a "bad attitude" who do not want to engage in interprofessional collaboration for the best of patients (Dey et al., 2011; Gregory & Austin, 2016; Löffler et al., 2017; Paulino et al., 2010; Rieck, 2014; Snyder et al., 2010):

You can't tell a doctor anything, he can't learn from anybody, he's supposed to know it all... (CP) (Dey et al., 2011, p. 25)

Some CPs positioned the GPs as having a monopoly on the patient, and were conscious of not impeaching on their professional territory. There was a perception among several CPs that the GPs sometimes perceived what was intended as helpful requests or advice from the CPs' side as criticism, and the CPs therefore tried not to step on the GPs' toes (Dey et al., 2011; Löffler et al., 2017; Paulino et al., 2010; Weissenborn et al., 2017). Some CPs lacked the confidence to confer their clinical opinions. Previous negative response from the GPs could result in the CPs avoiding contacting the GP to make an intervention, although they considered the intervention important (Dey et al., 2011; Löffler et al., 2017; Paulino et al., 2010):

Sometimes we actually fear calling there, because we are scared of being snapped at. You know, we've sometimes had such bad experiences... (CP) (Löffler et al., 2017, p. 3)

The GPs' storyline

We found the main GPs' storyline to be that they delivered good enough patient care on their own. The included primary articles presented several accounts of the GPs showing

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limited interest and awareness of the CPs' competencies and possible contributions to a collaboration (Dey et al., 2011; Löffler et al., 2017; Paulino et al., 2010; Rieck, 2014):

(...) I dare say that the majority of physicians doesn't have the slightest idea of what pharmaceutical care is. (Physician) (Paulino et al., 2010, p. 597)

Some GPs presented a negative attitude towards CPs who were calling them on the phone with what they perceived as unnecessary inquiries, and it was underlined that CPs were of little help when calling to point out mistakes without offering a specific proposal for a solution (Löffler et al., 2017). The GPs seemed to hold the opinion that the CPs would be the ones with most to gain from a collaboration, while they themselves and the patients would have less to gain (Dey et al., 2011; Paulino et al., 2010; Snyder et al., 2010), hence they were less motivated to collaborate. Some perceived the CPs to be useful collaborators in the way that they could perform less important tasks to free the GPs' time (Bradley et al., 2012; Paulino et al., 2010):

I would much prefer that I spent my time dealing with complex stuff than spend my day doing unnecessary things that somebody else can do. (GP) (Bradley et al., 2012, p. 43)

The GPs generally positioned themselves as more competent than the CPs (Bradley et al., 2012; Dey et al., 2011; Gregory & Austin, 2016; Löffler et al., 2017; Paulino et al., 2010; Rieck, 2014; Rubio-Valera et al., 2012; Weissenborn et al., 2017). In agreement with the CPs, the GPs also positioned themselves as the ones with the most responsibility (Dey et al., 2011; Gregory & Austin, 2016; Löffler et al., 2017; Snyder et al., 2010).

Some GPs defined their limited relationship with the CPs as a good one, seemingly not perceiving their limited collaboration as a problem in the same way that the CPs did (Dey et al., 2011; Löffler et al., 2017). At the same time, some positioned the CPs as encroachers into the GPs' domain (Bradley et al., 2012; Löffler et al., 2017; Paulino et al., 2010):

Pharmacists aren't doctors. I think every monkey should stay on his own branch. (Physician) (Paulino et al., 2010, p. 599)

In relation to this, the CPs were positioned by the GPs as unreliable and incompetent until the opposite had been proven. For the CPs to gain the GPs' trust, they had to gradually *earn* it over time through being proactive and proving their clinical skills in a way that had a positive impact on patients' outcomes (Gregory & Austin, 2016; Snyder et al., 2010; Van et al., 2011):

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You just know, after a while. You can tell if they're competent, committed, someone you want to rely on. You have to see them in action. (Family physician) (Gregory & Austin, 2016, p. 239)

The GPs' positioning of CPs as "shopkeepers" or businesspeople was found in several of the included articles (Bradley et al., 2012; Löffler et al., 2017; Paulino et al., 2010; Rieck, 2014; Rubio-Valera et al., 2012; Van et al., 2011). This position had two aspects: the first was that the GPs mistrusted the CPs' agenda because of the commercial aspect of community pharmacy. The CPs were seen as businesspeople, and the GPs were therefore uncertain about whether the CPs' agenda was patients' benefit or their own economic benefit (Bradley et al., 2012; Löffler et al., 2017; Paulino et al., 2010; Rubio-Valera et al., 2012; Van et al., 2011). The other aspect was the GPs' lack of trust and confidence in CPs' clinical abilities (Bradley et al., 2012; Gregory & Austin, 2016; Löffler et al., 2017; Paulino et al., 2010; Rieck, 2014; Weissenborn et al., 2017). This could be based both on previous bad experiences with individual CPs (Gregory & Austin, 2016), and on prejudice towards the profession as a whole, with the GPs viewing the CPs as "merely shopkeepers" with low clinical competence (Paulino et al., 2010; Rieck, 2014; Van et al., 2011). Because the CPs do not make their profit from the delivery of clinical services, but rather from the products they sell, they were not regarded as being part of the healthcare system on an equal level as other healthcare personnel (Rieck, 2014):

Well, most of the allied health professionals, physios... I don't know that much about how they actually work, but my understanding is that most of the money is made from their professional advice. So, it's actually themselves and the quality of their advice they give, they make money for. Where pharmacists are different, they make their money from what they actually sell. (GP) (Rieck, 2014, p. 442-443)

The stories of successful collaboration

Some CPs and GPs described various degrees of successful collaboration. In these stories the two groups of professionals had a more coinciding storyline which was about a mutual interest in collaborating and a shared motivation in improved patient care, while they still held different positions:

... we both have different jobs but we both have an end goal and that is to take care of the patient ... (Physician) (Snyder et al., 2010, p. 316)

I think it's easier working with some doctors because we share the same belief in what we're here for... we're both part of the total solution for patients... we're meant to work together. (CP) (Van et al., 2011, p. 369)

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Both CPs and GPs acknowledged a “personal relationship” or “knowing each other”, preferably through face-to-face interactions, as important for successful collaboration (Bradley et al., 2012; Dey et al., 2011; Gregory & Austin, 2016; Löffler et al., 2017; Paulino et al., 2010; Rathbone et al., 2016; Rieck, 2014; Rubio-Valera et al., 2012; Snyder et al., 2010; Van et al., 2011; Weissenborn et al., 2017). Many participants from both professions perceived this as being essential primarily in that it made the GPs aware of the CPs’ competencies, services and possible contributions (Bradley et al., 2012; Paulino et al., 2010; Rieck, 2014; Snyder et al., 2010). But it was also highlighted as an opportunity for the two professions to align role perceptions, clinical goals and perspectives (Paulino et al., 2010; Rathbone et al., 2016; Rubio-Valera et al., 2012; Van et al., 2011; Weissenborn et al., 2017). This could help reduce stigmatized views towards the other professional in both directions (Paulino et al., 2010; Rubio-Valera et al., 2012). In this, both the GPs and the CPs themselves positioned the CPs as the proactive part. This in the sense that the CPs primarily were the ones who had to take the initiative to establish a personal relationship, prove their clinical competence, make their possible contribution to a collaboration familiar, and initiate and maintain a collaboration with the GPs. This proactive approach by the CPs was described in several of the included studies as being important to foster a successful collaboration (Paulino et al., 2010; Rieck, 2014; Snyder et al., 2010; Van et al., 2011):

... the pharmacist has to play an active role, because the novelty comes from him, not from the physician. (CP) (Paulino et al., 2010, p. 600)

When the GPs had gotten to know the CPs, they more often positioned them as trustworthy, clinically competent, helpful and supportive (Bradley et al., 2012; Gregory & Austin, 2016; Rieck, 2014):

If the right patient gets to the right person, they do a better job perhaps than the doctors... more thorough for certain things ... certainly advice regarding drug interactions, it could be argued that the pharmacist does that better ... we’re all fairly modern in our approach, we can live with it. (GP) (Bradley et al., 2012, p. 43)

Nevertheless, this did not necessarily apply to the profession in general, but could be limited to the individual CPs whom they had an interpersonal relationship with (Paulino et al., 2010).

