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Exploring Boundaries of Healthcare Roles: The Boundary Work of Hospital Professionals in a Community-Based Health Intervention

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Abstract

This article examines how hospital-based professionals establish and negotiate their roles without relying on institutional agendas and logics, representing a reconfiguration of professional boundaries through community-based participatory research. Operating outside traditional clinical settings, we examine through interviews and observations how these professionals interact with elderly residents and researchers in shaping a community-oriented role for health professionals. Using Sida Liu's concepts of boundary making and boundary blurring, the analysis shows how professional roles are actively enacted through individual reflection and collaborative efforts. Instead of simply reproducing or dissolving familiar roles, boundaries are intentionally reaffirmed, adapted, or co-created in response to the specific context and relational

dynamics. The findings enhance boundary work literature by highlighting the micro-social and situational aspects of professional role negotiation. The study also prompts broader questions about how hospital-based professionals can engage in community healthcare practices through flexible, participatory approaches.

Keywords

Boundary work, Professional roles, Community-based participatory research, Hospital professionals, Situated practice, Role negotiation, Healthcare transformation

Introduction

European healthcare systems are transforming in response to demographic shifts, rising multimorbidity, and health inequalities (McKee et al., 2020; Rechel et al., 2013; Spitzer & Reiter, 2024). In Denmark, a strategic response has involved reforms aimed at strengthening local healthcare services and delivery, traditionally a task associated with municipal care and general practice (Brinckmann, 2022; Indenrigs- og Sundhedsministeriet, 2022, 2024). However, hospital-based practices are also increasingly extending into patients' homes and community settings through initiatives such as home-based admissions (Fischer et al., 2024; Rasmussen et al., 2021), telemedicine (Lunde et al., 2017), and transitional programs like "Get Home Safe" (Goberg-Côté et al., 2024). While these efforts promote proximity and patient-centeredness, they are often still shaped by institutional logics of standardization, outcomes, and efficiency.

Danish studies (Jønsson, 2018; Merrild et al., 2017; Vedsegaard, 2019; Ørtenblad, 2020) suggest that addressing health inequalities also requires rethinking how health is defined and by whom it is defined. Principles of community-based participatory health interventions allow such rethinking, emphasizing co-creation, equity, and lived experience (Israel et al., 2012; Morales-Garzón et al., 2023; Wallerstein et al., 2018). Despite ideals of promoting and anchoring change in local agendas, objectives such as symptom management or prevention against admission prevail in practice (Campbell et al., 2020; Dabelko-Schoeny et al., 2020; Kristiansen et al., 2021; Termansen et al., 2023). Moreover, the role of hospital-based professionals in community life, in conjunction with the promotion of local agendas, remains largely unexplored.

This article builds on such insights by examining a participatory configuration (Langley et al., 2019) that intentionally suspends institutional agendas. Here, we aim to understand the situated and microsocial dynamics of how hospital-employed health professionals engage in community-based practice and meaning-making. Hence, the overarching research question guiding the article is:

How are professional roles relationally enacted when hospital professionals' practices are reconfigured in a community context guided by responsiveness, exploration, and shared experimentation?

Method

Research design and setting

We investigate professional role enactment through the explorative community-based WeARe (Welfare And Relations) project. Unlike clinical or controlled interventions, WeARe does not aim to produce specific changes or effects; instead, it commits to exploratory inquiry, identifying local agendas, and guidance through relational ethics (Israel et al., 2012; McNamee, 2019). It is situated in a non-profit housing association with approximately 400 residents in the Danish capital region. We engaged with this area due to its predominant population of elderly citizens living with multiple chronic conditions, proximity to the institutions involved in the research project, sociodemographic factors, and perspectives on social determinants of health and health inequity (Bak & Vardinghus-Nielsen, 2018; Diderichsen et al., 2022; Sundhedsstyrelsen, 2020).

Collaboratively developed in 2022 by researchers, hospital staff, and community members, WeARe centered on local social activities. Four hospital professionals recruited for the project (a nurse, physiotherapist, occupational therapist, and geriatrician) participated in exploring enactment of professional roles outside the boundaries of hospital-defined care. While a particular theoretical framework did not initially guide the intervention, it was inspired by principles of community-based participatory research (CBPR) (Blumenthal et al., 2013; Israel et al., 2012; Wallerstein et al., 2018), emphasizing co-creation, mutual learning, and attentiveness to structural inequities. Additionally, the project drew on relational constructionist traditions (Hersted et al., 2019; McNamee, 2019; Phillips et al., 2021) to explore how knowledge, roles, and practice emerge in and through situated interaction.

