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Healthcare Professionals' Identification of, and Solutions to, Health Problems for *Hard to Reach* Patients with Diabetes

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Abstract

This article examines how healthcare professionals understand children with type 1 diabetes and their families, and how they consider them *hard to reach*. Based on observations and analysis of healthcare professionals' case conferences, the article finds that families' lack of compliance with professional recommendations is explained by parental lack of resources, ability, willingness, and complex social and personal problems of the family members. To find solutions to these diabetes management problems, the professionals integrate and synthesize knowledge based on experience, judgment, and practical skills. They also recognize organizational limitations of the healthcare system and, consequently, dependency on other organizations with other functions and knowledge. The article contributes to new knowledge about how organizations and professionals try to address and solve problems of health inequality in practice. A major finding is that the capacity to address individual health literacy depends just as much on organizational health literacy.

Keywords

Children with type 1 diabetes, health inequality, healthcare professions' practice and knowledge base, problem identifications and solutions

Introduction

Professions and their understanding of problems and solutions play an essential role in society's welfare organizations with crucial importance for society's ability to coordinate, integrate, and collaborate on solving societal challenges such as health inequalities.

International and Danish research shows that health inequalities among diabetes patients occur to a large extent (e.g. Borschuk et al., 2015; Martin & Topholm, 2020; Walker et al., 2019). Research identifies a convergence of biological, social, psychological, and economic factors in families' everyday lives, which constitute a barrier to proper self-care (e.g. Akhter et al., 2016; Li & Whyte, 2021; Tsiouli et al., 2013). It also shows that families with low socioeconomic classification have a harder time managing everyday life with diabetes (Levin et al., 2013; Sanders et al., 2019).

This problem of health inequalities is often addressed by the concept of "health literacy" (e.g. DeWalt, 2009; Kickbusch et al., 2013; Nutbeam, 2006), covering "*the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others*" (U.S. Department of Health and Human Services, 2024). Research shows a connection between low health literacy, low self-rated health, and unfavorable health behavior (DeWalt, 2009; Maindal & Vinther-Jensen, 2016). Patients' abilities to understand and act on health information are very important in relation to type 1 diabetes, since 99% of the medical management of diabetes is expected to be carried out by the patients themselves in their daily lives (McLaughlin et al., 2015). However, there is a growing recognition that the capacity to address individual health literacy also depends on organizational health literacy.

Organizational health literacy addresses the health literacy of organizations, recognizing that the healthcare system must have the capacity to adapt its programs to support different patients' abilities to live with their own disease as well as to prevent potential risks (Khorasani et al., 2020; Trezona et al., 2018). This challenges the idea of the patient as solely responsible and gives healthcare systems and professionals a crucial role in helping people cope with chronic and lifelong diseases as a way of reducing health inequalities. It is generally recognized that professionals administer, combine, and use diverse and specialized sources of knowledge in order to decide how practical problems should be handled in specific situations (Grimen, 2008; Molander & Terum, 2008). However, there is little knowledge about how healthcare professionals address complex health issues associated with inequality in practice (Garzón-Orjuela et al., 2020). The aim of this article is to contribute to new knowledge about this.

The empirical material of this article stems from a qualitative case study conducted across two different hospitals in Denmark, where professionals are involved in a special treatment program for children with type 1 diabetes (T1D) and their families who are considered *hard to reach*. The term *hard to reach* represents the healthcare professionals' perception of patients who, for various reasons and despite many attempts, do not benefit from health information, do not comply with normal programs based on self-care, and consequently have a very poor regulation of diabetes. The treatment program is organized as an interdisciplinary healthcare professional effort centered on high-frequency home visits and intersectoral meetings with professionals outside the healthcare system. The treatment program is carried out by doctors, nurses, psychologists, social workers, and dietitians in two treatment teams, cf. the methodology section. The assumption behind the organization of the treatment program is that some families are *hard to reach* and that interdisciplinary knowledge and skills are required in order to improve the health conditions of the child and prevent health inequality (Steno Diabetes Center, 2020).

Based on empirical data consisting of observations of 12 case conferences, this article investigates and answers the following research question: how do healthcare professionals understand children with type 1 diabetes and their families, and how do they consider them *hard to reach?* As a part of the treatment program, the case conferences represent an organizational effort to strengthen healthcare professionals' capacity to understand families' problems with managing diabetes (problem identification), and to solve these problems (problem solving). As empirical material, the case conferences reveal observations and communications about families as *hard to reach*. By analyzing the case conferences, it is possible to develop knowledge about how professionals address complex health issues associated with inequality in practice.

Theory

The research question calls for theory that enables investigation of how healthcare professionals understand and try to solve problems. Therefore, we draw on theories about knowledge practices of professions combined with a system-theoretical perspective on welfare organizations.

Over time, research on professions has offered many and partly conflicting definitions and perspectives on the role and practice of professions in modern society (e.g. Burrage, 1993; Molander & Terum, 2008). However, across these differences, there is a common understanding that professions contribute to solving practical problems for lay people by applying their knowledge base acquired through education (Molander & Terum, 2008). The knowledge base of professions is shaped over time, often by drawing on different disciplines and forms of scientific knowledge, technical-instrumental skill knowledge on how to produce a result, and practical-moral knowledge in the form of ethical considerations and actions (Gilje, 2017). This makes professional knowledge highly fragmented, but more sensitive to the external world and the aim of understanding and finding solutions that might benefit people. Grimen's point is that knowledge is integrated and synthesized in professional practice and varies according to the specific problem that arises in practice (Grimen, 2008). It is thus the nature of the problem that determines which combined knowledge is relevant to solve it. Grimen calls this integration "a practical synthesis" (Grimen, 2008, p.74). A practical synthesis is created in a process where professionals reflect and analyze how a specific problem can be solved in a responsible manner with high professional quality. Therefore, professional actions involve forms of reasoning where discretion and judgment become important (Grimen & Molander, 2008). In relation to this, Grimen argues that professional practice has a normative side, where the professional must balance moral, political, and legal judgments without clear rules for prioritization (Grimen, 2008). Gilje (2017) adds additional dimensions to the action level of practical synthesis. These are "knowing what," which is well-founded knowledge, "knowing how," which is knowledge about how to do something in practice, and theories of "tacit knowledge," which shed light on how knowledge can be implicitly articulated in practice (Gilje, 2017, pp.27-32). A practical synthesis is therefore both heterogeneous through the integration of different scientific disciplines, and also through the use of different practical forms of knowledge that are combined and synthesized in practice. In this article, we perceive the healthcare professionals of the treatment program as a group of experts with different educational backgrounds and theoretical and practical knowledge. The group is working together for the purpose of creating practical syntheses that can improve their understanding of and capacity to solve the problem of children with poor diabetes regulation.

