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Table of Contents

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A Discretionary Toolkit: Reasoning When Teaching Controversial Issues in Norwegian Upper Secondary School

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Abstract

Using a toolkit approach in combination with the concept of street-level bureaucracy and theories of discretion, this article has empirically investigated the resources that influence teachers' discretionary reasoning when teaching controversial issues. The analysis has been based on 32 classroom observations at two upper secondary schools in Oslo, Norway, in one Religion and Ethics and one Social Science class, and interviews with 16 teachers who taught the same subjects. The results have shown that professional competence, professional and personal values, and relationships with pupils worked as a toolkit of resources that teachers could draw upon when making discretionary judgments in different contexts. A better understanding of teachers' use of discretionary reasoning may enable curriculum developers and policymakers to support teachers in the complex social landscape of teaching controversial issues.

Keywords

Street-level bureaucracy, discretionary reasoning, toolkit, controversial issues, teacher practice

This article empirically investigates which resources influence teachers' discretionary reasoning when teaching controversial issues. Teachers' work is filled with planned and unexpected situations where they can choose among several courses of action. They must handle subjects such as racism, immigration, or religion. These issues can stir controversy and emotionally-charged responses in their classrooms, and thus require discretionary judgment in terms of how to present the subject matter and how to respond to different kinds of reactions among pupils.

Several studies have researched how teachers handle controversial issues in the classroom (Hess, 2004; Oulton, Day, Dillon, & Grace 2004; Stray & Sætra, 2016). However, little is known about which resources teachers draw upon when facing challenging teaching situations or how discretionary reasoning plays a role when choosing among different courses of action. Teachers are responsible for pupils' upbringing and learning. As professionals, teachers have specialist knowledge that distinguishes them from the unskilled. A core element of professional work is the use of discretion (Freidson, 2001; Lipsky, 2010). Lipsky (2010) termed the professionals who are responsible for implementing public policy in close contact with client's street-level bureaucrats. Teachers are tasked with implementing broad educational policies as they are stated in curricula through direct interaction with pupils and can therefore be described as street-level bureaucrats. Besides teachers, typical street-level bureaucrats are police officers, social service workers, or health workers—professions that are representatives of the welfare state.

According to Lipsky (2010), street-level bureaucrats' work is both (1) highly scripted and controlled and, at the same time, (2) dominated by improvisation and responsiveness. Molander (2016), describes the tasks they carry out as being "such that political authorities cannot specify exactly what the problems are, exactly what to do and exactly how much resources to deploy in particular cases" (p. 2). Ideally, street-level bureaucrats respond to the needs of individuals they meet. They are expected to use discretionary judgment because they have little direct supervision, and their work is too complex to be reduced to established guidelines.

A wealth of studies focuses on the use and limitations of discretion among professionals responsible for implementing public policy in close contact with clients. Common threads in the literature on teachers and discretion are how large the discretionary space is after applying the rules and regulations, and how teachers handle the discretionary space available to them (Hagelund, 2010; Karseth & Møller, 2018; Maynard-Moody & Musheno, 2003; Svensson, 2019). Researchers debate whether teachers, as street-level bureaucrats, have the same space for discretionary judgment now as when Lipsky wrote his book in the 1980s (Boote, 2006; Taylor, 2007). In a study from the United Kingdom, Taylor and Kelly (2006) claim that teacher's discretionary judgment has changed, and that one must analytically divide discretion into parts to understand whether it still plays a role in teachers' practices. They argue that discretionary judgment based on rules is used less often than

judgment based on values or tasks. A South African study concludes that teachers exercise a high degree of discretion in interpreting school rules, prioritizing what to teach, and emphasizing guidelines (Mutereko & Chitakunye, 2015).

Studies have shown that *discretion* is a slippery, hard-to-capture term (Brodkin, 2012; Evans & Harris, 2004). Overall, one can say that "to have discretion is to have authority to decide in cases where rules and standards do not prescribe determinate results" (Molander, 2016, p. 10). Researchers such as Hupe (2013) and Molander (2016) distinguish between two understandings of discretion: on the one hand, how much freedom rule-makers give to the actors who comply with the rule, and on the other, the ways in which actors actually use this freedom in specific circumstances. The concept of *discretionary reasoning* is related to this second understanding. Despite the fact that discretion is seen as an inevitable part of professionals' work, Grimen and Molander (2008) and Molander (2016) claim that the literature on professions does not fully address the concept of discretion and that the actual exercise of discretion—the discretionary reasoning—often remains an unanalyzed residual category.

Further, Watkins-Hayes (2009) argues that researchers and policymakers emphasize the outcomes of bureaucrats' decision-making rather than focusing on the complex social process of making discretionary decisions. It is, however, important to understand how discretionary reasoning works: If discretionary judgment is to be trusted, then it must appear reasonable to people other than the person exercising the discretion. There is a need for research that can provide a better understanding of teachers' use of discretion by unpacking what influence their discretionary reasoning. This article analyzes how teachers draw upon different resources as a toolkit for discretionary judgments using teaching of controversial issues as a case.

Von der Lippe (2019, p. 2) argues that what should be understood as controversial depends on both the social context and the political climate and may differ in both time and place. What are perceived as controversial issues depend on context and vary between country, city, school, and classroom. In one classroom, discussing immigration can stir controversy; in another, climate change may be perceived as controversial. Studies on controversial issues, both internationally and in Norway, focus mainly on if or how teachers handle these issues in the classroom (e.g., Anker & von der Lippe, 2016; Hess, 2005; Stray & Sætra, 2016). However, to my knowledge, none combine that focus with theories of discretion. In this study, I apply a broad understanding of controversial issues, understood as issues that teachers perceive to be particularly challenging or sensitive to teach because there was no scripted way to handle the situation and thereby demand teachers' use of discretion. Exploring what influences teachers' discretionary reasoning through the lens of controversial issues can contribute to understanding teachers' practices and help unpack how teachers exercise discretion. Thus, the research question is: How do teachers draw

upon different resources to make discretionary judgments when teaching controversial issues?

The framework I use for exploring this question is inspired by theories of discretion and street-level bureaucracy combined with Swindler's (1986) toolkit approach. The analysis is based on interviews with 16 teachers who taught Religion and Ethics or Social Science at three upper secondary schools in Norway's capital city of Oslo and 32 observations of one Religion and Ethics class and one Social Science class at two of the schools where I conducted the interviews.

Perspectives on discretion

Embedded in being a teacher is the uncertain nature of teaching. Helsing (2007) notes that teachers "experience uncertainties due to the complex nature of their work, which is centered on human relationships and involves predicting, interpreting and assessing others' thoughts, emotions, and behavior" (p. 1317–1318). Dealing with uncertainties requires discretionary judgment. My understanding of discretion follows previous research, defining discretion as "an area where one can choose between permitted alternatives of action on the basis of one's own judgment" (Wallander & Molander, 2014, p. 1). Molander and colleagues (Grimen & Molander, 2008; Molander, 2016; Molander et al., 2012; Wallander & Molander, 2014) separate the interlinked structural and epistemic aspects of discretion to distinguish rules from reasoning in decision-making. Delegating discretionary power assumes the actor performing the discretion has good judgment and can decide based on reasoning (Grimen & Molander, 2008; Molander, 2016). When explaining *structural discretion*, Molander (2016) refers to Dworkin's metaphor: Discretion is a doughnut hole surrounded by a belt of restriction. The discretionary space for judgment—the hole—can be bigger or smaller, and discretion is the "freedom of choice *delegated* by authority" (p. 21). Previous research shows that several institutional or contextual factors influence teachers' discretionary space and, thereby, action in the classroom (Andresen, 2020; Karseth & Møller, 2018; Svensson, 2019).

Epistemic discretion—discretion as reasoning—assumes discretion is based on reasoned judgment and decisions, regardless of how large or small the discretionary space is. Under conditions of indeterminacy, where the available reasons do not warrant one outcome, actors must rely on their own discretionary judgement to make a conclusion (Molander, 2016). Zacka (2017) stresses that discretion is "not doing as one pleases" (p. 34) within regulatory boundaries but is internally constrained by a reasonableness standard. For example, street-level bureaucrats must explain the grounds upon which they based their chosen course of action (Lipsky, 2010; Zacka, 2017). Grimen and Molander (2008) define epistemic discretion as reaching a conclusion from a situational description in combination with a norm, and the norm justifies the steps between the situational description and the conclusion. Following Molander (2016), such action norms are similar to what Toulmin

(2003) calls warrants. In a practical reasoning context, the warrants' strength is the most important variable. Warrants can be strong or weak, and discretion can be a form of reasoning when the warrant is weak. Thus, although people may be conscientious and thorough in their reasoning, they can reach different conclusions about the same problem (Grimen & Molander, 2008; Molander, 2016).

Much extant literature views discretion as influenced by different forms of reasoning. For example, Karseth and Møller (2018) understand professional competence as central for discretionary reasoning. Others see street-level bureaucrats as moral agents (Zacka, 2017) or as influenced by ethics codes or values (Taylor & Kelly, 2006). Maynard-Moody and Musheno (2000), in turn, see discretionary judgment as embedded within the relationships between street-level bureaucrats and citizens. A recent study on discretionary reasoning in Norwegian welfare offices shows how an institutional logic or a "norm of action" guide the frontline workers reasoning when concluding a case (Håvold, 2019). In a similar vignette study, Møller (2016) demonstrates how Danish caseworkers use different forms of categorization to evaluate their clients. Both studies highlight certain factors that influences the discretionary reasoning of the frontline workers decision-making regarding their clients.

Teachers as professionals exercise discretion in a different manner. During a classroom session, they continuously make discretionary judgments based on the context of that particular subject and the class they teach. They must choose what teaching strategy will give the best learning outcome, how to address a certain issue given the composition of pupils, and whether they should prioritize a coming exam or the school system's more general educational ideal. Harrits (2016, p. 13) argues that professionals such as teachers who are in close contact with citizens combine a logic based on formal training and knowledge with a more personal, relational, and emotional-based logic when making discretionary judgments.

Inspired by Swidler (1986), these different resources can be conceptualized as *cultural resources,* which teachers can incorporate into their daily work. Due to the complex nature of teachers' work, it may be useful to view these resources as a repertoire that teachers can draw upon when making discretionary judgments. Swidler views people as competent users of such toolkits and differentiates between situations in which people follow established action strategies without much reflection or resistance (settled lives) and those in which they test new strategies (unsettled lives). I argue that teaching potentially controversial issues can be seen as unsettled situations, where teachers must adapt teaching strategies to the current theme and context using discretionary judgment. Watkins-Hayes (2009), inspired by Swidler, had developed the term *discretionary toolkits* in her study of welfare officials who are in close contact with their clients. She writes, "Discretionary toolkits denote and organize the capabilities, perceptions, resources, and choices that organizational actors have at their disposal to shape institutional actions and outcomes" (p. 56). Focusing on the discretionary reasoning of teachers in situations where they teach

potentially controversial issues at two different upper secondary high schools in Norway, this article will explore what kind of discretionary toolkits teachers draw upon when teaching controversial issues.

Data and methods

Data for this analysis were drawn primarily from 16 interviews with seven Religion and Ethics teachers and nine Social Science teachers at three upper secondary schools—one on the west side and two on the east side of Oslo, Norway (anonymized as Western High, Eastern High, and Eastern High 2). I also conducted 32 classroom observations in one Religion and Ethics class and one Social Science class at Western and Eastern High.

The analysis used the case of Norway. In Norway, 93% of 16- to 18-year-olds attended upper secondary schools, and there has been a strong ideological tradition for educational institutions preparing children to take part in a democratic society (Møller & Skedsmo, 2013; Union of Education Norway, 2019). A central aspect of the Norwegian school system has been to teach democratic citizenship, cultural diversity, and critical thinking (The Education Act of 1998, §1-1) in a society that has become increasingly diverse through modern immigration. Regardless of social background, gender, religion, or ethnicity, everyone has the right to be included in what is often called the Norwegian unitary school. The public educational system thus exposes individuals to a common frame of reference (Kjeldstadli, 2014).

In Oslo, 40% of pupils were immigrants or children of immigrants. However, the ethnic diversity vastly differed among Oslo schools. The two schools where I conducted classroom observations were purposively selected to vary in pupils' ethnicity, socioeconomic backgrounds, and grade-point average needed for acceptance. All but two interviewed teachers worked in those two schools (the other two worked at "Eastern High 2"). I did not observe lessons in Eastern High 2 due to conflicting teaching schedules but the two teachers I had been in contact with were interested in participating in an interview. At Eastern High and Eastern High 2, most pupils in the Educational Program for Specialization in General Studies were immigrants or children of immigrants. (General Studies prepares pupils for higher education; their other option is a vocational education program.) At Western High, pupils in the same program were mainly of Norwegian descent.

The interviews were conducted during and after 3 months of observation. While observing, I sat in the front or back of the classroom writing field notes throughout the lesson. I gained access to the schools through the principal at each school. The teachers and pupils were informed about the project and gave informed consent. Although data from the interviews form the main basis for the analysis, my observations in the four classrooms were discussed with the informants during the interviews and helped shape the interview guide. For instance, I used examples from the classroom observations to start conversations around different topics and to encourage teachers to elaborate on situations I observed. The interviews were conducted in meeting rooms or empty classrooms at the school and lasted

about an hour each. I recorded the interviews and had them transcribed afterwards. All informants and schools are anonymized in this article.

The 16 teachers' educational backgrounds varied. Three had specific teaching education from a university; 13 had general academic backgrounds in Norwegian literature, sociology, religion, history, social anthropology, political science, or economics before completing a 1-year undergraduate teacher-training program required to teach at upper secondary schools in Norway. One teacher was from another Nordic country; the rest were of Norwegian descent. I chose to observe the subjects of Religion and Ethics and Social Science because the curricula specified that the subjects necessitated discussion and reflection (The Norwegian Directorate for Education and Training, 2006; 2013). They exemplified issues that, in the interviews, teachers described as demanding their sensitivity and discretion. Both subjects were obligatory for all pupils who attended upper secondary school in the General Studies program.

I analyzed my observation fieldnotes and interview transcripts inspired by principles of thematic analysis—a method to identify, analyze, and report key patterns or themes in a dataset (Braun & Clarke, 2006). The first coding round for this article was data driven, and the concept of teachers' discretionary reasoning was present in many codes. In the second round, informed by the previously presented perspectives on discretion, I looked for excerpts in which teachers talked about what had influenced their discretionary reasoning when teaching controversial issues. Three themes became prominent in the material: professional competence, professional and personal values, and relationships with pupils. I viewed these themes as resources in the teachers' discretionary toolkits. In the following analysis, I use quotes from selected teachers, which illustrates broader patterns in the empirical material.

Results

I present the three resources—professional competence, professional and personal values, and relationships with pupils—separately to illustrate their differences and to show how teachers used parts of their discretionary toolkit in different contexts. Inspired by Molander (2016), I address the resources that teachers said shaped their everyday discretionary reasoning when teaching controversial issues. Discretion as reasoning emphasizes how discretion allows tailoring decisions to each case. The analysis showed that the interviewed teachers drew upon different resources from their toolkits interchangeably, depending on the topic and context, to make their discretionary judgments

Professional competence

The analysis showed that teachers' professional competence and education guided their classroom work and served as a resource for discretionary reasoning. The teachers' professional competence combined knowledge of the subjects they taught, pedagogy, subject didactics, practice, and the educational system's goals to promote democratic

citizenship, tolerance, and inclusion. Teaching controversial issues gave teachers an opportunity to encourage pupils to think critically, articulate their problems, and understand other pupils' opinions, but it demanded much from the teachers (Stray & Sætra, 2016). Having knowledge of different topics and the schools' core values—that is, having professional competence—is the main resource teachers could draw upon in these situations. Professional understanding and competence were important because the teachers saw themselves as professional agents due to their strong professional identity (Harrits & Møller, 2014).

The Religion and Ethics and the Social Science classes had only a few lessons during the week but many obligatory topics to cover. Thus, teachers had a discretionary space wherein they needed to make discretionary judgments of what to prioritize. The teachers I interviewed had different educational backgrounds and thus different competences to draw upon when judging if and how to teach certain topics. Some argued that their educational backgrounds provided competence in teaching controversial issues; others disagreed. For instance, one teacher (Nina) explained that her teacher education stressed the aim of giving pupils knowledge about different religions to understand the world in which they lived and, through that knowledge, become more tolerant:

> The whole point with Religion as a subject was that [pupils] should be able to live as religious people or in a religious society and understand what that means. So, it is possible I have been influenced by that. And that's what I see they need. They need tools to understand and handle the situation they are in.

Nina's religion class was characterized by a diverse pupil composition. The pupils came from different cultural and religious backgrounds. Nina explained that she made discretionary decisions to expose her pupils to religious critique and prejudiced views on religion. These topics were perceived as controversial. However, embedded in Nina's professional identity was her mandate to teach her pupils how to handle these situations in the real world. She stated that felt she had the competence to do so.

Teachers who claimed they did not have enough competence to teach a subject made discretionary judgments to minimize the topics that could be controversial. This seemed to follow disciplinary distinctions: Both interviewed Social Science teachers with backgrounds in social economics stressed they did not always feel competent to teach controversial issues such as immigration or racism. Gina, a Social Science teacher at Western High, stated, "I think all the Social Science teachers in this school are better teachers than me. . . . I am the worst among the good." She laughed when she spoke but, during the interview, explained that she often experienced not having enough knowledge about sociological topics. Another teacher with an economics background at the same school had a similar experience; he stated that he felt the need to rely on the textbook, which he described as not nuanced enough: "Of course, I went through . . . prejudice and socialization and stuff

like that. But I notice that it has something to do with my own skills. I am aware that I am not very good at it."

Complex topics such as racism, religion, or sexual orientation demanded authority or confidence from teachers. The teachers had to feel able to use their discretion to handle possible prejudiced outbursts from pupils and present different sides of controversial issues. Being a relatively new teacher with an educational background in social economics is an example that emphasizes how a lack of competence leads to teachers' decisions to avoid certain issues. When teachers handled uncertain teaching situations created by controversial issues, they needed to draw upon their professional competence to make discretionary decisions on how to answer outbursts, how to present a topic, and what strategy would work best to create a constructive learning environment. This finding aligned with a prior study of how teachers used discretion to decide which pupils would receive special education in Norway: The teachers' educational background is understood as an important epistemic mechanism and being a professional with the proper background is central to discretional reasoning (Karseth & Møller, 2018).

Professional and personal values

In Norway, teachers are relatively free to choose how much time to spend on each topic and which teaching strategy to use in the classroom. Thus, professional competencies played a significant role when teachers chose a course of action in specific situations. However, when talking about their use of discretion, the teachers I interviewed also mentioned personal values as a resource for their discretionary judgments. This finding agreed with that of Zacka (2017), who suggests that being a street-level bureaucrat calls for people who can make normative considerations that pull in different directions because they are exposed to vague mandates, competing demands, and unforeseen dilemmas. In my interviews, the teachers addressed situations where they relied on values as a resource to make discretionary judgments. Espen, a Social Science teacher at Western High, explained:

> Some [decisions] are a professional assessment—what do we need to cover and how are you going to do it—the professional bit. When you choose topics, you need to do some evaluations: What is important when they will be examined? That must be covered. . .. During a discussion, I think that if something is unacceptable, then you just must feel it in your bones; I do not think this is okay. You also must think about the consequences it will have for fellow pupils.

Espen described how he based some discretionary decisions on what he felt was acceptable and other decisions on his professional competence. His reasons for choosing a course of action depended on the situation at hand.

At the same time, all the teachers were mindful about imposing their own values and beliefs. Vegard, a teacher at Eastern High 2, noted that it was not in a teacher's job

description to produce political or religious clones. He tried to be conscious about separating his role in teaching Social Science curriculum from his personal values and opinions. That many teachers felt this way might reflect an ideal of "impartiality," as a basic principle of professional ethics, as well as for the exercise of public authority more generally in liberal democracies (Rothstein, 1998). In this sense, the norm of impartiality implies a limitation of the room for discretion and of moral agency.

However, the teachers had different thoughts on how to ensure that pupils did not perceive them as partial. While some teachers were careful to keep their opinions private, others chose to be open about their own personal standpoints in various political and moral issues. Both sides argued that their choices benefitted the pupils.

The classroom context played a big part in whether teachers chose to draw upon values as a resource. My observations of the two Religion and Ethics classrooms and my interviews with those teachers showed a between-school difference in the strategies teachers applied to share (or not share) their own values. This possibly stemmed from pupil demographics. At Eastern High, it was difficult for most teachers to be neutral because there was no middle ground. There, pupils talked about their own or their parents' immigrant backgrounds, and religious beliefs were more visible via symbols (e.g., some girls wearing headscarves) and verbal expressions (e.g., pupils stressing their own religions). Pupils who are open about their values and beliefs demanded more openness from the teacher to create a good learning environment. At Western High, where most pupils had a majority background, both the teachers' and the pupils' values were implicitly understood as more similar than at Eastern High.

At Eastern High, Nina chose to be open about being an atheist (common in Norway). During my first day of observing her Religion and Ethics classroom, she asked the pupils to send her a letter about their religious beliefs (if they were comfortable doing so). Later, she told me that all the pupils in her classroom said they were religious—Muslim, Hindu, and (one) Christian—and that she had told the pupils she was atheist. In the interview, we discussed her views on sharing her lack of religious belief:

> *Do you tell the pupils you do not believe?*
>
> I told them that the first lesson.
>
> *Why? You answered it a little before, but—*
>
> To show them I can treat everything in the same way—neutral. I basically do not believe that one religion is more important than another. . .. Had I been a Christian, I would have said that, too. And, of course, I had told them that it was not going to affect me as a teacher. I am an atheist. I do not believe in God or any gods . . . [but] they will not get me to say that religion is nonsense. . .. I am just saying I don't

> believe. But [being an atheist] might also give me the strength to teach and highlight important aspects of religions and treat them equally. So, when a pupil expresses a statement or comment—saying that this sounds very strange in one religion—it is easier for me to say, "Yes, what do you think that [religious] person would say about your religion?" After all, they must familiarize themselves with different point of views.

Caroline, a teacher at Western High, taught a class in which most pupils had a majority background. Although she chose not to tell her pupils of her religious beliefs, the goal in her neutrality was the same as Nina's.

> I do not think it really matters whether they know. They probably have guessed that I am not a Buddhist. I think they will get that I have a Christian background, so I guess they will understand that I have more knowledge about Christianity.
>
> *Is it because you do not want to influence your lessons?*
>
> The only reason I have not told them is that I want to teach [all religions] in the same way; that I do not prioritize one form of Christianity. I guess I would rather be looked at as a Religion and Ethics teacher than a representative for one religion.

Both Nina and Caroline argued that their motives for telling or not telling their religious belonging was concern for the pupils—so that the pupils would experience a neutral presentation of all religions. Nina chose to tell her pupils, predominantly Muslims and Hindus, that she was atheist. Caroline, a Christian in a classroom where all but three pupils had a majority background, did not announce her religious belief. She wanted the pupils to perceive her presentation as neutral but said they might guess her religion because she knew more about Christianity. Both teachers' reasonings stemmed from the same influence—their own values—but led to different discretionary judgments.

Relationship with pupils

I found that good social relations is a teacher resource for making discretionary judgments for two reasons. First, good relationships gave teachers valuable information about the pupils. They could then choose a teaching strategy based on their knowledge of the pupils or class dynamics. Teachers who had a relationship with the pupils knew which pupils struggled at home or had psychological issues that required their sensitivity. They also knew which pupils to push to be active during classroom discussions and which did not feel comfortable expressing opinions in public. Sætra (2020) argues that good social relationships constructed by the teacher and pupils is a core element to create a learning environment where controversial issues can be discussed. Second, good relations reduced the teachers' risk in trying new approaches. When the pupils and teachers had mutual trust based on good relationships, the pupils knew the teachers meant well.

Maynard-Moody and Musheno (2000) draw attention to relationships between street-level bureaucrats and their clients as a context for exercising discretion in what they call the citizen–agent narrative. They argue that street-level bureaucrats define their work in terms of relationships and not only rules and regulations. Teachers' everyday practices differ from other street-level bureaucrats' encounters because teachers meet with pupils regularly and for long periods. Thus, teachers may develop relationships with pupils that influence their discretionary judgment more than for street-level bureaucrats in other professions. Some of the interviewed Religion and Ethics and Social Science teachers taught the pupils in additional subjects; some were head teachers responsible for the class environment and individual development talks with all pupils each semester. Heidi at Eastern High claimed the pupils in her class—mostly immigrants or children of immigrants—were open to having a relationship with the teacher:

> [It] gives teaching a new dimension. I know them very well; I know who they are. It is quite unique with Eastern High—you have a group of pupils that lets you get very close to them. Other pupils . . . have a lot of adults that care; parents, coaches, a team that is ready to help. Many of our pupils have a bunch of siblings and do not have that contact with their parents. And to be able to be there for a pupil, to be able to guide them for a few years—it is quite a cool thing to be able to take part in.

When observing Heidi's class, it was evident that she knew her pupils. She called them by name, made jokes, and challenged their views. However, not all the teachers had such close relationships with their pupils. For example, Anne taught Social Science at Western High for an average of 3 hours each week. I conducted my observations during the first semester, when she had known the pupils for only a month. With more than 30 pupils in the classroom, little space, and much noise, it was challenging for her to get to know the pupils. The lack of relationships made it harder for Anne to use discretionary judgment and to teach. She explained that she did not know which pupils to push, and which needed more space. Good relationships with pupils shaped the exercise of discretion not only because of having information, but also because a trusting relationship made teaching controversial issues less risky.