Discussion

Differences in organization within the primary care systems of the seven countries included in our metasynthesis could potentially be problematic in terms of transferability (Malterud, 2001), but despite large geographical distances, the systems in which the pharmacists and physicians worked were found similar enough for the studies to be synthesized. We found

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coherence across the countries in the way pharmacists and physicians perceived their challenges related to collaboration, something that strengthens the transferability of our findings. Our use of the eMERGe reporting guidance (France et al., 2019) should increase transparency, and the use of CASP (Critical Appraisal Skills Programme, 2017) should ensure that the included studies are of acceptable quality. A limitation of the included studies was that they were generally more descriptive than interpretative. Yet, they served the purpose of our study, and the use of positioning theory (Harré & Langenhove, 1999b) made it possible for us to extend the level of interpretations to present what we perceive as new insights. This theoretical framework has influenced our results by affecting which findings we have placed emphasis on. Using other relevant theoretical frameworks, such as sociological theories of the professions (Traulsen & Bissel, 2004), most likely would have led to different findings, as a result of a different focus. Nevertheless, positioning theory was chosen after a thorough discussion of different possible theories, as this approach allowed us to go into a dialogue with our data and identify how GPs and CPs described and positioned their professions in general, as well as in relation to each other.

The first and last authors are both pharmacists, and this influenced how findings were understood and interpreted. These two authors could for instance easily recognise and identify with the CPs' description and positioning of their profession as well as the way the relationship between CPs and GPs was described. Their knowledge of the pharmaceutical profession as well as international research on this profession, ensured the interpretations of the CPs' positions and storylines were relevant and reasonable. Although originally trained as a pharmacist, the last author received her research training in a research group consisting of primarily GPs. Her academic knowledge of GPs' training and work, enabled us to make relevant and reasonable interpretations also of the GPs' positions and storylines. The second author, who is a highly competent qualitative researcher from the field of pedagogy, had no insider experience or knowledge, neither of the medical nor of the pharmaceutical profession. To avoid that interpretations developed into more biased opinions, the second author therefore used her "outsider" position continuously in the discussions about the findings and how these best could be interpreted and communicated. In these interdisciplinary discussions, preconceptions were discussed openly. Preliminary findings were also presented and discussed at national and international research conferences. Together, these measures ensured reflexivity (Malterud, 2001) as well as a nuanced perspective in our metasynthesis.

We found that the CPs tended to interpret their own position as a profession in relation to the profession of the GPs, whereas the GPs did not seem to rely on the CPs to define their position. The GPs were generally not concerned with how the CPs perceived them, whereas the CPs emphasized the GPs' perceptions about them and about their rights and duties as a

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profession. The CPs were positioned both through interactive and reflexive positioning as somewhat dependent on the GPs' approval to be allowed to have a clinical opinion. There seemed to be an overall acceptance by the CPs of this position, instead of them trying to renegotiate their position to a more autonomous one. Other authors have touched upon similar findings, for example Svensberg, Källemark Sporrang, Håkonsen & Toverud (2015, p. 261) found that: "Some pharmacists questioned their place in patient care, based on doctors' attitudes". In an exploratory study about the lack of responsibility and confidence among pharmacists, it was mentioned that the hierarchical structure of the medical system made some pharmacists feel that: "asking permission" was necessary to be able to make clinical decisions (Frankel & Austin, 2013, p. 157), and Rosenthal, Austin & Tsuyuki (2010, p. 39) states that: "Pharmacists seem to be overly concerned with the perception that other health care workers and other professions have of them". Notions about a hierarchical structure of the medical system and a territorial behavior of the GPs were also found in our metasynthesis. The CPs were found to promote what they saw as their unique and complimenting competencies, while the GPs were found to highlight their superiority over the CPs. This strategy was similarly observed in a study by Lee, Lessem & Moghaddam (2008), with participants competing for internships. Lower-status participants were seen to focus on their unique qualities instead of directly comparing themselves to the others, whereas higher-status participants directly compared themselves with a focus on being "better". The strategy of the CPs, focusing on their complimenting skills, may be born from a wish to maintain inter-group harmony (Harré, Moghaddam, Cairnie, Rothbart & Sabat, 2009). By not positioning one's group as being in competition with another group, but rather differentiating oneself from the others through the search for vacant spaces, one can avoid conflict (Harré et al., 2009). The GPs, being a higher-status group compared to the CPs, did not seem to have the same fear of inter-group conflict.

The CPs were found to position themselves as not having the right or duty to take responsibility for the patients' outcomes. There may be several reasons for this, such as their perception that the GPs are the ones responsible for the patients and, as mentioned above, the CPs' wish to avoid conflict with the GPs. Another aspect is that they may lack the confidence, which for some CPs could be legitimate due to an actual lack of clinical competence, while it for others could be due to an underestimation of their own skills in combination with a great respect for the GPs and their opinions. However, we found that the GPs only trust CPs on the basis of regular clinical recommendations that improves patients' outcomes. This finding implies that the CPs' defensive demeanor, perhaps based on their perceived lack of responsibility, could bring them into a negative circle by contributing to the GPs' mistrust in them. This is in line with conclusions from Blöndal, Jonsson, Källemark Sporrang & Almarsdóttir (2017). In their study they interviewed 20 GPs on Iceland, and found that to improve communication between GPs and CPs, the CPs need

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to demonstrate their potential, use their expertise and dare to take responsibility for patient care.

In the stories about the CPs and GPs involved in good working relationships, there was not a lot of focus on the GPs' positions. In addition to the importance of knowing each other personally and having aligned perspectives and goals, the main focus was on the changed positions of the CPs from passive to active, unfamiliar to familiar, questionable to trustworthy, incompetent to competent, encroaching to supportive and subordinate to equitable. The most important change in the position of the GPs was that they moved from being unaware to being aware of the CPs' competencies and possible contributions to a collaboration. This suggests that the CPs are the ones who have to make the changes in order to enhance the collaboration with the GPs.

Renegotiating new positions—introducing new storylines

The acceptance or rejection of prevailing storylines determines whether a relation between two groups with different power remains stable or changes. Storylines and positions are not written in stone and can be altered through the introduction of new positions and storylines. Thus, group positions can be renegotiated, and a subordinate group can introduce new storylines for itself, thereby creating social changes in the established intergroup relation. In this way, group positions that used to stand in opposition to each other ("us vs them") can be realigned into complementary positions ("we must work together") (Tan & Moghaddam, 1999). One way of introducing such new storylines could be through IPE, where students from different professions within health care, among them medical and pharmacy students, come together to learn with, from and about each other with the goal of facilitating effective future collaboration and hence improved quality of care (Bondevik, Holst, Haugland, Baerheim & Raaheim, 2015). IPE is currently promoted as the way forward to increase interprofessional collaboration within health care on a global level (WHO, 2010; Frenk et al., 2010).

The dominant storyline among the CPs and GPs involved in successful collaboration was found to be that they had a shared motivation and a common goal: improved patient care. The CPs who were not involved in successful collaboration also held the view that a collaboration with the GPs would benefit the patients, whereas the GPs not involved in successful collaboration had doubts about the possible patient benefits. These GPs were unsure of the CPs' skills and motives based on the perception of them as shopkeepers. If the CPs could manage to change this storyline to one about them both working for the best of patients, this would increase the probability of a successful collaboration between them. However, to be able to do this, the CPs must first change their own storyline about themselves. The CPs should try to replace the old storyline about their group being less

responsible with a new storyline, where they use their unique competencies to improve patient care by making clear recommendations, have the confidence to stand up for these recommendations, and thus also share responsibility with the GPs for the outcomes, positive or negative. When the GPs experience the CPs making clear recommendations that improve patient outcomes, our findings suggest that their trust in the CPs increases. This would be an important step in the right direction towards working for a better collaboration and the common goal of improved patient care.