However, the understanding of practical synthesis does not fully capture how different welfare organizations affect professional practice or patients. Therefore, there is a need to add an organizational perspective that focuses on how professionals' ability to understand and solve practical problems is embedded in an organizational context.

The welfare state is differentiated into fairly closed sectors that solve specialized tasks in an organizational context, such as the healthcare system/the hospital services, the social welfare system/social services, etc., which becomes crucial for the self-perception of the organization and how problems are observed and addressed (Luhmann, 2000). Luhmann perceives organizations as social systems that reproduce themselves through communication and decisions for the purpose of coordinating action, and in doing this, they distinguish and draw boundaries between what is internal (system) and external (environment) (Kneer & Nassehi, 2002; Luhmann, 2000). Following this, organizations have functions to fulfill in relation to an environment and form internal programs that specify roles with expectations for behavior and decisions, e.g. of professionals. Luhmann suggests that we study organizations as social systems by deploying the functional method and analysis focused on studying how systems observe and identify problems (problem identification) and solutions to these problems (problem solutions) (Luhmann, 2000). Problem identification contributes to reducing complexity for the system by identifying (and thus delimiting) the problem as something that can be managed and addressed through problem solving, and often this involves understanding and explanation (Luhmann, 2000). However, the way problems and solutions are defined, understood, and explained may vary. This means that there could potentially be other solutions to the same problem, and herein lies a critical potential with regard to identifying alternatives. For example, a basic function and goal of the hospital is to diagnose, treat, and cure diseases. Consequently, this is the main problem in focus prior to solving problems related to health inequalities. That said, professionals at the hospital may observe, reflect on the need, and decide to work with these inequalities in a way that involves both the patients and their families (Andersen, 2008) and may consequently try to create an alternative approach to problem identification and solution.

By using the functional method to analyze how professionals create practical syntheses about *hard to reach* families, we not only gain an understanding of what forms of knowledge are used to create solutions but also learn that these appear in a systemic context that organizes a particular horizon of understanding.

Methods and design

The article is based on data collected by Anette Stamer Ørsted in the PhD project "Better life with diabetes—A case study of the possibilities and obstacles of healthcare systems and healthcare professionals to practically solve a problem with social inequality within healthcare." This study is qualitative and designed with an abductive and dialectical approach (Blaikie, 2000).

Data foundation

The empirical data consists of observations of 12 case conferences (in the following analysis, they will be referred to as "CC") conducted as a part of the treatment program. As mentioned, the case conferences can be understood as the professionals' systematic reflections on problems and solutions related to diabetes treatment in the families (cf. problem identification/problem solution). Therefore, the data is exemplary in illuminating healthcare professionals' syntheses of children and families considered *hard to reach*. Case conferences include doctors, nurses, psychologists, social workers, and dietitians involved in the treatment program at two hospitals, each lasting approximately one hour, conducted between November 2021 and January 2023. The participation of professionals has taken place at each of the two hospitals and has varied due to practical reasons, but several of them were consistently present. Representatives from the specific treatment team (a nurse and a doctor) assigned to the case presented at the case conference were always present. The analysis is concerned with how practical syntheses are formed at the conferences and constitute a common basis for how problems are understood, and possible solutions are proposed. Therefore, the analysis is not concerned with individual differences between the professionals but with recurring problem identifications and solutions. All case conferences were audio-recorded and transcribed, and the first author was present, observing all interactions between professionals.

The first author has also followed the treatment program through participation in 10 selected home visits and 21 cross-sectoral meetings throughout the project period, and by conducting 15 interviews with selected families. This data is given a particular focus elsewhere (Ørsted & Engen, 2025; Ørsted, under preparation). This has provided an in-depth insight into how the professionals perceive, synthesize, and identify problems.

Inclusion criteria and participants

The selection of patients for case conferences was made by the healthcare professionals. The 12 case conferences focused on nine out of 19 children included in the treatment program based on the argument that these children and their families were considered *hard to reach*. The tables below provide an overview of the basic characteristics of the children and the professionals (Table 1) and how the professionals characterized the vulnerabilities of the families at the time of inclusion in the treatment (Table 2). The professionals' characterizations draw on years of knowledge about the families gained from meetings at hospitals, home visits, and cross-sectoral meetings.