A toolkit for discretionary reasoning

In Religion and Ethics and Social Science, the topics that could be challenging to handle required teachers' discretionary reasoning. In the preceding sections, I illustrated how the teachers in my study drew upon different resources in their toolkits when making discretionary judgments. Looking at different resources as a discretionary toolkit was a useful analytical tool to understand the complex social landscape of discretionary judgments when teaching controversial issues. The following example from an observed Social Science lesson at Eastern High shows how one teacher used two resources in a particular teaching situation.

The topic of the lesson was causes of crime and covered both individual and structural explanations. The topic could be controversial because the pupils lived in an area where the crime rate was higher than in other parts of Oslo. In the first period, Heidi, the teacher, lectured on the topic and showed videoclips the class could discuss. The pupils seemed tired and unengaged. In the second period, Heidi assigned the pupils to "Vote with Your Feet." Heidi presented statements such as, "Is the age of criminal responsibility, 15, too low?", "Are you for the death penalty?", or "Do you think Norwegian prisons are too comfortable?" The pupils would walk to a corner of the classroom representing "Agree," "Disagree," or "I don't know." After choosing their standpoints, they debated. The pupils could move to a different corner if other pupils' arguments changed their views. Heidi challenged pupils on why they agreed or disagreed with the statements. The assignment created lively debate and more enthusiasm among these pupils than it had in the first period, when those pupils sat at their desks. In the first period, pupils had been passive; when the second period started and the pupils participated in the assignment "Vote with Your Feet," the entire room buzzed.

Teaching a controversial issue, such as reasons for criminality, could be understood as an unsettled situation, using Swindler's (1986) term, and required the teacher's discretionary judgment. Heidi based such a judgment on her professional competence and relationships with the pupils to choose a more dynamic assignment and awaken engagement. From her relationships with the pupils, she knew they could engage and discuss reasons for criminality, but she had to choose the right forum in which to do so. Her professional competence had taught her that assignments such as "Vote with Your Feet" were a good way to create debate and engage pupils. In a later interview, Heidi elaborated how she drew upon her professional competence and relationships with her pupils to make a discretionary judgment on what teaching strategy worked best:

I always try to think that everyone learns differently. Some need something visual, something to look at; some need to hear something; some need to be provoked. So, I try to have a number of different elements in a teaching session to try to awaken as many as possible. I researched it myself in my master's thesis, that to participate in the classroom dialogue is very central for a learning outcome.

In this lesson, Heidi challenged her pupils' opinions but did not express her own views. The pupils presented contrasting opinions, so there was no need for Heidi to disturb that discussion by expressing her values. Something that could be perceived as the "right" opinion (because it came from the teacher) might limit pupils from voicing their own opinions. Several teachers explained that in other situations, if a group of pupils were one-sided in an argument, then the teachers might challenge the pupils' standpoint with their own opinions or play devil's advocate. Heidi's example illustrated that to understand teachers' practices when teaching complex and controversial issues, one must look at available resources as a toolkit for teachers to draw upon when making discretionary

judgments. What works in one context or situation may not work in another. Some teaching situations require a combination of all three resources—professional competence, professional and personal values, and relationships with pupils—and possibly others to make a good discretionary judgment, whereas other situations would demand only one resource.

Discussion and concluding remarks

In Norway, where the school system is one of the few institutions that meets almost all young citizens, it is important to understand what influences teachers' discretionary reasoning. This is particularly the case when dealing with potentially controversial issues in an increasingly diverse society. Using a framework drawn from street-level bureaucracy and theories of discretion (Lipsky, 2010; Molander, 2016), this article has delved into teachers' discretionary space and looked at how they draw upon different resources when several courses of action were available. I found that three forms of resources—teachers' professional competence, professional and personal values, and relationships with pupils—shaped the teachers' discretionary reasoning when teaching about controversial issues. I argue that teachers use this repertoire of resources as a discretionary toolkit that can be activated in different contexts.

The first resource to be highlighted was teachers' educational backgrounds, or lack of education, which influenced their feelings of competence and confidence when teaching controversial issues. The teachers perceived having the right competence as a resource for making discretionary judgments of if or how they would handle topics that might create debate or conflict. Karseth and Møller (2018) argue that teachers with formal educational backgrounds rely on that background when making discretionary judgments concerning special-education needs. I found that although teachers may have had proper formal qualifications, teaching controversial issues required competence that was more specific. Without sufficient professional competence on certain topics, teachers could not draw upon it as a resource to make discretionary judgments in challenging situations.

The second resource was the teachers' own professional and personal values. The interviewed teachers felt it important to expose pupils to different perspectives and beliefs, especially when teaching controversial issues, and the teachers' own values could be a resource in choosing if and how to present an issue. However, the two observed school contexts—where one was ethnically and religiously diverse while the other was far more homogeneous—differed in terms of how teachers talked about drawing on values as a resource. At the diverse Eastern High, flagging one's own beliefs was perceived as important in order to show that one did not have a hidden agenda, while at the homogeneous and wealthy Western High, the teachers' own beliefs were more often taken for granted as being neutral.

The third resource was the teachers' relationships with the pupils. This was a resource for discretionary judgment in two ways. First, information about pupils allowed teachers to judge what strategies worked with different pupils. Second, good relations made discussing controversial issues less risky because the pupils and teacher knew each other and thus allowed a larger space to say "wrong" things without assuming bad intentions. All interviewed teachers talked about good relationships as a resource. However, many taught pupils for only a few hours per week and did not have time to build relationships. For many teachers, this was a major challenge for developing trust and a classroom environment for discussing controversial issues in a constructive way.

Using the street-level bureaucracy perspective and discretion perspectives complemented the literature on controversial issues by unpacking what might influence teachers' discretion and what resources they drew upon in difficult teaching situations. This aided the understanding of discretionary reasoning by showing how the different resources that the teachers drew upon—competence, values, and relationships—led to different discretionary judgments, and how such discretionary reasoning depended on both the topic taught and its context. The present findings largely support previous studies in the field, such as Karseth and Møller (2018), who emphasize the role of professional competence, Taylor and Kelly (2006) and Zacka (2017), who focus on the values and morality of street-level bureaucrats, and Maynard-Moody and Musheno (2000) who view discretionary judgement as embedded in the relationship between citizens and the street-level bureaucrat. However, this article's main contribution lies in combining different understandings of what influences discretionary reasoning with Swidler's (1986) toolkit term, thus providing an analytical framework that captured teachers' complex everyday work. Looking at the different resources as a discretionary toolkit showed how these different entities informed and framed social interactions (Watkins-Hayes, 2009).

This study had some limitations. I observed four classrooms in two Oslo schools and interviewed 16 teachers at three schools. However, although this relatively limited empirical material does not allow us to generalize findings directly, I argue that the framework developed for the present study is applicable for researchers looking at similar cases in other contexts. For example, future research could investigate forms of resources that other street-level bureaucrats and teachers in other contexts draw upon when making discretionary judgments.

In terms of implications for practice, I argue that if schools are to fulfil their democratic ideals by providing a conductive space where pupils with different backgrounds can engage with controversial issues, one needs to focus not only on teachers' competence, but also on facilitating trusting social relationships between teachers and pupils. This may help to provide a broad set of resources, which teachers may draw upon when using their discretionary reasoning in complex and demanding situations.

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A Gendered Analysis of Work, Stress and Mental Health, Among Professional and Non-Professional Workers

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Abstract

This study examines the differences in mental health experiences of workers in professional and non-professional roles, with a particular focus on the influence of gender. We examine: i) the perceived mental health of a subset of professional workers including accounting, academia, dentistry, medicine, nursing, and teaching, chosen because they represent different gender composition and sectors; and ii) work stress and work absences. Statistical analyses were applied to data from the Canadian Community Health Survey and a related Mental Health and Well-Being survey. Those in the selected professions reported better mental health, higher job satisfaction, and a lower prevalence of mental disorders, but higher self-perceived life and work stress compared to workers in non-professional roles. Workers in these professions reported higher job security and higher job control, but also higher psychological demands. Women in these professions showed significantly higher physical exertion and lower job authority and *higher rates of work absences*.

Keywords

Mental health, work related stress, professional workers, gender differences

Introduction

Workplace mental health is an issue of rising importance. Indeed, the workplace is where we spend most of our time and as such plays a critical role in our overall mental health. Work can be both positively rewarding but workplace stress can also undermine mental health. Left unacknowledged, lost productivity from two of the most prevalent mental health issues—anxiety and depression—costs the global economy approximately $1 trillion US each year (Health, 2020). The growing price tag associated with mental health issues is due in large part to absenteeism and turnover, as well as reduced productivity and organizational citizenship behavior and presenteeism (Kelloway et al., 2005).

Professional workers are a particularly interesting subset of workers to examine their mental health experiences. Professions are occupations based on specialized educational training based on a foundation of esoteric knowledge, highlighting the important of competence and mental acuity in the production of professional service work (Brante, 1988). Mental health challenges can be uniquely complex given these roles (van den Burg et al., 2008). The link between professional acuity and mental health is a neglected topic in both the mental health and the sociology of professions literatures. Where addressed, the focus tends to be on how employers can attract professionals, unleashing their innovative potential and productivity (Mutlu, 2020; Giauque et al., 2010), ignoring the implications of unceasing productivity for mental health, including burnout. Further, because of the client-facing nature of professional work, many professional workers are regulated, and as such face unique threats associated with disclosure of mental health issues as it relates to the maintenance of their professional license.

An explicit gender lens has been conspicuously absent in the study of workplace mental health, regardless of whether focused on professional or non-professional workers. This is surprising given it is such a significant factor in the experience of mental health and the help-seeking (Affleck et al., 2018; Seidler, Dawes, Rice, Oliffe & Dhillon, 2016). Men and women disclose and access supports differently, and experience tensions created by workplace absences differently, due in part to inequities in social relations at work. Gender is not only embodied in individuals but also in the occupations and professions within which they work (Davies, 1996), but the mental health implications of these dynamics are rarely explored.

Our analysis aims to examine: i) the perceived and measured mental health and health conditions of a subset of professional workers; and ii) the work-related conditions including various elements of work stress and work absences. Our analysis also takes gender more fully into consideration across both issues, both at an individual and professional levels.

The professional workers we focus on represent a mix of professional status, gender composition and work context features. Dentistry, medicine, academia, and accounting are traditionally masculine professions that are feminizing (Phillips, 2009; McKay & Quiñonez, 2012; Gammie & Whiting, 2013; Hedden et al., 2014), whereas nursing and teaching are traditionally and persistently feminine. The predominant gender of the professions reflects their varying degrees of status within their respective systems of professions—with academia, accounting, medicine, and dentistry reflecting more dominant, and nursing and teaching more subordinate positions (Davies 1996). Related to this, the work contexts for these professional workers are also diverse, ranging from unionized salaried positions of nursing, teaching and academia, with both regular and irregular schedules, to independent public sector contractors in solo or group practice, to owners of clinics in the private sector (physicians, dentists, and accountants). Although there are some distinct differences between the sectors that these professional and non-professional workers work, there is some overlap for workers considered non-professional in health care and education. Moreover, there are feminized and masculinized sectors across both professional and non-professional work.

The datasets upon which we draw enables us to compare the circumstances of these professional workers with non-professional workers. The questions guiding our research include: How does the mental health of professional compare across cadres and in contrast with non-professional workers? How does gender influence the difference in mental health within professional workers and between professional and non-professional workers?

Literature Review

Workplace Mental Health

There has been an increased interest in workplace mental health and psychologically healthy workplaces internationally. Mental health challenges, such as depression, anxiety disorders, and adjustment disorders, present a major problem in the OECD countries (OECD, 2015). Research shows that adverse working conditions and management practices can lead to work stress (Bhui et al., 2016; Cazabat, Barthe & Cascino, 2008), and in psychological distress and other mental health issues among the employees (Chandola et al., 2010; Nieuwenhuijsen, Bruinvels & Frings-Dresen, 2010).

The influence of psychological health and safety in the workplace is gaining traction among regulators, insurers, and researchers. In 2013, the Mental Health Commission of Canada launched the National Standard of Canada for Psychological Health and Safety—the first of its kind in the world. It is a set of voluntary guidelines, tools, and resources intended to guide organizations in promoting mental health and preventing psychological harm at work. Most recently, the World Health Organization declared in May 2019 that burnout is an

occupational phenomenon, rather than as a medical condition, marking a turn to explicitly develop evidence-based guidelines on mental well-being in the workplace.

Gender Differences in Work-Related Mental Health

Research on workplace mental health reveals poorer mental health among women (Harnois & Bastos, 2018; Lamontagne & Shann, 2012; Pedersen & Minotte, 2016). For instance, one Australian study revealed how the prevalence of poor mental health was significantly higher in working women than working men (Lamontagne & Shann, 2012). Such gender differences in mental health at work can be attributed to a variety of factors. These include the inequitable distribution of working and employment conditions, as well as gender-based harassment and bullying (Attell et al., 2017; Campos-Serna, Ronda-Pérez, Artazcoz, Moen & Benavides, 2013; Dionisi, Barling & Dupré, 2012; Elwér, Harryson, Bolin & Hammarström 2013; Geoffroy & Chamberland, 2015; Harnois & Bastos, 2018). Gender differences in mental health at work is also related to the gendered division of labour at the home. Job strain has been found to have a direct adverse effect on life stress among women but not among men (Padkapayeva, et al., 2018).

Work-Related Mental Health of Professional Workers

At present, there is a dearth of literature on work-related mental health of professional workers broadly, though in some cases there exists profession-specific literature.

Health professionals often experience mental health issues, the most common being: stress (Ahmad et at., 2015; Rice, Glass, Ogle & Parsian, 2014), burnout (Galian-Munoz, Ruiz-Hernandez, Llor-Esteban & Lopez-Garcia, 2014; Huri, Bağış, Eren, Umaroğlu & Orhan, 2016), anxiety (Puriene et al., 2008; Saksvik-Lehouillier, Bjorvatn, Hetland & Mjeldheim, 2012), depression (Huri et al., 2016; Ohler, Kerr & Forbes, 2010) PTSD (Beck, Logiudice & Gable, 2015; Ben-Ezra, Palgi, Walker, Many & Hamam-Raz, 2014), and substance use/addiction (Merlo, Trejo-Lopez, Conwell & Rivenbark, 2013; Monroe & Kenaga, 2011).

Some of these mental health challenges are rooted in the irregular and inflexible work schedules, shift work, and required overtime (Ahmad et al., 2015; Pezaro, Clyne, Turner, Fulton & Gerada, 2016;), but there is also the inherently stressful nature of their work (Crompton & Lyonette, 2011; Hakanen, Schaufeli & Ahola, 2008; Jolivet et al., 2010). Studies also focus on the role of work-related factors—such as settings, and models of care—in mental health of healthcare workers (Boran, Shawaheen, Khader, Amarin & Hill Rice, 2012; Hildingsson, Westlund & Wiklund, 2013; Newton, McLachlan, Willis & Forster, 2014).

Professional workers in the education sector face unique mental health challenges. Academic professionals are noted as exhibiting a spectrum of mental health issues, including stress (Berg, Huijbens & Gutzon Larsen, 2016; Craft & Masegerg-Tomlinson, 2015), depression (Deaville, 2009), anxiety (Berg et al., 2016), and bipolar disorder (England, 2016; Skogen, 2012). A recent RAND Europe (2017) report detailed that about 37% of academics

have common mental health disorders and those levels of burnout appear higher among university staff than in the general population. Studies show how the increasing infiltration of performance management metrics in academia, as well as heavy workloads and long hours lead to growing stress levels among academics (Berg et al., 2016; Shin & Jung, 2014; Higher Education Network, 2015. In the case of secondary and elementary school teachers, the literature points to their experiences of a range of stress-related mental health issues including sleep disorders (Do Valle, Do Valle, Valle, Malvezzi, & Reimao, 2013; Vannai, Ukawa & Tamakoshi, 2015), depression (Brunsting, Sreckovic & Lane, 2014; Ferguson, Frost & Hall, 2012), burnout (Kosir, Tement, Licardo & Habe, 2015; Skaalvik & Skaalvid 2015), and anxiety (Brunsting, Sreckovic & Lane, 2014).

Research on professional workers in other sectors is also growing. In accounting, for example, there is some research that highlights that four in ten accountants suffer from stress related problems (White, 2021). Some studies highlight how role conflict, ambiguity, overload, as well as a dominant supervisor are the most common sources of occupational stress, burnout, and depression among accountants (Kelly & Barrett, 2011; Jones, Norman & Wier, 2010; Ozkan, Ozdevecioglu, Kaya & Özs, 2015). A Turkish study, for example, identified work-related stress as an important factor influencing life satisfaction and burnout levels of accountants (Ozkan & Ozdevecioglu 2013). While literature offers some insights into the impact of gender on accountants' work and health (Gallhofer, Paisey, Roberts, & Tarbert, 2011; Guthrie & Jones, 2012; Dambrin & Lambert, 2008), this issue remains insufficiently explored for this profession.

Mental Health, Professional Work & Gender

The relative lack of literature focused on the influence of gender is remarkable because women predominate in some professions, such as nursing and teaching, and their numbers are growing in other traditionally male professions, such as medicine, academia, and accounting (Phillips, 2009; Gammie & Whiting, 2013; Hedden et al., 2014). Where data do exist on specific professions, these are rarely compared across professions, nor from an explicit gender lens (Adams, Lee, Pritchard & White, 2010; Dewa, et al., 2014; Frank & Segura, 2009). Nurses, for example, indicate that they had a greater chance of experiencing depression than other workers (Shields & Wilkins, 2006), some of which could be attributable to their predominant female gender but also to the gendered nature of their work. In the case of medicine, female doctors had 32 per cent higher odds of experiencing depression than their male colleagues (Canadian Medical Association, 2018). The importance of gender on teacher mental health is only emerging with one study noting how male teachers are less likely to reach out for social support, reflecting the broader gender trends in help seeking for mental health concerns (Ferguson, Mang & Frost, 2017; Klassen & Chiu, 2010; Klassen & Chiu, 2011).

The literature has not yet fully considered gender and work-related mental health among women professional workers as a broader group to identify whether health consequences are *profession* specific or *gender* specific. Although some research exists for specific professions, there is a need for a deeper understanding of impact of gender on mental experiences of workers in both professional and non-professional sectors. The aim of this study was to understand differences in workplace mental health experiences between professional and non-professional workers, with a particular focus on the influence of gender.

Methods

Data sources

This article features analyses based on data from the combined 2013/2014 Canadian Community Health Survey (CCHS), which collects information about health status, health care use, and health determinants for about 98% of the population aged 12 or older. It covers household residents in the provinces and territories; but members of the Canadian Forces and residents of correctional institutions, those who live in First Nations communities ("reserves") or other Indigenous settlements, and some remote areas are excluded. The CCHS produces an annual microdata file and a second microdata file combining two years of data, every second year. The combined data are the same as the two individual annual data files, but also contain data for Yukon, the Northwest Territories, and Nunavut. The two-year data can be used to disaggregate estimates to represent smaller populations and rare characteristics. In total, 185,176 of the selected units in the 2013-2014 CCHS were in-scope for the survey, out of which a response was obtained for 128,310 respondents representing 30,014,589 individuals aged 12 or older. The survey's response rate was 66.2%. In this study, those aged 15 or older who worked were selected for analysis. Its sample size was 62,359 representing 17,804,335 Canadians. Table 1 shows selected characteristics of the sample.

	All			Men			Women		
	Sample N	Weighted N	%	Sample N	Weighted N	%	Sample N	Weighted N	%
Case study professions	5,329	1,482,920	8.33	1,439	461,986	4.91	3,890	1,020,934	12.15
Doctors	276	95,087	0.53	150	60,624	0.64	126	34,463	0.41
Dentists	63	24,251	0.14	42	13,549	0.14	21	10,702	0.13
Nurses	1,340	343,932	1.93	117	35,363	0.38	1,223	308,569	3.67
Professors	870	277,574	1.56	403	137,256	1.46	467	140,318	1.67
Teachers	1,936	472,597	2.65	407	103,280	1.1	1,529	369,317	4.39
Accountants	795	256,495	1.44	313	110,189	1.17	482	146,306	1.74
Other professional /managerial workers	11,221	3,640,146	20.45	5,893	2,159,335	22.97	5,328	1,480,811	17.62
Non professional workers	45,809	12,681,269	71.23	22,874	6,779,354	72.12	22,935	5,901,915	70.23
Total	62,359	17,804,335	100.00	30,206	9,400,675	100.00	32,153	8,403,660	100.00

Data source: CCHS 2013/2014

Table 1. *Occupational distribution of case study professions, aged 15+, Canada 2013-14.*

In addition to the annual survey, every five years a specialized focused content theme is selected. This analysis also includes the 2012 Canadian Community Health Survey–Mental Health (CCHS-MH) focused content to measure mental morbidity. The 2012 CCHS-MH measured prevalence of six disorders (major depressive episode, bipolar disorder; generalized anxiety disorder; alcohol abuse and dependence; cannabis abuse and dependence; and other substance abuse and dependence) in accordance with the World Mental Health—Composite International Diagnostic Interview 3.0 (WMH-CIDI). WMH-CIDI is a standardized instrument for the assessment of mental disorders and conditions according to DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) criteria, and is widely used in population surveys. CCHS-MH's sample consisted of the household population aged 15 or older in the 10 provinces and had similar exclusions as the CCHS. The response rate was 68.9%, yielding a sample of 13,989, which represented 28.3 million Canadians. In this study, those aged 15 to 75 who worked or were absent from work in the week before the survey were selected for analysis. Regardless of the number of hours worked, all types of work were included such as part-time jobs, seasonal work, contract work, self-employment, baby-sitting and any other paid work. The sample size was 13,989 representing 18 million individuals (Table 2).

	All			Men			Women		
	Sample N	Weighted N	%	Sample N	Weighted N	%	Sample N	Weighted N	%
Case study professions	1,084	1,401,460	7.79	302	422,307	4.40	782	979,153	11.64
Doctors	70	101,002	0.56	39	61,652	0.64	31	39,350	0.47
Dentists	22	40,659	0.23	...			F	...	...
Nurses	269	312,519	1.74	17	17,387	0.18	252	295,132	3.51
Professors	205	263,027	1.46	106	137,825	1.44	99	125,202	1.49
Teachers	374	516,288	2.87	79	114,418	1.19	295	401,870	4.78
Accountants	139	157,828	0.88	47	61,542	0.64	92	96,286	1.14
Other professional /managerial workers	2,728	3,860,667	21.45	1,572	2,280,809	23.79	1,156	1,579,857	18.78
Non professional workers	10,177	12,738,214	70.77	5,002	6,884,650	71.81	5,175	5,853,565	69.58
Total	13,989	18,000,341	100.00	6,876	9,587,766	100.00	7,113	8,412,575	100.00

F Suppressed due to small cell size
Data source: CCHS 2012

Table 2. *Occupational distribution of case study professions, aged 15+, Canada, 2012.*

Case Studies

As noted above, a select group of professions was chosen to enable a more in-depth comparative analysis of the findings with a particular focus on gender. The professional workers included in this analysis focused on physicians, dentists, nurses, professors, teachers, and accountants. These professions represented a range of professions where women predominate, and where their presence is growing (i.e., feminisation).

In the surveys, Case Study Professional (CSP) workers and non-professional workers were identified based on self-reported occupations translated to the 4-digit codes from the National Occupational Classification for Statistics (NOC-S) 2006 from the CCHS 2013/2014 data and National Occupational Classification (NOC) 2011 for the CCHS 2012 data. Non-professional workers were workers whose skill level was not professional (the second digit of NOC codes was not 1) and skill type was not management (in 2006 NOC-S, the first digit of the codes was not A; in 2011 NOC, the first digit of the codes was not 0). To ensure consistency of the occupation variables in the analysis, the table of "Concordance: NOC-S 2006 and NOC 2011" (Statistics Canada, 2015) was used.

Measures

- **Self-rated mental health** was measured by asking respondents, "In general, would you say your mental health is: excellent? very good? good? fair? poor?" If the responses were fair or poor the respondent was considered to have low self-rated mental health.

- **Self-reported mental disorder** was determined by asking respondents about disorders that had been diagnosed by a health professional and that had lasted or were expected to last six months or longer.

- **Self-rated health measures** an individual's perception of their overall health using a single question rated on a five-point scale (excellent, very good, good, fair, or poor). The responses of fair or poor were considered as low self-rated health.

- **Self-perceived life stress** measures an individual's perception of overall stress in life. Respondents was asked, "Thinking about the amount of stress in your life, would you say that most days are: not at all stressful? not very stressful? a bit stressful? quite a bit stressful? extremely stressful?" Respondents answering quite a bit or extremely were classified as having high self-perceived life stress.

- **Self-perceived work stress** at the main job or business in the past 12 months was measured by asking: "Would you say that most days at work were: not at all stressful? not very stressful? a bit stressful? quite a bit stressful? extremely stressful?" Respondents answering quite a bit or extremely were classified as having high self-perceived work stress.

- **Mental disorder** (WMH-CIDI) included measures of the prevalence of six mental disorders (major depressive episode, bipolar disorder, generalized anxiety disorder, and abuse of or dependence on alcohol, cannabis, or other drugs) in accordance with the World Health Organization version of the Composite International Diagnostic Interview 3.0 (Kessler and Ustun, 2004). In this analysis, respondents who met the criteria of any of the six disorders were classified as having "any mental disorder."

- **Work stress** was measured in the CCHS using an abbreviated version of Karasek's Job Content Questionnaire (JCQ) (Karasek, 1985). The CCHS measured work stress of respondents working at jobs or businesses in the past 12 months. Twelve items in the JCQ are used to measure job control (skills discretion and decision latitude), psychological demands, job insecurity, physical exertion, and workplace social support. Each item was scored using a five-point Likert scale from strongly agree to strongly disagree (items 4, 5, 8 and 10 are reverse scored): Item Subscale

- **Skill Discretion** included three questions: 1) Your job requires that you learn new things; 2) Your job requires a high level of skill and 3) Your job requires that you do things over and over.