Empirical material

The empirical material analyzed in this article includes:

- Fieldnotes from weekly community café meetings and public events from spring 2022 to spring 2024, which were open-ended in their focus, but included interactions and expressions related to health and illness. Professionals, as well as the first (NTM) and second author (TSL), took fieldnotes, focusing on interactions with community members and reflections on how they were or were not able to draw on professional experience. It is specified in brackets if health professionals produced a field note referenced. The fieldwork comprises over 150 hours of participatory facilitation and observation of interactions in community settings.

- Four in-depth interviews—one with each of the professionals—were conducted approximately one year into the intervention by the first author. The interviews were thematic, open-ended dialogues that revolved around professionals' experiences in community settings related to their hospital-based practice. The nurse, physiotherapist, and occupational therapist are early-career health professionals (between 30 and 40 years of age), with interests in academic and scientific work. The geriatrician has +30 years of healthcare experience and has been involved in numerous research projects.

All materials were collected in Danish and selectively translated into English by the first author for analytic and publication purposes. The first author produced the first and final draft of the manuscript, and all listed authors contributed to the writing process.

Ethics

Principles of relational and participatory ethics informed the study; perspectives that treat research as an ongoing practice of interpersonal relating (Barad, 2007; McNamee, 2019; Phillips, 2025). Special care was taken to include a diverse range of community voices, supported by outreach from the nurse and occupational therapist.

To protect the privacy of individuals involved, professional and community identities have been anonymized via pseudonyms. Community members were informed about the research purpose in advance, reminded during attendance, and provided verbal consent when participating in community events. No personal medical records were accessed, and no permits from ethical administrative bodies were required, as advised by the juridical department servicing researchers of the Capital Region of Denmark (Region Hovedstaden, 2025b). The project was filed within the regional legal administrative portal and database "Privacy" (Region Hovedstaden, 2025c), and the data was stored on a closed drive secured by the CIMT, which services the healthcare institutions of the Danish capital region (Region Hovedstaden, 2025a).

Analytical framework and strategy

The analytical framework and our interpretations of the data have emerged through iterative exchanges of conceptual and empirical guidance and focus. In the following, we present processes and concepts central to this abductive analytical approach (Timmermans & Tavory, 2012).

Our relational perspective on professional roles stems from our approach to intervention and change processes, initially inspired by methods for CBPR (Israel et al., 2012), later developed through perspectives on relational ethics (McNamee, 2019) and by social constructionist change processes (Hersted et al., 2019). The microsocial perspective on roles has emerged through iterations of open analysis and engagement with theory on social boundaries in relation to professions. The concept of social boundaries and the related concept of *boundary work* are, however, not traditionally applied in relation to individual professionals' enactment

of roles. Conceptual studies have emphasized that social groups, as professionals or professions, struggle for epistemic authority (Gieryn, 1983) and jurisdictional control (Abbott, 1988) through symbolic boundaries (discourse) and social boundaries (practice) (Lamont & Molnár, 2002). While these studies offer valuable insights into the relationships between groups of professions or professionals and other professionals, they do not address microsocial dynamics on an individual professional scale, which is the empirical scale of our inquiry. Inspired by Sida Liu, we therefore find it relevant to interpret health professionals' community roles as individually situated and performative positions that are not predefined, but dynamically demarcated and negotiated relative to the context in which they are embedded and emerge (Liu, 2015, 2018, 2024). In relation to the concept of social boundaries, Liu notes, inspired by Abbott (1995), that this implies a focus on "things of boundaries" instead of "the boundaries of things" (Liu, 2015, p. 18). In our case, this signifies a focus on boundary work as a process of professionals enacting and negotiating their respective professional community-based roles, rather than viewing the community configuration itself as defining and distributing tasks, responsibilities, and jurisdictions (Liu, 2018). This distinction is important, as the WeARe intervention also constitutes a socially structuring space of boundaries (of things or roles) to be negotiated—a new set of logics. Our focus in this case is on how professionals engage in interactions, reflections, and practices that constitute a professional role within, rather than across or along, the boundaries of this community-based boundary configuration (Langley et al., 2019). This microsocial, interactionist, and situated perspective not only sets our inquiry apart from traditional focus on the boundary work of social groups but also the general orientation towards interprofessional dynamics across levels of analysis, such as competition, collaboration, or task-shifting between different professions (Allen, 1997; Comeau-Vallée & Langley, 2020; Cregård, 2018; Zink et al., 2024). Our conceptual interpretation and application of boundary work theory are a result of our iterative processes, which involve switching between open-ended thematic coding and theoretical interpretation. The empirical material, comprising fieldnotes and interviews, has been analyzed by the first author (NTM). Preliminary codes were developed with attention to situated expressions of professional experiences, interests, and preferences; interactional moments revolving around health and illness between professionals and community members; and reflexive accounts of and perspectives on one's own and other professionals' practices. Emerging themes were then collaboratively refined through memo writing (first and second author), iterative analytical discussions (authors 1-4), and repeated readings and dialogues involving the entire author group. Ultimately, we drew on Liu's (2018) conceptualization of boundary work in practice.