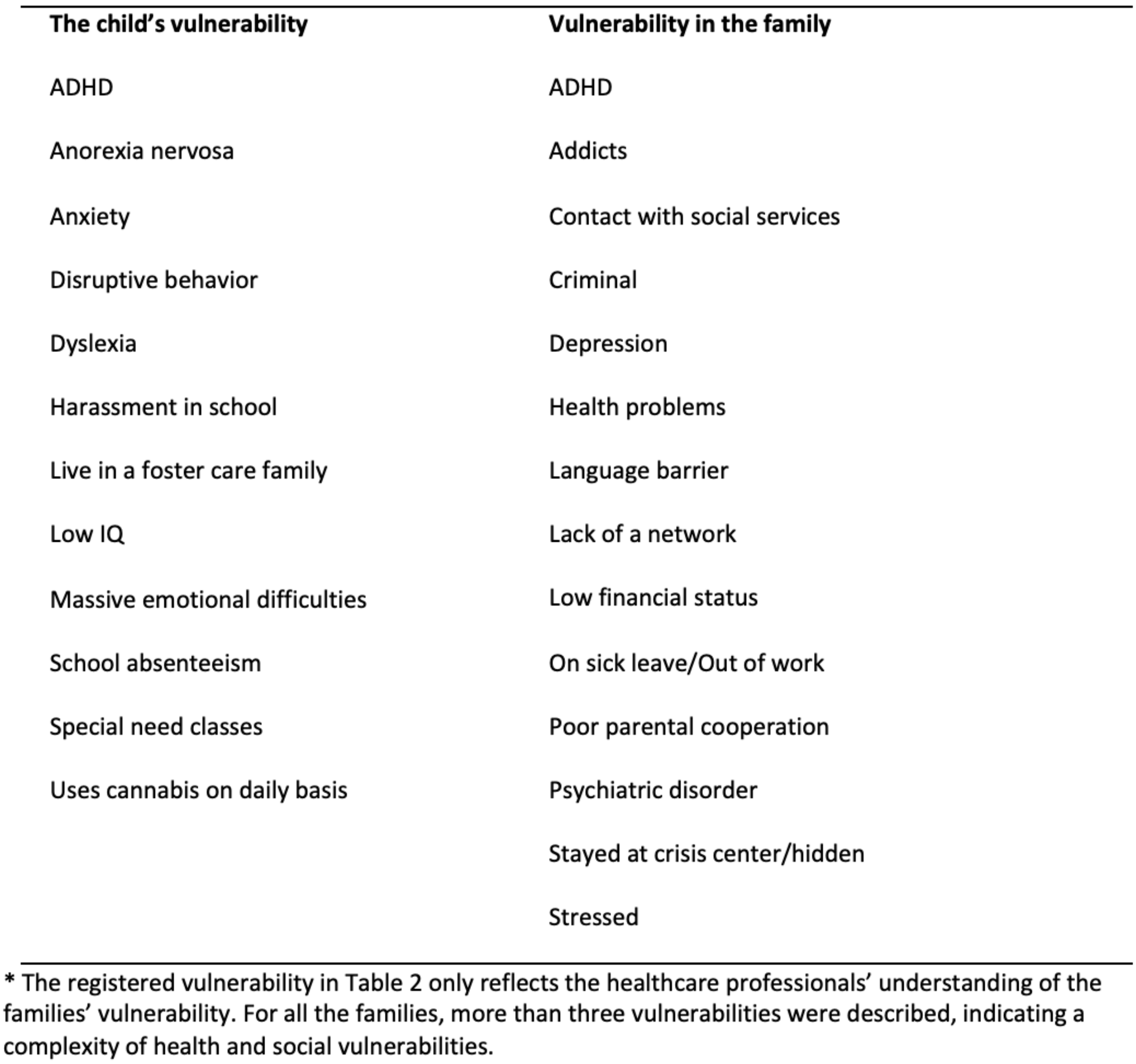
Table 1

Professionals' descriptions of children and professionals participating in case conferences

Children (n=9)	**Healthcare Professionals (n = 17)**
Age	**Profession**
< 9 = 3	MD, specialist in diabetes = 4
9 – 13 = 1	Nurse, specialist in diabetes = 8
14 – 18 = 5	Social care worker = 2
	Psychologist = 2
	Dietitian = 1
Gender	**Gender**
Female = 5	Female = 16
Male = 4	Male = 1
Ethnicity of children	**Organization**
Danish = 6	University hospital of Skovly = 9
Middel East = 3	Hospital of Kerndrup = 8

Table 2

*The Professionals' descriptions of the vulnerabilities of children and their families at case conferences**



The child's vulnerability	**Vulnerability in the family**
ADHD	ADHD
Anorexia nervosa	Addicts
Anxiety	Contact with social services
Disruptive behavior	Criminal
Dyslexia	Depression
Harassment in school	Health problems
Live in a foster care family	Language barrier
Low IQ	Lack of a network
Massive emotional difficulties	Low financial status
School absenteeism	On sick leave/Out of work
Special need classes	Poor parental cooperation
Uses cannabis on daily basis	Psychiatric disorder
	Stayed at crisis center/hidden
	Stressed

* The registered vulnerability in Table 2 only reflects the healthcare professionals' understanding of the families' vulnerability. For all the families, more than three vulnerabilities were described, indicating a complexity of health and social vulnerabilities.

Analysis method

The analysis takes an abductive and dialectical approach where empirical data, professions theories, and system theories are used using the functional method. The purpose is to investigate what healthcare professionals identified as problems and solutions at case conferences and critically reflect on recurring problem understandings and solutions that give rise to a particular understanding of *hard to reach*.

Initially, the analysis was carried out in a process where the first author conducted an inductive and open reading of the case conferences focused on professionals' problem identifications and solutions. The second step of the analysis identified the meaning-bearing units of the problem as they appeared at each of case conferences. The third step of analysis involved organizing the meaning-bearing units into themes across the case conferences. Finally, and based on these themes, the first author made an analytical generalization using the theoretical perspectives of professionals' knowledge-based observations and how organizations shape professionals' views on problems to be solved.

Ethical considerations

The collection of data has included ethical considerations about informed consent and the researcher's position. All informants in this study have been informed verbally and in writing about the purpose of the study and the first author's participation in the activities, and have given written consent for the first author's participation and collection of data in the project. Regular meetings were held between the professionals and the first author, where participation was agreed and discussed.

The study has been reported to the Ethical Research Committee, registered at Aalborg University, Denmark.

Findings

The following analysis presents three understandings of problems and solutions (problem identification/problem solution) that emerge through the shaping of practical syntheses during the case conferences.

Parents as primary collaborators in children's diabetes treatment

Across the case conferences, one understanding of patients as *hard to reach* revolved around a problem identification focused on the collaborative role of parents of young children with diabetes. This problem identification expects parents to take responsibility for daily routines such as blood sugar measurements, carbohydrate counting, and insulin administration by the professionals. Parents are thus the focal point of communication, and collaboration with parents is deemed crucial for healthcare professionals' ability to influence a child's diabetes.

When healthcare professionals identify parents as the primary cause of why families are *hard to reach*, they distinguish between *parents who have resources/lack resources* to manage their child's diabetes. The healthcare professionals indicate that parents' lack of resources hinders the healthcare system's task of treating diabetes. This problem identification draws on the healthcare system's expectation and logic of self-treatment, where parents are perceived as managers and responsible for the child's current and future health (e.g. Mol, 2008). Thus, biomedical knowledge and the ordinary organization of diabetes treatment define that parents must incorporate a medical form of expertise into parenting.

During the case conferences, the professionals elaborate this understanding through practical syntheses that further split this understanding into three different explanations for a lack of resources: (a) a lack of cognitive ability, (b) problems of cooperation among parents, and (c) a lack of willingness and prioritization of resources for diabetes management (difficult to collaborate with).