- **Decision Latitude/Authority** included questions about how 1) your job allows you freedom to decide how you do your job and 2) you have a lot to say about what happens in your job.

- **Psychological Demands** included questions related to how hectic one's job is and whether one was free from conflicting demands that others make.

- **Job insecurity**, was measured by the question, "Your job security is good."

- **Physical exertion**, was measured by, "Your job requires a lot of physical effort."

- **Workplace support** had three items: 1) You are exposed to hostility or conflict from the people you work with; 2) Your supervisor is helpful in getting the job done; and 3) The people you work with are helpful in getting the job done.

- **Job strain** is measured as a ratio of psychological demands and decision latitude which includes skill discretion and decision authority. This variable indicates whether the respondent experiences job strain.

- **Job satisfaction**: Respondents were asked if they were very, somewhat, not too or not at all satisfied with their jobs. Those not too satisfied or not at all satisfied were classified as having job dissatisfaction.

- **Work absence**: The CCHS asked: "Last week, did you have a job or business from which you were absent?" For this study, those who responded positively to this question were considered to be absent from work.

Analytical techniques

Analyses were conducted using SAS 9.3. Univariate analyses including correlations, t-tests, and chi-square analyses looking at group differences (between case study professions and non-professional workers) in work absence, work stress, and other self-rated health

measures. Survey sampling weights were applied so that the analyses would be representative of the Canadian population. Bootstrap weights were applied using SUDAAN 11.0 to account for the underestimation of standard errors due to the complex survey design. In this article, when two estimates are said to be different, this indicates that the difference was statistically significant at a 95% confidence level (p-value less than 5%).

Results

Demographics

The CSP workers in this analysis made up about 8.3% or 1.5 million workers in Canada in 2013/14 and a vast majority of these workers (69%) were women. The largest occupational group among CSP workers were teachers or professors (32% of all CSP workers); for all occupations of CSP except doctors and dentists, women were the majority. In contrast, non-professional workers made up approximately 71% of all workers in Canada and approximately 47% of whom were women.

On average, CSP workers were older than non-professional workers (average age: 43 vs. 41) and more educated. Among non-professional workers, 16% had obtained a bachelor's degree or higher whereas 74% of CSP workers had at least a bachelor's level education (97% for medical doctors; 53% for nurses; 84% for teachers; and 65% for accountants). In terms of income, 70% of overall CSP workers belonged to the top two income quintiles (42% in the highest and 28% in the second highest quintile) compared to 43% of non-professional workers.

Self-perceived Health and Mental Health

CSP workers reported better self-perceived health and mental health than non-professional workers. In general, there was a very low proportion of CSP workers who reported low self-perceived health (4%) or self-perceived mental health (4%). No gender differences among CSP workers were found. Similarly, CSP workers showed a low prevalence rate (past 12 months) of specific mental disorders. This was the case for both men and women in the CSP worker category who were less likely to have a mental disorder in the past 12 months than non-professional workers. Based on WMH-CIDI measurement in the 2012 CCHS, the prevalence rate of major depression for CSP workers was 4.0%; generalized anxiety disorder, 1.5%; mood disorder, 4.1%; substance use disorder, 1.5%. Notably, CSP workers were less likely to have self-disclosed substance use disorders (alcohol/drug) in the past 12 months compared to non-professional workers (1.5% vs. 5.9%).

Work & Stress

Stress

Figure 1 depicts the work and life stress of CSP and non-professional workers. CSP workers reported high (quite a bit or extremely stressful) work and life stress (33% and 38%

respectively) compared to non-professional workers (23% life stress and 25% work stress). Nurses reported the highest work stress (55%) followed by doctors (48%). Interestingly, doctors reported the highest life stress of all groups at 40% with nurses among the fewest to report high life stress (33%) yet nurses showed a much higher rate of life stress than non-professional workers who were the least likely to report high life stress (23%). Of all CSP groups, professors were the least frequent to report high life stress (30%) and least frequent to report work stress (28%) showing no significant differences from non-professional workers.

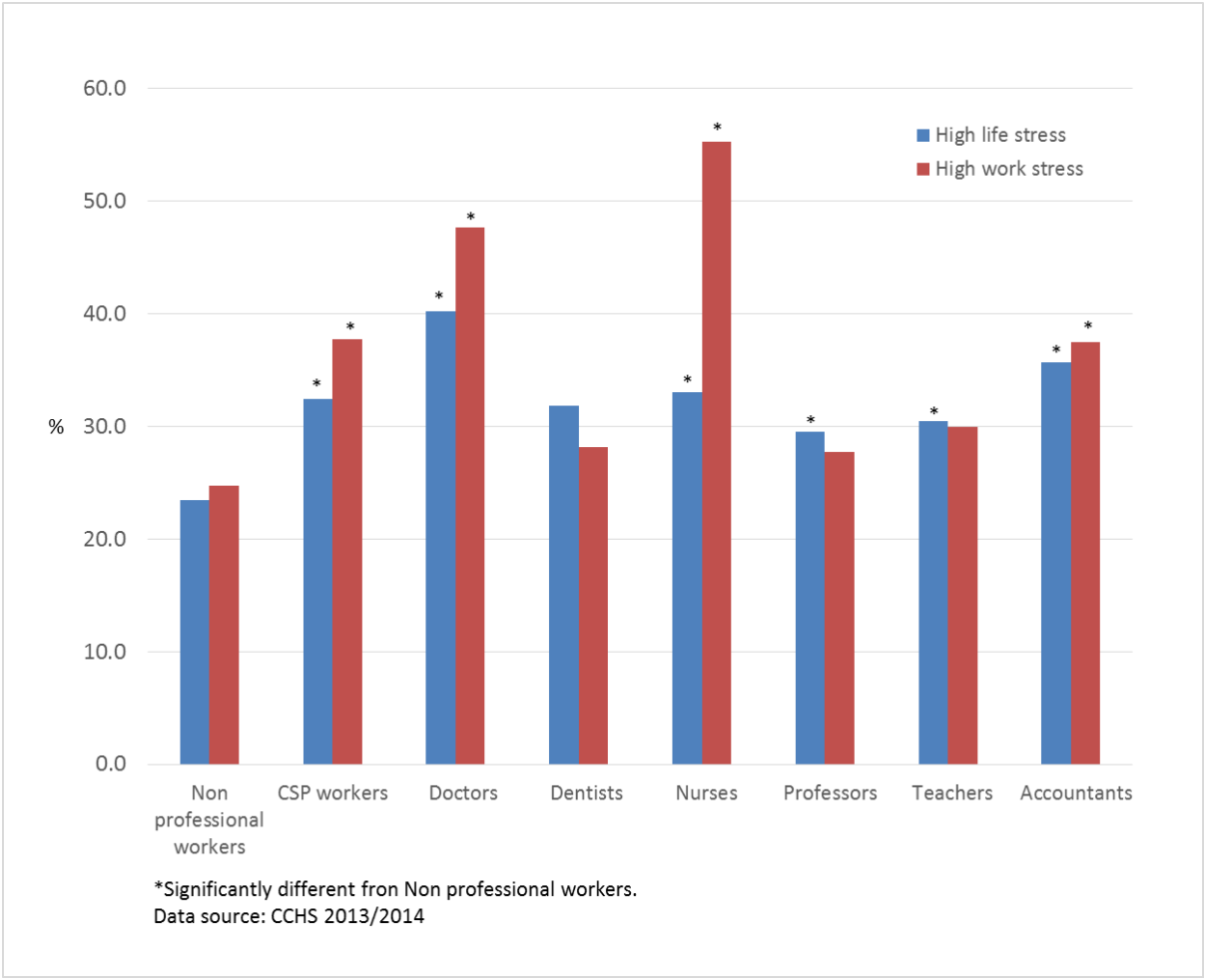

Figure 1. *CSP workers reported high (quite a bit or extremely stressful) work and life stress compared to non-professional workers. Nurses reported the highest work stress while professors reported the lowest.*

Figure 2 depicts the gender differences in work stress among the CSP and non-professional workers. Among CSP, women showed a higher rate of self-perceived work stress than men; differences were particularly striking for professors and teachers. Male teachers and professors were significantly less likely to report high work stress not only than their female colleagues but also than their non-professional counterparts. On the other hand, the rates of high self-perceived work stress for women professors and teachers were higher than the

rates for non-professional workers. While relative to the other CSP professions, fewer professors and teachers reported high work stress, these are the only two professions that displayed a gender difference suggesting the importance of the intersection of gender and sector and that for work stress, the sector is more important than gender. No gender differences were found for the other CSP professions.

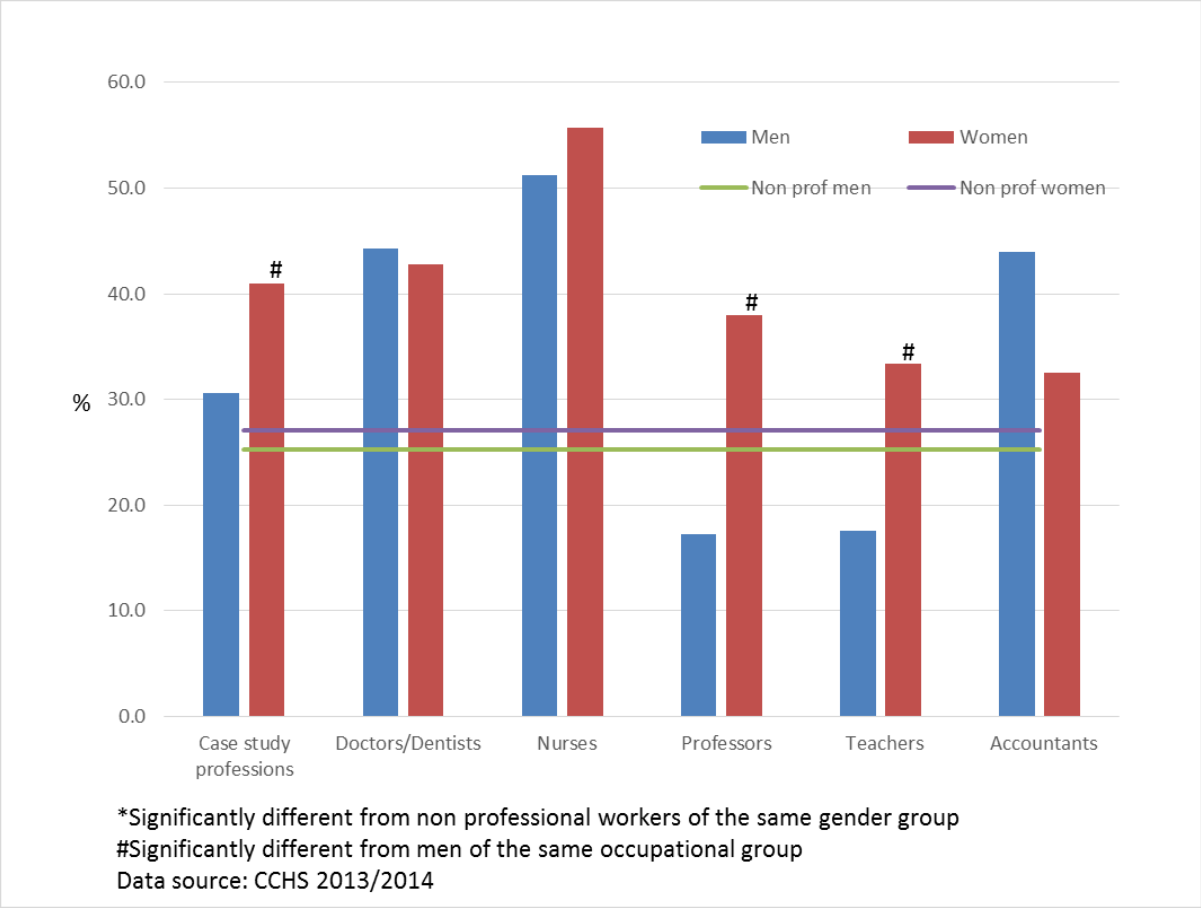

Figure 2. *Among case study profession (especially teachers), women showed a higher rate of self-perceived work stress than men. No gender difference was found for non-professional workers.*

Another gender differences in self-reported life and work stress to note is that CSP workers did not show gender difference in life stress, but they did show a difference in work stress; female CSP workers were more like than their male counterparts to report high work stress. For non-professional workers, significant gender differences were found in both life and work stress; female non-professional workers reported a higher level of stress than male non-professional workers.

Job satisfaction and characteristics

Shifting to data from the 2012 CCHS mental health-focused survey, it was found that both male and female CSP workers reported significantly higher levels of job satisfaction than

non-professional workers (see Figure 3). For both men and women, higher proportions of teachers and professors reported that they were satisfied with their jobs. Male doctors also showed higher level of job satisfaction than their non-professional counterparts. Among CSP workers, accountants reported a low score of job satisfaction. Their job satisfaction was significantly lower than that of dentists, professors, and teachers.

With respect to job characteristics, it was found that CSP workers showed higher levels of job control (indicated as lower scores of job authority and skill discretion) than non-professional workers. Male CSP workers showed a higher level of decision authority than female CSP workers. There was no gender difference in skill discretion, but accountants showed a relatively lower level of skill discretion compared to other CSP workers. Male and female accountants were not statistically different from their non-professional counterparts in skill discretion.

Overall, a higher level of psychological demands was found among female CSP workers compared to their non-professional counterparts. Male and female doctors, nurses and teachers showed higher levels of psychological demands than their non-professional counterparts. Interestingly, psychological demands reported by women professors were statistically lower than that of non-professional workers.

Compared to non-professional workers, a higher proportion of CSP workers, both men and women, reported that their job security is good. On the other hand, male CSP workers reported a lower level of physical exertion than their non-*professional* counterparts. Specifically, male doctors, professors, teachers, and accountants showed lower levels than non-professional workers. There was no difference in physical exertion between female CSP and non-professional workers. Moreover, female nurses reported a higher level of physical exertion than their non-professional counterparts. Among female CSP workers, only accountants showed a lower level of physical exertion than non-professional workers.

There were no overall differences in scores of workplace support between CSP workers and non-professional workers. Nurses, however, showed a lower level of workplace support (indicated as higher scores) than non-professional workers. Similarly, no overall differences in job strain were found between CSP workers and non-professional workers. Here too, nurses showed a higher level of job strain than non-professional workers. Male and female professors showed a lower level of job strain than non-professional workers.

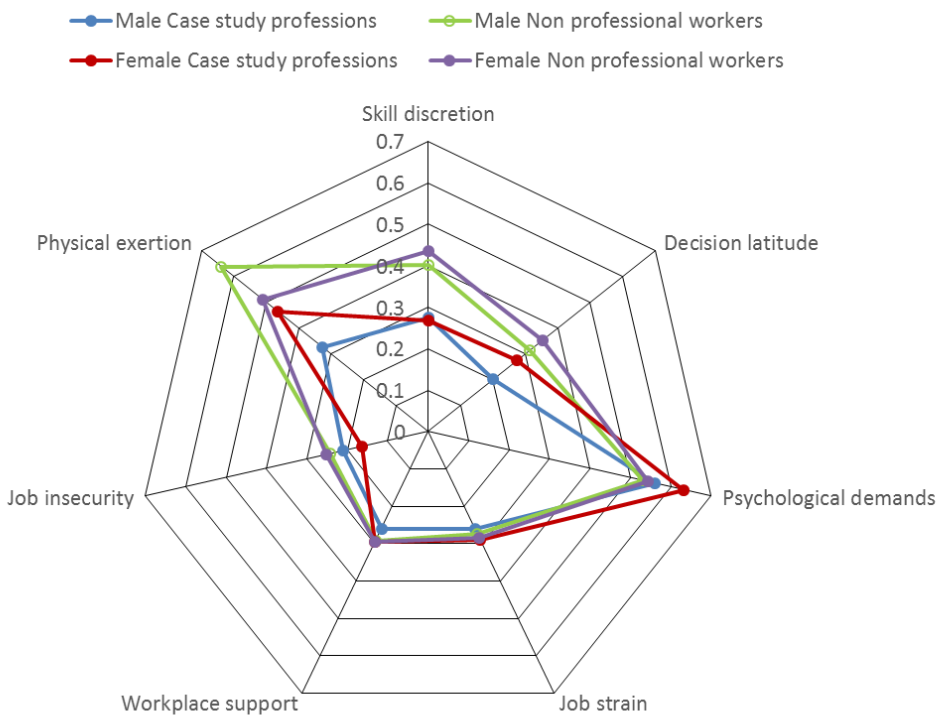

Figure 3. *Compared to men, women workers in case study professions showed a higher job strain, physical exertion, and lower job authority.*

Work absences

Shifting back to the 2013-2014 CCHS data, we found that work absences (i.e., the previous week) were more frequently reported among CSP workers (13%) compared to non-professional workers (7%). Also, higher rates of work absence were reported by female CSP workers (15%) compared to male workers (9%), a similar pattern as for non-professional workers (7% for women, 5% for men).

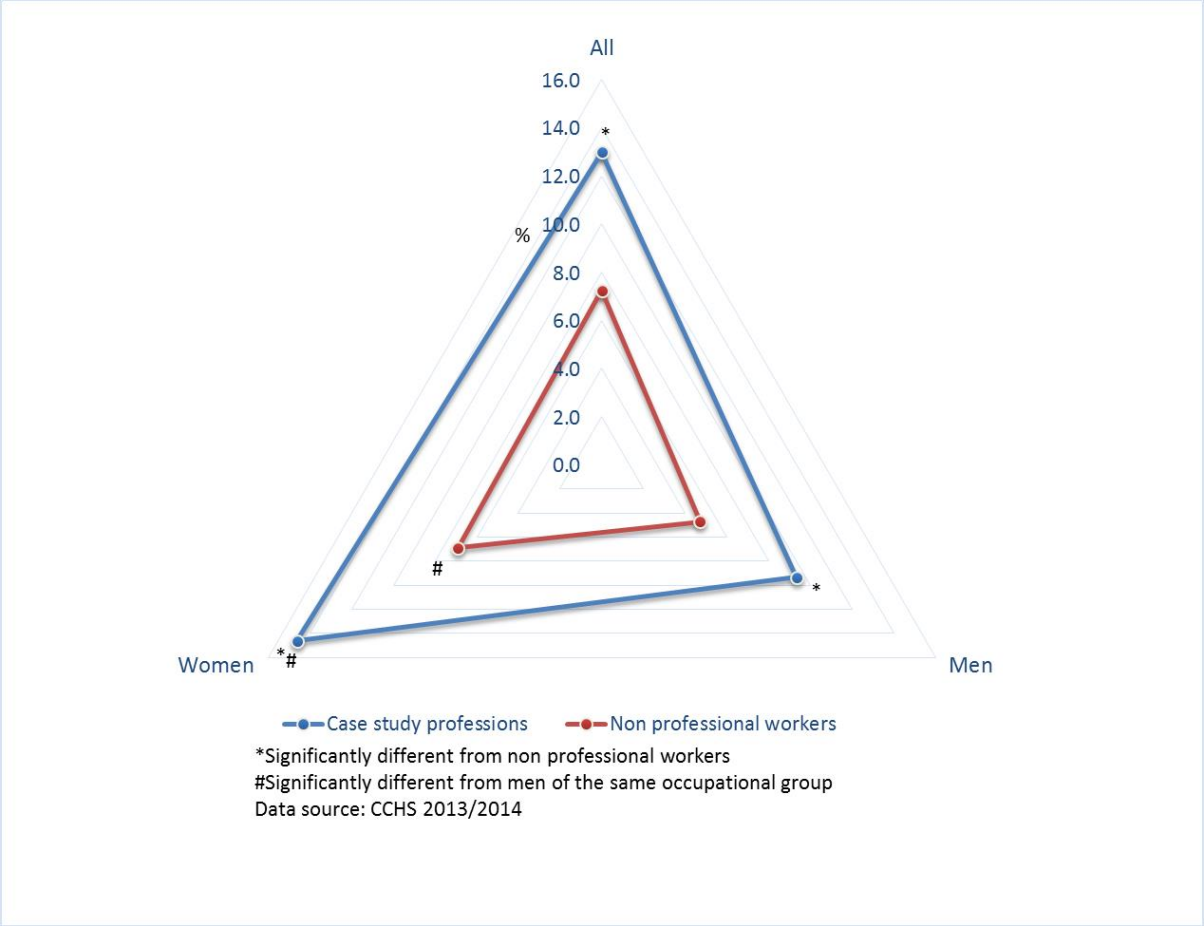

Figure 4. *Higher rates of work absence (last week) were reported among CSP workers than among non-professional workers. Also, higher work absences were found in female CSP workers than male workers.*

Discussion

There are two key trends to highlight from this comparative analysis that help to advance our knowledge of the nature of mental health and work experiences of a select group of professional workers, especially as it compares to 1) non-professional workers, and 2) with respect to its gender dimensions. Specifically, while the literature on mental health experiences of workers in healthcare (Ahmad et al., 2015; Hakanen et al, 2008), accounting (Kelly & Barrett, 2011; Ozkan et al., 2015), teaching (Brunsting et al., 2014; Kosir, Tement, Licardo & Habe, 2015) and academic sectors (Berg et al., 2016; Deaville 2009) brings some insights on different mental health issues they face and the adverse work-related factors that lead to these, our analysis adds two comparative dimensions across professional worker groups.

First, with respect to how our professional workers compare to non-professional workers, findings from this study suggest that accountants, academics, dentists, doctors, nurses, and teachers were more likely to report higher self-perceived health and mental health, a lower prevalence of mental disorders, and reported higher job satisfaction than non-professional

workers. Although our findings did not necessarily corroborate reports of a higher prevalence of mental health issues among these select professional workers, our findings do concur with the growing body of literature on the work-related sources of stress they differentially experience. Specifically, they reported higher self-perceived life and work stress than non-professional workers, and higher work absence than non-professional workers. Specifically, for our selected professions, work stress was higher in job control (skill discretion and decision authority), psychological demands, job security, and lower physical requirements than non-professional workers. The seemingly paradoxical finding of high job satisfaction yet higher stress is reflected in other studies (e.g., Skaalvik & Skaalvik 2015), though few include a comparison with non-professional workers.

Second, there were interesting trends where gender was a significant differentiator. Although all female workers were more like than their male counterparts to report high work stress, women in our selected professions reported a higher rate of self-perceived work stress, higher physical exertion, and lower decision authority than men in these professions. Women in our selected professions reported higher level of psychological demands than women non-professional workers, as well as higher rates of work absences. These findings are similar to the key trends in the literature on gender, work and stress, specifically, how women's poorer self-reported mental health is related not only to women's adverse working conditions and work environment (Attell et al., 2017, Elwér, Harryson, Bolin & Hammarström 2013; Geoffroy & Chamberland, 2015; Harnois & Bastos, 2018) but also to higher levels of life stress which could be in part to challenges in maintaining work-life balance (Bourgeault, Luce and Macdonald, 2006).

Within specific CSPs, noticeable gender differences also emerged. For example, self-perceived work stress was notably higher for female professors and teachers, which could reflect the challenges women face in a profession that tends to be structured according to a masculine work ethic (Alemán, 2014). Female nurses reported a higher level of physical exertion than their non-professional counterparts, which corroborates earlier research which has only included nurses (Mark & Smith 2012). Nurses, regardless of gender, reported lower levels of workplace support than non-professional workers, an interesting trend for further analysis.

Strengths

The strengths of this research includes its large population-based sample, which includes data on a range of job features, as well as its ability to capture different dimensions of workers' health. It also afforded a comparative dimension across professional groups and the ability to compare with non-professional workers, and the intersection of gender with professional/non-professional work—helping to address a key gap in the literature. These findings have important implications for profession and gender-specific workplace mental health promotion initiatives amongst these professional workers.

Limitations

There are some important methodological considerations to note. First, the two surveys used different versions of occupational classifications—CCHS 2013/2014 used NOC-S 2006 while CCHS 2012 (used for the measure of mental disorder and work stress) used NOC 2011. CSP workers were slightly under-represented in NOC 2011 than in NOC-S 2006 (7.8% vs. 8.3%).

Second, the reference periods used in this analysis for the health measures were also not consistent: for self-rated mental health, life stress, self-rated health, an unspecified reference period implying the present; for WMH-CIDI measured disorders, the past month, the past 12 months (used in this analysis), or lifetime; for work stress measures, the past 12 months; for self-reported mental morbidities, disorders that had lasted or were expected to last 6 months or more.

Third, due to insufficient sample sizes, this study could not examine differences in mental health disorders asked in the 2012 CCHS-MH (major depressive episode, bipolar disorder, generalized anxiety disorder, and abuse of or dependence on alcohol, cannabis or other drugs) for specific professional groups or gender groups of CSP. Instead, this study examined prevalence by gender for having *any* of the six disorders.

Fourth, since respondents included in this study were all active workers, the sample is likely biased towards healthy workers and does not capture those who are on leave or those who have health conditions preventing them from working. As such, our results likely underestimate the occurrence of mental health problems, particularly the most severe mental health problems.

Finally, it is important to note that the data are based on self-report, though the biases this may reveal applies across professional and non-professional cadres and gender. Because the analyses are in one point in time (i.e., cross-sectional), any causation between variables cannot be inferred.

Future Research

This study lays a foundational base for more focused empirical research focused on these professional workers, presently being undertaken in partnership with their national professional associations; this will enable us to delve further into the initial insights from the data analysed herein. Future research could also involve multivariate analysis of datasets with larger sample sizes to tease apart the relative influence of the different variables, such as whether some of these trends are related to full time and part time status, and worker's social identities (race, Indigenous identity, immigration status). Health and labour-market indicators, such as include job interruptions, changes in employment and income, more relevant to long-term workplace conditions would also be a promising area for future

exploration. Future research could also employ a longitudinal analysis to track down the path of work-related health of individual workers in specific professions.