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Appendix 1

Search strategies in electronic databases

Database: Embase (Ovid) <1974 to 2016 Dec 05>

Searched 6. Dec.2016

- 1 pharmacy/ (73968)
- 2 pharmacist/ (65541)
- 3 (pharmacist* or pharmacy or pharmacies or drug store*).ti,ab,kw. (104064)
- 4 1 or 2 or 3 (143294)
- 5 general practitioner/ (89958)
- 6 exp primary health care/ (148865)
- 7 general practice/ (81848)
- 8 private practice/ (16044)
- 9 (((family or general or primary care or private) adj2 (doctor* or physician* or practitioner* or practice)) or GP*).ti,ab,kw. (325261)
- 10 5 or 6 or 7 or 8 or 9 (490616)
- 11 trust/ (10443)
- 12 (trust* or mistrust* or distrust* or reliance).ti,ab,kw. (72015)
- 13 11 or 12 (75712)
- 14 4 and 10 and 13 (465)

Comment from librarian: Primary medical care is secondary to primary health care

Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) <1946 to Present>

Searched 6. Dec.2016

- 1 Pharmacy/ (12998)
- 2 Pharmacists/ (13735)
- 3 (pharmacist* or pharmacy or pharmacies or drug store*).ti,ab,kw. (55978)

Positioning Each Other

- 4 1 or 2 or 3 (66260)
- 5 general practitioners/ or physicians, family/ or physicians, primary care/ (24250)
- 6 Primary Health Care/ (69460)
- 7 exp General Practice/ (73996)
- 8 Private Practice/ (8202)
- 9 (((family or general or primary care or private) adj2 (doctor* or physician* or practitioner* or practice)) or GP*).ti,ab,kw. (280705)
- 10 5 or 6 or 7 or 8 or 9 (371065)
- 11 Trust/ (8009)
- 12 (trust* or mistrust* or distrust* or reliance).ti,ab,kw. (58449)
- 13 11 or 12 (61708)
- 14 4 and 10 and 13 (114)

Comment from librarian: Family practice is secondary to General practice.

Database: PsycINFO (Ovid) <1806 to Nov Week 4 2016>
Searched 6. Dec.2016

- 1 pharmacy/ or pharmacists/ (1665)
- 2 (pharmacist* or pharmacy or pharmacies or drug store*).tw. (5376)
- 3 1 or 2 (5398)
- 4 general practitioners/ or family medicine/ or family physicians/ (7719)
- 5 primary health care/ (15069)
- 6 private practice/ (1296)
- 7 (((family or general or primary care or private) adj2 (doctor* or physician* or practitioner* or practice)) or GP*).tw. (39337)
- 8 4 or 5 or 6 or 7 (51011)
- 9 "trust (social behavior)"/ (8163)
- 10 (trust* or mistrust* or distrust* or reliance).tw. (50268)

Positioning Each Other

11 9 or 10 (50415)

12 3 and 8 and 11 (24)

Comment from librarian: Family medicine is used as a keyword in this database on articles about general practitioners (GPs). This is strange, since GPs is also a keyword.

Svemed+ (Karolinska Institutet)

Searched: 6. Dec. 2016

2	noexp:"Pharmacy"	142
3	noexp:"Pharmacy" AND noexp:"pharmacists"	11
4	pharmacist* OR pharmacy OR pharmacies OR "drug store*" OR farmasøyt* OR farmaceut* OR apotek*	2685
5	#2 OR #3 OR #4	2685
8	noexp:"General Practitioners"	230
10	noexp:"Physicians, Primary Care"	8
11	noexp:"Physicians, Family"	1286
12	noexp:"primary health care"	2001
13	exp:"General Practice"	3167
14	noexp:"Private Practice"	256
15	((family OR general OR primary care OR private) AND (doctor* OR physician* OR practitioner* OR practice)) OR GP*	5304
16	allmennlege* OR allmännläkar* OR "praktiserende læge*" OR fastlege*	279
17	#8 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16	6640
18	exp:"trust"	128
19	trust* OR mistrust* OR distrust* OR reliance OR tillit* OR "stole på" OR förtroende OR tillid	260
20	#18 OR #19	260
21	#5 AND #17 AND #20	1

Positioning Each Other

Web of Science (Thomson & Reuters)

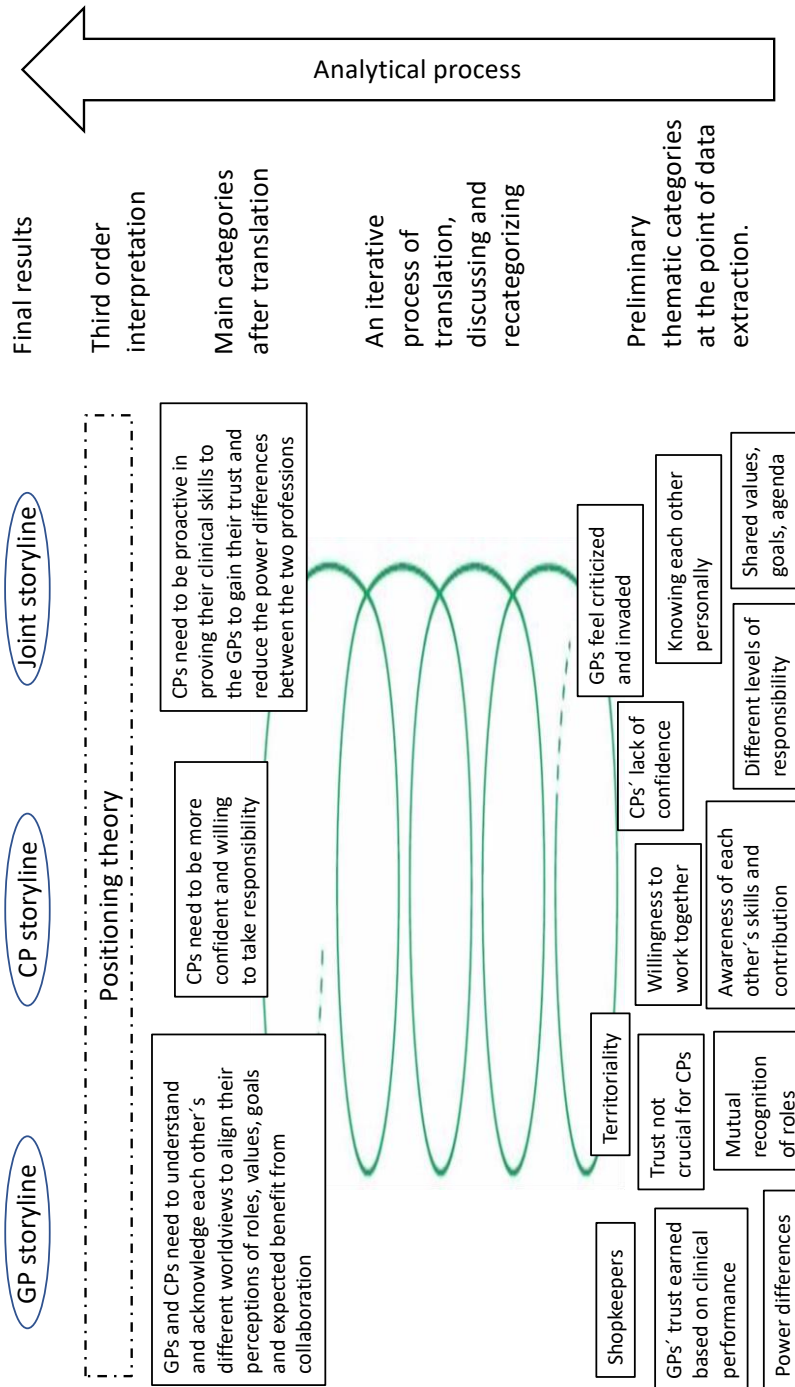
Indexes=SCI-EXPANDED, SSCI, A&HCI Timespan=All years