A first practical medical-oriented synthesis points to the problem of a lack of cognitive abilities as a problem for diabetes care and is evident in the case conferences about a child who has just started primary school. The mother has a chronic disease and a psychiatric disorder. She is on sick leave and has not been at work for an extended period, and due to the child's challenges, the municipality has allocated support to the family. The doctor states, "There are many things that she (the mother) cannot manage [...]. She lacks the energy to handle everything in daily life. She cannot manage both the practical work and taking care of the boy" (CC2, p.3). The nurse elaborates on the problem identification, saying, "Some of it is because she has this disease, but it's difficult to know how cognitively well she is functioning" (CC2, p.3), or "I don't think she does it out of malice, but she cannot handle it" (CC1, p.5).

The professionals assess that the mother lacks resources in terms of following their guidance and making the necessary behavior changes to take care of her son's well-being. With the logic of the healthcare system and in the view of the healthcare professionals, lack of resources is perceived as a lack of health literacy. The mother's lack of cognitive abilities is not compatible with the existing treatment logic's expectations of a high degree of self-care, and, consequently, the family is considered *hard to reach*.

Another practical medical-oriented synthesis regarding parents' resources/lack of resources appears in how the healthcare professionals find it challenging to support children's diabetes treatment due to poor parental collaboration. The nurse describes the problem in this way, "He needs more insulin when he is with mom, but we need to have dad involved in setting it up because he doesn't acknowledge it otherwise" (CC2, p.7), or "We are simply dependent on the parents wanting to collaborate on this, and that we can be in the same room when we discuss further diabetes treatment" (CC1, p.6).

The nurse notes that medical decisions cannot be implemented without collaboration between the parents. They find it problematic that divorced parents don't acknowledge decisions about the child's treatment if they are not consulted individually. The healthcare professionals are challenged by a contextual practical problem (poor parental cooperation) that is difficult to reconcile with the treatment approach. This problem identification involves a form of "knowing that" a lack of cooperation can challenge medical decisions. But they don't seem to "know how" to solve the problem (Gilje, 2017), because a parental conflict is a non-medical issue. The example shows that "knowing that" is necessary but not sufficient without "knowing how" to improve diabetes care. This lack of capacity to find a solution makes the parents *hard to reach*.

A third practical medical-oriented synthesis regarding parents' resources/lack of resources concerns parents of younger children who, despite challenges in daily life, are expected to have resources, but where these are not considered sufficient to manage their children’s diabetes. The case conference about a little girl is an example of this. The girl is considered to be relatively well regulated but has fluctuating blood sugar levels and skin problems due to her pump and sensor, and “diabetes is something that is handled with the left hand” (CC3, p.3). The nurse communicates that support for treatment is challenged because the girl’s mother takes control of the home visits in a way where communication of the everyday challenges of the family becomes dominant. Faced with this challenge, the doctor wonders about the resources that the mother appears to have when it comes to getting support from the municipality:

> It must be because she has some resources, and there is a massive effort being made to help the family [...] She has some resources that she puts into this and gets what she wants out of it. It’s impressive. (CC3, p.7)

The nurse also explains the problem identification, saying, “diabetes is not problematized much compared to how much I think they delve into other problems” (CC3, p.4).

In the quotes above, the mother is observed as a person who might have resources that are not prioritized for managing her child’s diabetes. At case conferences, the professionals communicate about the mother’s burdens, stress, and lack of energy in daily life as the cause of poor control of the child’s diabetes. However, the problem is identified as a lack of prioritization of the child’s disease as the cause of lack of compliance with medical instructions for diabetes treatment. This indicates how the healthcare professionals focus on the hospital’s objectives and programs on treating diseases.

The analysis shows that the healthcare professionals observe a particular problem related to younger children’s disease and treatment that depends on parents’ resources/lack of resources to take responsibility for diabetes. Being *hard to reach* is considered to be an individual problem caused by parental resources, whether it’s a lack of health literacy, difficult cooperation, or a lack of prioritization. The healthcare professionals reflect on these problems mainly by applying biomedical knowledge, medical programs, and observing through diagnoses and treatment. A basic premise of systems theory is that problems are translated in accordance with the particular horizon and self-description of welfare organizations (Mik-Meyer & Villadsen, 2007). This means that healthcare professionals medicalize and individualize parents who are coping with having children with diabetes. In order to explain why families are *hard to reach*, they tacitly include generalized understandings in our society of what it takes to be a good and responsible parent, emphasizing individual responsibility for self-management, cooperation and capacities to comply with the advice of healthcare professionals, and the healthcare system’s development of the patient role (e.g. Hilden, 2002; Petersen & Lupton, 1996).

The professionals' medical-oriented syntheses have implications for the solutions considered appropriate to help the families. For many years, they have tried medical guidance solutions provided by the healthcare system. However, when the problem is observed as a lack of individual resources and responsibility for self-treatment, it becomes difficult for the professionals to see how medical programs can contribute to a solution. They become dependent on knowledge beyond their own system and expertise, cf. social systems theory. Therefore, they try to reach out and mobilize collaboration with other organizations, such as social services, whose task is precisely to support families' resources. Therefore, the problem determines the knowledge to be used to achieve good solutions (Grimen, 2008).

Adolescents with unregulated diabetes and lack of behavior change

The analysis shows that the term *hard to reach* is also related to a category of prolonged unregulated diabetes and a lack of behavior change in adolescence. Common to the young people's health conditions is that they have been hospitalized, and their situation is of great concern among the professionals, who see a potential risk of further hospitalizations and late complications. The young people are in transition to adulthood, where they are expected to handle diabetes regulation to a greater extent on their own, making them the focus of communication in the case conferences.

Initially, the professionals' problem identification regarding the young people revolves around whether they themselves *perceive/do not perceive a problem* with diabetes management. Thus, the young people's awareness of the disease is in focus. The professional's communication reveals a sense of powerlessness, because they do not know how to make the young people recognize the importance of good diabetes management. At the same time their explanations for the lack of behavior vary.