Liu identifies three forms of boundary work: Boundary making, boundary blurring, and boundary maintenance. Our iterations of analysis led us to center on the first two typologies:

- **Boundary making** refers to how professionals reassert, reinterpret, or selectively adapt their professional roles in new contexts. This may involve translating hospital-

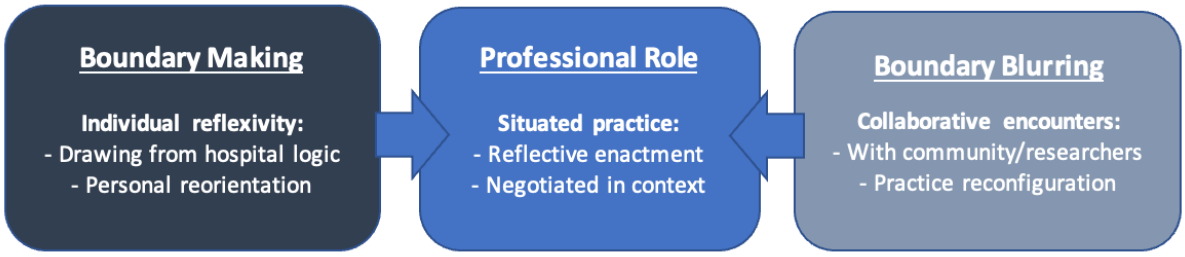
based expertise into forms of engagement suitable for a participatory, community setting, or affirming familiar practices, redefining what it means to be a nurse, a physiotherapist, an occupational therapist, or a doctor outside the hospital.

- **Boundary blurring** captures moments in which professional roles unfold in relation to others, such as researchers, residents, or other professionals, through interaction rather than assertion. In our analysis, such moments may give rise to hybrid practices or shared agendas that are neither strictly clinical nor entirely non-clinical.

Figure 1 presents our interpretive model of professional role formation as situated between these two boundary processes.

Figure 1

Community-based Professional Role as Situated Between Boundary Making and Boundary Blurring



Analysis

The nurse: Situated role enactment between reflexivity and collaboration

Reflective role repositioning (boundary making)

The nurse described how her community role allowed her to engage in care differently than in the hospital setting. She emphasized the opportunity to interact based on presence and attentiveness: "I thought it was nice that there was no agenda. That I just showed up as myself (..) I brought all my nursing experience with me. However, I arrived without any intention of us having to do something specific." (Interview—Nurse). In contrast to the hospital, where clinical care is organized around defined tasks and time pressures, the community setting allowed her to let care unfold through conversation and attentiveness:

> The nursing profession is a caring field, and during the studies, one learns a great deal about holism and seeing the whole person. So, having the time to sit down, have a cup of coffee, and talk with these individuals to hear what occupies their daily lives and what is meaningful to them is how I utilize my nursing skills. (Interview—Nurse)

These statements reflect a boundary-making process grounded in situated and relational responsiveness relative to her profession and interpretation of institutionalized practice. By drawing on familiar nursing expertise while adapting to the slow tempo and open-endedness of the cafés, she reoriented her role from a proactive care provider focused on patient flow efficiency to a present participant who listened and followed the lead and flow of community members. Her reflections suggest that this was not merely anchored in a shift in context, but in a more general desire to renegotiate nursing practice—a return to values that were otherwise difficult to uphold in hospital settings due to the pace and workflow. She further emphasized interpersonal continuity:

> It definitely allows for the possibility of following up on things […] They also feel acknowledged because you can follow up on the fact that I actually heard what you said the last time we met, and I am interested in what you have experienced since then. (Interview—Nurse)

She explained how continuity is largely absent in the hospital, where she often lacks conditions for relational care. Thus, her experiences of community-based engagement became a way of reclaiming a part of her professional role that had been marginalized by the hospital's focus on efficiency and throughput.