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Declaration of interest statement

The authors have no financial interest or benefit that has arisen from the direct applications of this research.

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Clinical Teaching as a Challenge in Transforming the Nursing Profession in Estonia

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Abstract

The changes in European healthcare education, building on the Bologna Process, aimed at the integration of clinical work and teaching and promoted a holistic patient and learner-centred professional paradigm. The article, based on the findings of two qualitative studies (2017–2019), focuses on the transformation of the nursing profession in the context of the Estonian healthcare curriculum reform. Thematic written interviews accompanied by a drawing task were collected from clinical nurse teachers and graduating students. The data was analysed using hermeneutic content and comparative analysis.The findings showed that the students had internalised the patient-centred paradigm and integrated teaching into their clinical work, but their learning was hampered by the institutional atmosphere dominated by clinical values. Among the nurses, only the "ideal clinical teachers" had combined clinical work and teaching in their professional paradigm. The tensions in the clinical internship limit the attainment of the reformed profession.

Keywords

Clinical teaching and learning, healthcare education reform, nurse, patient- and learner-centred professional paradigm, professional development, transformative learning

Introduction

Healthcare education faces the presence of the medical and the patient-centred professional paradigms. The medical or clinical healthcare paradigm focuses on illness, primarily based on declarative knowledge and quantitative indicators, such as clinical analyses, procedures, and medication (Epstein & Street, 2011). The patient-centred healthcare paradigm emphasizes communication and functional and also metacognitive knowledge to build on input from patients where declarative knowledge must be applied to solve problems or to plan learning and teaching (Ericson, Masiello, & Bolinder, 2012). In hospital settings, the current emphasis of the work is on a clinical approach at the expense of a more comprehensive understanding of the social nature of healthcare (Bleakley, 2006) and educational aspects of the healthcare profession (Frenk et al., 2010).

The impact of the clinical environment on healthcare education has been thoroughly studied and the internship period is recognised as a powerful influencer (Isba & Boor, 2011; Nordquist et al., 2019). According to studies, informal learning is widespread in the clinical environment, where the acquisition of practical knowledge takes place on the basis of the hidden curricula in everyday activities (Lempp & Seale, 2004; Wiese, Kilty, & Bennett, 2018). Previous research indicates how difficult it is to engage healthcare professionals in teaching, since they focus more on their development as mono-professional clinicians than as multi-professional clinical teachers (Dent, Harden & Hunt, 2017; Kotkas, 2018). This is why many practitioners, managers and policymakers do not consider teaching in a hospital setting an important topic (Zabat & Stabler-Haas, 2009). In the current hierarchical system, simplified assumptions still prevail suggesting that long-term work experience and good manual skills are sufficient for clinical teaching. However, the lack of a patient-centred approach can lead to misunderstandings and communication problems and hinder the development of a learner-centred environment during internships (Stoilnicova-Hartmann, Franssen, Augustin, Wouters, & Barnard, 2018).

To enhance the patient-centred practice, European health care curricula were modernised and harmonised as part of the Bologna Process in 2000, with a cross-curricular patient- and learner-centred approach (The Council of Europe, 2000). The new profession was expected to combine clinical work and teaching. However, little attention was paid to the challenges of integrating the clinical internship with education in healthcare colleges. Yet, clinical teaching also needs learning goals, self- and teacher-centred learning, mentoring and the theory of adult learning: the functions of clinical teaching are educational, supportive, and administrative (Kilminster & Jolly, 2000). Despite recommendations in support of clinical

teaching (Ramsden, 2003), there is hardly any research describing the pedagogical practices implemented in a clinical internship, and how far they promote the achievement of the new professional paradigm.

In Estonia there is about 8,000 clinical nurses. There are no previous studies on the experiences of the curriculum reform among clinical teachers, or on the impact of clinical teaching on the students' achievement of the goals of the new curriculum. This article is based on two studies. The first, conducted in 2017, examined changes in conceptions about teaching among experienced clinical nurse teachers. The second study in 2019 explored nursing students' conceptions about teaching. The aim of both studies was investigation of teaching in clinical practice since the implementation of the healthcare education reform in Estonia. On the basis of these two studies, in this article we pose the following two research questions:

1. How did the conceptions and values about "teaching" among clinical nurse teachers change during the students' internships?

2. What do the nurse students' conceptions about "teaching" show about the possibility of changing the professional paradigm of nursing in the context of clinical practice?

The analytical concepts guiding the hermeneutic interpretation of data are professional paradigm, professional development, and transformative learning. In the following we present the study context and theoretical background, then the research methodology and analytical strategies before we discuss the findings.

Context of clinical teaching in Estonian healthcare education

Until 1991, the training of Estonian nurses took place in medical schools on the basis of different curricula approved by the Soviet Union Ministry of Education. It was possible to study nursing after graduating from both basic and secondary school; accordingly, the length of study was 3 or 2 years, including an internship of one year. The healthcare education reform in nursing (hereinafter "the reform") began in early 2000: the emergence of nursing sciences and the new curricula aimed at upgrading the qualifications of nurses to higher education level and extend their professional autonomy. It was only possible to start studying after graduating secondary school and studies was extended to 3.5 years. Subjects from various theoretical approaches, research and evidence-based nursing practice were added to the nursing curriculum to support the achievement of professional paradigm and the lifelong professional development of nurses. Due to the extension of studies, the volume of internships increased.

Before the reform, all nurses had to go through continuing training courses to maintain their professionalism, but purely clinical skills courses were preferred, and specific teaching-related training was not compulsory. The reform should have also meant a change in the

pedagogical training for clinical teachers. Still, the 57-hour pedagogical training included in all nursing qualifications was considered sufficient for teaching in the clinical environment, although the integration of teaching into the new professional paradigm required nurses to be able to create a learner-centred environment using a patient-centred approach (Kõrgharidusstandard, 2000). Studies are supplemented by internships in the future workplace, where students should apply theoretical knowledge and practice clinical decision-making and self-reflection. While teachers in healthcare colleges have master's degrees, nurses teaching student nurses in the clinical internship ('clinical teachers') have diverse educational backgrounds based on older curricula.

Although nursing pedagogy has been in the basic curriculum since 1997, the reform emphasized professional paradigmatic changes in approaches to teaching and learning: (1) from remembering facts and learning-by-doing to critical analysis and the synthesis of information for decision-making; (2) from adapting professional qualifications and acquiring key competencies to reflection and cooperation; (3) from mechanical learning and teaching to developing well-grounded professional priorities and achieving a patient- and learner-centred approach (General Professional Standard for Nurses, 1999; Higher Education Standard, 2000; The Council of Europe, 2000; Nursing Training Development Plan, 2002).

This required collaboration between clinical teachers, health care colleges and internship institutions in developing programmes and instruction for clinical teachers to achieve competency in planning, implementation, feedback loops and reflection (cf. Zakari et al., 2014). Although all teaching professionals are expected to create an emotional, supportive, and secure environment for reflection (Sarv, 2013), skills for achieving this in the Estonian healthcare system are limited (Reva, 2008). Therefore, professional associations, internship institutions and two healthcare colleges started a 57-hour pedagogical course in 2002 to prepare clinical teachers.

The changing professional paradigm of nursing: Theoretical background

In this article, our aim is to interpret the change of nursing paradigm in the context of clinical teaching and learning. Therefore, the main analytical concepts related to the reform, are professional paradigm, professional development, and transformative learning. The reform suggested a new understanding of professionalism as a practice, where knowledge and competence develop through an awareness of teaching skills as an integral part of the nursing profession. The integration of knowledge and practice in clinical nursing and teaching could free nurses from the previous subordinate role in the clinical hierarchy, subsumed to decisions by physicians (Elston & Gabe, 2013). The reform officially provided nurses the right to engage in clinical teaching, and new opportunities for the ownership of their knowledge and practice, and new paths for development of the patient-centred professional paradigm.

An occupational group gains professional status due to objective and subjective qualities of the tasks they perform for society (Abbott, 1988: 39). External forces, such as technology, may lead to changes in objective tasks, but the qualities of the subjective tasks are affected by the activities of other professions. To achieve and maintain their jurisdictional status, professions should be able to expand their cognitive domain through the use of abstract knowledge about new areas of work and to define them as their own (Abbott, 1988: 91, 102). In healthcare, the hierarchies and paradigm differences between physicians, university educated teachers in nurse training institutes, and clinical teachers have traditionally been rigid (Elston & Gabe, 2013). Each profession has their own way of understanding themselves and their work, and their own habits for occupational practice, whose acquisition involves the significant subjective development of a professional identity (Evetts, 2012).

The internship of clinical nursing has in the past followed an expert-novice system, where the expert teaches the beginner, building on Patricia Benner's philosophy of professional development in nursing (Benner, 1982). According to the model, students must act according to what the teaching nurses believe is correct and traditional (Weissmann, Branch, Gracey, Haidet, & Frankel, 2006). Expertise is associated with a professional who works intuitively, drawing unconsciously on a repertoire of context-specific paradigmatic cases (Alligood, 2014). At the highest level of this professional development, the practitioner constructs informal theory out of practice, applies it in practice, and reflexively modifies it according to changing clinical situations (Rolfe, 1997).

The success of curricular reforms, which transform professional as well as teaching and learning paradigms, depends on the quality of the strategies and practices adopted by the teaching staff responsible for their implementation. Traditionally, the change of such paradigms has been interpreted as a purely cognitive process, drawing on rationality and cognitivism, such as in experiential learning, critical thinking, and reflective practice (Bleakley, 1999).

The reform was guided by the social-constructivist and social learning approach and adult and social learning theories. In the reform, social learning theory was connected with the previous paradigms of professional practice and teaching-learning in the clinical environment: the terminology of critical reflection—reflexivity, critical-self-reflection or critical thinking—as the core of transformative learning (Taylor, 1998; Mezirow, 2000) was used to describe patient-centred expertise and clinical decision-making (National development strategy for nursing and midwifery, 1999; European Commission, 2000; Nursing training development plan, 2002; WHO, 2013). Critical self-reflection should help teachers and students to connect clinical practice to studies in the healthcare college, and to promote professional development.

However, patient- and learner-centred and reflective methods have shown to be inefficient without integration with practice (Bloom, 2005). The perspective change requires the

experience of dissonance between current and new perspectives, examining them and becoming estranged from the old situation. Forsetlund et al. (2009) argue that learning that is linked to conscious professional development and practical educational intervention is more effective. The reform assumed that clinical teachers would adopt the transformative learning approach, change their teaching practice, reflect this critically and become able to make decisions and choices about the content and process of learning.

Findings from studies about the implementation of the Bologna Process in other professional areas indicate contradictory results. After the Finnish Police Curriculum Reform, which upgraded police degree training to university of applied science level, graduates successfully developed new competences (in research, information systems use, English language and communication skills), but the police-specific professional competencies even decreased (Laitinen, 2020). High levels of degree training and workload have also shown to cause interruptions and the prolongation of professional studies and to hinder internships (Masic & Begic, 2016). In some studies, healthcare students constantly report challenges in clinical practice, such as conflicts between learner and teacher, unclear responsibilities and learning Tynjälä goals, overload, fear of making mistakes and feeling unnecessary in the team (Tynjälä, Välimaa, & Boulton-Lewis, 2006; Sommer et al., 2016). In some countries, study programmes are even considering leaving the Bologna model or using pre-Bologna curricula in parallel, although corrections in the deficiencies in clinical courses have failed (Morgan, 2004). Furthermore, the level of the autonomy of the nursing profession is still found to be low in Europe, Britain, and the US, despite this academisation (Toffel, 2020). Still, studies indicate that the internship is critical for the students to develop their own teaching skills quicker than before the reform (Gray & Smith, 2001).

Research methodology

This article draws on data from two separate qualitative studies: one on clinical nurse teachers and the other on nurse students. Although teachers and students are implementing the reform in clinical practice together, the potential differences in their experiences are expected to reveal how the paradigm shift operates in there. Both studies are included in one article to comprehensively interpret the interaction and transformation of the parties involved in the process, to illustrate differently experienced curricular reform in nursing.

Data collection and participants

The empirical data from the two studies consisted of two types of the data: interview texts and drawings. Commitment to teaching is expressed through action and the way teachers explain and justify their actions (Lindlof & Taylor, 2002). In order to reveal perspectives on learning and teaching, teachers and students were asked questions to help them explore the topic and to probe for further thoughts and reflections. They were invited to critically reflect upon their experiences and express this in writing (text-based interview technique) in

their own words. In addition, drawing was used as an opportunity to illustrate and interpret the written interview text (Literat, 2013; Puglionesi, 2016). While visual data enriches the written data by allowing the discovery of additional layers of meaning, the drawings were expected to illustrate especially hidden aspects that are more difficult to express in words (Glaw, Inder, Kable, & Hazelton, 2017). The empirical data was collected using a text-based interview technique and drawing tasks with eight nurses and 66 students. Participants were chosen as purposeful case participants (Larsson, 2009). Data collection was ended after empirical saturation was achieved (Hirsjärvi, Remes, & Sajavaara, 2005).

In the study of the clinical nurse teachers, written and drawn data was collected between October 2017 and February 2018 in Tallinn, during three education development meetings for clinical teachers. The total number of registered clinical teachers in Estonia in October 2017 was 71. Eight voluntary clinical teachers who met the criteria participated in the first study. The group of nurses involved clinical nurse practitioners, who had completed the additional training, had teaching experience of 15 to 25 years, repeated the practice supervision course, and had had special reflection training to implement the new curriculum. Therefore, they were considered "ideal clinical teachers" and representative of the conceptual change in their teaching and the reflective transformative learning of patient- and learner-centred teaching practice. To understand the conceptual change and the transformation of the teaching and learning paradigm, in-depth structured thematic (text-based) interviews were used with the subsequent three open-ended self-analysis questions: "Why and how am I teaching?", and "What factors have transformed my teaching perspective?". They were invited to critically reflect upon their experiences and express this in writing in their own words. The interview question—"How am I teaching?"—elicited a drawn response in order to collect visual data about meanings, emotions and values related to teaching.

In the study on nurse students, empirical data was collected from a purposeful, homogeneous group of participants. They represented all Estonian final (third) year nurse students and could share their personal experience of the transformation in their clinical practice. The data was collected between February 2018 and May 2019 in Tallinn after the students had returned to college from their last internship. The (text-based) interviews took place in meetings with two groups of students in two pre-exam seminars. Interview texts were collected from 66 volunteers, who were asked similar questions to those asked of the teachers: "Why and how am I teaching?", and "What factors have transformed my teaching perspective?" To visualise the learning experiences in the clinical environment, they had to draw a response to the third question: "How was I trained in practice?"

The anonymity of the participants and informed consent requirements of the General Regulation on the Protection of Personal Data were ensured.

Hermeneutic content analysis

Data analysis was carried out in two stages using hermeneutic and comparative analyses (Larsson, 2009; Polit & Beck, 2010). The analysis process included five steps: 1) empirical data was prepared for hermeneutical analysis and read carefully; 2) the units of analysis were explored as segments for coding; 3) the units provided the basis for a coding system; 4) codes were generated; 5) thematic codes were applied and analysed across all empirical materials (Saldańa, 2009).

During the first step, the clinical nurse teachers' interview texts were read repeatedly and coded focusing on how they reflect the changing content, process, and emotions of teaching, how they perceive their position as teachers, and how this affects their professional and teaching practice. The shifts and related dilemmas and emotions from previous to new meanings and practices in teaching were coded. During the second step, the students' interview texts were read repeatedly focusing on how they reflect the changing content, process and emotions of learning and teaching, how they perceive their position as novices in healthcare, as learners and teachers, and what kind of experience they obtained through the internship. The shifts and related dilemmas and emotions from previous to new meanings of learning in healthcare, and dilemmas and conflicts between perspectives on meanings for the teachers and students were coded.

The reading gave an initial sense of the meanings. During reading, notes were made on emerging key meanings and themes, such as interesting ideas, confusions, and challenges. Empirical material was first classified according to aspects of the patient- and learner-centred professional paradigm, followed by comparison of similarities and differences between teachers and students. The notes were used for an analysis of the written material with a focus on whether the teaching and learning paradigms of the 2000 curriculum reform had been adopted in clinical practice. They were also used to deepen the interpretations by analysing the connection between the drawings of the meaning schemes that emerged in the earlier iteration. The sub-themes related to transformative learning extracted from the teacher interviews revealed a dilemma between clinical work and teaching, the importance of both clinical and teaching skills in healthcare practice, and personal qualities supporting the new role. The sub-themes characterising the students' written responses about teaching included teacher incompetence, lack of social relatedness and unjustified autonomy. Examples that indicate this can be seen in sentences like: "There is little patient-centredness in the hospital" and "There are many similarities in nursing and teaching".

The sub-themes related to transformative learning were extracted from the teachers' written interview texts to reveal dilemmas in integrating clinical work and teaching, the importance of clinical and teaching skills and personal qualities supporting the new professional paradigm. From the students' written responses, the identification of sub-themes focused on clinical teaching in practice and on teacher qualities. Teachers' and students' paradigms were finally compared to highlight their similarities and differences.

Findings

In the following we present the findings from the two studies on respectively clinical nurse teachers and the other on nurse students and how they have experienced the curricular reform in nursing. The findings of the data analysis from both studies are presented according to the questions, asked from the participants. The quotations, as empirical examples, have been translated from Estonian into English accurately and carefully preserving the context of the content.

Clinical nurse teachers

The dilemma between clinical work and teaching was mentioned repeatedly by teachers, when they listed factors considered critical in going through the change in professional and teaching and learning paradigms, and in building self-confidence for the new role. The teachers suggest the high workload and the lack of time among clinical nurses as one major obstacle to becoming a clinical teacher. Another factor identified as a hindrance was the lack of support from the rest of the clinical community, colleagues, and management. This was indicated by the concern of the respondents that patients may be neglected due to their additional teaching obligations.

> […] There is a lot of theoretical talk (in school -xx); however, in hospital as the place for the internship, it is impossible to implement many skills in real life; for example, if there are 25 patients in the ward and only one nurse. […]

In teaching practice, efforts were made to achieve the same roles considered important in nursing practice, using evidence-based nursing knowledge reflectively. During the internship the clinical teachers highlighted characteristics valuable in teaching (and nursing), such as being *encouraging, helpful, positive, professional, inspiring, thought-provoking,* and *open-minded*. The ideal clinical teachers also emphasized psychological competences—the ability to *identify, understand, comfort, see one's strengths and weaknesses, take into account individual differences,* and *the ability to innovate*. They experienced the similarity of patient and learner-centred approaches, and analysed, and assessed the respective skills of their students. Values important for teaching expressed in the teachers' written interviews included their dedication to the healthcare profession, desire to learn, self-management, empathy, and patience.

> […] "I am"—as the teacher, probably a person who wants to be very clear about what the purpose of my learning or further training is and what the result or goals should be. /…/ In general, I also conduct an analysis of what was relevant in the training and where to focus, and what to explain next. /…/ I think I am proactive but maybe provocative too, because I use reflection and drama in teaching. Slightly when being more playful, you can try it yourself, and it gives you a better understanding and a new level of knowledge. […]

The teachers identified their teaching practice as a factor that had strengthened their identification with the healthcare profession and their professional development.

> […] Self-directed independent learning, the opportunity to teach patients or students, and self-development helped me become a clinical teacher. Also, as a teacher now, I look forward to learning from people as well as from topics and discussions. And I want to simplify the earlier knowledge gained, enrich it with clinical experience. /…/ The teaching in my opinion is about acquiring knowledge, applying it, developing skills, understanding, and thinking, problem solving and critical thinking. […]

These clinical nurse teachers liked the term *clinical teacher* because it was a good description of the tasks and context of their work and helped them better explain and reason their pedagogical activities in the clinical environment. Doing so will reveal the knowledge that guides their professional activities and decisions. This implied reflection on teaching and belief in oneself as a teacher: most nurses considered that despite their pedagogical education and experience, they are still developing as teachers. The drawn response to the question "How am I teaching" visualizes the professional learning-related meaning scheme: equal relationship to students, learning with and from students and positive emotions (Illustration 1).

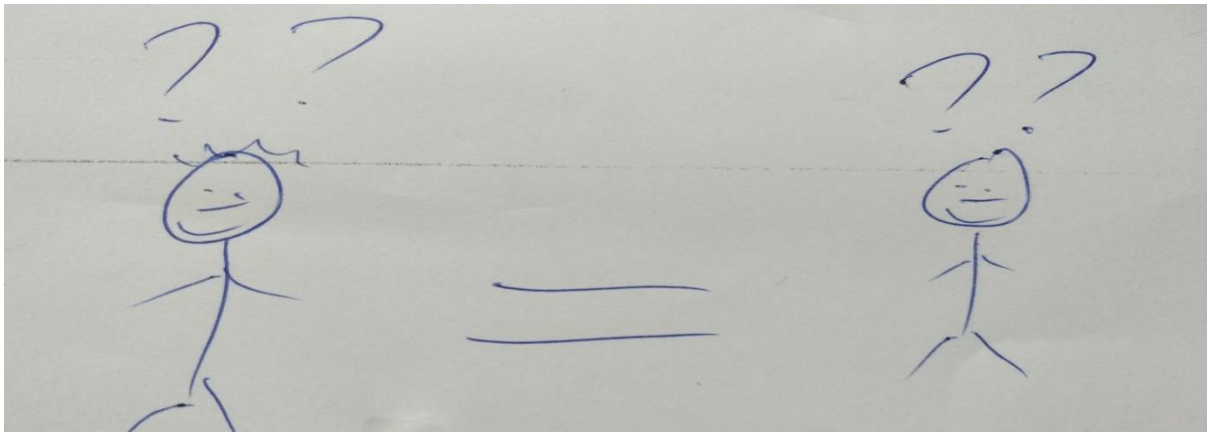

Illustration 1. Clinical teacher's visualisation: "How am I teaching".

The clinical teachers valued their role as teacher and were successful in teaching. They had received continuing training during the curriculum reform, used critical self-reflection and reflection in their daily practice and found the time for teaching and associated it with positive emotions. Some were able to compensate the shortcomings in their pedagogical knowledge with excellent clinical experience, practical skills and being a positive role model, using self-management and teaching techniques unconsciously.

Nurse students

The findings from the analysis provided illustrations about learning during the internship, when the clinical teachers were able to involve the student in the learning process, which included the critical analysis of information needed for decision-making in the team.

> […] My practice-based experience has always been very pleasant—I have received positive feedback and clinical teachers have been calm, even when I have done something wrong. […]

The students' desire to teach indicated that clinical practice provided them opportunities both for social and constructivist learning. The analysis showed that the greatest autonomy and opportunity to practice critical thinking in the learning process exists in the context of patient education, compared to previous clinical procedures. Using a patient-centred approach in teaching patients, amplified the students' identities as nurses. They referred to this as a new factor that made them active in learning and developing themselves professionally.

> […] My own experience in the field of teaching is (still -xx) judged to be insufficient, but the support of the clinical teacher is valuable. […] Nurses teach on the basis of their practical experience, but sometimes trainees teach instead. […] I've already been in the role of a teacher, and it feels great to pass on my knowledge to someone. In doing this, I felt how my own knowledge and skills were anchored... /…/ Teaching is a privilege, but it also means responsibility. […] But really, our job is much like a teacher... […]

Concerning learning competences, which relate to specific clinical knowledge and experience, students still only considered manual skills as "learnable by doing". The students "remembered facts" from the curriculum but valued the role of the clinical teacher in acquiring professional knowledge and professional development as 'most important'.

> […] The greatest and most important teachers are the hospital staff who teach real-life activities. /…/ Now I have realized that the best skills come from the work environment or the internship. Not everything has gone smoothly in practice… […]

From the perspective of professional development, the analysis showed contradictory learning opportunities due to varying contexts because the curriculum change has not led to a professional paradigm shift in the teaching practices of all nurses.

> […] I have come across very different teachers. […] There has been a lot of talk at school about the patient-centred approach in different lectures. In practice, however, little is seen. The work culture in hospitals is already well established, and it is very difficult for the trainee to break it. […]

However, students often equated teaching with continuing professional development, and in their professional understanding rather than in their teaching and learning paradigm, they considered the roles of the healthcare professional and teacher to form an integrated whole.

> […] In my view, a nurse's profession is (just like) a teacher's profession. […] The healthcare professional must teach others—to learn by themselves. […] Already (as a nurse—xx), everyone is asking different things about their health. Now I realize that answering these questions (correctly—xx) is a patient-centred approach and teaching at the same time. You can teach in healthcare only if you have a very broad knowledge base, and still, you must constantly upgrade yourself. […]

In their drawings, nurse students reflected more complex situations than in their writing. The drawings were dominated by the teacher, portrayed as a larger figure transmitting skills and knowledge (Illustration 2).