Searched: 6. Dec. 2016

- # 1 46,370 TOPIC: (pharmacist* or pharmacy or pharmacies or "drug store*")
- # 2 147,776 TOPIC: (((family or general or "primary care" or private) NEAR/2 (doctor* or physician* or practitioner* or practice)) or GP)
- # 3 97,927 TOPIC: (trust* or mistrust* or distrust* or reliance)
- # 4 87 : #3 AND #2 AND #1

Appendix 2

Figure describing the analysis process from preliminary thematic categories to final results



Appendix 3

Excerpt from the analysis grid

Theme	Bradley et al. 2012	Dey et al. 2011	Gregory & Austin 2016	Löffler et al. 2017	Paulino et al. 2010	Rathbone et al. 2016	Rieck 2014	Rubio-Valera et al. 2012	Snyder et al. 2010	Van et al. 2011	Weissenborn et al. 2017	Our translation
Shopkeepers	Distrust was associated with the commercial aspect of pharmacy	X	X	GPs perceived that pharmacists would have their own agenda by making money of patients	CPs as business-people. Mistrust about whether the aim of pharmacy services was patient benefit or economic benefit for the pharmacy	X	GPs perceived CPs to be at a lower level of the primary health care hierarchy than other health care professions due to the retail component of pharmacy (remuneration through the sale of products)	Negative opinion due to perception of a "private-public" conflict. A belief that CPs, through selling medication, had a greater interest in non-rational use of medicines	X	Lack of trust in CPs' agenda (whether they acted in the best interest of the patients) and clinical ability due to perception of CPs as "shopkeepers"	X	GPs mistrust CPs due to retail aspect of pharmacy

GP: general practitioner, CP: community pharmacist

¹ We use the terms “CP” and “GP” in this article to refer to community pharmacists and physicians working in primary care, although the terms used in the primary articles upon which this metasynthesis is based varies (e.g. pharmacists, family physicians, physicians). One of the primary articles includes a mix of general practitioners and hospital physicians, but for pragmatic reasons we chose to use the term GP throughout our article since the vast majority of physicians included in the primary studies were general practitioners.

² Defined by Atkins et al. (2008) as: “the comparison of themes across papers and an attempt to “match” themes from one paper with themes from another, ensuring that a key theme captures similar themes from different papers”.

Situating Boundary Work: Chronic Disease Prevention in Danish Hospitals

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Abstract

This paper investigates how health professions compete and cooperate in addressing emerging local work tasks defined in relation to new globalized health challenges, such as type 2 diabetes. It identifies which professional groups have claimed responsibility for the tasks and by means of which kinds of interactions and infighting. The materials entail workplace-related artefacts and documents; in-depth interviews and extended conversations with health professionals about goals, dilemmas, and practices linked to prevention of lifestyle-related diseases; and site visits at Danish hospitals. Grounding Abbott's framework of jurisdictions and his meso-level vocabulary in a situated account of professional boundary work, the analysis follows the ways that nurses in particular create, and sometimes stabilize or standardize, techniques for a disease prevention programme less than a decade old. The paper argues that processual theory of boundary work would benefit from grounding in a situated account of forms of professional boundaries within emerging jurisdictional tasks.

Keywords

Health promotion, lifestyle modifications, health professions, work practices, boundary objects, workplace artefacts

Introduction

Reducing the global burden of noncommunicable diseases (NCDs), such as type 2 diabetes, is an overriding priority in the work of the World Health Organization (WHO). NCDs are the leading cause of death globally (WHO, 2014, p. xi) and health professionals are mobilized to identify individuals at risk. However, it is not always evident which professions are responsible for this work. From a global perspective, some crucial and increasing risks for NCDs are highlighted by the Global Study of Disease Burden 2015: obesity, high fasting plasma glucose, and alcohol use (Murray et al., 2016). It is well known that such health risk factors are prevalent among patients at hospitals and might aggravate their pathway and clinical outcome (Oppedal et al., 2011). Interventions aimed at helping patients in healthcare settings to quit daily smoking, control alcohol use and nutrition, and attain a healthy level of physical activity—so-called clinical health promotion—have been indicated to improve treatment results, and also have proved cost-effective (Tønnesen, Svane, Groene & Chiou, 2016, p. 13). However, we have few insights into situated work practices for handling the new health challenges.

In Denmark and elsewhere, health professionals in hospitals are mobilized to identify individuals at risk as a way of reducing the probability of their developing, or worsening, the most common and deadly NCDs. In the case of so-called lifestyle-related disease prevention, the transnational authority of the WHO has laid the global epistemic foundation for raising the professional and political stakes of this challenge. The WHO has estimated that four lifestyle factors combined—weight, exercise, diet, and smoking—are associated with an 80 per cent reduction in the risk of common and deadly chronic diseases (Mathers & Loncar, 2005), and lifestyle-related disease prevention figures prominently as a policy idea in numerous public health reports, including in Denmark. Within the last decade, all Danish public hospitals have implemented a screening programme among their inpatients to evaluate their habits of smoking, nutrition, alcohol intake, and physical activity, thereby deciding whether interventions should be recommended to prevent or avoid worsening chronic diseases. Yet, which professions or professional groups are supposed to handle such tasks at hospitals—and how?

Drawing on empirical material gathered from Danish hospitals in 2017 and 2018, this paper investigates how health professions compete and cooperate in addressing emerging local work tasks defined in relation to the new globalized health challenges. It will be demonstrated how nurses account mostly for those who compete, participate, and collaborate in this new area of possible inter-professionality, as well as assuming responsibility for its coordination. In the analysis, professional boundary work is a key concept that covers the varieties of situated work in which professions and professional actors engage in order to forge jurisdictional claims, including symbolic boundaries within and between professions (Gieryn, 1999; Liu, 2015). Such dynamics are demonstrated by considering the lifestyle-related disease prevention programme as a boundary object, first

and foremost by *situating* the boundary work addressing this specific programme. It is argued that the empirical material of local professional work indicates how nurses re-establish professional boundaries in a new territory. The concluding discussion addresses how processual theory of boundary work can benefit from grounding in a situated account of forms of professional boundaries within emerging jurisdictional tasks. In the following section, the theoretical framework and contribution, along with the concepts informing this paper, are outlined, inspired as they are by the American sociologist Andrew Abbott's sociology of professions, as well as by sociological literature on professional boundary work.

Theoretical frame: Professional boundary work on the ground

Exploring how new health promotion initiatives alter the foundations for professional jurisdiction, this paper traces the emergence of *prevention of lifestyle-related diseases* as a trans-local professional proto-jurisdiction by concentrating on profession-driven interventions and initiatives in Denmark. The term "trans-local" refers here to a focus on how professional groups compete and cooperate in creating local change in relation to a border-transcending challenge (Blok, Lindstrøm, Meilvang & Pedersen, 2018). The term "proto-jurisdiction" captures the way professions renegotiate established boundaries under conditions of institutional change (Abbott, 1995). In this case, prevention of lifestyle-related diseases has emerged in the form of novel professional work tasks over the past 10-15 years, thereby still constituting a relatively elastic and ambiguous arena where, in particular, medical doctors and nurses lay claim to certain degrees of control.

In order to contribute new insights into the intra- and inter-professional responses to an emerging work task arena—or proto-jurisdiction of health professions, related to global health problems—this paper employs a jurisdictional (Abbott, 1988, 2005) research approach. According to Abbott (1988, p. 20), professional relations are organized via jurisdictions, defined as "problem-spaces" that link professional groups to particular work tasks over which they claim expert authority. However, how health professionals impact upon, and are themselves influenced by, changing local as well as global contexts for their work is a question yet to be systematically explored within sociological research on global transformations and changes in professionals' work. Addressing lifestyle-related disease prevention is frequently articulated as a border-transcending global challenge that requires new transnational forms of professional expertise and political regulation (Faulconbridge & Muzio, 2011; Kuhlmann & Saks, 2008). Rather than take such "global" claims for granted, this paper will demonstrate how prevention of lifestyle-related diseases as a new trans-local professional proto-jurisdiction is enacted in a workplace arena. In line with this approach, the analysis will ground Abbott's framework (1988, 2005) in a more situated account of professional boundary work and follow the way health professionals create and sometimes stabilize or standardize techniques for lifestyle-related disease prevention at Danish hospitals.