Collaborative role reconfiguration (boundary blurring)

While the nurse aimed to prioritize socially and non-clinical interactions, clinical knowledge remained an integral part of her professional experience and training. It would surface occasionally, but could also be considered a process of continuity reflecting her professional desire. One such example, compiled from multiple fieldnotes, involved a recurring interaction with a resident we will refer to as Lester:

> Lester was a frequent guest at the cafés. After a researcher initially noticed an ulcer on his face, concerns about skin cancer were raised. In later cafés, when both the nurse and physiotherapist were present, the researcher mentioned the concern again, prompting Lester to raise it as well. The professionals gently encouraged him to seek medical attention, and the issue re-emerged in conversations over time; Lester was apprehensive about diagnosis and treatment due to previous experiences with cancer treatment resulting in feelings of disappointment and mistrust. Eventually, Lester appeared with a band-aid covering the affected area, indicating that he had received treatment. (Fieldnotes—compiled and paraphrased)

This example illustrates how the nurse's role emerged collaboratively and contextually, with clinical engagement surfacing through the establishment of relational trust through recurring interactions and shared experiences. The boundary between clinical and non-clinical practices became blurred through responsiveness in situations that evoked clinical knowledge and reflexivity, as well as an individual's reorientation on how the issue could be addressed. The

nurse reflected on her strategy for striking a balance between relational and clinically informed demarcation of her role, illustrating the entanglement of making and blurring of boundaries in the professional role enactment processes:

> Well, I have certainly been very conscious about not being moralizing, nor approaching it with the intention of saying, "You should perhaps quit smoking," or "You should reduce the number of cigarettes you smoke," and so on. I do that when I am out at the hospital […] here I try to motivate, rather than reprimand. (Interview—Nurse)

Her approach was thus not one of withdrawing expertise, but instead of rethinking its expression to avoid a paternalistic expert role. She deemed this unproductive in the community context, while it would be more fitting in the hospital setting. Through her responsive and dialogical mode of engagement, the nurse's role came to reflect a negotiation between institutionalized professional commitments and a participatory and relational ethos, which she was able to align with her training and desires related to nursing. This process of boundary making and boundary blurring shaped a role that remained rooted in her interpretation of—and motivation within—nursing, while becoming distinct from her typical nurse enactment in hospital care. Thus, rather than creating a new professional role, she made certain enactments of nursing possible that she did not find possible in the hospital setting.

The physiotherapist: Situated role enactment between reflexivity and collaboration

Reflective role repositioning (boundary making)

Early in the WeARe intervention, the physiotherapist expressed ambivalence about participating in the project. Without predefined outputs or measurable effects, his role initially appeared at odds with the production-oriented logics of hospital care:

> Can I justify spending my time on this instead of "keeping things running" at the hospital? I dislike the term "keeping things running," but that is precisely what I am doing. So, I was looking for where physiotherapy fits into this, or where the health benefits of this approach are. Moreover, I was on board with the idea that it should be creative and curious. (Interview—Physiotherapist)

While expressing skepticism about the institutional overemphasis on productivity expectations, he acknowledged the relevance of physiotherapy as a productive and outcome-oriented approach. Instead, he struggled to situate his expertise in WeARe—a context that prioritized open-ended, long-term impact and responsiveness over measurable outcomes. However, over time, he found that dialogical interaction and attentiveness could themselves be expressions of his professional practice: "There were some conditions out there that made it possible to cultivate this hermeneutic approach to conversation, which is also physiotherapy, but which often gets deprioritized." (Interview—Physiotherapist). This emphasis on dialogical relational care mirrored the nurses' reflections, suggesting a shared appreciation for aspects

of their professions that were not prioritized or possible to enact within the hospital. However, unlike the nurse, the physiotherapist described an initial uncertainty about whether his actions in the community cafés were even physiotherapeutic, until his understanding evolved through reflective conversation with others, including the research team:

> A lot of the insights from this came through talking. You and I had good talks every time we could, and those dialogues really helped. I talk things through. I gain insights when people talk to me, and I share my thoughts with them in return. […] I think that is generally true when doing this kind of abstract, non-specific social work. You need someone to do it with. (Interview—Physiotherapist)

His role was thus shaped not only through engagement with community members but also through dialogue with colleagues in the project. Through team meetings and informal exchanges at the community site, he came to recognize that his own understanding of physiotherapy included practices he had already been performing, such as supporting residents' mobility, advising on posture, and encouraging physical activity. This again illustrates the close relation between individual reflective reorientation and collaborative constellations in boundary work processes. In the interview, he elaborated on how he had come to think of his role in the community setting:

> It was physiotherapy in a new way, but not about inventing a new form; it was more about rediscovering a way of doing physiotherapy. Some of what I learned during my studies, and what I say I do, I was actually doing here. That is it, maybe it is more about rediscovering than inventing. (Interview—Physiotherapist)

This reframing of the professional role through reflective engagement constituted a key process of boundary making, as he came to articulate and revalue practices and approaches that had been overshadowed in the hospital context for him. What makes this collaborative process also an example of individual demarcation is the way the physiotherapist comes to value and understand their professional role, as a hermeneutical practice of relating to community members and colleagues, and becoming aware of physiotherapeutic aspects of their interactions that they did not come to realize autonomously.

Collaborative role reconfiguration (boundary blurring)

The physiotherapist's professional role also emerged through interactions with community members that blurred the boundaries between clinical and everyday practice. During a group walk to the local park, he noticed a resident struggling with posture while using a walker:

> He asked if he could raise the handles slightly, and when she tried it, she exclaimed, "This feels much better. I do not have nearly as much pain in my hands." "That is good," he replied. "There is no reason to walk like an old lady. Chest out!" He demonstrated how to maintain her upright posture, and she responded with a smile. (Fieldnotes)

This moment, casual and social in form, also involved professional knowledge. However, he did not frame it or interpret it as a clinically informed interaction, and the resident was not treated as a patient. Instead, expertise and care emerged through interaction, preceded by previous encounters, resulting in familiarity and the resident's recognition of his professional expertise. Later during the walk, another resident experienced a leg cramp. The physiotherapist responded calmly, assessing, reassuring, and advising him to pace himself. These small acts did not constitute formal treatment. However, they reflected how his role could adapt responsively to the social setting, without the physiotherapist realizing it himself, at least until it was collectively reflected upon.

These encounters exemplify boundary blurring as a recalibration of professional expression not consciously directed towards familiar clinical ways of performing his role. His role is enacted spontaneously in response to situations where his expertise unexpectedly becomes relevant. Thus, his physiotherapeutic role would not merely be demarcated by his individual drive and reorientation towards hermeneutic dialogue but was also collaboratively enacted in ways shaped by community members, assistive technologies, collective physical activities, and relational rapport. Furthermore, his recognition and interpretation of health professionalism emerged through collaborative, reflexive dialogues anchored in the principles of CBPR and relational ethics.

The occupational therapist: Situated role enactment between reflexivity and collaboration

Reflective role repositioning (boundary making)

In the interview, recorded in her own fieldnotes, the occupational therapist reflected on how her professional role was shaped by her responsiveness to individuals' lived experiences and aspirations. She emphasized that the WeARe context allowed her to return to the "core" of occupational therapy: Working with what matters to people in their everyday lives.

She gave the example of a resident, here referred to as Eric, who strongly identified with being able to bathe in his bathtub. From a hospital-based perspective, she explained, this would have been discouraged due to the high risk of falling. However, his repeated emphasis on the importance of this activity caused her to reflect on negotiations between hospital logics and those of the lived experiences outside the hospital:

> We ended up talking more about what it would take for him to be able to do it safely. It made me think: Okay, maybe this really is important enough that we should try to support it rather than just warning him off. (Interview—Occupational Therapist)

She connected this to another case, a hospital patient who lived in a non-traditional communal housing environment. Her experience with WeARe influenced her role back in the hospital:

> During that period, I was much more open to saying: Okay, let us figure out how to get you home. Normally, we would have pushed for a rehabilitation center. However, it did not work for him. So, I went deeper into the case to find a way to support what mattered to him. (Interview—Occupational Therapist)

These reflections illustrate how boundary making can involve the adaptation of professional expertise to support responsive, person-centered practices; not by abandoning clinical judgement, but by allowing lived experiences and contextual factors to reshape what becomes possible and desirable. These examples show that even when practices unfold in interaction with others, the demarcation of her role was shaped by a reflexive process rooted in her own reorientation and experience of what occupational therapy is and how it should be practiced: being responsive to everyday life and activities. She did not view her expertise as predefined, but rather as something that took shape through context-sensitive negotiation, one that was attuned to the lived experiences of community members. While her negotiations—similar to those of the nurse and physiotherapist—drew on experiences from professional training and what was possible in a hospital setting, she also expressed the ability to draw from experiences she had in the community in negotiating and finding ways to practice occupational therapy in the hospital, emphasizing the patient's everyday life.