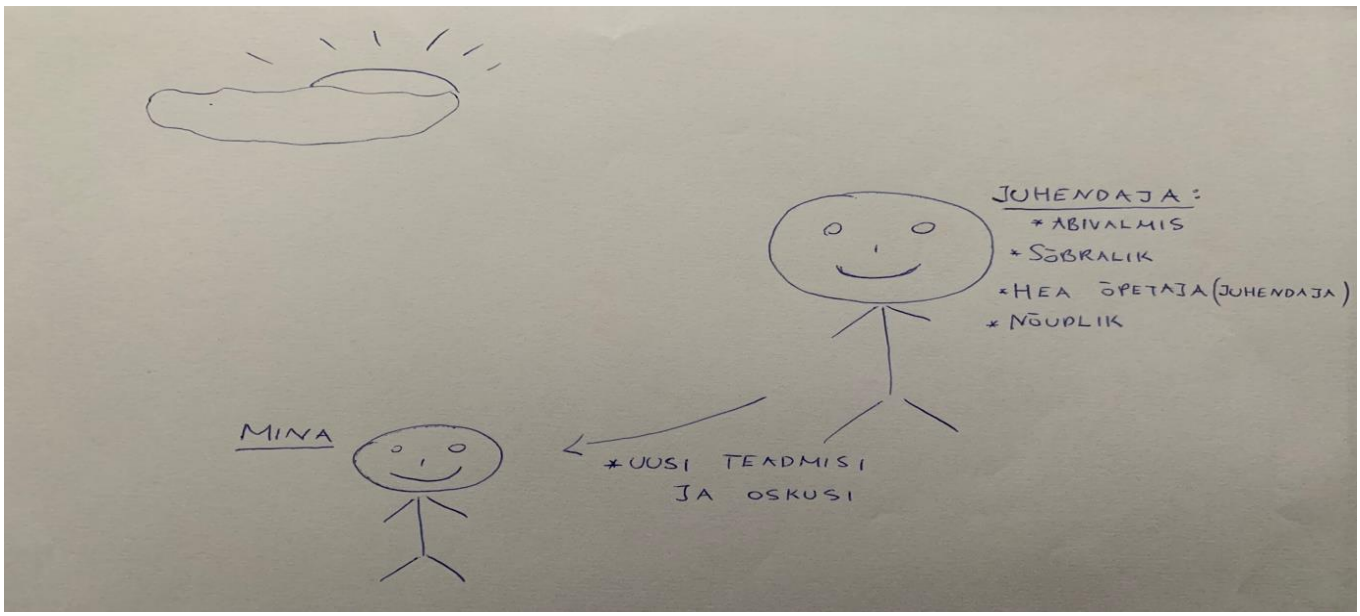

Illustration 2. *Nurse students' visualization: "How I was trained in practice".*

In contrast, the valued qualities for the teacher, added to their drawings, mentioned a helpful, friendly, good, or demanding teacher or mentor.

Concerning the *why* and *how* interview-questions on teaching, the students' drawings showed tensions during the internship, especially between the paradigms and values of the students and teachers. Some drawings by the students show that the internalization of the new professional and teaching-learning paradigms indicated in the written expression of the ideal clinical teachers was far from the reality in their clinical practice (Illustration 3).

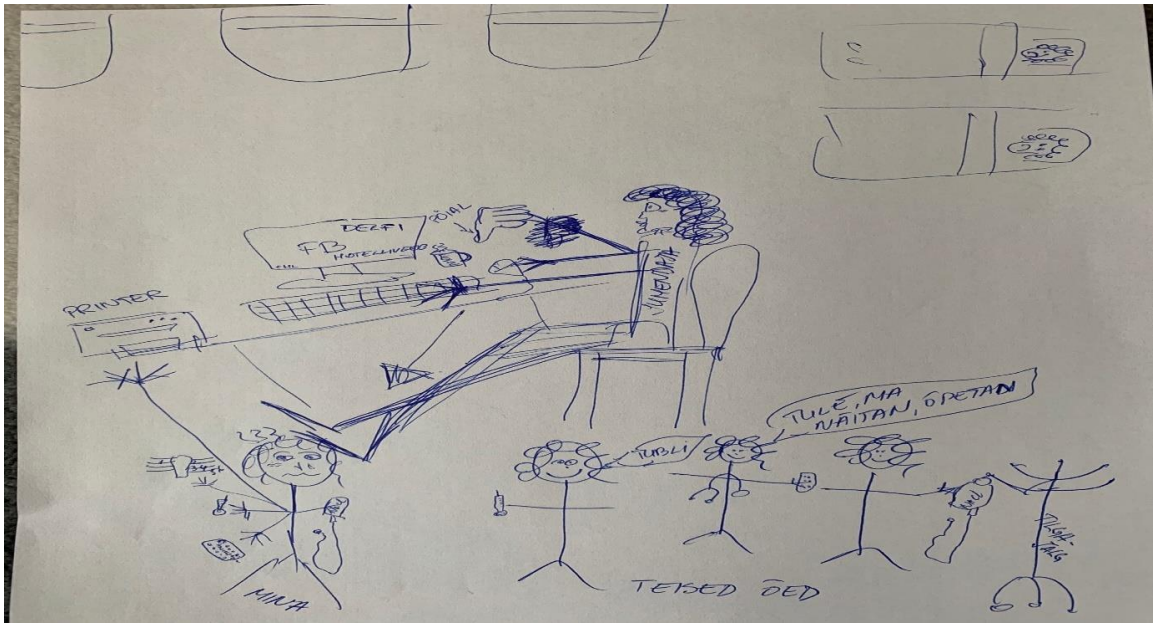

Illustration 3*. Nurse students' visualisation: "How I was trained in practice".*

The student (under the feet of the nurse) demonstrated fear (tears) about making mistakes or harming patients (when exercising invasive procedures), as well as unclear learning goals and responsibilities and excessive workload (five hands). The pictures illustrated, that the teachers do not fulfil their clinical and teaching responsibilities, and so both the student and the patients are left alone. Drawings showed that nurses had not progressed from the level of mechanical teaching in the context of patient education and had limited skills in creating an emotionally supportive and secure environment for learning. In addition, the students' written responses about teaching in their clinical internships were characterised by barriers to learning, such as *teacher incompetence, lack of social relatedness* and *unreasonable autonomy.*

> […] Not all people qualify as teachers and then they should not teach! […] In order to be taught at all, more communication and understanding of what the student wants to achieve and what skills are already available are needed. With a high workload and being in a hurry, teaching is often neglected. […]

The most frequently mentioned deficiencies in the skills of the teachers were the *inability to communicate* and the *lack of psychological knowledge*. The students expressed feeling small, unnecessary and redundant in the practice institution, indicating a need for significantly more support and commitment from the clinical teachers. The findings revealed factors that hinder teaching, such as *treating students in the hospital as free labour* and *clinical teachers being indifferent and short of time*.

Discussion of key findings

The findings showed that the goals of the 2000 curriculum reform in Estonian healthcare education—the adoption of a patient-centred approach among all healthcare professionals through the new curriculum and the improvement of their teaching competencies in continuing professional development—have been partially achieved.

The study of clinical nurse teachers and the first research question: How did the conceptions and values about "teaching" among clinical nurse teachers change during the students' internships? The findings showed that for the clinical nurse teachers the reform had an indirect impact on the acquisition of the new professional paradigm, as the students challenged the teachers' conceptions and values about teaching. The nurse teachers had adopted teaching methods that had not been taught in the old curriculum, and they mastered and valued reflection. They acted as ideal clinical teachers because it revealed to them the new professional paradigm of nursing. The teachers' perspectives on the professional paradigm changed due to a self-reflective process, becoming first patient-centred and then learner-centred. Self-reflection and critical analysis guided them to learn how to teach in order to develop well-grounded professional priorities in their students. Experienced "ideal clinical teachers" showed that teaching practice, accompanied by critical self-reflection seems most powerful in the formation of professional identity, which integrates the clinical work and the teaching. Yet the challenge in clinical teaching is to go beyond the professional identity of a nurse, which seems to dominate other professional identities, as long as the main obligation of teachers is to perform their clinical responsibilities (cf. Stalmeijer et al., 2013).

According to the findings, the dominance of medical conceptions and values in the clinical institution and among its staff seem to hamper the emergence of the new professional paradigm. The clinical nurses were expected to transform their professional paradigm while continuing their regular work, without the support of the (reformed) healthcare colleges. Nevertheless, despite their professional autonomy, ideal clinical teachers also expected support from colleagues and the management for their learning and teaching. The new curriculum recommendations do not recognize the interdependence of change between all professional paradigms in healthcare. Training for clinical teachers is not mentioned in the new curriculum recommendations and development plans for the nursing profession. When the specific nature of their work is not recognized in the design and implementation of the new curriculum, the "obligation imposed by society" (Abbot, 1988) is not enough for the transformation of the clinical nurse profession.

The study of nurse students, and the second research question: what do the nurse students' conceptions about "teaching" show about the possibility of changing the professional paradigm of nursing in the context of clinical practice? The findings show that the students had already internalized the meaning schemes of the new professional paradigm in the

college before the internship. As novices, students still considered learning-by-doing the most effective method in acquiring nursing skills, but they had a full experience of the reformed curriculum and could integrate the new professional paradigm into their clinical practice. Conceptions about teaching can be interpreted as belief about the clinical setting as fundamental for professional development, and which still has no alternatives. The students' professionalism during the internship seemed to rely on the connections they formed between the theory adopted in the healthcare college and the practical knowledge. Alongside staffing shortages, some clinical nurses were responsible for teaching students without preparation or proper teaching qualifications, which caused tensions between the teachers and the students.

Comparative discussion

Based on the findings, clinical nurse teachers as well nurse students still seem to question their roles in setting goals and carrying out learning in the professional growth process. While the students emphasized the role of the teacher in passing on knowledge, the clinical nurse teachers stressed the organisation of student activities and enabling student understanding. The students experienced a difference between the old and the new curriculum when cooperating with the ideal clinical teachers, who allowed them to train and work safely as independent professionals. While the ideal clinical teachers showed positive emotions towards the students in their writings and drawings, the students repeatedly indicated they confronted contradictions between the curriculum and the internship environment. While many of the reform goals were pictured in the partial interpretation categories, the professional paradigms of the old and new curriculum seem to be intertwined, indicating how vague the impact of the reform may be in hospital culture. Concerning clinical teachers, as nurses "in general", students had many experiences which did not match with the findings from the "ideal clinical teachers" of this study. The findings show that the reform had mainly affected change in nurses' knowledge, it had not led to conceptual changes about teaching as part of their profession, with the exception of the ideal clinical teachers. So, the different professional education background can influence the formation of professional identity and professional development.

Conclusions and recommendations

We assumed that after 17 years since the reform, teaching in clinical practice would be closer to the students' expectations. The findings showed the persistence of disparate professional paradigms. The achievement of the goals of the Estonian healthcare curriculum reform depends on the conceptions related to teaching and learning and on educational background of the clinical nurse teachers. When pedagogical tasks are added to medical tasks externally, nurses remain vulnerable to changes in their central tasks without support in terms of professional theory and internship practice (cf. Abbott, 1988: 39). The power of clinical nurses to expand their cognitive domain, add new fields of work and define them as

their own (Abbott, 1988: 102) depends on the support from the entire healthcare system and the professional system of the clinical institutions.

The studies focused on the implementation of reform policies and the experience among Estonian healthcare professionals. Since a similar reform has been implemented across European higher education, the results can be generalised beyond the national context. The study shows similarities with findings in other professional areas experiencing reforms following the Bologna Process, with the formal upgrading of educational institutions and practice-oriented professions to the level of higher education. With no recognition of their distinctive knowledge and practice in the context of the professional area, the reform policies may be difficult to achieve (Masic & Begic, 2016; Laitinen, 2020). The findings are also relevant for professional studies in general, since they confirm that professional paradigmatic change includes external as well as internal forces and requires collaborative and holistic analysis and reflection on how the diverse fields of knowledge and practice, including teaching, could be integrated between the professionals and institutions.

The progress towards a new professional paradigm and identity also requires collective mobilisation of clinical teachers into a specialist professional association (Sarv, 2013). Until this happens, clinical teachers will continue to feel isolated. The current short-term training is not enough to generate among them a sense of community. The creation of a special clinical teacher position and accreditation of the relevant professional competencies that promote the integration of teaching into the clinical nurse profession must be included in the nursing development plan.

The professional paradigmatic shift towards the clinical nurse profession, which integrates the patient-centred clinical nursing paradigm with the patient- and learner-centred teaching paradigm requires the integration of curriculum development and implementation involving healthcare colleges and clinical internship institutions. It requires collaboration among teachers in colleges, all the staff of the internship institutions and the patients, to assess the achievement of patient-centredness during the internship. In order to achieve a learner-centred professional paradigm, clinical teachers should participate in continuing pedagogical training in order to practice teaching rather than only build on their long-term experience in practice. It is important both in healthcare institutions and colleges to monitor who is appointed as clinical teachers and how students' clinical internship takes place. If clinical teaching is not prioritised in the internship institution, the requirements for quality cannot be fulfilled.

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Professionals and Volunteers: The Importance of Recognising Diversification in the Healthcare Division of Labour

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Abstract

In sociological research on relationships between professionals and volunteers, professionals are often contrasted with volunteers as abstracted, distinct and homogeneous groups. Focusing on healthcare in selected modern societies, and adopting a neo-Weberian and complementary boundary work perspective, this essay argues the landscape is more complex than between paid groups with exclusionary social closure and the unwaged in the market. First, diversification exists within health professions themselves based on social closure, with hierarchies and differential scopes of practice. Second, unpaid volunteers vary in responsibility depending on factors like employment sector and social background, including qualifications and experience. Third, in the paid workforce, there are interstitial non-professionalised health occupations, such as the neglected, lower educated health support workers, forming the largest, most heterogeneous healthcare labour force. Drawing on studies of healthcare, it is argued that recognising the diversification and interplay

between professionals, volunteers and support workers is vital for enhancing health policy.

Keywords
Diversification, division of labour, healthcare, professions, volunteers

Introduction
A burgeoning literature by sociologists and other contributors exists on volunteers in healthcare in modern neo-liberal societies (e.g. Eliasoph, 2011; Hardill & Baines, 2011; Handy & Srinivasan, 2004). Much of this compares volunteers with other workers – contrasting, amongst others, unpaid volunteers with paid workers (Handy, Mook & Quarter, 2008) and volunteers with managers (Kreutzer & Jäger, 2011). Some publications have been more subtle in acknowledging different levels at which professionals and volunteers operate in healthcare (e.g. Hoad, 2002; Merrell, 2000; Overgaard, 2019). However, in work comparing volunteers with healthcare professionals and other highly ranked paid workers, they are often depicted as abstracted, distinct and homogeneous groups. This fails to reflect complexities in the healthcare division of labour—which go beyond differing national cultures that impact on the healthcare workforce (de Bont et al., 2016).

This essay develops a more elaborated account of the comparison and interlinkages of volunteers with professionals in healthcare, illustrated largely but not exclusively by the Anglo-American context and Northern Europe in the modern neo-liberal world. The interrelated elements of the division of labour are examined as a backdrop to future research into the professional-volunteer relationship. The central research question is: *What are the characteristics of, and divisions within and between, the various players in the healthcare arena relevant to the interface of professionals and volunteers?* This question is explored primarily through a neo-Weberian lens, followed by a brief elaboration of the methods used. The analysis focuses on occupational diversification in healthcare and raises various sub-issues concerning the relationship between professionals and volunteers, including professional boundary creation, the role of support workers, self-help and informal carers. In arguing for the importance of recognising diversification in the healthcare division of labour, the essay finally discusses the implications for future studies of professionals and volunteers, as well as policy and practice.

The relationship between professionals and volunteers: Theory and methods
For neo-Weberians the key to theoretically understanding the division of labour lies in differential market positions (Saks, 2016). Accordingly, neo-Weberians define professions in terms of exclusionary social closure in the market, drawing on the classic work of Max Weber (Parkin, 1979). Professionals have an advantaged position in an interest-driven,

competitive marketplace as they typically command greater financial and other privileges based on legal closure. A neo-Weberian market perspective on the relationship between professionals and volunteers also implies differentiating both groups, rather than simply distinguishing paid professional groups and the non-professionalised unwaged. Following neo-Weberian market logic, there are additionally interstitial occupational groups critical to healthcare provision.

This theoretical approach is complemented by a boundary work perspective. Here studies of professional-volunteer relationships highlight that boundary work is not just about interest-based strategic boundary protection in neo-Weberian accounts, but also the shaping of boundaries in occupational interaction (Hoad, 2002; Merrell, 2000; van Bochove, Tonkens, Verplanke & Roggeveen, 2018). The emphasis on work originates from the interactionist tradition linked to Weber (Saks, 2016) which highlights that boundaries are not just "out there" (Halffman, 2003), but are constantly (re)crafted. Boundary work is often understood as demarcation work, studying the erection and maintenance of boundaries (Fournier, 2000)—as, for instance, through monopolisation, expansion, exclusion and protection (Gieryn, 1995)—but it is also about boundaries being bridged or crossed (Halffman, 2003). This helps to explain why professionals and volunteers (and/or support workers) sometimes emphasise differences, while in other circumstances, they are less relevant.

Methodologically this essay draws on our earlier macro to micro research on healthcare professions and health support workers (e.g. Saks, 2015b; Saks, 2020) and voluntary work and professional-volunteer relationships (e.g. van Bochove & Oldenhof, 2020; Verhoeven & van Bochove, 2018). We also undertook a selective literature review of theoretically-based empirical studies known to us through referencing healthcare, based on their rigour and relevance to our research aims (for similar approaches, see Hallett & Barber, 2014; Nixon & Crewe, 2004). On this basis, we found that, while contributors on healthcare professions and volunteers in modern societies were attentive to internal diversity, the implications of diversification for the relationships between professionals and volunteers—as well as non-professionalised groups of health support workers—were largely unexplored.

Historic literature on volunteers is predominantly survey-based and focused on background characteristics and motives (Wilson, 2012). Although Taylor (2005) argues that 'rigorous qualitative research' on voluntary work is scarce, recent research includes qualitative and ethnographic studies of the volunteer experience—including relationships with clients, other volunteers and paid professional staff. Various studies apply a boundary work perspective to settings from social and long-term care (van Bochove et al., 2018) and palliative care (Claxton-Oldfield, Gibbon & Schmidt-Chamberlain, 2011) to well women clinics (Merrell, 2000), hospitals (Handy & Srinivasan, 2004) and patient organisations (Kreutzer & Jäger, 2011). This has involved unstructured, semi-structured and structured interviews, participant and non-participant observation, and focus groups with varying numbers and types of subjects.

Neo-Weberian research on professions in the modern healthcare division of labour has focused on high-level policy analysis at the macro level, centred on primary and secondary literature (Saks, 2015b). It has mainly concentrated on doctors (e.g. Chamberlain, 2015; Stevens, 2003), but has sometimes overviewed the historical and contemporary position of other health professions like nursing and midwifery (Borsay & Hunter, 2012) and allied health workers' relationships with paid health support workers (Nancarrow, 2020). Drawing on these fields, this essay charts the nature and divisions within and between volunteers and professionals in healthcare. The resulting complexity is very apparent in the form taken by healthcare professions, where our analysis begins.

Healthcare professions in the division of labour

The neo-Weberian concept of exclusionary closure underlines how health professions regulate competitive market conditions in their favour with state support by creating legal monopolies. Consequently, professions with which volunteers deal are able to restrict opportunities in their own interests to a limited group of eligibles, whilst creating legally defined outsiders (Saks, 2012). The definition of a profession varies depending on whether market control is seen as direct or derivative. In the former case, the medical profession in Britain is viewed as having power over service provision through a self-regulating association of equals (Parry & Parry, 1976). In a more derivative sense, medicine is defined as a profession because of its legitimate organised autonomy over technical judgements and the organisation of work (Freidson, 2001) or because of its power over consumers (Johnson, 2016).

Central to these neo-Weberian definitions is that professions command high income, status and power underwritten by the state, based on prescribed educational credentials (Parkin, 1979). There are national differences, though, in the exercise of their authority. In welfare state-driven Britain, for instance, medicine involves a de facto monopoly whereby those on the register have legal protection of title, while other non-professional healthcare workers can practise under the Common Law. In the more entrepreneurial United States, though, a de jure professional monopoly operates through state-by-state licensure (Saks, 2015b). The power of medicine, though, is fast-changing with, inter alia, rising corporatisation, the New Public Management, expanding state regulation and the emergence of multinational professional service firms (Chamberlain, Dent & Saks, 2018). Such trends have been moderated by resistance and adaptation in healthcare professions through hybridisation in which professionals act as intermediaries between managers and clients (Noordegraaf, 2016). Moreover, strong patterns of self-regulation in healthcare exist outside the Anglo-American context in countries like Australia, Canada and Germany (Saks, 2021).

Such patterns necessarily impact on the relationship between professionals and volunteers. So too does differentiation between health professions in terms of social closure, manifested in varying scopes of practice and hierarchical positioning in the professions.

Further divisions are based on factors like gender and ethnic minority status (Andrews & Wærness, 2011). Neo-Weberians have viewed less esteemed professions than medicine as experiencing dual closure, encompassing both professional exclusivity and the solidaristic union-style tactics of the working class (Parkin, 1979). This certainly applies to semi-professions like nurses in Britain who have professional standing, but are lesser paid and lower status than doctors, despite enhanced specialisation (Borsay & Hunter, 2012). Nonetheless, as Carvalho (2014) relates in the Portuguese case which has applicability elsewhere (Noordegraaf, 2016), nurses have resisted deprofessionalisation through local negotiation with managers and organisational hybridisation.

The professional pecking order is relevant to the dynamic relationship between professionals and volunteers given frequent interest-based conflicts (e.g. King et al., 2019), not least in relation to supporting healthcare personnel (Nancarrow 2020). The impact on volunteers is accentuated by the categorisation by Turner (1995) in which medicine dominates modern healthcare, reinforced by allied and other health professions, labelled subordinate professions. They complement limited professions including occupations with legally protected territory linked to particular body parts or therapeutic methods—like dentistry, optometry, pharmacy and podiatry. Finally, the category of exclusion encompasses marginal non-professionalised practitioners of complementary and alternative medicine—even if chiropractors and osteopaths have now become state licensed professions on both sides of the Atlantic (Saks, 2015a).

The relationship of volunteers to professionals: The impact of diversification

Professionals are not the only stratified group in the market. Volunteers are as well, which also impacts on their interface with professionals. Wilson (2012), for instance, considers factors influencing factors such as personality traits, education level, life course and gender. However, his review was mainly based on articles centred on social surveys. Greater detail is therefore needed on how unwaged volunteers relate to paid professional staff and other healthcare workers. But if “collaborative working between volunteer and paid workers has been under explored” (Merrell, 2000, p. 93), more recent micro-level and meso-level qualitative studies have focused on interactional boundary work between these groups, including professionals in health and social care (e.g. van Bochove et al., 2018). Much of this literature addresses mutual tasks and/or responsibilities, especially volunteers assisting or replacing paid professionals and asks whether professionals can reciprocally take volunteers’ positions in voluntary organisations.

Some studies draw a line between the roles of volunteers and professionals. The study of six patient organisations in different European countries by Kreutzer and Jäger (2011), for example, depicted them as “dual identity associations”—in which volunteer and managerial identities were inherently opposed. Handy and Srinivasan (2004), meanwhile, observed

from their study of 31 Canadian hospitals that non-market emotional support by volunteers contrasted with market-like interactions of medical professionals with patients. These studies emphasise differences in tasks between volunteers and paid workers in identities, motivations and other qualities. The boundaries between them seem clear and stable as healthcare professionals and managers use a different discourse to volunteers and have different tasks. However, other methodologically well-grounded studies of care settings have shown that the differences between professionals and volunteers are not clear cut, but ambiguous and dynamic (Hardill & Baines, 2011; Hoad, 2002; Merrell, 2000; Taylor, 2005; van Bochove et al., 2018). Two important reasons for such variations in boundary demarcation and blurring are suggested—differences in types of professional closure and differences among volunteers.

The impact of differences in professional closure

Cross-national comparisons of professional-volunteer collaboration are scarce, but Overgaard (2015) helpfully compared two hospices in Denmark and Australia. She found that in Australia volunteers took over some tasks of paid staff and received training to minimise risks, while in Denmark there was no overlap with volunteers and paid staff. As the differences were not attributable to care service characteristics or the individuals involved, Overgaard concluded that professional closure was decisive. In the Danish welfare state, care is the responsibility of qualified paid staff and in palliative care nursing professionals maintained a monopoly. In contrast, in Australia, families have primary responsible for care-giving—which explains why nursing professionalisation has been less successful—with volunteer training to minimise risks in taking over selected tasks. More recently, Overgaard (2019) argues that earlier findings do not imply Australian women favour voluntary over paid work, but instead lack paid work opportunities. Researchers, therefore, need to move from descriptive accounts of volunteers' activities to understanding the varied principles in specific countries that shape divisions of labour.

Not only is there a variation in cultural perceptions of volunteers and professional closure, but differences are also found between sectors in particular societies. In her study of 29 volunteers in Britain, Taylor (2005) found that professionalisation levels differed substantially between healthcare and community work. A study in The Netherlands based on 144 in-depth interviews with professionals and volunteers and observations in 14 care and social support organisations came to similar conclusions (van Bochove et al., 2018). In long-term care organisations, such as nursing homes, the boundaries between volunteers and professionals were clearer than in social support organisations, including community centres. In nursing homes, volunteers were generally excluded from the professional domain of the nurse, given their assumed lack of knowledge, skills, authority and reliability. Against this, the roles of social workers and volunteers largely overlapped, with volunteers perceived as "professionalised" invited to take over care tasks and receive privileges normally reserved for paid staff. It was concluded that differences in exclusionary social

closure explained these outcomes. In less federalised countries, like the United States, further complexity exists because of variations in health professional closure between states—with resulting implications for relationships with volunteers (Saks, 2015b).