Considering professional boundary work as “situated” involves in this case a focus on both conflict and cooperation at the workplace level between health professionals and professions, or professional segments (Bucher & Strauss, 1961), not to mention occupational strategies that emphasize specific knowledge, training, and skills (Apeso-Varano, 2013). Given this paper’s aim to forge an analytic vocabulary capable both empirically and conceptually of keeping its focus on dynamic professional interactions within workplace boundaries, I join related attempts at furthering an interactionist approach to inter-professional change (e.g., Liu, 2018). *Situating* boundary work hints at Liu’s very important work on lawyers (e.g., Liu, 2015) and professional change, which places at the centre of attention the situated interaction of professionals and professional groups over, within, and across boundaries. Yet, in defining “boundary maintenance”, he does not include situated workplace-based professional interactions in his three-fold distinction, which also encompasses “boundary making” and “boundary blurring” (Liu, 2018, pp. 48-49; see also Blok, Lindstrøm, Meilvang & Pedersen 2019, p. 595). Likewise, “situating boundary work” critically hints at Abbott’s more abstract work on “linked ecologies” (2005) and his general approach to the workplace arena in *The System of Professions* (1988). As argued elsewhere (Blok et al., 2019), Abbott is pointing to outcomes rather than the means and tactics of boundary work (see for example Abbott’s listing of settlement types, 1988, pp. 69-79). In this paper, interactionist concepts are chosen as a way of exploring situated tactics and workplace processes involved in the making and maintaining of inter-professional boundaries, herein the concept of boundary object (Star & Griesemer, 1989).

By viewing a lifestyle-related disease prevention programme as a boundary object, this paper will show how health professionals articulate their prevention work tasks in terms that are close to what Abbott has called the “jurisdictional dispute” (1988, pp. 69-79). Considering a boundary object implies an analysis of how it functions as a coordinating, but also a contested, object between professional groups. To use Star’s characterization of such objects, they are “a sort of arrangement that allow different groups to work together without consensus”, and what matters for boundary objects is “how practices structure, and language emerges, for doing things together” (Star, 2010, p. 602). The forms this work may take overall are not arbitrary, Star emphasizes. Such forms have arisen owing to “information and work requirements” (Star, 2010, p. 602), and the usefulness of the “boundary object” is underlined at the organizational level in particular (Star, 2010, p. 612). The analytical scope in this paper is concretized to the hospital as the workplace level in which health professionals are developing and using a disease prevention programme—or escaping it, or experiencing limited access to it. Thus, for example, “workplace artifact”, as defined by Bechky (2003), will illustrate workplace relations and how task boundaries are created, maintained, or challenged.

Whereas social boundaries often refer to lines of demarcation (Lamont & Molnár, 2002), Liu characterizes boundary work as a social process and defines the boundary for a profession

as “a site of conflict and cooperation between two or more professional or non-professional actors seeking to establish jurisdictions over similar work” (Liu, 2018, p. 46). As Liu also has suggested (2015, 2018), the varieties of situated boundary work in which professions and professional actors engage in order to forge jurisdictional claims, niches, and linkages have yet to be further explored. Within the goal of tracing “prevention of lifestyle-related diseases” as a new set of professional tasks and identities, I will draw on Liu’s notion of boundary and typology of boundary work. In *situating* boundary work, the discussion will, as mentioned above, deviate from Liu’s proposed typology (Liu, 2015, 2018), since Liu does not retain the definitions of all the forms (i.e., boundary maintenance) at a situated workplace level. By these means, I aim to capture the significant ways that Danish nurses seek to navigate emerging task arenas on the ground as they encounter new health challenges.

Context, methods, and analytical strategy

The Danish hospital sector is mainly publicly owned and regulated through political-administrative decisions. Serving a population of about 5.8 million, the health system is relatively small and the actual number of public hospitals about 50 (see e.g., Kirkpatrick, Dent, & Jespersen, 2011, pp. 494-495, for more information about the Danish health system). Most hospitals are specialized in the treatment of diseases, and yet in Danish hospitals, as well as those in many other countries, health professionals are mobilized to identify individuals at risk in order to reduce the development of the most common and deadly so-called lifestyle-related chronic diseases. In Denmark, there have been inter- and intra-professional discussions about this issue. Who should handle the prevention of such diseases and how? Indeed, the concepts and practices of health promotion and disease prevention are not new to hospitals. However, concepts, along with practices, have changed over recent decades.

The “KRAM screening & intervention” is a less than a decade-old implementation at Danish hospitals, implying that in principle all inpatients should be asked about their so-called lifestyle habits. KRAM (in English: SNAP) is an acronym for smoking, nutrition, alcohol intake, and physical activity—at Danish hospitals, related to lifestyle disease prevention. Managing prevention of such diseases may be presumed to be carried out within an inter-professional area of expertise. In considering “KRAM screening & intervention” as a professional boundary object, I was able in undertaking my research to capitalize on current health policy developments and to “study the ways in which these changes in occupational frontiers were being managed by staff in the workplace” (Allen, 2000, p. 335). As argued elsewhere (Blok et al., 2019), under such conditions of institutional change, and without external specifications about how such tasks should be addressed, inter-professional boundary work takes on a specific importance in that it pertains simultaneously to a renegotiation of established workplace routines.

Methods

This paper draws on research I carried out in four hospitals, mainly in the northern part of Denmark, between May 2017 and June 2018. The study included site visits, field observations, conversations, and in-depth interviews with health professionals and managers about goals, dilemmas, and practices related to “KRAM screening & intervention” (see Table 1 below). Observations were carried out on one of the wards through attendance at “KRAM screening” of new inpatients and “KRAM conversation” about recommended interventions with inpatients close to being discharged from the hospital. Elsewhere in the organization, I observed among other activities patient education about “KRAM risk factors”. On the ward, I mainly accompanied some of the nurses, but also one of the healthcare assistants. I gained insight into informal collaboration on the ward and how personnel communicated among themselves both directly and by means of aids such as laminated pocket sheets, flow charts of working processes, noticeboards, lists of inpatients with messages about the KRAM screening, discharge sheets, etc.

Managers at the hospitals’ divisions for health promotion information all agreed to participate and gave access to the hospitals in which observations, conversations, and interviews were performed. One of them acted as a gatekeeper and granted access to the ward studied here, as well as to patient education meetings about lifestyle risk factors. I generated data through field notes, as far as possible recorded contemporaneously in a notebook; through tape-recorded in-depth semi-structured interviews with ward nurses and other nurses, doctors, dietitians, and clinical and HR managers; as well as through spontaneous or planned extended, sometimes repeat conversations (not tape-recorded, but collected thorough notes), with healthcare assistants, nurses, physiotherapists, and a non-smoking consultant. In all, I engaged in a total of 25 interviews and extended conversations.

Table 1. Overview of data sources

	Site visits	Interviews	Participants	Documents
Lifestyle disease prevention	Danish hospitals (4), one repeat four times (1-4 days per visit); workplace artefacts (23 items)	In-depth interviews (11), extended conversations (14); transcribed material, in sum 578 pages	Nurses (12), dietitians (4), physiotherapists (4), doctors (2), others (e.g., healthcare assistants) (3)	Prevention policy (7) and practical intervention materials (32), educational programmes (9)

In Denmark, there are no institutional boards for the approval of social science studies, but the study was carried out in accordance with the ethical guidelines for the social sciences as

specified by *The Norwegian National Research Ethics Committees* (NESH, 2016). Consent from the individuals or their representatives was obtained and confidentiality promised. Thus, all identifying information has been removed from the material used in this paper. The interviews and not least the extended conversations proved to be an important source of data. The perspectives from different professional groups have afforded an enhanced understanding of my observations. I have compared my own empirical data with materials from different sources in order to make more thorough judgements as to how I should interpret the data or material. This material included documents (e.g., standard procedures and registration forms), reports (for example, by the WHO and the Danish National Health Authorities), workplace artefacts, and educational programmes that have developed or revised their curricula to include disease prevention (see Table 1 above).