At the case conferences, the professionals compare the adolescent's self-care in diabetes management with their approach to other activities in their lives. This is, for example, the case for a young girl whose life is "filled with everything except diabetes" (CC4, p.1):

> So, all the commitment she demonstrates towards school, she doesn't have that towards diabetes. She has told you several times that it doesn't matter whether she takes a bolus or not. (CC4, p.1)

In the quotes, the nurse distinguishes between the girl's approach to schoolwork versus her self-care in diabetes management. The professionals wonder why there is such a mismatch between the resources and attention she dedicates to school and the responsibility she takes for her disease, indicating that the problem is a talented girl who is not interested in diabetes care. Thus, initially, a biomedical understanding of the young people's physiological needs makes it difficult to accept their behavior. However, it is also recognized that the girl is in a phase of life "filled with everything" other than diabetes, such as doing well in school and having an active life with peers. Thus, the professionals draw on tacit knowledge about young people's everyday life, including how living a "normal" life and taking care of a disease that requires continuous attention and action is a balancing act. The professionals observe a girl with resources, who, nevertheless, is *hard to reach*. The practical synthesis is no longer about the impact of socio-economic factors on health inequality, but integrates common knowledge about what it means for young people to live with chronic disease, a kind of tacit *knowing what* (Gilje, 2017).

The professionals also try to find explanations for the young people's indifference to the disease, theorizing that it is due to lack of resources and poor literacy. For example, a young boy's insulin shock resulting in a physical accident is related to his upbringing and a lack of an adequate role model. The doctor says, "Yes, it's something to do with his personal history. His father also has T1D" *(CC6, p.5).*

The nurse backs this up with a similar comparison between the father and son:

> Another thing is that he (the father) himself has T1D and has previously said that he just has glucose tablets, gummy bears, or candy in his pocket. He can feel when his blood sugar drops, and that's what he has taught him (the son). They don't measure blood sugar. They feel it dropping and then quickly consume carbohydrates. That's the role model he has had his whole life. (CC6, p.7)

In the quotes, the boy's self-care and understanding of managing diabetes are explained by the parents' lack of individual competencies to follow treatment instructions. The listing of the father's use of glucose tablets, gummy bears, and candy, and the idea of being able to control diabetes without measuring blood sugar, shows a practical synthesis depicting a young person suffering from a lack of a parental *role model* capable of introducing *health literacy* in the form of good habits. The healthcare professionals identify a problem of lack of socialization and reproduction of problematic behavior, making the adolescents *hard to reach*.

Over time, there have been various attempts to make the adolescents change their behavior. These have involved frequent home visits, text messages, treatment changes in relation to the pump, counseling programs, changes in the diabetes team, acute hospitalizations, bringing medication, etc. Common for these solutions is that they are based on an individualized medical-oriented synthesis corresponding to the healthcare system's programs and primary knowledge base (cf. Luhmann, 2000). The solutions are targeting young people and focusing on supporting and motivating them to take responsibility for their own disease. In other words, the healthcare professionals try to strengthen young people's health literacy.

During the case conferences, the professionals develop different practical syntheses about the problem of reproduction of problematic behavior, but they find it difficult "knowing how" to link these to solutions appropriate for diabetes treatment. The reproduction of problematic behavior is a problem so complex that a solution requires complex theoretical and practical syntheses (Grimen, 2008), in this case going beyond the healthcare system. They recognize that solutions and "knowing how" must be found with the help of social welfare professionals with knowledge of social problems and the capacity to provide social services that can support diabetes in everyday life. Therefore, in the treatment program, they try to establish cooperation with other welfare organizations, such as the municipality, through networking meetings, meetings with schools, etc., and try to convince them to support diabetes treatment.

Risk of relapse—Diabetes as a piece in a larger puzzle

A third cross-cutting problem is the identification of *hard to reach* families who are challenged by pressing personal, social, and cultural issues beyond the problem of diabetes care. Diabetes treatment is therefore pushed into the background, and the healthcare professionals' focus on a potential risk of relapse to poor regulation in the future.

During the case conferences, the professionals distinguish between families *who are being/not being challenged* by a multitude of problems that hinder diabetes treatment or pose a risk of relapse. The problems are considered to be so massive and pressing that diabetes treatment must await other problems to be solved.

This is evident in one of the case conferences about a young girl. The nurse expresses that she has developed a closeness with the girl and has gained insight into what the nurse calls "psychological terror or violence" of a parent. The nurse seeks guidance on how to handle this knowledge,

> What I would like your advice on is that I get an incredible amount of information, and I just feel like, little girl, this is just not fun. […] I'm thinking, how do I support her in the situation itself—not that it's me who should treat her, but I feel like she tells so many things. (CC8, p.2)

The nurse has developed a close contact with the family, which has given her significant insight into the girl's living conditions. She wants to act based on this lay knowledge but is aware of the limitations due to her role in the healthcare system. This results in a form of powerlessness when it comes to finding solutions. The healthcare professionals recognize the importance of helping the girl, but this is not within the scope of the function and knowledge base of their own organization (Luhmann, 2000). They observe that the solution requires knowledge and interventions from the child protection system, holding the legal authority to act on suspicion of violence.

This need for collaboration with the social welfare system becomes even more evident in the case conference about a girl who has a severe psychiatric disorder that complicates diabetes management. The nurse expresses uncertainty about her role and function in relation to the family:

> Psychiatry comes every other week with a psychologist, a nurse, a social and healthcare assistant, and a social worker, and does more or less the same thing. I think it doesn't make sense if we each sit in our own little backyard and work that way (CC9,pp.3). […] And furthermore, I think it's foolish that I'm trying to use homespun psychology with the tools I have to do it with. Then there are others who are more qualified (CC9, pp.5). […] I actually needed clarification as to what it is I should do? It makes sense to figure out who does what (CC9, p.10). She concludes, I think that diabetes is a very small piece in this whole puzzle. (CC10, p.7)

In the quote above, the problem identification revolves around the nurse's difficulties finding her function and role among all the other professionals from different sectors who offer solutions to the girl's personal and health problems. She suggests that different experts should not perform the same function but should cooperate and create solutions based on their role, expertise, and qualifications to address specific problems (instead of "homespun" solutions). Thus, the nurse observes the girl from a cross-disciplinary perspective, including how the girl's situation arises from a problem of collaboration between systems. From a systemic and organizational perspective, the nurse looks beyond the boundaries of the hospital and identifies an alternative and interdisciplinary solution that draws on knowledge from other systems (Luhmann, 2000).

The professional's observations and recognition of the organizational limitations of the treatment program have implications for the problem solutions identified. The professionals do not communicate about making parents or young people responsible for treatment based on a biomedical perspective. Instead, there is a focus on complex pressing social problems and the role healthcare professionals should play in this context. A nurse points out, "If you could clean up all the other stuff, you could help with diabetes at some point. All the other stuff overshadows much more. Until we get to the diabetes part" (CC10, p.10).