The impact of differences among volunteers

Nonetheless, the type of professional closure in specific societies cannot explain all variations from a neo-Weberian perspective. Several authors have shown that other mechanisms are involved in the everyday practices of volunteers and professionals. Differences between volunteers—and how professionals perceive them—appear most important. Merrell (2000), in a qualitative study of two community well-women clinics, and Hoad (2002), in an analysis of 14 community care schemes for older people centred on semi-structured interviews, both underline in their boundary work research the importance of seeing the volunteer workforce as differentiated in social and work backgrounds in interacting with healthcare professionals. Such variation can affect the degree to which volunteers substitute for, or complement, professional and other paid staff. This is accentuated by research that differentiates between long-term and short-term volunteers (Eliasoph, 2011) and corporate and student volunteers (Handy, Mook & Quarter, 2008). The presence of experienced "professional" volunteers can therefore lead to seemingly peaceful boundary deconstruction even if conflicts are still possible.

Boundary work research projects based on interviews and observations in nursing homes, day care centres and community centres by van Bochove support this interpretation in The Netherlands (van Bochove et al., 2018, Verhoeven & van Bochove, 2018). Although van Bochove and colleagues (2018) argue that the roles of paid health and social care professionals are more distinctive in nursing homes than community centres, even here boundaries sometimes crossed. The perceived characteristics of volunteers were important, alongside the circumstances under which nurses worked. Possession of a workload requiring experience allowed paid professionals to hand tasks to "professionalised" volunteers—and where "welcoming work" was performed by paid professionals, boundaries were changed. However, these boundaries were not completely diminished, as professionals decided which volunteers should be welcomed and when. Overgaard (2019) therefore rightly notes that the form and content of voluntary work differs across contexts and does not just reflect volunteers' personal preferences. There may also be legal constraints on the tasks volunteers perform from sector to sector in different countries—such that professionals are not the only group impacted by state regulation (Milbourne, 2013).

Different organisational engagements of volunteers in the public and private sectors may greatly influence the nature of the interactions with professionals in healthcare and other fields too. Verhoeven and van Bochove (2018) found different types of volunteers in their study of client care for groups including the elderly and disabled. Like Taylor (2005), they noted that generational, socioeconomic, cultural and health differences shaped volunteer

priorities and expectations of work. Some volunteers had mild disabilities themselves and wanted to be useful, such as by assisting clients with more severe disabilities, and wanted to belong to a community (Verplanke, 2014). However, professionals argued that such volunteers were "taking more than they can bring"—as they cost them time instead of lightening their workload—and they therefore preferred more "vigorous" volunteers (Verhoeven & van Bochove, 2018) with motives such as using voluntary work to acquire skills for future paid employment (Verplanke, 2014).

Some volunteers were trained during voluntary work and became more professionalised, or were already professionals in the same or another field of work using their skills in volunteer roles (van Bochove & Oldenhof, 2020). Hoad (2002) in England and Handy, Mook and Quarter (2008) in Canada noted that, in some organisations, this can occur coterminously. Worryingly, some volunteers may have predatory motives—as illustrated by allegations of humanitarian charity volunteer abuse in the Calais Jungle camp in France (Bulman, 2016), paralleling the rising number of heath professional scandals (Chamberlain, 2015).

The impact of the market situation of volunteers

The importance of market structures in which volunteers are situated in their relationship with professionals in boundary work also needs to be grasped. Hardill & Baines (2011) and Muehlebach (2012) in Britain and Italy respectively suggest that volunteers in health and care are used to fill gaps in the retrenching welfare state. In neo-Weberian terms, the practice of labour substitution in the market indicates that volunteer roles are becoming increasingly "work-like" and "responsibilised" (Hardill & Baines, 2011; Merrell, 2000). Just like paid professionals and other workers, unpaid volunteers have to be recruited, selected and dependable. Ganesh and McAllum (2012) argue that professionalisation is a "colonising logic" reshaping volunteering. According to them, volunteering is associated with feminine values such as emotions and caring, while professional work has more masculine overtones, focused on efficiency and achievement. The professionalisation of voluntary work thus means marketisation and rationalisation, which may lead to more convenience- than need-based service delivery.

The boundaries between volunteers and professionals are therefore becoming more blurred and the challenge has increased because the professionalisation of volunteers might lead to the deprofessionalisation of subordinated professions (Andrews & Wærness, 2011). However, as van Bochove and Oldenhof (2020) show, such professionalisation can coincide with the facilitating recruitment of paid volunteer coordinators. Such match-making activities between volunteers and professionals is increasingly important.

It is also vital to distinguish the formal activities of volunteers from other responsibilised actors, such as the growing number of clients who engage in self-help (Mik-Meyer, 2017) and the numerous informal family carers across Europe (Verbakel, 2014). This separation has been challenged by Litwak (1985), as we move towards increased welfare mix,

outsourcing and task shifting. This highlights the complexity of the healthcare division of labour, as professionals working alongside volunteers become more involved in supporting self-sustained and informal care (Smith, 2007).

Non-professionalised healthcare work

Nonetheless, the interstitial group of waged non-professionalised health support workers, lying between professionals and volunteers, forms the largest and most invisible part of the modern healthcare labour force (Saks, 2020). This is illustrated in Britain where more than one million health support workers outnumber registered professional nurses and doctors combined (Cavendish, 2013). They also occupy a pivotal position in delivery/service integration with a growing ageing population with chronic conditions and limited resources. As such, these workers provide crucial frontline paid healthcare support in private and public settings internationally (Saks, 2020). However, they do not possess professional qualifications and are not directly regulated by statutory professional bodies—even if, like volunteers, there are legislative boundaries to their work (Manthorpe & Martineau, 2008).

However, although support workers are part of the paid occupational landscape in a competitive market, as the United States illustrates, health support workers are generally low waged and live on part-time and short-term contracts, with limited education and career prospects (Polson, 2013). A similar situation prevails in Canada and Britain, which may partly justify defining such workers as a "precariat" (Zagrodney & Saks, 2017)—not least as they are seen exploitatively as a cheap labour substitute for more expensive professional personnel (McKee, Dubois & Sibbald, 2006), and contain disproportionate numbers of minority ethnic and female workers (Saks, 2020). Governments and employers therefore need to assess the balance of risk against savings on expenditure—just as with the work of volunteers in professionalised environments.

One reason for caution in ascribing the homogenous label of "precariat" to health support workers is that they are similarly differentiated to professions and volunteers. This is exemplified by the study of health support worker regulation by Saks and colleagues (2000) for the United Kingdom Departments of Health—based on a literature review, a survey of health and social services chief executives, interviews with key players, focus groups and regional workshops with stakeholders. Over 300 different types of health support workers were found, from healthcare assistants and alternative practitioners to dental nurses and occupational therapy aides. Moreover, their job descriptions were often inconsistent, even within the same category—with further differentiation in organisational employment, ranging from people's own homes to residential establishments and hospitals. This diversification results in many varied links between professionals and volunteers. Indeed, at the top of the health support work hierarchy professionalisation is possible—as recently happened with operating department practitioners (Saks & Allsop, 2007).

The significance of such diversification for the relationship between professionals and non-professionalised health workers—paralleling the connections between health professionals and volunteers—needs to be understood. Bach, Kessler and Heron (2012) analysed interest-based boundary disputes between nurses and healthcare assistants in Britain. They found that healthcare assistants tended to take over direct patient care, while nurses were responsible for complex administrative tasks. The nurses were ambivalent about this: they did not want to undertake the "dirty work" of healthcare assistants, but recognised their practice fell short of the holistic ideology of the future nurse. Boundary work between medical professionals and non-professionalised health personnel—including alternative medicine practitioners—has also been studied internationally, including in Britain and the United States (Saks, 2015b). Following Merrell (2000), this highlights the need for further research on the relationship between paid non-professionalised healthcare workers and volunteers in the complex division of labour.

Discussion

The central research question of outlining the characteristics of, and divisions within and between, the various parties in healthcare relevant to the interlinkage of professionals and volunteers has now been addressed. In so doing, this essay has drawn on empirical research in modern neo-liberal societies from a neo-Weberian perspective and the complementary interactionist analysis of boundary work. It is argued that there needs to be greater recognition of the differential occupational environments surrounding professionals and volunteers if their market-based role in delivering services is to be understood. In this respect, a wider and more sophisticated appreciation is required than that between the "catch-all" categories of professionals and volunteers. At the extremes, this includes the interface between medical professionals and untrained volunteers in the division of labour, given the former's leadership and coordination role (Weiss, Tilin & Morgan, 2013). However, in terms of delivery such relationships have multiple reference points including the client, informal carers, allied and limited health professions, and paid non-professionalised health workers—in addition to differentiated volunteers themselves.

Future directions

Along with the variable rights and responsibilities of healthcare groups in different socio-political and organisational contexts, two types of diversification need to be acknowledged in future research. The first is diversification within groups of professionals and volunteers and associated co-working. The second is diversification from adding more actors into the healthcare division of labour—going beyond simplistic professional-volunteer relationships to consider their interface with non-professionalised health workers, clients and carers. This requires greater understanding of dyads, triads, and larger groups, involving relationships based on different levels of expertise linked to experience and/or certificated knowledge (Bertucci et al., 2010). Such research into the impact of diversification and boundary work is

crucial to both our academic understanding and more informed healthcare policy, as well as meso- and micro-level decision making.

Policy recommendations

Progressing public and private sector policy and practical decision making is particularly important where more extensive multi-dimensional collaboration in healthcare is required in fast-changing environments. Defining best practice for collaboration between professionals and volunteers in light of further research is key to minimising risk and maximising benefit to clients and the wider public (Chamberlain, Dent & Saks,2018). The research considered in this article has already highlighted that more attention should be given to the occupational and organisational context of work and the characteristics of volunteers in deciding the optimum skill mix. This should go beyond using volunteers to fill gaps, to more extensively employing their skills in synergy with professionals and other paid workers. From a boundary perspective, a pragmatic balance is needed between encouraging others to join their domain and demarcation work emphasising differences in knowledge, authority and reliability (van Bochove et al., 2018).

Limitations

One limitation of this essay is the literature review based on combining earlier research findings of the authors with selective updated literature searches. A more systematic literature review would increase its rigour. Future research would also be enhanced by increasing sensitivity to the histories and cultures of national socio-political contexts in modern societies using comparative methods (Burau, 2019). Further work here could also be undertaken on professionals and volunteers in under-researched countries, such as Poland (Krakowiak & Pawłowski, 2018). These, though, are agendas for researchers building on this necessarily short essay.

Conclusion

Specific international contexts therefore need to be considered in more detail as they impact on future healthcare policy prospects—in terms, for instance, of acceptable risks and responsibilities for professionals and volunteers (Overgaard, 2015). This essay argues researchers should study the relationship between professionals and volunteers further in modern societies from a neo-Weberian and complementary boundary work perspective—albeit with a neo-institutionalist focus on competing institutional forms, from state and public sector organisations to private corporations and citizens themselves (Saks, 2016). This macro context, alongside more micro- and meso- analyses of professionals and volunteers, will improve understanding of the interface between them. Central to this agenda is recognition of a diverse healthcare division of labour, which acknowledges that professionals and volunteers are not the only players in the game, nor are they clearly-defined and cohesive groups. Such more refined theoretical and empirical research will

promote further policy and practice enhancements serving clients and the wider public interest (Chamberlain, Dent & Saks, 2018).

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Students' Interprofessional Workplace Learning in Clinical Placement

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Abstract

Students' learning in the workplace during their clinical placements is an important part of their education to become healthcare professionals. Despite the number of studies of student interprofessional learning in clinical placements, little is still known about the significance of interprofessional learning and how it is facilitated and arranged for to occur. This article aims to investigate interprofessional learning between students collaborating in a workplace-driven arrangement integrated into a clinical placement. A focused ethnographic research approach was applied, comprising observations of ten students participating in the arrangement organised by clinical supervisors on a medical emergency ward at a Swedish university hospital, followed by group interviews. Using a boundary-crossing lens, the article analyses the workplace arrangement, in which students' learning across professional boundaries and their negotiations around a boundary object were prerequisites to coordinate their interprofessional knowledge and manage emerging challenges while being in charge of care on the ward.

Keywords

Boundary crossing, clinical placement, interprofessional workplace learning, healthcare education

Introduction

A significant aspect of healthcare education revolves around learning a profession and working together with other healthcare professionals. In recent years, new forms for students' interprofessional learning in workplaces during clinical placements have attracted significant attention (Kent, Hayes, Glass, & Rees, 2017; Paradis & Whitehead, 2018). Interprofessional learning refers to educational situations in which students from two or more professions learn about, from and with each other to improve healthcare practices (WHO, 2010). Interprofessional learning is therefore important for students' development of a professional identity and belonging in healthcare. In clinical placements, which is the workplace-based part of the professional education, students can learn about their profession under supervision in natural environments. Although the workplace is regarded as a natural site for interprofessional learning (WHO, 2013) it has been suggested that interprofessional learning requires active engagement and planning (Shot, Tummers & Noordegraaf, 2020). In their systematic review, the authors point to the need for professionals to actively bridge professional and task-related gaps, to negotiate overlaps and to create spaces for such interactions.

Pedagogically, students' interprofessional learning in the workplace has been organised as student activities during or in relation to clinical placements in arrangements that are well known from educational settings. This covers a wide range of activities such as Schwartz rounds (Clancy, Mitchell & Smart, 2020), patient interviews, case studies, structured workshops, ward rounds, shadowing, observations (Anderson, Thorpe, Heney & Petersen, 2009; Kent, Courtney & Thorpe, 2018; Kent, Glass, Courtney, Thorpe & Nisbet, 2020; Kent et al., 2017; Wright, Hawkes, Baker & Lindqvist, 2012), student-led primary care clinics (Kent & Keating, 2015) and student teams (Bondevik, Holst, Haugland, Baerheim & Raaheim, 2015; Gudmundsen, Norbye, Abrandt Dahlgren & Obstfelder, 2019). These initiatives mostly report productive and desirable learning outcomes among students. In a review of interprofessional workplace learning activities, Kent et al. (2017) show that dialogue and reflection were most significant for augmenting students' knowledge of professional roles, teamwork, communication skills, safety matters and understanding patient perspectives. Similarly, other reviews have singled out teamwork and collaboration skills as the most frequent learning outcomes (Kent & Keating, 2015). Students involved in interprofessional activities experience positive influences on their professional development, yet they might have feelings of uneasiness and self-consciousness when assigned to interprofessional team activities (Anderson et al., 2009). It may thus seem that being at the edge of one's comfort zone enhances possibilities for interprofessional deliberations. Alternatively, this might be

connected to a sense of being acknowledged in the team and in one's upcoming professional role, providing a sense of belonging to the future profession (Bondevik et al., 2015).

Despite the plethora of student interprofessional learning arrangements, few studies acknowledge or take departure in the context of the workplace and its affordances. Studies show that the workplace setting—with its staff, patients, artefacts, and socio-historic context—provides richer possibilities for learning the professional practice than university-based educational tasks do (Baerheim & Raaheim, 2020; Lapkin, Levett-Jones & Gilligan, 2013; Teunissen, 2015). For example, students in interprofessional teams in nursing homes are exposed to multiple interests concerning professional identities and knowledge, as well as clinical and social principles that appear in the workplace (Baerheim & Raaheim, 2020). As the students dealt with patient problems within the interprofessional team, and in dialogue with the nursing home staff, they furthered their understanding of what constitutes professional work. Furthermore, it has been stressed that giving students responsibility for their actions enhances their interprofessional learning in workplaces (Baerheim & Raaheim, 2020; Gudmundsen, Norbye, Abrandt Dahlgren & Obstfelder, 2019). The workplace context creates a natural site for teamwork that reduces competitive behaviours and facilitates interprofessional collaboration (Bondevik et al., 2015), yet many studies fail to properly describe in what way student interprofessional learning initiatives are situated in the workplace (Abu-Rish et al., 2012).

In healthcare education, certain aspects must be learnt on site in the workplace, where professional practice is performed. In this context, students encounter the complexity of everyday healthcare work (Teunissen, 2015) and the challenges practitioners deal with in relation to interprofessional collaboration, such as a multitude of interprofessional modes of collaboration (Reeves, Xyrichis & Zwarenstein, 2018), professional expert domains and values, the complex relationship between the professional and the team (Lingard et al., 2017), and issues of power structures and stereotypes (Nancarrow et al., 2013). In terms of arrangements, clearly framed common goals are essential for interprofessional discussions (Baerheim & Raaheim, 2020; Laing & Bacevice, 2013) and practitioners' innovative thinking for supporting interprofessional workplace learning (Laing & Bacevice, 2013). This underlines a need to work on the accomplishment of interprofessional learning, and to make it part of the everyday work (Shot et al., 2020), but, as argued in this article, student interprofessional learning needs to be facilitated and arranged for and cannot be assumed to occur naturally by merely gathering different professionals.

In this article, the aim is to investigate interprofessional learning between students collaborating in a workplace-driven arrangement integrated into a clinical placement. We do so by following students in an interprofessional learning activity arranged by clinical supervisors. The purpose of this workplace-driven interprofessional arrangement was to

strengthen students' interprofessional learning and collaboration between students who carried out their clinical placement on a medical emergency ward.

Theoretical framework: A boundary crossing perspective

The theoretical lens through which interprofessional learning among students collaborating in a workplace-driven interprofessional arrangement is explored departs from a boundary-crossing perspective (Wenger, 1998; 2010). A common notion in the literature on boundary crossing is that there are potentials for learning at the edges of boundaries. Boundaries are defined as "sociocultural differences between practices leading to discontinuities in actions and interactions" (Akkerman & Bruining, 2016, p. 243; cf. Akkerman & Bakker, 2011, p. 133). This implies that learning opportunities are opened up as participants face challenges in practices and boundaries are crossed, reorganised, or even dissolved (Engeström, Engeström & Kärkkäinen, 1995; Wenger, 1998). Boundary-crossing thus concerns "the effort to establish or restore continuity in action or interaction across different practices" (Bakker & Akkerman, 2019, p. 4; cf. Bakker & Akkerman, 2014, p. 225). As resources for learning, boundaries have the potential to contribute to joint action and the sharing of problem spaces between practices (Akkerman & Bakker, 2011). When actions and interactions do not lead to desired developments, or require great efforts to solve emerging problems, this leads to discontinuities due to sociocultural differences between practices (Bakker & Akkerman, 2019).

Students' learning at professional boundaries and bridging boundaries to other professions can be confusing and blurred. Conflict-filled professional boundaries arise out of the differences in knowledge of medicine and caring, as well as inequalities in professional roles and attitudes (Jentoft, 2020). There is often a strong desire to defend the interests of the particular professional group (Hall, 2005; Santy, 1999) and a lack of understanding of other professional roles (Fox & Reeves, 2015). This implies that negotiations of professional boundaries can be limited to negotiations that are acceptable within the specific professional practice (Smith, 2018). Other researchers suggest that it is the ambiguity between professional boundaries that forces students to collaborate across boundaries and coordinate their actions to deal with "wicked" problems (Veltman, van Keulen & Voogt, 2019). As Jentoft (2020) claims, students' interprofessional abilities are strengthened when different professional perspectives are encountered in situations that require collaboration and negotiation. Students' professional learning is not just about becoming experts in their professional territory; professional development through collaboration and negotiation is also needed to move or reconstruct old boundaries (Jones, 2007).

The challenge in interprofessional workplace learning lies in helping students to cross different professional boundaries, in our case within the workplace-driven arrangement for supporting interprofessional learning. How learning can be evoked in boundary-crossing, by

acting, interacting, and negotiating at boundaries, has been described by Akkerman and Bakker (2011; Bakker & Akkerman, 2019) with four learning mechanism referred to as identification, coordination, reflection, and transformation. All four mechanisms correspond to ways in which boundary-crossing can initiate processes of learning, leading to professional development (Bakker & Akkerman, 2019) and thus interprofessional development in practice.

The first learning mechanism is a process of identification by "othering" and achieving legitimacy within the group (Akkerman & Bakker, 2011; Bakker & Akkerman, 2019). This involves defining and comparing similarities and differences between practices for achieving shared understanding and respectful acceptance. In negotiations, boundaries between two or more professional practices are encountered and reconstructed, but differences are not necessarily overcome.

The second learning mechanism is a matter of coordination, which requires establishing communicative bridges, permitting the translation of work and increasing boundary permeability between practices (Akkerman & Bakker, 2011; Bakker & Akkerman, 2019). In coordinating, boundary objects often constitute a unifying link which gathers different professional groups and has the function of establishing continuity in a negotiation situation. Boundary objects are often shared objects such as artefacts (things or tools) that serve as bridges for intersecting practices (Star & Griesemer, 1989). Boundary objects express meaning or a competency standard for a profession that guides the use of the object for performing the job (Grealish, 2015). The object can also be a device to communicate with others and keep track of what must be done (Akkerman & Filius, 2011). As long as no one questions the object's meaning, it serves as a joint object allowing different professions to work across boundaries and to stay unified (Star & Griesemer, 1989).

The third learning mechanism is reflection, that is, crossing professional boundaries whilst realising explicit differences across one's own and others' practices (Akkerman & Bakker, 2011; Bakker & Akkerman, 2019). In reflection, the negotiation involves accessing a comprehensive understanding by either making or taking expanded perspectives, for example of a boundary object (Veltman et al., 2019). Perspective-making means looking upon oneself and reflecting on the knowledge practice that one belongs to. Perspective-taking implies taking others' perspectives into account from the angle of one's own practice. Critical self-assessment, joint meetings and the sharing of experiences stimulate boundary learning and increase our understanding of professions (Bakker & Akkerman, 2019). On the other hand, lacking the ability or opportunities to take others' perspectives can create misunderstandings that have negative consequences for bridging boundaries (Akkerman & Bakker, 2011).

The fourth learning mechanism, transformation, leads to profound changes and reconsiderations of actions in practice (Akkerman & Bakker, 2011; Bakker & Akkerman, 2019). In this mechanism, the negotiation of boundary objects is knowledge transforming and develops unanimous objectives for different professional groups or practices. Transformation can thus change existing practices and create new ones, targeting so-called in-between or hybrid practices (Engeström et al., 1995) or hybrid learning environments (Zitter, Hoeve & de Bruijn, 2016). Hybrid learning environments require rethinking the educational curriculum to overcome traditional boundaries between education and work (Zitter et al., 2016), such as in healthcare education, in which students navigate across boundaries between the university and healthcare workplaces.

In sum, the theoretical lens of boundary crossing, including the four analytical concepts of learning mechanism, can provide useful ways to explore and understand the complexity of interprofessional learning between students from different professions in the workplace during their clinical placement.

Methodology

Research setting

The study reported on here is part of a larger research project focusing on new ways of organising clinical placement that refers to workplace initiatives of non-traditional clinical placement—not one-to-one supervision. This article particularly focuses on a workplace-driven interprofessional arrangement to promote interprofessional learning between students who performed their clinical placement in a medical emergency ward at a Swedish university hospital. At the ward, the staff worked in care teams consisting of physicians, registered nurses and nursing assistants, providing medical assessment, treatment, and care around the clock. On weekdays, occupational therapists and physiotherapists worked as part of the ward's team with assessment and rehabilitation of patients. The healthcare staff regularly received students from different professional healthcare education programmes who carried out their clinical placements on the ward. The workplace arrangement on the ward was a recurring one-day activity that was initiated and carried out by clinical supervisors once every semester for students placed at the ward to enhance interprofessional work between students. The student group was given responsibility for the treatment and care and rehabilitation of the patients during the morning shift, from 7 am to 2 pm. This included taking on all ordinary activities in caring for the patients, rounds, handovers, communicating with other hospital departments and journal writing. Two supervisors were present to ensure patient safety, but the students were responsible for the ward.

Research design, participants and selection

The research method shares characteristic with focused ethnographies (Higginbottom, Pillay & Boadu, 2013) by its focus on uncovering and describing participants' experiences of taking part in the one-day interprofessional learning arrangement. Data was collected through participant observations and group interviews. The observations made it possible to access actions and discussions that took place between students and the subsequent interviews focused students' reflections on their actions and experiences from the activity. Using multiple data is advocated in focused ethnographies, allowing the researchers to corroborate, contrast and deepen the findings.

Ten students—five nursing students (four female, one male) from semester three, one nursing student (female) from semester six, two physiotherapy students (one female, one male) from semester three, one occupational therapy student (male) from semester four and one medical student (male) from semester eight—and two supervisors—one registered nurse and one occupational therapist—participated in the selected occasion. They were observed regarding activities and collaborative interactions that were carried out during the workplace-driven arrangement. The students had been enrolled on the programmes for different lengths of time, and their experience of clinical placements therefore varied. Following the observation, the students were invited to participate in group interviews. Six of the ten students chose to participate in two mixed-profession group interviews.

Data collection

The participant observation took place over the course of one day between 6.45 am and 3.00 pm and focused on student actions and interactions with one another and other professionals in the ward's public spaces. Students were not followed into the patients' rooms for ethical reason. The participant observations were exploratory in focusing on interprofessional learning between students, i.e., the researchers did not take departure in a specific theoretical account. Nonetheless, the observations were based on the assumption that interprofessional learning is a social accomplishment, and therefore they can be seen as purposefully driven (Higginbottom et al., 2013). Two researchers observed the one-day interprofessional activity by taking field notes focusing openly on when, where and how students carried out tasks and interacted with one another, with whom they did so, and which tools were used. Individually, each researcher followed the students who were moving around the ward's different spaces and interacting with others in changing constellations. Having two researchers present made it possible to cover more of what was going on in this fluid setting.

During the following days, two group interviews with students were conducted to capture the students' reflections on the interprofessional workplace activity. The interviews were used as a way of deepening the understanding of the studied interprofessional activity, letting the participants be experts with their knowledge and experience (Higginbottom et

al., 2013). One group consisted of two nurses and one physiotherapist, and the other consisted of one nurse, one physiotherapist and one occupational therapist. A semi-structured interview guide was used, with topics addressing their thoughts and feelings about dealing with and collaborating around patients' care and being responsible for the ward. The students were also asked to reflect on their learning and moments of interprofessional actions observed by the researchers during the activity, as a way for the researchers to deepen their understanding of the course of events. During the interview, the students discussed some issues together, addressing each other in a direct way, and when answering some questions, they gave their answers directly to the researcher. The interviews were recorded and transcribed verbatim.