Collaborative role reconfiguration (boundary blurring)

A recurring theme in the occupational therapist's fieldnotes is how small, informal conversations evolved into moments of collaborative experimentation. One such example involved a community member, here referred to as Birgit, who had expressed on multiple occasions that she desired more mobility and independence in transportation. During a community café event, the occupational therapist and physiotherapist joined Birgit and other residents in a lively discussion about electric scooters. When Maggie, another resident, offered to fetch her own scooter so Birgit could try it, the professionals helped facilitate the process. The situation unfolded as a collaborative effort, not staged as an assessment or intervention, but as an empowering and collective activity. As Birgit tested the scooter, visibly happy, the conversation turned to application logistics, and the physiotherapist and residents aided her in finding the contact number.

Several weeks later, the occupational therapist followed up. Birgit had not applied, prompting a wider discussion among residents about referral processes. One woman noted that she had been referred to physical training even when seeking help for dizziness. This sparked a group conversation, captured in the occupational therapist's own fieldnotes:

> The nurse says she does not know much about what training can or cannot fix, and neither do I. What I can say, though, is that referrals for training are often part of an assessment process… However, of course, one has to understand what is actually going on underneath. (Fieldnotes)

Here, the occupational therapist responded to the residents' frustrations by sharing her knowledge in a way that supported the conversation rather than steering it. She was not trying to defend or explain rationales that may have been expressed about the training. However, she was transparent about the limits of her knowledge, suggesting rationales other than treatment and remaining sensitive to their experiences when expressing that a thorough understanding of the patient should accompany decisions about training. While the example illustrates a collaborative situation, it also underscores that collaborative interaction does not preclude individual role demarcation. In this case, she drew on her expertise while allowing her boundaries to shift responsively, which in this instance aligned with her individual reorientation, prioritization, and attunement to the everyday life concerns and lived experiences outside the hospital setting.

The geriatrician: Situated role enactment between reflexivity and collaboration

Reflective role repositioning (boundary making)

The geriatrician did not express a desire to reform her professional role, unlike the three other professionals. Instead, she described how the WeARe setting offered a space for professional practice in ways she was familiar with. In the interview, she reflected on her perceived value of community engagement:

> It is fun to get out of the hospital walls. That is also why I enjoy conducting home visits, as it allows me to see people in their own surroundings. It is different when you are in the hospital. There is a role there. Out here, you meet people more directly. (Interview—Geriatrician)

She took part in shared meals, group singing, and community events. To her, this did not constitute novel configurations of care. Instead, it was familiar practices that she could align with her professional interests and experiences. In response to the interviewer's suggestion that informal activities such as singing, arts and crafts, and community dinners might be unfamiliar in relation to her professional role, she noted that similar activities were once part of her practice in a former municipal hospital: "Back then, we had training facilities, and they [patients] would go into the kitchen, bake cakes, wash clothes, and we would see how much they could do before going home. That seems to have faded away." (Interview—Geriatrician). The community configuration had made it possible for her to draw boundaries from experiences in a clinical context that were not currently supported by the hospital's specialization and efficiency logics. Thus, to her, the relational, socially oriented approach and community outreach aligned with boundaries of clinically informed tasks and responsibilities—some present others' historical.

When residents in the WeARe intervention asked about medications, she occasionally looked up information using an open-access Danish site. However, she did not access medical records nor engage in personal consultations:

> Sometimes I take out my phone and check medication guides if they ask about something. I cannot remember everything off the top of my head. However, there have not been any problems; no one expects me to take over their medical care. (Interview—Geriatrician)

In this way, her role involved general geriatric knowledge while refraining from individual clinical engagement, distinguishing her role from that of a general practitioner or hospital clinician. Her actions reflected a deliberate orientation toward interpersonal responsiveness, integrating social and medical practices, while upholding the distinction between institutional mandates and informal responsive participation. Thus, despite the familiarity with current and historic practices, she demarcated a community-based role differentiated from the tasks, jurisdictions, and responsibilities of the (historic) municipal hospital and home visits; one in which professional experience could be applied in a responsive manner and through taking part in social activities.