The nurse reflects that it is not possible to progress with diabetes treatment given the turmoil in the girl's life. The nurse observes that the girl's problems are all-consuming for the family's daily life and views the whole family's situation. In this case, it concerns family everyday life, the parents' attachment to the labor market, the girl's social and school life, and their interactions with professionals from the public sector due to the girl's extensive problems. Therefore, the practical synthesis contains lay knowledge about everyday life and mental illness in combination with diabetes, which they transform into a synthesis that results in a prioritization of the sequence of problem solving, starting with pushing diabetes into the background. In this way, diabetes treatment is connected to and aligned with the need for social services and/or interdisciplinary solutions, considering severe troubles in the family's life.

In the observation of families being challenged/not being challenged, the professionals broaden their mono-disciplinary focus on diabetes as a disease and shape their communication around a broader focus on pressing social problems and families' everyday life. Practical syntheses about individuals being *hard to reach* are substituted with professional reflections and lay knowledge about how complex personal and social problems are *hard to reach* for systems, organizations, and professionals. There is a focus on better support to families enrolled in many organizations and on holding other professions accountable as a precondition to prioritizing, targeting, and balancing interventions to specific needs. This does not remove uncertainty with regard to the kind of *know how* needed, but it leads to the healthcare professionals attempting to enable connections to other professions and systems to utilize different systemic capacities and forms of social, biomedical, psychological, etc. knowledge.

Discussion of findings

Our study finds that professionals consider families as *hard to reach* if they do not comply with professional recommendations, and this problem is explained by parental lack of resources, ability, and willingness (problem identification 1 and 2). These problem identifications emerge from medical-oriented syntheses and knowledge stemming from the healthcare professional's role and the function of the healthcare system. However, they also reflect the need for a more heterogeneous knowledge base and consequently, the combination of different forms of knowledge to find solutions, cf. Grimen. The latter appears in problem identifications concerning the reproduction of problematic behavior for diabetes management, ideas about what it is like to be a young person living with a chronic disease, etc. The medical approach distributes responsibility for diabetes care to the individual parent or adolescent. Consequently, it becomes crucial for treatment that patients are capable of both understanding health information and acting on it in a way that leads to good disease management and self-care. Thus, the findings illustrate precisely how ideas of individual health literacy are integrated as a particular *know how* in the healthcare system and how professionals address health inequalities in practice. Other research addressing how differences in treatment arise due to professionals' understandings of patients supports our findings. For example, Shim (2010) argues that professionals' interactions with patients who possess higher "cultural health capital" provide easier access to treatment in the healthcare system (Shim, 2010, pp.3-6). However, theories of professional practice and systems theory enable us to see how professionals can recognize the limitations of their knowledge and capacity to solve complex pressing social and personal problems associated with health inequality. In particular, problem identification three shows that professionals do not only observe the family and individual family members, but also the healthcare system as an organization in an environment of other organizations. In these cases, professionals transcend the idea of individual health literacy as the explanation for inequality in health, and critically reflect on organizational limitations and dependencies with regard to the knowledge of other organizations and professions. They combine different forms of knowledge based on the specific situations of families, thereby using their judgment in accordance with Grimen's idea of practical synthesis (Grimen, 2008) in an attempt to create alternative approaches to problem identification and solutions. Thus, uncertainty and situations where solutions are not evident can lead to professional reflection and a search for knowledge (Nissen, 2015). Seen from a system theoretical perspective, problem identification contributes to reducing complexity for the system by identifying (and thus delimiting) the problem as something that can be managed and addressed through problem-solving (Luhmann, 2000). Thus, critically, one can say that behind the observation of families as *hard to reach* is a healthcare system with organizations and professionals that suffer from problems of reaching out and finding solutions to health inequality. Thus, the role of professionals and the solutions are also *hard to reach*. The analyses therefore indicate that inequality in health is not only a problem of individual patients' lack of health literacy or capital, but also a result of systemic and organizational limitations.

Following the above, strengthening organizational health literacy becomes important. *Organizational health literacy* addresses the health literacy of organizations, recognizing that the healthcare system must have the capacity to adapt its programs to support different patients' abilities to live with their own disease as well as to prevent potential risks. An organization characterized by organizational health literacy, according to the literature, focuses on improving patient engagement and literacy in the healthcare process. It is considered an organizational priority. There is a particular focus on providing health information, training staff in health communication, and addressing health literacy with specific management activities (Khorasani, 2020). The findings in this article can contribute to the very open definition of organizational health literacy when it comes to the target group of patients with complex and interacting social and health problems. Here, the results show that organizational health literacy also must involve a reflective, coordinated, and targeted effort in the organizational interface between health and social systems. This can be done by taking into account the concept of boundary spanning. Boundary spanning is about solving complex problems and managing interdependencies at the interface between organizations and interprofessional knowledge (Van Meerkerk & Edelenbos, 2021). Boundary spanners are professionals who "pro-actively scan the organizational environment, employ activities to collect information and to gain support across organizational or institutional boundaries, disseminate information, and coordinate activities between their 'home' organization or organizational unit and its environment, and connect processes and actors across these boundaries" (Van Meerkerk & Edelenbos, 2021, p.1439). Boundary spanning can strengthen organizational health literacy if organizations and professionals learn from and apply each other's knowledge and responsibilities in a coordinated and holistic way based on patients' situations and needs. Given the cross-border nature of social and health problems, further research on inter-organizational health literacy and boundary spanning is needed. It will be explored in the PhD project "Better life with diabetes—A case study on the opportunities and barriers for health systems and professionals in solving a problem of social inequality in health in practice."

Conclusion

The aim of this article was to investigate how healthcare professionals identify, reflect on, and solve problems with patients considered *hard to reach* and therefore pose a problem of health inequality. The analysis shows that professionals consider families *hard to reach* if they do not comply with professional treatment recommendations. This can be explained by their lack of resources, ability, willingness, and/or complex social and personal problems of the family members. These understandings and explanations rely on practical syntheses integrating scientific medical knowledge about chronic diseases and treatment prescriptions with lay knowledge about specific families, their personal and social problems, and capacities for managing diabetes. Thus, they combine different forms of knowledge according to the specific problem that arises in practice in line with the idea of practical synthesis (Grimen, 2008). The analysis also shows that professionals recognize that people's complex personal and social problems cannot be solved solely by the healthcare system. Solutions to health inequalities create a dependency on other professionals and organizations with other functions and knowledge. Therefore, solutions must not only focus on individual health literacy, but also on organizational health literacy, which expands the perspective to be intra-organizational. The article's findings suggest that the capacity to manage individual health literacy depends just as much on organizational health literacy.