Data analysis

The analysis was inductively performed and carried out as a sequence of steps by the authors. First, both researchers' fieldnotes were closely read and situations in which students from two or more professions had to work things out by collaboration was identified. The two researchers' field notes were then placed side by side and were compared to create a more detailed reconstructed description of the course of events (Gherardi, 2012). Categories included, for example, interprofessional collaboration concerning medical issues and treatments or patients' need for care. In the further analysis, we chose to follow one event, in which students negotiated the mobility of a patient, and trace the students' interprofessional discussions and actions as we discovered they were stretched out in time. We started out in the enriched field notes and then turned to the group interviews where the students discussed the same event. This provided us with a sequentially ordered narrative of the students' interprofessional collaboration and their reflections on actions and interactions. In a final step we applied the theory and analysed the data using the boundary-crossing mechanisms described earlier.

Ethical considerations

This study received approval from the Regional Research and Ethics Committee in Linköping, Sweden (2017/493-31). Informed consent was obtained from students and supervisors, including information about the voluntary nature of participation and the possibility to withdraw their consent. Data have been anonymised to maintain confidentiality.

Students' interprofessional learning and collaboration

Before the students participated in the workplace-driven arrangement, they received little information from the supervisors who would carry out the interprofessional learning activity. Although the students carried out their clinical placements on the same ward, they had had little or no contact with each other in advance. When the students gathered in the morning, they had the opportunity to briefly introduce themselves to each other before the activity began.

> It is early in the morning (6.45 am) and the two supervisors welcome the students in the nurses' station located at the centre of the ward. It slowly becomes crowded as they drop in, one by one. The students, an occupational therapist (OTstud), two physiotherapists (PTstud) and four nurses (Nstud), introduce themselves to each other. The medical student will join later. (Fieldnotes)

The framing of the activity was carried out in the morning meeting, as can be seen in the fieldnotes.

> The nursing supervisor (Nsup) starts the activity by describing the schedule for the day. She divides the students into smaller care teams and assigns different patients to them. The Nsup says: "Take care of the patients based on your profession-specific competencies and form a working plan for the day together." The supervisor then does short handovers for each patient. The students listen attentively and take notes. After finishing the handovers, the Nsup says: "Meet the patients first and get a picture before reading their medical records. Talk to your fellow students and plan your work together. Go see the patients early on." (Fieldnotes)

The nursing supervisor's instructions included the formation of interprofessional care teams and the allocation of patient responsibilities. The handovers provided the students with profession-specific information about their patients. Furthermore, interprofessional and collaborative work was emphasised as the supervisor stresses interaction, joint planning and patient interviews as starting points for their work.

Othering at professional boundaries

After the call for collaborative work, the supervisors left the nurses' station. The students picked up on this line of structuring their work and started to talk to each other, within and across professions.

> The PTstud talks to a Nstud and they start planning what to do first. Two other Nstuds talk about profession-specific issues. The OTstud sits down on his own and makes notes. The students ask each other questions and make suggestions about how to coordinate their work. A Nstud is looking for a MEWS trolley and finds out there is only one available. She then suggests to the others: "Let's take the morning control status in order and begin in room 1", to which all agree. The OTstud asks a Nstud about one patient's need for a walking aid. The medical student has not appeared. (Fieldnotes)

Initially, the dialogue focuses on achieving a shared understanding of the set task. They plan how to deal with the task in a serious manner, whilst negotiating professional boundaries by "othering" (Akkerman & Bakker, 2011). The students identify professionally relevant information and tasks to which they give voice when interacting. The physiotherapy and nurse students for example verbalise and share what activities they see as relevant to

pursue and the occupational therapy student asks a nurse student for additional information about a specific patient. By listening to one another, comparing professional skills and tasks, it is possible for the students to identify individual and collective ways of providing patient care. Knowledge sharing was stimulated as they asked questions and suggested directions for the work, contributing to interprofessional collaboration and legitimacy.

Following the sequence above, the students went on together to meet the patients.

Coordinating around an emerging boundary object

The following fieldnote sequence illustrates students' interprofessional coordination around a boundary object. It outlines how students from three professions are able to discuss a patient's ability to walk from different perspectives by means of an emerging boundary object, a beta support which is a kind of walking aid.

> 8.00. The OTstud, PTstud and a Nstud stand in the corridor by the ward, discussing a patient they have just visited. The patient has a cast on one leg and the students discuss the risk of falling and his ability to walk and move. The OTstud focuses on the patient's social situation in general and on how the patient will be able to move around when he returns home. The PTstud points out: "We have to talk to the patient about the cast." The OTstud verbalises an idea about using a beta support as a walking aid, instead of the walking table available on the ward, as it seems that the patient has a beta support at home. The other students agree with this suggestion. The OTstud and PTstud continue to discuss the patient and whether or not to put strain on the plastered leg. The PTstud says: "We have to test and see how the patient walks, because he can't take the walking table home." The students agree to let the patient test the beta support later in the day. (Fieldnotes)

In this situation, the beta support becomes a boundary object that leads to negotiations about what to do for the patient, and why, from different professional angles. With a common focus on the walking aid, the students address multiple professional perspectives. This is visible in how the physiotherapy student's perspective is directed towards the ability to walk safely and the occupational therapy student's perspective on the patient's ability to move around upon returning home. The beta support here becomes a shared meaningful object, which is useful for the coordination of different professional perspectives of both caring and rehabilitation, on the ward and afterwards. It also leads to a discussion about inherent restrictions concerning the cast, which the students are unsure about. The beta support enabled a communicative bridge and increased professional boundary permeability (Akkerman & Bakker, 2011), as it triggered interprofessional deliberation and learning. This is visible in how the students acted together in terms of idea generation for and planning of the continued treatment.

The boundary object also constituted a common ground for collective action, and thus guided the students' work with the patient.

> 9.50 at the nurses' station. A Nstud says to the PTstud that the patient with the cast doesn't want to use the walking table and asks him about the beta support. The PTstud leaves to fetch one. On returning, the OTstud and PTstud decide to meet the patient with the cast together. Before doing so, the PTstud says: "I want to check about the restriction for the patient with the cast. How can I do that?" (Fieldnotes)

> 10.03. The students go into the patient's room and then return to the corridor with him. OTstud and PTstud let him practise his walking. The OTstud asks the patient about his walking equipment at home. (Fieldnotes)

As the nursing student raises the issue of the patient's reluctance to use a walking table as a walking aid and brings up the beta support discussed earlier as an alternative, the beta support is transformed from being an idea discussed between the students into a hands-on plan involving active interprofessional collaboration. In dealing with the patient's mobility, the use and implications of the beta support take on different professional meanings as the students collaborate to examine and assess the patient. The occupational therapy student now talks to the patient about which walking equipment he has access to at home rather than solely relying on information gained elsewhere. The physiotherapy student focuses on letting the patient practise his walking in the corridor. The students collaborate in the execution of patient care, supported, and enabled by their common attention to the boundary object and what it entails in terms of patient mobility. However, it becomes apparent that collaboration around boundary objects necessitates situational understandings in order to function as communicative bridges as the medical student appears in the corridor.

> 10.20. The PTstud and OTstud stand in the corridor planning their work. The PTstud turns to the medical student and asks him about the restriction. The medical student says: "I haven't looked into that, so I'll have to get back to you." He then goes into the nurses' station. (Fieldnotes)

He has not been involved in the student teamwork or in the treatment of this particular patient. As the physiotherapy student asks for his medical point of view regarding the cast's restriction for the patient, he is unable to lean back on the affordances of the previous negotiations of the boundary object and is unable to share professional knowledge that is relevant in the situation. In this instance, the beta support did not function as a boundary object connecting and coordinating different professional competencies.

Reflecting on one's own and others' practices

Verbal reflections of one's own and others' practices were not observed as the students carried out the teamwork. However, in the subsequent focus group interview, the physiotherapy and occupational therapy students reflected on their collective work regarding the patient with the cast.

> "I'm thinking about the mobility function of patients, therein lies the difference. You see the function in a different way to me. I'm thinking more about what the patient is able to do right now, how can we exercise. You think about how the patient will manage at home. That's the function in its entirety but then there are different aspects of it, I think." (Focus group interview)

> "We talked to each other the day after, discussed our professions a bit. Even if we come to the same conclusion, or the same result in the end, maybe we have different ways of getting there. But in some cases, maybe one of us misses an aspect, but then we can complement each other very well there, in having a habilitation perspective with the occupational therapist and rehabilitation perspective with the physiotherapist. That it goes very well hand in hand, I think." (Focus group interview)

The students verbalised their professional stances by using the professional concepts of habilitation and rehabilitation as a way to discern their different yet complementary professional roles at the boundaries between each other's practices. When the students reflected upon their perceived experiences of working together with the same patient, it seems that a comprehensive picture of how their professions linked into each other emerged. This in turn seemed to constitute a basis for interprofessional learning about how their professional knowledge formed part of an entirety, of 'patient care'.

Discussion

The article provides insights into the possibilities of promoting healthcare students' interprofessional learning in order to learn a profession by working together with other students and healthcare professionals in the workplace during the students' clinical placement. The chosen theoretical perspective of boundary crossing enabled us to understand interprofessional learning between students who collaborated in the workplace-driven arrangement arranged by supervisors on the medical emergency ward. The findings draw attention to three points of discussion concerning (1) the design and role of workplace-driven interprofessional arrangements, (2) students' interprofessional learning by negotiating at the edges of professional boundaries, and (3) boundary objects' meaning for students' learning of interprofessional collaboration.

The set-up of the workplace-driven arrangement was a precondition in itself that triggered interprofessional learning and collaboration among the students. The arrangement was a new and unfamiliar situation for the students and went beyond traditional ways of clinical supervising. As an authentic situation created by practitioners in the workplace, it challenged the students' interprofessional and professional learning in ways that differ from activities in the educational context. The arrangement provided the students with patient responsibility and accountability for their actions, which seemed to enhance their professional workplace learning (Baerheim & Raaheim, 2020; Gudmundsen, Norbye, Abrandt Dahlgren & Obstfelder, 2019) as they had to rise to the occasion when they encountered the complexity of professional work practice (Teunissen, 2015). The students learned things in the workplace by necessity as they had to deal with the patients' problems using their professional knowledge in collaboration with one another and in the group interviews the students' expressed enthusiasm about the activity and their learning opportunities to act as professionals.

In this workplace-driven arrangement, the conducive factor was that the supervisors brought together students who were placed on the ward for their clinical placements. The supervisors who organised the activity set aside time and took the opportunity to bring the students together to support their learning and interprofessional teamwork. However, it can be a challenge to arrange such workplace activities, due to students' different schedules, and to find time and staff resources (Furness, Armitage & Pitt, 2012; Morison & Jenkins, 2007). We never got to know why the medical student did not participate fully in the activity. The clinical supervisors played an important role in framing the activity and stimulating the students' learning, but they were also responsive to the need to step back and let the students assume responsibility for the patients.

The supervisors' instructions on meeting the patients first and not reading their medical records seemed to be an important trigger for the students' negotiation at professional boundaries. Delaying reading medical records and starting by seeing the patient was not the usual procedure for the students when beginning clinical work. This gave the students considerable scope for manoeuvre which challenged them in terms of seeing their own professional requirements in relation to the content of the patient report; this was not reported in a profession-specific manner, but rather in a patient-centred manner. The supervisors showed that they trusted the students by stepping back and allowing the students' ideas, actions, and interactions across professional practices (Akkerman & Bakker, 2011; Bakker & Akkerman, 2019) to be at the foreground, regardless of their experiences of clinical placement and level of education.

As the findings indicate, the clinical supervisors' engagement and their framing of and acting in the situation was a precondition for the students to begin to negotiate across professional boundaries. This leads us to the second point of discussion regarding students'

interprofessional learning across professional boundaries when dealing with the patient. The findings demonstrate that, in the negotiation at the edges of the professional boundaries, it was important for the students to have first gone through 'othering' (Akkerman & Bakker, 2011) before going on to coordinate their actions in relation to the patient with the cast. In the phase of othering, the students interacted and conveyed their experiences as well as their own professional competencies in relation to the task at hand. Through attentiveness to their fellow students' professional stances, a shared orientation and legitimacy of how to proceed was enabled in a relatively short time. The students' professional views on the situation at hand were progressed in the light of the others' perceptions of the task. Meetings at boundaries compelled the students to reconsider their assumptions and look beyond what was known and familiar, and this may have led to new insights (Akkerman & Bakker, 2011). As the findings indicate, when the students crossed boundaries, they seemed to learn something new about their own and others' practices. These interprofessional learning experiences enabled them to look upon themselves through the eyes of others, and to explore new information and strategies while encountering unfamiliar areas of practice (Engeström et al., 1995). In comparing professional similarities and differences, the students created a common ground for understanding each other's professional perceptions of the task at hand and being open-minded to ideas from other students.

The learning mechanism of coordinating (Akkerman & Bakker, 2011; Bakker & Akkerman, 2019) was set in motion as the students started to work together with the assigned patients. The learning potential was thus directed towards the students' own and the other students' professional views, as well as making meaning of the task. For example, the students discussed the patient's mobility and his need for a walking aid and followed up these ideas in action together with the patient. The students did not question each other's suggestions about how to take care of the patient. Rather, they added to each other's thoughts and knowledge and, thus, the coordination progressed quite smoothly. However, it was evident that not participating in the negotiating dialogue before coordination impaired the medical student's possibility to establish communicative bridges (Akkerman & Bakker, 2011; Bakker & Akkerman, 2019) with the other students. The medical student arrived later to the workplace-driven activity and was not involved in the first part of the day where instructions were given and 'othering' between students took place. Accordingly, the medical student was not given the same opportunity to participate as the other students and to approach the task as a collective endeavour. When the students returned to this situation of coordinating their actions, they reflected on the benefits of their complementary professional stances.

The reflective learning mechanism seemed to be created in the students' verbalising of their interprofessional task. Patient-focused interprofessional workplace activities combined with facilitated dialogues and reflections have previously been associated with increased

awareness of other professions' competencies (Kent et al., 2017), understanding of professional work in practice (Baerheim & Raaheim, 2020) and seeing the value in working in interprofessional teams (Lingard et al., 2017; Reeves, Xyrichis & Zwarenstein, 2018). In the group interviews, the students' reflections on their professional differences and complementary knowledge of the patient's need for care provided expanded perspectives on what and how their own and others' professional knowledge contributed to the patient's care (Jentoft, 2020). The notions of habilitation and rehabilitation was used to verbalise and express both similarities and differences in occupational and physiotherapy practices, and while acknowledging profession-specific knowledge they also opened up the boundaries between the professions (Christiansen, Taasen, Hagstrøm, Hansen & Norenberg, 2017).

The third discussion point will address the importance of boundary objects (Star & Griesemer, 1989) as objects for stimulating interprofessional learning and collaboration. The beta support became a shared object as it directed the students' attention to finding and performing joint actions from their different professional competencies in relation to the patient's needs. As a boundary object, the beta support became a resource for sharing a collective problem space among the students. The beta support afforded various qualities of meaning for the students and from their different professional perspectives. At the same time, it also created a unifying link between the students as the object was acknowledged recurrently in their interactions, advancing the students' joint actions to find a suitable solution for the patient with the cast. By approaching the beta support from different angles, the students expanded their perspectives by making and taking professional viewpoints at the interplay between the boundary object and the professional perspectives.

Limitations

The theoretical stand of learning mechanisms, as suggested by Akkerman and Bakker (2011) and Bakker and Akkerman (2019), has been useful for the fine-grained analysis of students' actions and interactions for interprofessional learning and collaboration across boundaries. One limitation, however, is that the fourth mechanism—transformation—was difficult to apply to the studied workplace-driven arrangement organised by the clinical supervisors. Our understanding is that this mechanism requires more profound changes in organising clinical placements as a shared commitment between higher education and healthcare services for supporting students' interprofessional learning (Bivall, Gustavsson & Lindh Falk, 2021).

A further limitation concerns the relatively small body of empirical material, focusing on one site (ward) and one specific occasion of the workplace-driven arrangement. Nevertheless, the empirical material allows us to discern details of students' interprofessional learning across boundaries, by following the students' negotiations, actions and interactions when caring for the patient. One strength was that two researchers observed the specific occasion, and, in the analysis, the comparison of field notes led to a reconstructed thicker

description of the chosen activity, a patient's possible need for a walking aid. The description was then validated by using the group interview data to gain a deeper insight and achieve trustworthiness. The findings are not intended to be generalised but rather to provide insights into students' interprofessional learning in the particular context studied.

Conclusions and implications

There are many studies showing a wide range of arrangements to support students' interprofessional learning in workplaces during or in relation to clinical placements. The findings in this article, despite deriving from a small data set, provide insights in a workplace arrangement to promote students' interprofessional learning that was driven by clinical supervisors on a ward. As such, the arrangement was not governed by professional education, but was carried out within the framework of student clinical placements. In the workplace arrangement, the students are in the midst of everyday work activities, requiring them to make professional and interprofessional judgements in order to learn and carry out the work on the ward. One conclusion is thus that when students are given sufficient scope for manoeuvre in authentic workplace situations, they take on the responsibility by dealing with caring for patients. For this to happen, they first need to deal with othering to be able to coordinate their interprofessional competencies and manage emerging challenges while being in charge of the care on the ward.

A second conclusion is that the clinical supervisors have significant importance for setting processes of learning in motion, by stepping back and trusting the students to take over the care on the ward. It is the clinical supervisors and other professionals who can provide students with this kind of room for manoeuvre in everyday workplace activities. This kind of workplace-driven arrangement that supports students' interprofessional learning then becomes an extension of their educational programme for becoming skilled professionals. The implications of the findings of this study demonstrate that local workplace arrangements driven by practitioners have to be recognised as an important part of traditional clinical placements. However, this kind of arrangement does not arise by itself; it has to be organised and carried out as pedagogical arrangements within workplaces. Clinical supervisors also need to be encouraged and supported by professional education, as well as by colleagues and healthcare management. However, more research is needed to discern the significance of organising pedagogical arrangements in workplaces for developing students as skilled healthcare professionals.

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To Co-Opt or To Be Co-Opted? The Role of Professional Elites in Strengthening Professional Control Vis-à-Vis Clients

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Abstract

This article studies how professional elites, as exemplified by *first teachers* (FTs)—a new prominent position for teachers in Sweden—respond to clashes between market and professional logics, and how this affects professional control vis-à-vis clients. Based on a collaborative ethnography, findings suggest that the professional elites use different responses to the clashes between the logics. Professional control can be strengthened by FTs *co-opting* the market logic strategically in the interest of the profession. However, FTs sometimes also succumb to cliental influence, becoming co-opted themselves by the market logic, which weakens professional control. Tentatively, context needs to be highlighted in order to understand why different responses are used, and in this identity work and relationships to managers seem essential to create a foundation for FTs to respond in ways that increase professional control vis-à-vis clients.

Keywords

Professional elites, stratification, clients, cliental influence, co-optation, professional control

Introduction

This article explores how professional elites respond to clashes between market and professional logics and how this affects professional control vis-à-vis clients, in the context of Swedish schools. Societal developments with the growth of bureaucratic and market logics in the public sector, challenge the position and power of traditional professions (Anderson & Cohen, 2015; Carvalho & Correia, 2018; Gleeson & Knights, 2006; Noordegraaf, 2020)

In Swedish schools, the teaching profession has been strongly affected by several marketization reforms. In the 1990s, an independent school choice reform was implemented, whereby each pupil now represents a sum of money, which the school loses if the pupil chooses another school. A "customer's choice model" has been introduced and parents and pupils are increasingly referred to as *clients* (Blomqvist, 2004; Fredriksson, 2009, Helgøy & Homme, 2007; Nordgren, 2008). The Swedish school system is now described as one of the world's most liberalized (Blomqvist, 2004; Schriber, 2015). Alongside a growing cliental role for pupils and parents, the status of teachers in Sweden has been depicted as diminished and there are wide discussions of de-professionalization (Alvehus, Eklund & Kastberg, 2019a; Fredriksson, 2009; Frostenson, 2012; Stenlås, 2009).

Whereas, thus, some authors describe a weakening of professionalism in which professional autonomy is curtailed (Anderson & Cohen, 2015; Evetts, 2009; Hanlon, 1999; Power, 2003; Stenlås, 2009), others highlight a more active role for professionals (Alvehus, Eklund & Kastberg, 2020; Noordegraaf, 2015). Recently, scholars have reinvested interest in stratification as a means to regain professional control when professions are threatened by an altered environment (Alvehus et al., 2019a; Alvehus, Eklund & Kastberg 2019b; Alvehus et al., 2020; Currie, Lockett, Finn, Martin, & Waring, 2012; Waring, 2014; Waring & Bishop, 2013). Originally, Freidson (1984; 1985) described how the medical profession was stratified where some professionals inhabited elite roles whereas others remained closer to the core work. The elites could keep professional control within the profession by acting as professional representatives at managerial levels (ibid). However, there is a risk that stratification hinders professional unity and creates intra-professional conflict (Adams, 2020; McDonald, Checkland, Harrison, & Coleman, 2009). This can be connected to elite professionals becoming consumed by, or in other words, *co-opted* by a managerial logic (Currie et al., 2012). Thus, practical effects of stratification on professions are ambiguous and need further scholarly attention (Alvehus et al., 2020).

Stratification has become a relevant concept to describe changes in the Swedish teaching profession (Alvehus et al., 2020). In 2013 a *first teacher (*FT) reform was introduced. The reform involves financial contributions from the state for municipalities to establish FT positions in schools. Teachers can apply and earn around 500 Euros (5000 Swedish krona) extra a month. The requirements for the position are broad, but state that FTs must have a

teacher's certificate, four years' experience of teaching, and work with school development of some sort (Swedish Code of Statutes, 2013, p. 70).

The main objective with the reform is to increase pupil performance by strengthening the teaching profession, since teachers are targeted as an important factor when it comes to improving pupils' results. The reform has grown on a yearly basis, making the FT position established throughout the Swedish school system and encompassing many school subjects. Research on FTs has described an ongoing stratification with the creation of elite roles for teachers (Alvehus et al., 2019b; c.f. Freidson, 1984; Freidson, 1985). Before the reform, the teaching profession was flat since career opportunities for teachers were restricted to becoming principals. The FT reform created possibilities for teachers to make a career within their profession. Just as other studies on stratification show how elites often have organizational responsibilities (Freidson, 1984; Freidson, 1985; Waring, 2014), studies on FTs illustrate how these teachers engage in school development work and become affiliated with managers. However, importantly, the FTs continue to identify themselves as teachers and be closely connected to the core work (Alvehus et al., 2019a; Alvehus et al., 2019b; Alvehus et al., 2020). Whereas they participate in managerial work within the frames of the FT position, the research indicates that FTs do not succumb fully to the managerial logic. On the contrary, these studies show that FTs largely are perceived of as legitimate by their colleagues since the FTs enhance the professional position by representing teachers at managerial levels while still not threatening the individual autonomy of the non FTs. Thus, the core work of teachers has not necessarily been challenged by the FT position (Alvehus et al., 2019b; Alvehus et al., 2020).

The elite position does not only include closer intertwinement with managerial spheres, but also tighter connections to clients. FTs come in contact with cliental matters in different constellations than other teachers. For example, FTs discuss cliental issues in managerial boards, and they participate in regular meetings between FTs, parents and managers where clients assert influence. This means that FTs not only face cliental demands within the frames of the traditional professional-cliental relationship, but also in managerial settings. Thus, FTs have a special stance in the organizations and potentially an important role in reconciling not only managerial and professional spheres but also the cliental one, i.e. they might balance both managerial, market and professional logics (See Lawrence & Suddaby, 2006; Waring, 2014).

Whereas elites are described to be at the forefront of handling all types of logics, research on professional elites, including that on FTs, has foremost centred around the balancing of managerial and professional logics and how professional control could be strengthened towards management (Alvehus et al., 2020; Freidson, 1984; Freidson, 1985; Waring, 2014). However, professionals are challenged just as much in relation to clients (Andersson & Cohen, 2015; Carvalho & Correia, 2018; Freidson, 2001), and this is specifically relevant in the context of Swedish schools. It is thus far unclear if elites can strengthen professions also

in relation to increasingly influential clients. The general aim here is therefore to increase our understanding of the role of professional elites in strengthening professional control, by specifically addressing the question: *How do professional elites respond to clashes between professional and market logics and how does this affect professional control vis-à-vis clients?*

The contributions of this article are two-fold. Firstly, the article adds to the literature on professional elites by focusing on an institutional conflict that has not been sufficiently studied in the literature on stratification. Secondly, the article sheds light on the professional-cliental relationship and how professions could be strengthened in this, matters which seldom have been the main focus of empirical investigation (Bourgeault, Hirschkorn & Sainsaulieu, 2011).

Theoretical framework

The market logic versus the professional logic

To understand how increasing cliental influence challenges professional control, it is beneficial to look at the concept of logics. Freidson (2001: 6-7) describes the professional system as built up of bureaucratic, professional and market logics, and defines logic as "a systematic way of thinking that can embrace and order most of the issues with which they deal". These logics ultimately define who control the conditions and the content of professional work. The professional logic is built upon trust in the professions to have the capacity to organize and define what should be produced. This calls for widespread autonomy of the professions to control both the content and context of professional work (Alvehus et al., 2019b; Freidson, 1994). In professional organizations, professionals have a unique position, since they, through education, have gained access to abstract knowledge, not accessible to those outside the profession (Freidson, 2001).