Analytical strategy

This paper's qualitative approach follows Abbott's contextual sociology (2001) in stressing the concrete relations, settings, and situations in which professional power is shaped and exercised. The empirical work therefore also includes site visits and observations. The methodology of interviewing provides access to agendas, understandings, and opinions of health professionals based on their daily work and experiences with health promotion and prevention of chronic diseases. The study was directed at eliciting the health professionals' own terms for and ideas about their practices and experiences related to "KRAM screening & intervention". The practices, strategies, and rhetorical devices they employed in exercising occupational demarcation will be treated here as examples of professional boundary work (Gieryn, 1999; see also Allen, 2000, p. 327).

The Danish hospital context is an arena where disease prevention and health promotion are not clearly demarcated as the domain of one specific profession, and so in this analysis it will be demonstrated how different forms of professional boundary work are under way. A situated analysis of boundary work in this instance makes for the first step to discussing professional and wider institutional change. Drawing on Clarke, Friese, & Washburn's *Situational analysis in practice*, it is assumed that "*the conditions of the situation are in the situation*" (2015, p. 98, their italics for emphasis). This means that there is not a "context" for such a notion of situation: Instead, "*the conditional elements of the situation need to be specified in the analysis of the situation itself as they are constitutive of it*" (Clarke et al., 2015, p. 98, their italics for emphasis). This notion of situation—I will not dwell here on philosophical or other disciplines where this notion is seminal (see, for example, Dewey, 1949[1938])—derives its heuristic value when Clarke et al. (2015, p. 99) suggest making different kinds of mapping: situational maps; social worlds/arenas maps; positional maps.

The mapping has been useful to analyse across different types of material and elements, and the initial situational mapping suggests much inter- and intra-professional repositioning of tasks. The following analysis draws on maps of the kind that lay out "the major human,

nonhuman, discursive, historical, symbolic, cultural, political, and other elements in the research situation of concern” (Clarke et al., 2015, p. 100) while also indicating relations among selected elements such as political issues or initiatives and how professionals handle such issues. The overall question underlying the situational mapping was: Who or what matters to “KRAM screening & intervention”? Worth mentioning here is the notion of “workplace artifacts” (Bechky, 2003), which below includes many elements ranging from flow charts to laminated pocket sheets to the manner in which health professionals use the procedure of “KRAM screening & intervention”. Preventive work emerges as a possible arena for nurses in particular, wherein workplace artefacts are developed and demonstrate important professional coordination work at stake.

Situated boundary work

In this section, the findings will encapsulate the ways professionals on the ground—in this case, nurses in particular—seek to navigate emerging task arenas that are not always well defined. These findings are structured into three subsections concentrating in particular on nurses’ efforts to extend, defend, or refashion established work boundaries when handling “KRAM screening & intervention” at Danish hospitals.

Effecting control over the process of screening and intervention

When a nurse engaged in developing a flow chart for the process of “KRAM screening & intervention” mentioned that healthcare assistants were interested in becoming involved in the screening task, she emphasized the importance of knowing about specific diagnoses. In particular, she stressed the importance of knowing about instances of comorbidity in order to administer the programme, not least the intervention part, without risks:

... when you recognize the criteria for a metabolic syndrome, you have to intervene yourself, based on: What are the criteria? And then you say: “Okay, then, in fact I can see my patient really has the precursors to metabolic syndrome. We need to start some kind of KRAM prevention!” This means we’re confronted with certain issues that demand the development of healthcare assistants’ skills to be able to handle the task like the nurses can. (...) This means when we produce guidelines and test them in clinical settings, and we see there are different levels of skill, then ... we see there are differences in how to read guidelines. These are our experiences. And there’s no consensus on in how much detail the tasks should be described. It’s clear that because something’s obvious to a nurse, it doesn’t mean it’s obvious to a healthcare assistant. And I think this may be the same for a nurse and a doctor.

What appear as arguments over safety—namely the importance of having insights into the medical implications of comorbidity, thereby triggering an ethical dilemma if healthcare assistants cross perceived occupational boundaries—might be in fact disguised turf wars.

Arguing for the importance of having achieved knowledge of pathology to handle the screening and intervention programme in a safe and proper manner may indeed be seen as a marker of an occupational identity, thus marking the legitimate boundaries between the nurses' and healthcare assistants' training.

The flow chart of the screening and intervention process documented lifestyle risk factors, as well as different medical conditions, with respect to occupational knowledge and authority. However, this nurse's account also allows for the possibility of knowledge transfer that Abbott calls "workplace assimilation" (1988, pp. 65-66). In particular, when there is too much work to do, which is the case in many hospital wards, subordinate professionals or nonprofessionals (have to) learn from a given profession's knowledge system. Yet, as we will see below, other nurses emphasized that theoretical training equivalent to a nurse's education should be required.

A nurse who worked as a coordinator of health promotion at another hospital emphasized as well that all aspects of the KRAM screening should be carried out by qualified staff who had finished a Professional Bachelor's degree programme:

I've argued that KRAM advisers [appointed in each ward] as a minimum should hold a Professional BA degree. It means they should be physiotherapists or occupational therapists in their department and midwives in the maternity department, and dietitians and nurses. (...) We had some healthcare assistants who wanted to work with it. (...) However, we maintain that although they're allowed to talk to the patients about health promotion—this isn't an issue—those who should serve as the KRAM advisers and have the responsibility in the ward, and who can be asked about concerns regarding organizational issues—"What's meaningful in your area? What do you prefer in this case?" and so on—*this* [the nurse's emphasis] should come under the KRAM advisers' area, for those who hold a Professional BA degree.

Nurses' professional rhetoric about healthcare assistants can be seen as occupational identity work that may be considered a variant of boundary work. Nonetheless, how the labour was divided varied from ward to ward. In ward A, there was too much work for nurses to do all the KRAM screening and so healthcare assistants did it as well.

However, the nurses in ward A distinguished between identifying lifestyle habits and motivating patients. A head nurse said that healthcare assistants, like the nurses themselves, can and in fact do complete KRAM screenings to identify lifestyle habits:

Within some areas, the healthcare assistants have a much greater focus on lifestyle than us [the nurses]—in their training as well.

Yet when it came to disease prevention as a follow-up to the KRAM screening and thereby the task of communicating with patients before they were discharged, the same head nurse stated:

But they [healthcare assistants] are unable to undertake the talk with patients about prevention.

Only nurses completed the “KRAM conversation” to motivate patients close to being discharged. When I asked a nurse if doctors could complete the prevention talk with patients, she replied that this was an option and sometimes it happened, but not in a systematic way:

Maybe they tell the patient not to smoke—and sometimes they ask about alcohol use, but they don’t complete a KRAM screening.

She and more nurses from this ward also emphasized that the discharge sheet for following up on the “KRAM screening & intervention” was a nurses’ tool. The head nurse related how one of the doctors wanted to add something to the discharge sheet:

Yet he hasn’t received it [the authority to modify the sheet]. This [his suggestion] can’t currently be included. Here, on this sheet, we’re focusing on some other aspects.

The current political claim of prevention of lifestyle-related diseases seems to have created among certain segments of the nurses an ambition to establish a domain of professional practice that is relatively removed from doctors’ control. As for the doctors’ concern, attempts to control the “KRAM screening & intervention” can be interpreted as a strategy for maintaining their dominance, whereas for nurses, as illustrated above, this programme can be understood as an opportunity to extend their task area by means of workplace artefacts, for example, flow charts and discharge sheets used as jurisdictional tools.

Instruments to maintain authority

How established work boundaries were defended, in order to be maintained, was evident from the way the interviewees linked the task area to training necessary to handle the programme of “KRAM screening & intervention”. One of the interviewees, a nurse with an MA degree and a supervisor for health professionals involved in prevention of lifestyle-related diseases, said:

I’ve argued that as a professional encountering a patient with lifestyle-related problems, you need to have achieved a certain background knowledge. The reason is that first off, you need knowledge and, second, the situation implies the art of communication. And you definitely have this if you’ve graduated with a Professional BA degree. You’ve been trained, then, in some psychology and

communication, also pedagogy. Moreover, you've succeeded in passing lots of exams where you certainly can delve more deeply into some issues. And you've practised how to convey [these ideas] to other people—and this is the deepest you can go. You must feel 100 per cent confident in what you want to convey to others. Those who hold a Professional BA degree have tested this ability.