Collaborative role reconfiguration (boundary blurring)

One of the clearest examples of boundary blurring emerged during an early community café event, when a resident expressed interest in "old people's illnesses." The geriatrician responded openly, and this exchange led to the planning and facilitation of an informal health talk. She presented knowledge about aging and chronic conditions in a general, conversational style. The session took form through dialogue, with residents raising questions, sharing experiences, and suggesting future topics. Over time, health talks became a familiar activity in the cafés. They were referenced in broader discussions about the project's direction, such as when the nurse and occupational therapist discussed future community activities. While the geriatrician maintained a clear distinction between sharing general knowledge and offering personal clinical advice, her role was shaped collaboratively through these encounters. With her facilitation, individual health-related questions could be collectively reflected upon, thus supporting an orientation towards the group rather than individuals.

This example reflects boundary blurring as the professional role unfolded in interaction with others, neither predetermined nor entirely self-defined, but co-constituted through evolving practices and interactions. The geriatrician's role was informed by professional knowledge, but also attentive to how the context of the community setting shaped what was appropriate and possible. The geriatrician's enactment very much resembled that of the three other professionals in terms of responsiveness and mobilization of situated clinical expertise. However, the boundary work reflects a profession and experience that make for a more institutionally aligned role than the alternative.

Findings and discussion

Entangled role negotiation: Boundary making and blurring in practice

Using Sida Liu's distinction between boundary making and boundary blurring (2018), we have shown how professional roles were not merely transferred into a new setting, but actively shaped through ongoing micro-social processes.

Boundary making involved professionals drawing on prior clinical experience, institutional logics, and personal values to selectively frame and (re)orient their roles. For instance, despite being differently trained, both the nurse and physiotherapist emphasized the relational and dialogic aspects of care, which they found underprioritized in hospital practice. Of the two, this was perhaps more surprising for the physiotherapist, who also reflected that many of his physiotherapist colleagues seemed to thrive with current priorities, suggesting that for a configuration like WeARe, a specific orientation and preference for physiotherapists would be relevant in terms of recruitment. The nurse and occupational therapist, on the other hand, respectively expressed that relational and dialogical interactions were core to the nursing profession, and engagement with the lived experience and environment of patients was an occupational therapeutic ideal. The geriatrician enacted her role through selective demarcations, grounded in historical configurations of geriatric care, reflecting a more holistic and centralized perspective on treatment and rehabilitation than current configurations. In the interviews, she frequently referred to her previous professional experiences. Conversely, the younger and less experienced healthcare professionals often referred to their training and sense of professional identity when reflecting on their roles and practices.

Boundary blurring, in contrast, captured moments where roles unfolded collaboratively and co-produced in interaction with residents, researchers, and other professionals. These instances did not erase professional boundaries informed by clinical knowledge in favor of an idiosyncratic perspective on social interaction; instead, they reconfigured them through responsiveness and shared exploration. The physiotherapist's emphasis on dialogue and relational care suggests that the ways boundaries were blurred between relational and clinically informed interactions were not only a matter of profession but also a matter of preference and interests. While the geriatrician was quick to respond to the idea of health talks, she remained open to informal activities such as singing and dining. The physiotherapist was able to negotiate a way of interacting with community members that leveraged his expertise in physical exercise in conjunction with his relational ethos. As a result, both the nurse and the occupational therapist were able to enact care, focusing on continuity and everyday life perspectives, in ways they had not previously been able to do in the hospital setting.

While concepts of social boundaries and boundary work are well established in health and organizational studies (Abbott, 1988; Allen, 1997; Lamont & Molnár, 2002; Nancarrow & Borthwick, 2005), their application in community-based contexts has primarily centered on

institutional and interprofessional dynamics (e.g., Reynolds, 2018; Roussy et al., 2020; Wallace et al., 2019), leaving micro-social dynamics of boundary work less explored. This focus, we argue, becomes highly relevant when practices and roles can emerge responsively through interactions, experiences, and reflections as opposed to being defined by institutional mandates and agendas.

In this article, we have drawn on Sida Liu's processual, individual, and situated perspective on boundary work (2018) to analyze how professional roles are reflexively and collaboratively enacted in a participatory setting. While not initially designed to offer a novel theoretical contribution, our abductive engagement with the data suggests that this conceptual application of boundary work may offer new empirical insights into how professional practice and role-making occur outside—but not independently from—institutional scripts. We thus invite further inquiry into the value of Liu's perspective for understanding situated professional enactments in participatory health initiatives.