In the market logic, power is shifted towards clients to decide on what should be produced and the terms of production, i.e., clients are influential over the context and content of professional work. This leads to competition between organizations in which there is a need to offer service and attract clients. Tensions arise since cliental influence infringes on professional control (Bourgeault et al., 2011; Freidson, 2001). Thus, clashes between market and professional logics can be analytically derived when there are unclarities considering who should ultimately be in control. What is important to bear in mind is that the professional-cliental relationship has always been a central feature of the professional core work (Freidson, 2001) and is in a sense part of the professional logic. However, increasingly demanding clients who exert influence at the expense of professional control, are more aligned with a market logic. The distinction between the logics becomes clear when zooming in on logics at a relational level and tensions around control (Freidson, 1994; Freidson, 2001).

Stratification and the role of professional elites in handling competing logics

Whereas the institutional environment can apparently create conflicts, professionals need not be regarded as passive victims. The stratification thesis of Freidson (1984; 1985) includes an active and reactive role for professionals. Elites often have a helicopter view in the organizations, and how the elites respond to logics has effects on the institutional environment (Kraatz & Moore, 2002; Lawrence Leca, & Zilber, 2013; Waring, 2014). For example, when facing a managerial logic, elites can fully embrace a managerial identity, leaving professional values behind (Kurunmäki, 2004; Waring & Bishop 2013). Professional elites can also function as *hybrids*, since they handle both professional and managerial spheres, and they can develop hybridized identities, which leads to a hybridized professionalism (Blomgren & Waks, 2015; McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015). An organizing dimension can be seen as part of contemporary professionalism (Noordegraaf, 2007; Noordegraaf, 2015) which is made visible in the literature on elites. Through this perspective, a strengthening of professional control could occur by increasing professional influence over other realms than the purely professional one, bringing logics together while enhancing control over the content and context of professional work (Alvehus et al., 2019b, Alvehus et al., 2020; Freidson, 1984; Freidson, 1985).

However, the literature on stratification has not extensively been occupied with how individual responses of elites are connected to effects on the institutional environment. Therefore, we need to widen the perspective from the stratification thesis and include a theorization on individual responses to logics.

Analytical perspectives: Individual responses to competing logics

Pache and Santos (2013) describe responses to conflicting logics as consisting of *defiance, ignorance, compliance, combination* and *compartmentalization*. According to the authors, the response towards which individuals lean depends on the degree of adherence to the logic and the level of hybridity in the organizations. Defiance often occurs when a new logic is introduced, and involves actors rejecting the logic, which leads to a distance between the new logic and the familiar one. Ignorance is a form of non-response where actors are unaware of the elements of a logic, and compliance entails actors fully identifying with a logic. When actors are familiar with two different logics, and where hybridity is high (where the logics are equally dominant) Pache and Santos (2013) mean that a compartmentalization of logics is most likely, i.e., to keep them separated and comply with them to various extent in different contexts (see also Gautier & Santos, 2019). Where they have stronger connections to one of the competing logics, actors are more likely to combine them, accepting the less familiar logic but working hard to preserve the logic with which they identify most (see also Minbaeva, Muratbekova-Touron, & Nayir, 2015).

Taking combination, a step further, another strategy is *co-optation*. Andersson and Liff (2018) show how managers and professionals integrate logics by co-opting elements from each other's dominant logics and making them part of their own logics. This is done strategically to incorporate those parts of the competing logics that fit with their familiar logics. Thus, co-optation does not mean making logics exist side by side, but it entails an altering of the logics, and a full hybridization. Co-optation in this sense appears more reconciling than in other perspectives where professionals are described as co-opted and totally consumed by a managerial logic (Currie et al., 2012; Waring & Bishop, 2013). The latter scenario is more associated with a polarization of logics since there is a gap between professionals embracing the managerial logic and other professionals.

Thus, there is a variety of responses that can be used by elites when faced with competing logics, in this case clashes between market and professional logics. Responses could result in enhanced *polarization or hybridization* of the professional and market logics. Hybridization could potentially strengthen professional control if the professional position is enhanced and the market logic used strategically in the interest of the profession. Polarization of logics (c.f. Jacobs, 2005) seems counter-productive in this regard, since it reinforces a classic divide between the professional logic and others, not extending the professional position within organizations.

Method

This study builds on a larger collaborative ethnography exploring the implications of the FT reform. In a collaborative ethnography, researchers produce an ethnography together. Cross-case analysis is enabled by the research group collecting material at various sites (Barley, 1996). Three municipalities were included: a metropolitan municipality, a medium-sized municipality and a small-town municipality. Municipalities and schools were selected to contribute to both the breadth and depth of the study. Seven public schools from all levels of the school system participated. Different research techniques were used including interviews, observations and shadowings. The interviews were semi-structured and lasted 90–120 minutes. Questions were asked about the first teacher role in general but also about how cliental influence was perceived and handled. The latter was often introduced by a general question around how the FTs would describe the role of parents and children today, and this led to in-depth discussions. All interviews took place at the schools and were consensually audio recorded. In selecting interviewees, the aim was to achieve fair representation in terms of gender and years of working experience. Contact information with FTs was provided by the principals. For the purpose of this article, I have used interview

transcripts with FTs and field notes taken within the frames of the larger collaborative ethnography. Table 1 gives an overview of the data used in this paper[1].

	Number of interviews, shadowings and observations		
Case No.	*First Teachers (no. of interviews)*	*Shadowing (no. of weeks)*	*Observations (no.)*
1	5	3	9
2	8	2	4
3	4	1	10
4	5	1	11
5	7	2	6
6	6	2	6
7	5	1	7
Summary	**40**	**12**	**53**

Table 1. *Overview of data*

The schools were followed over a period of approximately one and a half years, starting in the spring of 2015. FTs were shadowed for one to two weeks each and this involved accompanying the selected FTs in their daily work. In informal conversations during shadowings we asked questions following up on themes from interviews. Meanwhile, in follow-up interviews we could confirm themes and interpretations stemming from field notes. The FTs were informed that we would abort the observation at any time if they felt this was necessary. Whereas we as researchers want to blend in, it is important from an ethical point of view that both we and the ones who are observed are aware of our role. This awareness means that our presence in the field might have an effect on the informants, something that we always need to keep in mind (Silverman, 2011).

We selected meetings for targeted observation where the FT role was accentuated. This could be meetings with parents, school directorates, and other meetings between teachers and principals at the schools. In shadowing and observations extensive field notes were taken. We aimed at broadly capturing all that happened during the days of shadowing and what was discussed at meetings. As it is difficult to both observe and register simultaneously, we tried to find time during the day to expand the field notes. As Emerson, Fretz & Shaw (2011) highlight, whereas we as researchers try to be close the field by writing

[1] Material was collected together with Gustaf Kastberg and Johan Alvehus. For an overall view of material collected in the project, see Alvehus et al. (2019a)

fieldnotes while observing, there is always a selectiveness in this process which is guided by the aim of the study. Drawing on the benefits of a collaborative ethnography, the research group met to compare and discuss the field notes, to more clearly focus on issues emerging in the material. By using the techniques of shadowing and observation we could highlight more informal practices than are visible in interviews (Czarniawska, 2007).

The study followed ethical guidelines from the Swedish Research Council. We have been careful to explain to all informants the aim of the project. We were always open about taking field notes. To preserve the integrity of the participants we promised to anonymize names of informants, schools and municipalities. Data material collected in the project has in turn been stored with respect to the integrity of participants, which means that also the working material has been coded with figured names of municipalities, schools and informants.

Analysing the material

This article builds on FT interview transcripts (874 pages) and fieldnotes from the collaborative ethnography (220 pages). Whereas I have used data collected within a larger research project, the targeted coding with reference to the research question of this article was conducted solely by me. The coding was done in NVivo and was theoretically informed, guided by Freidson's (2001) notion of logics. Yet, data played a key part in spotting the clashes. In the extensive material, cliental influence emerged as a common theme, increasing the validity of the study in the sense that the method led to illustrating the phenomena of interest (Kvale, 1995). Thus, the clashes were discovered in an abductive manner (Tavory & Timmermans, 2014) stemming from both theoretical concepts and empirical findings.

In interview transcripts I identified when informants spoke about cliental influence in problematic terms and how it collided with values of professionalism. In the fieldnotes from the collaborative ethnography, I also searched for more informal and subtle expressions of this clash and situations where matters concerning cliental influence were discussed, for example where FTs were complaining about it. The meetings with parents and school directorate meetings serve as examples where different perspectives of the professional work could lead to conflict between professional and cliental interests. The method used generated different types of material since when writing fieldnotes, there sometimes is not time to write down statements verbatim. In these cases, we have tried to summarize observations with the ambition of being as accurate as possible. This means that quotations of the informants will vary in this article depending on the context, for example if they are taken from verbatim interview transcripts or fieldnotes of the collaborative ethnography.

After having identified the clashes, I started exploring individual responses to competing logics, drawing on the work of Pache & Santos (2013) and Andersson & Liff (2018). In developing the coding on this, it became clear that a prevalent phenomenon was not very

well represented in existing theoretical categories. This was coded as *succumbence*. Thus, clashes were uncovered in a dialogue between theoretical pre-understanding, empirical findings, and theoretical refinement. When further analysing the outcomes of the responses in terms of how they affected professional control, this involved lifting one's gaze and connecting them to a theoretical discussion, leaving the craft of node development in NVivo. I identified the following clashes through this analytical process: *clashes regarding perceptions of the teacher role*, *clashes around control over grading, clashes concerning the content of development work* and *meetings as fora where logics clash.* In the Findings section each of these clashes will be presented.

Findings

Clashes regarding perceptions of the teacher role

Increasing cliental influence was creating ambiguities about what the teacher role was to entail. Some FTs described how parents and pupils expected teachers to be more and more service- minded. This induced clashes for those clinging to a more traditional teacher role based on trust towards the profession (c.f. Freidson, 2001):

> They (the parents) gladly want to have opinions about my job now/…/nowadays they want their children to have special treatment, and that the manner of which to do things that they think is good, well that is how we will go about it. And then they do not trust me to do my job. (FT, interview, school 4)

The increased influence of parents was described as infringing on professional control:

> Everyone is to have full insight into everything, by the parents. That they should have the right to intervene when it comes to how you plan your teaching hours, how the school should handle this part of the education. I do not think that they have anything to do with that, really. I do not care how my dentist does their job. They must trust that we are doing a good job. That is not the case today. (FT, interview, school 3)

This perception of the teacher role is characterized by defiance of the market logic where cliental demands appear distant. However, there were also FTs who mentioned more demanding clients as beneficial in making teachers perform better. When asked about parents questioning the teachers, one FT responded:

> I feel that it makes sense too. That you have to improve yourself!" (FT, interview, school 2)

It was common for FTs to state that cliental influence was of importance and that parents *should* be involved in improving education. As one FT expressed, when asked about the role of parents:

> They are very involved, and I think it is fun that they are. They should be involved! But it has become such an incredibly fuzzy boundary in some way, what is it we are supposed to do? I had a meeting the other day and there are so many demands on the school all the time. (FT, interview, school 3)

This stance illustrates the combination of logics since there is a recognition of the importance of cliental influence to improve teachers' performance, but at the same there is an insight that cliental demands cannot exist at the expense of professional values. This could be the start of identity work to co-opt elements of the market logic into the professional identity (c.f. Andersson & Liff, 2018).

Clashes around control over grading

One of the core tasks of all teachers is to set grades. This is something that affects pupils profoundly, thus it is of great interest to parents. Some FTs spoke of pressure to give pupils good grades since the results are shown in the statistics and are important for the schools to compare favourably in the competition with other schools. Furthermore, increased pressure from parents was described as problematic:

> We have a mother who we are dealing with now whose son did not pass Swedish. The mum was very upset about that. And he has been away a lot, generally passive, has not handed in things. So, there was no foundation for the teacher to give him an OK grade. And then the mother is on the rampage. (FT, interview, school 6)

Another FT described how a pupil had passed a grade as the result of pressure from parents:

> There are no resources. For this. Somewhere an error has been made, but it is also a result of you being very obnoxious as a parent. Then you can make sure that your child makes it through with fairly good grades. (FT, interview, school 7)

However, whereas FTs experienced this kind of pressure, they also spoke of how they stood up for themselves and defended the grades that they had decided on. Thus, whereas some FTs defied the market logic and were eager to mention the problems arising from this type of pressure, there were also examples of FTs trying to combine the logics, preserving the core of their professionalism while accepting the existence of cliental influence (c.f. Pache & Santos, 2013). At one observed school directorate meeting, the principal had been in contact with an angry parent who wanted their child's grade to be improved. One of the FTs calmly explained to the principal how he should talk to this parent and why the grade had been set. She stated that "We as teachers have the mandate to set grades." (FT, meeting protocol, school 4) She thus used her professional knowledge to meet cliental demands, while at the same time not harshly defying the market logic.

FTs also showed signs of at least a will to co-opt the market logic. This FT had fully embraced the existence of a market logic but had ideas on what needed to be done to incorporate it into professionalism:

> I want to stand up for giving them a good education, but for a market to function there has to be good customer competence too, they need to demand the right things. (FT, interview, school 5)

Whether FTs actively defied the market logic or tried to balance the logics differed. It seems that where FTs felt supported by principals, they were keener to make the logics function together. Meanwhile, where FTs were invited to managerial realms, they could use their position to handle this clash in constructive ways, balancing the market logic with the professional one.

Clashes concerning the content of development work

In managerial settings in the schools, FTs were often involved in different types of development work. Central in this are reports made by the School Inspectorate, an authority in Sweden with the responsibility to audit schools. These reports are accessible to the public and are a basis on which to compare schools. Schools are, among other things, measured on how well they adapt to cliental influence. The results displayed in the surveys and following reports by the Inspectorate affected the direction of the development work in ways that sometimes clashed with the professional logic. Sometimes FTs experienced that these reports were built on too little information:

> I have been part of two examinations when the School Inspectorate has been here when I have been a representative and the last one was, I think, completely horrible. Some pupils say something and suddenly we get massive criticism about something we know is about two or three pupils who are very dissatisfied with their education/…/if there is anyone who thinks that way, it is a dissatisfaction and then we have to address it. (FT, interview, school 7)

FTs sometimes experienced how development work came from above and was guided too much by values associated with the market logic, for example looking good in the statistics to attract pupils. In some observed meetings discussions illustrated a dissatisfaction with management, and a gap between managers and teachers. One FT reported in an interview:

> During this year it has felt like the School Inspectorate has ruled this whole school. (FT, interview, school 7)

In these situations, the FTs were not in a position to defy the market logic. Rather, they felt controlled by managers in a more passive manner. Thus, there was rather a *succumbence* to the market logic at managerial level.

However, there were also examples of development work more aligned with values of professionalism. FTs could actively stand up and question the principals when deemed necessary, in line with the response of combination. For example, at one meeting the principal had put forward that teacher conferences should be about pupils and not education. One FT objected and said that education cannot be separated from the pupils and that these conferences needed more time that the principal ought to take time from elsewhere (Principal and FT, meeting protocol, school 3).

The response of co-optation was also used. For example, at one observed meeting FTs were informed that, against the background of a conducted survey, the school needed to focus on pupils' influence. One FT came up with the idea that they could connect this to the question of grading techniques, in order to make it appealing to the rest of the teachers (FT, meeting protocol, school 4). Another example was a meeting where an FT had collected input on *how* the wider teacher collegium wanted to work with pupils' influence in the school's development work (FT, meeting protocol, school 4). Thus, development work to adapt to cliental demands was incorporated into all teachers' professional work. These examples can be characterized as co-optation, since the FTs not only combined a distant market logic whilst preserving professionalism but used elements of the market logic more actively to incorporate it into professional work (c.f. Andersson & Liff, 2018; Pache & Santos, 2013).

Meetings as fora where logics clash

In the schools there were regular meetings with parents –about once a month – where principals and sometimes FTs participated. These were fora for parents to exert influence. However, the meetings also gave the FTs a chance to respond to the parents. Some FTs felt that their position had given them confidence. An illustrative example was at one meeting where a parent expressed that parents must have confidence in teachers as a profession, but at the same time, teachers want the parents' point of view and therefore need to adjust to it (Parent, meeting protocol, school 3). One FT then questioned this person and said: "The focus should not primarily be to evaluate us as teachers." (FT, meeting protocol, school 3) Moreover, the FTs could use their knowledge of different rules and documents to back them up. An example of this was a meeting where FTs discussed an upcoming division of classes. The FTs planned for a meeting with parents since they were aware that parents would be upset. One of the FTs said during this meeting that she had written a defence with references to different paragraphs (FT, meeting protocol, school 6). Thus, the FTs found ways to co-opt elements of the market logic into their professionalism (c.f. Andersson & Liff, 2018). This is a sign of the very essence of professionalism changing, since FTs meet parents in different constellations than other professionals and use these meetings to exhibit their new professionalism (c.f. Noordegraaf, 2015).

Another type of meeting where cliental demands were addressed, and sometimes led to clashes with the professional logic, were school directorate meetings in which FTs often participated. At one of these meetings, an FT spoke up against the use of results of a parent survey, since the response rate was low (FT, meeting protocol, school 4). Thus, some FTs used these meetings to combine logics, inhabiting a role of representatives of their colleagues and preserving the professional logic (c.f. Alvehus et al., 2020; Pache & Santos, 2013).

FTs did not compartmentalize the logics in meetings, i.e., they did not leave their role as teachers behind when they entered managerial spheres. Rather, they tried to make the logics function together, either by co-opting elements of the market logic, or by combining the logics, preserving values of professionalism (c.f. Andersson & Liff, 2018; Pache & Santos, 2013).

For meetings to function like this, FTs need to be invited to managerial spheres, which was not always the case. FTs were not throughout equally active at managerial level and when asked about their perceptions of managerial work, some claimed that there was little room for any influence on behalf of the teachers. For example, one FT explained how meetings with managers and teachers were purely informational (FT, shadowing protocol, school 7). The role of the principal is thus essential in creating space in managerial settings for the FTs to flourish and increase professional control (c.f. Alvehus et al., 2020). Most commonly the principals were supportive of the teachers, in the cases studied. As one FT responded when asked about the principal's role in meeting parents:

> He is great at it. He takes full responsibility for everything and he supports us teachers/…/ So, it feels nice. (FT, interview, school 3)

Discussion

Thus far I have presented my findings on how FTs responded to clashes between professional and market logics. Now it is time to lift our gaze, to conclude how the responses affect professional control vis-à-vis clients. The main arguments here are that different responses display various potentials in strengthening professional control and that contextual differences need to be considered in order to understand why the responses are used. By zooming into this, we can increase our knowledge of the role of professional elites in strengthening professional control in the professional-cliental relationship.

In the theoretical section it was concluded that a strong profession ideally controls both the content and the context of professional work (Freidson, 1994; Freidson, 2001), which requires ownership of more spheres than the professional one (Alvehus et al., 2019b; Noordegraaf, 2015, Noordegraaf, 2020) Whereas, encouragingly, recent studies have shown that stratification could be a means to strengthen professional control vis-à-vis managers, (Alvehus et al, 2019a; Alvehus et al., 2019b; Alvehus et al. 2020), this article indicates that in

practice professional elites can reconcile market and professional logics and strengthen the professional position towards clients.

However, in order for the elites to strengthen professional control vis-à-vis clients, they need to respond to clashing logics in ways that bring the logics closer rather than isolating them. Whereas previous studies have shown that clinging to images of "pure professionalism" (Noordegraaf, 2007) in which professionalism is free of managerial influences is unrealistic (Alvehus et al., 2020; Noordegraaf, 2015, 2020), in the same vein, shielding professionalism from the market logic seems retrogressive and counterproductive. Thus, the response of defiance does not strengthen the profession since it leads to a polarization of logics and fortifies the image of professionals as victims of their surroundings. This can rather be interpreted as a weakening of the professions. Meanwhile, the response of succumbence takes this development even further, and consolidates professionals as incapable receivers of threats in the institutional environment. Succumbing to cliental influence can be illustrated by the market logic co-opting the professionals rather than the other way around, a risk that has been indicated with reference to managerial influences in other studies (Kurunmäki, 2004; Waring & Bishop, 2013).

Instead, if we embrace that professionalism increasingly is becoming more connective to other spheres and actors of the organizations (Noordegraaf, 2020), one realistic way for professionals to safeguard control vis-à-vis clients is to hybridize market and professional logics in strategic ways (c.f. Alvehus et al., 2020). In this article, the responses of combination and co-optation show most potential in leading to this effect, since they involve active agency of the elites to blend logics together without renouncing the professional logic. Co-optation is taking this process furthest, since by "owning" elements of the market logic (c.f. Andersson & Liff, 2018) rather than combining them alongside the professional logic, the response leads to a reformation of the very essence of professionalism (c.f. Noordegraaf, 2015). By being strategic in this, FTs can be helped in their careers, making themselves a position at managerial levels, but at the same time the FTs can represent the interests of teachers. This does not mean adhering to *all* elements of the market logic, which was defined here as succumbence and a more passive co-optation *by* the market logic. Rather FTs can shield some aspects at the core of professional work, such as grading, which many FTs also attempted to do. Thus, elements of the market logic can be co-opted as suitable to the profession (c.f. Andersson & Liff, 2018). Professional elites can then strengthen professional control, not in a highly traditional sense but in line with perspectives defining professionalism as something new and evolving (c.f. Alvehus et al., 2020; Freidson, 1984; Noordegraaf, 2015, Noordegraaf, 2020; Waring, 2014).

Table 2 sums up the effects of the different responses on the logics and on the profession.

Effects	**Responses**			
	Succumbence	*Defiance*	*Combination*	*Co-option*
Relationships between the logics	Polarization	Polarization	Hybridization	Hybridization
Professional control	Weakening	Weakening	Strengthening	Strengthening

Table 2: *Responses and their effects*

The variety of responses and effects show that introducing elite roles does not automatically lead to a strengthening of professional control vis-à-vis clients. By uplifting context, we can zoom in on the conditions guiding the use of different responses (c.f. Alvehus et al., 2020). Seemingly, for FTs to use their agency to hybridize logics, they must be willing to embark on identity work to include different logics in their professional identities (c.f. Bévort & Suddaby, 2016; McGivern et al., 2015). The strategy of co-optation requires active agency where the market logic is incorporated into the professional one, which entails an altering of professional identity. Seemingly, not all FTs were open to this, but some more actively engaged in defying the market logic. This is in line with other studies highlighting the importance of active individual identity work when exposed to competing logics (Bévort & Suddaby, 2016; Reay, Trish, Goodrick, Waldorff, & Casebeer, 2017).

From the findings of this article, individual identity work is not independent of the relations of the FTs to their wider organization (c.f. Waring, 2014). Interestingly, it seems that where professionals and managers were close and managerial and professional spheres not kept separate, FTs more easily balanced professional and market logics. Tentatively, bringing managerial and professional spheres and logics together involves an openness to include the market logic in the professional identity. In contexts where management was perceived of as a threat, FTs seemed more defensive of their professionalism, trying to preserve it by more harshly resisting influences from other logics. Whereas Pache & Santos (2013) claimed that the level of hybridity between two logics is an important factor guiding responses to two conflicting logics, from the findings in this article, it seems that the level of hybridity between managerial and professional logics is central when it comes to how a third logic, the market one, is perceived of and handled.

Whereas previous studies have highlighted the importance of elites' relationships to colleagues (Alvehus et al., 2020; Freidson, 1984; McDonald et al., 2009; McGivern et al., 2015; Waring, 2014) and the risk of elites shattering professions in terms of creating intra-professional conflict (Adams, 2020; Alvehus et al., 2020), in this article the relationship between managers and the elite gains a prominent position. Cliental influence is a common problem for all professionals and a threat against which they can unite, thus the handling of it is done in a substantiative context (cf. McDonald et al., 2009). Rather than focusing on

intraprofessional relations, when it comes to handling clients it seems important with a unified organization where managers side with the profession. This should not be taken for granted, since there were differences in the level of support that the FTs experienced. Thus, the identity work of FTs and the support of managers seem co-dependent and essential in determining whether FTs will play the role of co-opting the market logic or themselves being co-opted by it (c.f. Andersson & Liff, 2018; Waring & Bishop, 2013).

Concluding remarks

This article adds to the literature on the professional-cliental relationship and to that on professional elites, both in which there has been a lack of in-depth empirical studies making cliental influence and clashes between market and professional logics the main focuses rather than peripheral dimensions. This article shows that professional elites can strengthen professional control vis-à-vis clients foremost by the elites using the response of co-optation to hybridize professional and market logics. However, it seems that there are differences in the conditions guiding the FTs' responses and that in some contexts FTs risk succumbing to the market logic, becoming themselves co-opted by it.

Whereas this study started from a point of view where logics were seen as conflictual, the wide use of responses to hybridize logics, in line with other research, indicate that we might have to increasingly embrace a pre-understanding of logics as blended together (Alvehus et al., 2020; Andersson & Liff, 2018) and of clients as co-constructers of organizations (Alvesson, 2001; Anderson-Gough, Grey & Robson, 2000; Sturdy & Wright, 2011; Torfing & Triantafillou, 2016) rather than the "enemy" of professions. Perhaps future research can adapt this more settling view of logics and develop new insights on what the institutional environment consists of in professional organizations, as well as on how it is handled.

It is important to bear in mind that the focus on professional elites excludes the vast majority of professionals and only gives a limited picture. Future research could continue to empirically explore ordinary professionals' perceptions and handling of cliental influence, as there is a scarcity of studies doing so (Bourgeault et al., 2011). Arguably, those not in elite positions might struggle even more to incorporate different logics in their professional identities, or perhaps they do not feel the same pressure to do so, since they are less active than elites in different realms. These, however, remain questions for future empirical studies.

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