Thus, she emphasized that the “KRAM screening & intervention” was made possible through securing the appropriate patient communication derived through training and its grounds for developing qualifications.

Although “health promoter” is one of seven so-called “roles for doctors” included in the specialty training of Danish medical doctors, this area is not much evident or prestigious among doctors at Danish hospitals. As a medical doctor said:

I don't have the full overview of what's known, but of course many people have studied different ... what should we call them? Pedagogical methods? However, it's not the case that I have *one* [the doctor's emphasis] way of doing things. It's a bit like common sense. And I have thought about this in connection with helping our nurses ... with what I'll call “nursing professionalism” —the ability to do this [lifestyle disease prevention and health promotion]. And where ... do they position their professionalism? Is it only a matter of common sense or do they simply have a method they use? And this ... right here, it's not really my strength. And I don't think it's our nurses' either. I don't think so.

This example of downgrading the prevention tasks, and thereby the work of subordinate professionals, sheds some light on the status of lifestyle disease prevention and health-promoting work tasks and how this may affect where the occupational boundaries are drawn. Not least, as demonstrated in this subsection, the doctor's account lends a fresh perspective on how established work boundaries are defended when handling the programme of “KRAM screening & intervention”. As Allen has noted (2000, p. 332), two of nursing's key occupational boundaries are those at the interface with medicine and with support staff, respectively. The accounts above illustrate how the downgrading of these tasks undertaken by the subordinate profession ensures these professionals retain a lower status. This applies also when new work tasks have to be handled.

In order to undertake those tasks not covered in basic training, some of the nurses within this area of prevention and health promotion—in particular those with managerial responsibilities—had acquired extended training certificates such as an MA degree within a relevant area of education, for example, an MA in Public Health. The nurses serving as consultants or managers had reasoned the additional degree would prove advantageous for them. It has been suggested that doctors in this instance, as in some others, have dumped more low-prestige work on occupational groups lower in the implicit hierarchy. Yet changes

in Danish university-based doctor training programmes (SST, 2013) suggest as well that, far from giving up prevention as a task, this profession is also slowly annexing the agenda. With the public hospital system in constant flux and a general shortage of doctors and not least of nurses, as well as a steadily increasing focus on efficiency, it seems—as a third scenario—that occupational groups such as healthcare assistants could assume an enlarged role in the increased efforts to prioritize work tasks related to disease prevention and health promotion. In what follows, I will demonstrate, however, how stable boundaries are kept alive by refashioning occupational boundaries with a variety of workplace artefacts developed by nurses.

Boundary re-establishment in new territory

A nurse coordinating the “KRAM screening & intervention” programme at a local hospital stressed the importance of developing the necessary tools and procedures for this specific programme. She talked about the frustration experienced by nurses in particular when they felt that they had transformed patients previously considered “normal” into “problems”; such shifts resulted not only from the classification of patients into “high risk” categories within the screening system, but also from the placement of so-called lifestyle habits onto an agenda of patient communication in the hospital setting:

They [the health professionals doing the screening] tell me: “Whatever I try to say to the patient and however I say it—then I seem to end up communicating in one way or another, ‘You’re wrong about this!’”

The nurse showed how she herself had developed laminated pocket sheets with helpful knowledge, models, and advice used in particular by nurses in the patient-professional encounter. She explained that the staff themselves had enquired about tools they could use to handle situations with patients when required to ask them about their lifestyle habits, and that they experienced patients who went quiet when it was recommended they stop smoking:

If you’re too quick to present your agenda: “You need to stop smoking because of this and that ...”, then the patient probably won’t say a word. You’re better off asking: “What do you know about smoking? How is it related to your prostate?” This approach will make your message more appealing. So, we’ve created some exercises and (...) the staff asked me: “Can’t you make a framework [produce in writing a form of guidelines they can draw upon in these situations]?”

She summed up:

When do we know we have important knowledge to contribute to work practice? When the staff ask to get it laminated!

This is an example of how the staff needed some tools and received a variety of workplace artefacts, in particular laminated sheets as pedagogical tools, for refashioning their skills to motivate the patient in a non-blaming way. Moreover, this example illustrates how the training in communicative skills was used to justify responsibility for such refashioning.

Indeed, it turned out that how nurses defined their work boundaries was central to the interactional accomplishment of the division of labour among nursing, medical, and assistant staff when handling tasks of lifestyle-related disease prevention and health promotion in the hospital setting. This observation can be seen in light of specific aspects of the Danish healthcare management reform of 2007, not to mention how, since the mid-1980s, both the nursing and other medical professions in Denmark actively have sought to lay claim to the jurisdiction of hospital management (Kirkpatrick et al., 2011). Moreover, since the late 2000s, who does what in the hospitals' KRAM screening division of labour has not been explicitly addressed either at the national or counties level. Responsibility for agreeing to the division of labour is left to local determination, that is, certain doctors at the respective hospitals produce individual plans for staff involved in the screening programme.

However, in the workplace settings observed, it appeared to be the nurses' domain to produce plans for staff involved in the actual KRAM screening. At the level of everyday work practices, including new tasks and established routines, nurses are still sorting out the jurisdictional boundaries, with much inter- and intra-professional repositioning of tasks. National health policy, as well as regional regulations and reforms, is a conditional element, among others, of work task situations in Danish hospitals. From the accounts of health professionals were evident a spectrum of responses to their work environment—from feeling used to continually experiencing changing conditions and pragmatically reshuffling features of how they are accustomed to doing their work, to accommodating themselves by taking control of or suggesting new initiatives and using them for professional purposes (see also Allen, 2000, p. 339; Dent, 2008).

Control of education and training also is vital to retaining professional jurisdiction (Abbott, 1988; see also Allen, 2000, p. 341). In the field of disease prevention and health promotion, not only nurses, but also nutritionists, for example, are changing their jurisdictional claims; educational programmes are revising or have developed their curricula to include specialization within this field. The curricula for a Danish Professional BA degree in Nutrition and Health have changed in recent years (cf. curriculum 2010 compared with curriculum 2016) to include a specialty in health promotion and disease prevention. Thus, at the educational level, different professional areas indeed are involved in developing the field of disease prevention and health promotion. As such, health professionals' boundary work is linked not only to the workplace arena, but also to universities as well as to political institutions (cf. Abbott, 2005, about "linked ecologies"). However, the fact that this field is still developing implies that the practical tasks of handling disease prevention and health

promotion at Danish hospitals form a substantial part of what makes up the (proto-)jurisdictional boundaries.

Concluding discussion: Situating boundary work

In this section, I will discuss and sum up the ways processual theory of boundary work can benefit—or not—from grounding theoretical frameworks in the workplace arena in order to analyse conflicts or other dynamics involved in professional proto-jurisdiction. The focus, then, is on situated boundary work when a jurisdiction is not resolved. In sum, this paper's findings indicate that the onus for defining the boundaries of nursing within the arena of prevention and health promotion at Danish hospitals currently is left sometimes to the local hospital. Second, the findings hypothesize that this trans-local professional proto-jurisdiction is likely to emerge as the next site of well-known inter-professional struggles between doctors and nurses. Indeed, medical doctors have included "health promoter" as one of seven important roles in their specialty training programme. However, at some hospitals' health promotion units, which often are run by nurses as managers, doctors in training draw upon services from the unit. The findings have demonstrated how nurses justify their role and obtain qualifications, hereby distinguishing themselves within this area, which is what Liu (2015, p. 3) has referred to as boundary making.