Strengths and limitations

The study offers a unique insight into the complexities of how professionals address health inequalities in practice. Methodologically, a strength of this study is that the results are understood in the context of the extensive empirical material collected through interviews with families, focus groups with healthcare professionals, and observations from cross-sectoral meetings. However, theories of professional practice and systems theory are not focused on the experiences of patients, including how they observe and evaluate the encounter with the healthcare system. This is where phenomenological perspectives on patients' lived lives with diabetes can be combined. This is explored in the article "Everyday life with diabetes in families in vulnerable life situations—The daily balance of the responsibility for selfcare" (Ørsted & Engen, 2025).

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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:

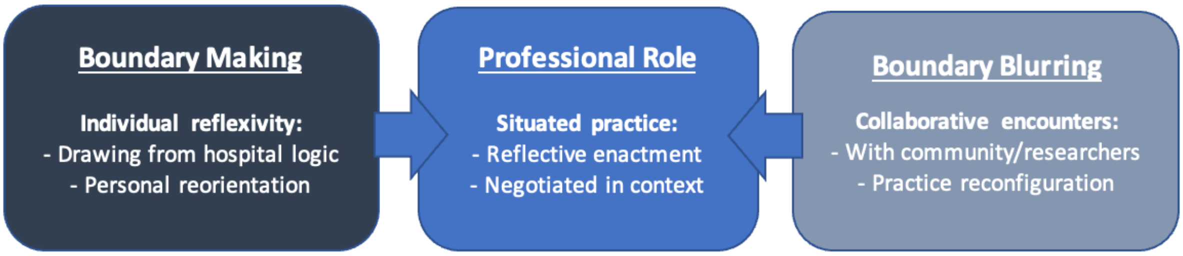
- **Boundary making** refers to how professionals reassert, reinterpret, or selectively adapt their professional roles in new contexts. This may involve translating hospital-based expertise into forms of engagement suitable for a participatory, community setting, or affirming familiar practices, redefining 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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Navigating Challenges in Shared Decision-Making in Danish Patient Care

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Abstract

Patient-centered care and patient choice are reshaping management practices in the Danish public healthcare sector. Patients are becoming more involved in their treatment and assuming greater control over their healthcare decisions. This transformation redefines relationships among patients, professionals, and the state. It raises important inquiries into how healthcare professionals navigate their new roles and responsibilities within this changing landscape. In this paper, we interviewed ten health professionals to delineate how they handle user involvement in daily clinical practice. Utilizing a sociology of profession framework for thematic analysis, our research revealed the disparities between the ideal and the actual implementation of patient-centered care. It highlighted the challenges healthcare professionals encounter in integrating shared decision-making practices and ensuring patients are adequately informed. We conclude that uncertainties regarding responsibility allocation and the boundaries of healthcare professional involvement often overshadow shared responsibility between healthcare professionals and patients.

Keywords

Deliberative democracy, patient choice, patient responsibility, proto-professionalism, shared decision-making

Background

The transformation towards greater patient choice is reshaping the relationship between patients, healthcare professionals, and the state. It has led to a redefinition of roles and responsibilities, as evidenced in studies by Dent (2006) and Dent & Pahor (2015). In the past, health organizations were perceived as interconnected systems consisting of various professions with distinct divisions of labour, reflecting the interests and goals of the professions themselves (Freidson, 1988). Within a hierarchical structure, medicine occupied the top position, while other health professionals had supporting roles and limited involvement in diagnosis and treatment planning (Freidson, 1988). Patients were once viewed as passive recipients of care, while physicians exercised therapeutic privilege to make decisions on their behalf. However, this traditional view of healthcare professionals, which emphasizes their monopolistic control over specialized knowledge and skills, fails to capture the complexities of modern healthcare systems (Kelley, 2005). As patient involvement increases, understanding how healthcare professionals respond to this shift becomes crucial. This study investigates how nurses and physicians engage with patients in shared decision-making.

There has been a notable shift in the perception of patients, transforming them from passive objects into active participants in their own care (Rose, 1996, p. 119). This shift is supported by healthcare policies that promote choice and involvement, particularly through informed consent and shared decision-making, encouraging patients to take an active role in their healthcare processes (Edwards & Elwyn, 2006; Sandman & Munthe, 2009). Informed consent and shared decision-making are not synonymous. Informed consent refers to the process of educating patients about their treatment options, including the associated risks and benefits, enabling them to make voluntary and informed healthcare decisions (Slim & Bazin, 2019). While informed consent is a critical component of the healthcare interaction and serves a moral and legal obligation, it does not inherently indicate an active shared decision-making process. Informed consent can occur independently of shared decision-making, as patients may consent to treatment without fully engaging in a collaborative decision-making dialogue.

On the other hand, shared medical decision-making is defined as “a process by which patients and providers consider outcome probabilities and patient preferences and reach a health care decision based on mutual agreement” (Frosch & Kaplan, 1999, p.285). Shared decision-making involves a deeper level of patient engagement, wherein patients not only receive information but actively participate in the decision-making process regarding their care. Despite policies promoting user involvement, the dynamics of shared decision-making can be empowering yet disempowering. Healthcare professionals significantly influence these interactions, often focusing predominantly on biomedical topics in consultations and thus overlooking broader aspects of the patient's illness management (Franklin et al., 2019; Say et al., 2006). Furthermore, research indicates that patients' ability to engage in shared decision-making may be hindered by insufficient knowledge, and healthcare professionals often lack the necessary resources—such as time—to facilitate meaningful involvement (Rose et al., 2017; Sjöberg & Forsner, 2022). In addition, studies indicate that healthcare professionals predominantly focus on biomedical topics in treatment consultations, often overlooking broader aspects of the patient's management of their illness (Jensen et al., 2016).