The WeARe intervention resembles what Langley et al. describe as a configurational boundary space (2019), but our focus has remained on individual role enactment entangled with collaborative practices within this arrangement. This can be considered a series of micro-social processes of professional *re*configuration. It adds to the boundary work and professional role literature by illustrating how specialized healthcare roles can be individually reoriented and collaboratively negotiated outside institutional mandates and logics (Bucher & Langley, 2016; Chreim et al., 2020; Zietsma & Lawrence, 2010), not through formal task shifts or interprofessional negotiation of responsibility and jurisdiction (Abbott, 1988; Eliassen & Moholt, 2023; van Schalkwyk et al., 2020; Zink et al., 2024), but through situated engagement and context-responsive practice.

Positioning specialized professionals in community proximity

Much of the Danish policy discourse on proximity of healthcare centers on strengthening primary care (Brinckmann, 2022; Indenrigs- og Sundhedsministeriet, 2024; Skjødt, 2019), and where the hospital is considered, this is often in relation to technologically assisted care or home admissions (Fischer et al., 2024; Lunde et al., 2017; Skytte Bjerregaard, 2024). This article points to another possibility: hospital-based professionals can perform clinically informed and relevant roles of relational and responsive care for and with community-dwelling elderly people when institutional logics are *suspended* and participatory conditions are supported. It is a possibility that somewhat inverts the point made in the post-COVID-19 pandemic scoping review on task shifting by Das et al. (2023). They define task shifting as the redistribution of healthcare services from specialized to less-qualified providers, which has become a highly sought-after and effective strategy across various domains of healthcare services during the pandemic. WeARe—which commenced just as restrictions on social gatherings was lifted—operates on the assumption that the specialized competencies of the hospital and its professionals has something to offer in terms of healthcare in closer proximity to the

lives lived outside the traditional boundaries of the hospital institution: An alternative to reproducing the specialized institutional agendas and scripts of the hospital; openness to exploration, uncertainty, and negotiation of the meaning of care and roles of healthcare. This adds nuance to the traditional distinction between primary and secondary care provider roles, and further suggests that proximity is as much about relational engagement and everyday life as it is about the location of services. However, this mode of professional role enactment remains fragile and contingent upon professionals' inclinations towards relational care, as well as institutional support and anchoring (Koh et al., 2020).

Limitations and critical reflections

The healthcare professionals were selected for participation by their respective managers, who considered their interest and skills in interpersonal professional practice and exploratory inquiry. The only exception to this is the nurse who was recruited through a job listing in which the WeARe-role was part of the job description. While this may constitute a selection bias, it could also be argued that the healthcare professionals reflect on and draw inspiration from professional communities and traditions, which our analysis has also highlighted. Thus, in a professional boundary perspective, each professional also reflects a collectiveness of practices, traditions, and tasks that are culturally, socially, symbolically, and jurisdictionally demarcated, rather than left to the individual professional's taste and discretion (Abbott, 1988; Lamont & Molnár, 2002).

As facilitators and researchers, we were part of the unfolding of the intervention. This dual role shaped how data was produced and interpreted. Dialogue-based interviews and shared field experiences were co-constructed, and our analysis reflects this embeddedness. The relational entanglement of researching subjects and the subjects being researched, on the one hand, supported rapport between the interviewer and the interviewee; on the other, it did not provide a neutral space where potential critique could be addressed. Having an interviewer not participating in field activities could have mitigated this limitation and might also have facilitated a dialogue that identified other relevant processes of role development. We do not consider these entanglements as problematic as they align with our participatory inquiry approach (Blumenthal et al., 2013; Israel et al., 2012) and our inspiration from action-based research and relational ethics (Hersted et al., 2019; McNamee, 2019). However, they are no less important to emphasize as part of the contingencies of the knowledge produced.

Conclusion

This article has explored how hospital-based healthcare professionals enacted their roles within an explorative, participatory, community-based intervention. Through multiple iterations of inductive and conceptual interpretations of data, we came to focus on two core processes: boundary making, where professionals reoriented their roles, drawing on hospital-based experience and professional values, and boundary blurring, where roles were co-shaped in dialogue with others and clinical and relational modes and agendas emerged and

entangled in the community events. Rather than creating new roles or reinventing existing ones, WeARe enabled the responsive articulation of professional boundaries among the participating professions. Professionals neither abandoned their expertise nor replicated hospital roles; they adjusted, adapted, and occasionally rediscovered dimensions of their practice and expertise. Our analysis has focused on, and highlighted how, professionals enact professional care roles when institutional logics are suspended, not through task- or identity- shifts, but through situated, collaborative practice and individual professional experience and expertise. It foregrounds empirical material of responsive and relational care roles when institutional logics and spaces are reconfigured through the displacement of hospital professionals in an elderly social housing community, inspired by participatory and explorative logics.

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