Considering "KRAM screening & intervention" as a boundary object, this paper has drawn on Star and Griesemer's (1989) understanding of such objects as artefacts fulfilling specific functions in bridging intersecting practices, as well as on Star's (2010) perception of such objects as certain arrangements that allow different professional groups to work together. This paper's findings have demonstrated such dynamics of "KRAM screening & intervention", first and foremost by *situating* the boundary work addressing this specific boundary object. In using this situating approach, which includes investigation of work practices and workplace artefacts, it has been possible to indicate only slightly other important components in jurisdictional work, such as political agendas, changes in organizations and education, as well as the linking of health professionals to transnational activities (e.g., WHO). The findings are based mainly on one kind of mapping out of the three available from Clarke et al.'s (2015) SA method, namely situational and relational mapping and not (yet) social world/arena and positional mapping. This focus hinders the "linked ecology" approach (Abbott, 2005) from being fully implemented. However, analysing professional boundary work through the lifestyle-related disease prevention programme considered as a boundary object prevents losing sight of the workplace arena and should be seen as an important step towards grounding Abbott's meso-level vocabulary in situated interactions among professionals.

The findings have illustrated how nurses in particular not only are (re-)constructing their own boundaries, but also the boundaries of other occupational groups. Most work tasks in a hospital fall within certain areas over which a specific profession has established

jurisdiction. However, the everyday tasks involving disease prevention and health-promoting work at Danish hospitals are not externally coordinated in their details. As the findings have demonstrated, this work is in many cases negotiable. Sometimes the jurisdictional relations in the workplace are blurred (see also Abbott, 1988, p. 66; Liu, 2015, p. 3). As Christiansen, Taasen, Hagstrøm, Kjellaug, & Norenberg (2017, p. 1), among others, have noted, borderlines between professions can also be “areas of contact that link social worlds and open opportunities for collaboration, learning, and development”, although the delineation between professions “has traditionally been used to construct boundaries around tasks and fields of knowledge and to exclude others”. In the case of creating and implementing the programme of “KRAM screening & intervention”, there are several tasks and situations requiring cooperation and coordination to solve problems and meet challenges, for example, when working under time pressure. As Abbott has noted, in the workplace, boundaries between professional jurisdictions can disappear or at least become very blurred, “particularly in overworked worksites” (1988, p. 65).

However, although Danish hospital wards in general are lacking nurses, in the study sites, it was nurses in particular, who had developed specific tools for doing the “KRAM screening & intervention” work. This paper has mainly focused on demarcation work and less on collaboration when analysing professional boundary work. A jurisdictional approach will often produce certain results and the findings therefore should reflect this perspective. In this study, nurses emphasized that they had the advantage of certain ideas about the most appropriate sites for prevention and knowledge linked to the dangers of health risks, along with an understanding of the importance of distinctly classifying the “normal” and the “pathological”; and they stressed, too, that they knew “how to communicate with patients”. Such statements from nurses could be considered conflictual as well as collaborative. Nurse managers also were establishing alliances with other professional groups with a Professional BA degree, such as physiotherapists, dietitians, midwives, and occupational therapists, while at the same time resisting coming under the control of the medical doctors. The establishing of inter-professional alliances, as well as demarcations, was an important element in the examined boundary work. In future research, collaborative learning will need more attention as well (see also Christiansen et al., 2017).

Medical doctors at Danish hospitals are in many cases formally responsible for areas related to and projects centred on prevention and health promotion. However, in practice, disease preventive work is emerging as a possible arena in which nurses might contest the hierarchized division of labour and management competencies (see also Kirkpatrick et al., 2011)—in part because the commitment of doctors to the prevention agenda seems to fluctuate considerably. Here, WHO recommendations and standards may well come to serve as a resource for nurses to reformulate their projects in ways that simultaneously enjoy professional and political legitimacy. At the same time, the nursing contribution to this new task could entail nurses’ “rejection of the old hierarchy of prestige which elevated technical

(medical) tasks over bedside (nursing) care” (Allen, 2000, p. 334). Future—and transnational—studies are needed to follow up on this issue.

Grounded in empirical material, this paper’s findings have distinguished nurses’ efforts to extend, or defend, or refashion established work boundaries when handling “KRAM screening & intervention” at Danish hospitals. Nurses, along with managers who were trained as nurses, have developed and initiated a number of workplace artefacts to show their competency in practising and managing a process of boundary work. These artefacts include, for example, flow charts and self-instruction packages, and specific discharge sheets for KRAM health risk intervention, but also measures supplementing training and education. The focus on such activities, which considers the programme of “KRAM screening & intervention” as a boundary object, perceived as a set of work arrangements allowing different professional groups to work collaborate, has situated the boundary work. The findings have gained analytical purchase for documenting relations that emerge when task boundaries are challenged. It has been illustrated how the development of workplace artefacts, sometimes distributed as laminated pocket paper sheets used in the patient-professional encounter, as well as flow charts outlining procedures for screening and intervention processes, can serve as jurisdictional tools. In these cases, this is especially true for nurses engaged in hospitals’ disease prevention work.

Thus, by situating processes of boundary making, or maintenance, or blurring (cf. Liu, 2015), this paper can set the situational foundations for moving to more mapping—aimed at tracing the wider local, national, and transnational professional, university, and political linkages at work in the emergence of new jurisdictional tasks (see also Blok et al., 2019). “Prevention of lifestyle-related diseases” considered as a trans-local professional proto-jurisdiction is likely to emerge as the next site of a well-known inter-professional struggle. In particular, the struggle will take place between medical doctors and nurses—but also among other health professionals involved—and this issue can differ transnationally. Thus, the definition and meaning of task areas are likely to become the subject of intense conflict. However, with the current shortage of health professionals in Denmark and elsewhere, nurses do not so much need to reduce the role of possible competitors as to use the new prevention tasks to strengthen their claims for a more elevated status. Indeed, the demonstrations of boundary work presented in this paper indicate this conclusion.

More research is needed to affirm whether doctors, nurses, healthcare assistants, or other professions or occupational groups, perhaps in particular segments within a profession (Bucher & Strauss, 1961), in fact have most to gain from leveraging ties both to local and global health problems. Overall, the interactive effect of the developments within Danish hospitals has created some jurisdictional ambiguity at the work boundaries between the professions of medicine and nursing in particular, and maybe also between nurses and healthcare assistants. This ambiguity raises many questions about the future jurisdiction of

prevention of lifestyle-related diseases in other countries as well, since NCDs represent a global problem.

This paper's grounding of Abbott's framework of linked ecologies and his meso-level vocabulary in a more situated account of professional boundary work hopefully has opened the way to exploring how health professionals create, and sometimes stabilize or standardize, techniques for prevention of lifestyle-related diseases at hospitals, not merely in Denmark but elsewhere. The paper has situated all the different forms of boundary work in Liu's typology (2015)—not only boundary making and blurring, as Liu himself has undertaken, but also boundary maintenance—by drawing on Bechky's (2003) notion of "workplace artifacts". Using this methodology, we have seen how nurses specifically are creating, but also stabilizing and maintaining jurisdictional claims, niches, and linkages. Yet, the ways nurses in particular seek to navigate emerging task arenas, which are not well defined, have been captured only at a situated workplace level, meaning the material does not allow me to draw conclusions about general jurisdictional claims. This type of qualitative study, developed to collect varied material, has been more concerned with obtaining reasonable grounds for the relevance of essential issues to the sociology of professions in order to discuss how prevention of lifestyle-related diseases, addressed as a proto-jurisdictional task, can contribute insights into the dynamics of boundary work on the ground.

Building on empirical observations from ongoing research, I have taken some steps towards fleshing out the trajectories of a novel trans-local professional proto-jurisdiction by sketching an analysis of situated work practices that address emerging local work tasks related to a globalized health challenge. This is only a starting point for further empirical enquiry, for example, elucidating the role of international networks such as *Health Promoting Hospitals* (e.g., Tønnesen et al., 2016), standards, and professional practices in framing the jurisdictional boundaries of global and local health problems. Further enquiry, I hope, will indicate a number of interesting directions for research more generally, both empirically and in terms of theory construction—thus addressing a research agenda resulting from a more comprehensive assessment of trans-local professional projects, including how their linked ecologies, such as those of politics and the university, are transnationalized.

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