Proto-professionalization among patients

Patient participation in clinical decisions is an integral part of the broader framework of patient-centered care, which emphasizes the importance of individual patient needs and values in healthcare delivery. This approach is fostered by legal principles that aim to mitigate physicians' liability by considering the risks and potential adverse events associated with treatment options (Childress & Childress, 2020). Additionally, ethical considerations have driven the pursuit of shared decision-making to create a collaborative environment where patients and health professionals exchange information and jointly make decisions (Childress & Childress, 2020). The goal of respecting and promoting patients' autonomous choices aligns with the principles of *deliberative democracy*, which encourages equitable power distribution and recognizes the patient perspective as vital in healthcare planning (Safaei, 2015). However, as highlighted by Dent (2006), the shift towards responsibilization—where patients are held accountable for their actions—may not yield the intended empowerment. Instead, patients may feel pressured to conform to their physicians' authority rather than actively participate in their treatment decisions. Dent (2006, p. 458) refers to De Swaan (1988) to explain that patients and their families experience a process of "proto-professionalization," influenced by contextual factors in clinical settings. These factors encompass the transmission of values, norms, and attitudes that shape interactions between healthcare professionals and patients, often without explicit acknowledgment. Many patients may not fully recognize these dynamics. For example, some patients intentionally override physician prescriptions and make their own treatment decisions. This phenomenon, termed intentional or intelligent non-adherence, occurs when a patient consciously opts to forgo, skip, or alter recommendations made by a healthcare professional (Lehane & McCarthy, 2007; Náfrádi et al., 2017; Wroe, 2002). In this context, health literacy plays a crucial role, defined as the degree to which patients can process essential health information and services needed for informed decision-making. Health literacy encompasses a range of skills—reading, writing, numeracy, communication, and critical thinking that individuals need to effectively navigate the healthcare system and engage in their care (Chinn, 2011; Schulz & Nakamoto, 2013).

Despite the recognized importance of informed consent and patient involvement as integral concepts of quality care, there remains a significant knowledge gap regarding how these concepts interconnect and influence patient-health professional interactions. Specifically, we lack empirical insights into the strategies healthcare professionals employ to engage patients in shared decision-making and how they consider health literacy in these interactions (Whitney et al., 2004). The extent to which these professionals prioritize patient involvement in decision-making processes remains unclear, underscoring the need for further empirical research to explore these dynamics. Drawing on professions-theory and the concept of deliberative democracy (Dent 2006, Elster 1998, Newman 2001), this study aims to investigate how healthcare professionals—specifically nurses and physicians—respond to varying levels of patient involvement in clinical practice. By examining their approaches to informed consent, risk communication, and shared decision-making, we seek to understand the evolving dynamics of the healthcare professional-patient relationship, particularly in relation to responsibility distribution and the perception of patients' resources and autonomy in decision-making. We ask:

How do healthcare professionals interpret their roles and responsibilities in the context of evolving patient engagement and the dynamics of shared decision-making?

Empirical context—The regulation of Danish health professionals

Like its Scandinavian counterparts, Denmark has implemented a public health service model in which regions own and operate hospitals. The financing of this system relies on general taxation, and access to care is largely free of charge. Historically, physicians and nurses have held influential positions within the healthcare system, enjoying significant autonomy (Kirkpatrick et al., 2011). Physicians have traditionally held a dominant position, while nursing and administrative roles have operated separately (Hindhede & Larsen, 2018). Presently, most health professionals in Scandinavia work as salaried employees in public hospitals. Their employment contracts outline their responsibilities and rights, while the public hospitals have the authority to organize and manage their work. Administrative and political accountability are supported using clinical performance data, patient experience data, and activity data at several levels (Vrangbæk, 2018).

Patient involvement in the Scandinavian health system is achieved through the mechanisms of choice, voice, and co-production (Dent et al., 2011; Vrangbæk, 2015). In Denmark, *choice* includes the ability for patients to select a public hospital when referred. *Voice* involves the establishment of formal rights for citizens within their relationship with the health system. For example, hospitals are obligated to provide patients with information regarding treatment options and associated risks, as well as obtain informed consent before proceeding with treatment. The Danish Healthcare Act §15 (Ministry of Health, 2024) explicitly states that patients should receive continuous, understandable, and customized information regarding their treatment options, including preventive measures and the consequences of not receiving treatment. Patients should also be informed about the potential risks involved in refusing to disclose or collect health information. Healthcare professionals have a responsibility to provide necessary information to patients unless the patient explicitly declines it. These formal rules regarding informed consent are part of a broader model for shared decision-making, which is also observed in Australia, Canada, England, Germany, and the Netherlands (Vrangbæk, 2018). *Co-production* relates to the active involvement of citizens in producing public services together with public organisations, such as bringing together health professionals and patients in the development of clinical guidelines (Dent et al., 2011). In Denmark, this particular aspect of health services is frequently lauded, but according to Vrangbæk, it often falls short of expectations (Vrangbæk, 2018).

Methods

The study is part of a larger research project aimed at gaining insights into how illness can affect people's everyday lives and how it impacts their thoughts and actions regarding their well-being. Questionnaires have been completed among various patient groups receiving treatment at hospitals in the capital region, totalling 500 responses.

In this sub-study, we employed a qualitative research design to explore healthcare professionals' approaches to informed consent, risk communication, shared decision-making, and their perceptions of responsibilities in the context of increasing patient involvement. We contacted the management of the wards that had facilitated access to the questionnaire component of the project (see Table 1), and they provided contact names of healthcare professionals for interviews who had experience with clinical decision-making processes.

Semi-structured interviews were conducted with 10 respondents individually at their respective wards (see Table 1). The interviews were conducted by the first and last author, who had no prior relation to the respondents. They focused on several key areas: the process of obtaining informed consent, strategies for risk communication, and methods of shared decision-making with patients. We also explored the professionals' views on their own responsibilities compared to those of patients, particularly in situations where responsibilities were shifting. To anchor the discussion, we asked respondents to provide a specific example of patient involvement by referencing their most recent patient encounter. The interviews were audio-recorded and transcribed immediately afterwards.

The data analysis process followed an abductive approach (Timmermans & Tavory, 2012). First, the transcribed interviews were imported into NVivo 14 software. The data was then initially coded using predefined subthemes derived from a profession-theoretical framework, which served as a starting point for analysis. However, throughout our coding process and subsequent analysis, we remained attentive to the emergence of new subthemes that extended beyond the confines of the theoretical framework. In doing so, we aimed to acknowledge the significance of potentially unexpected empirical findings and ensure respect for our respondents' statements.

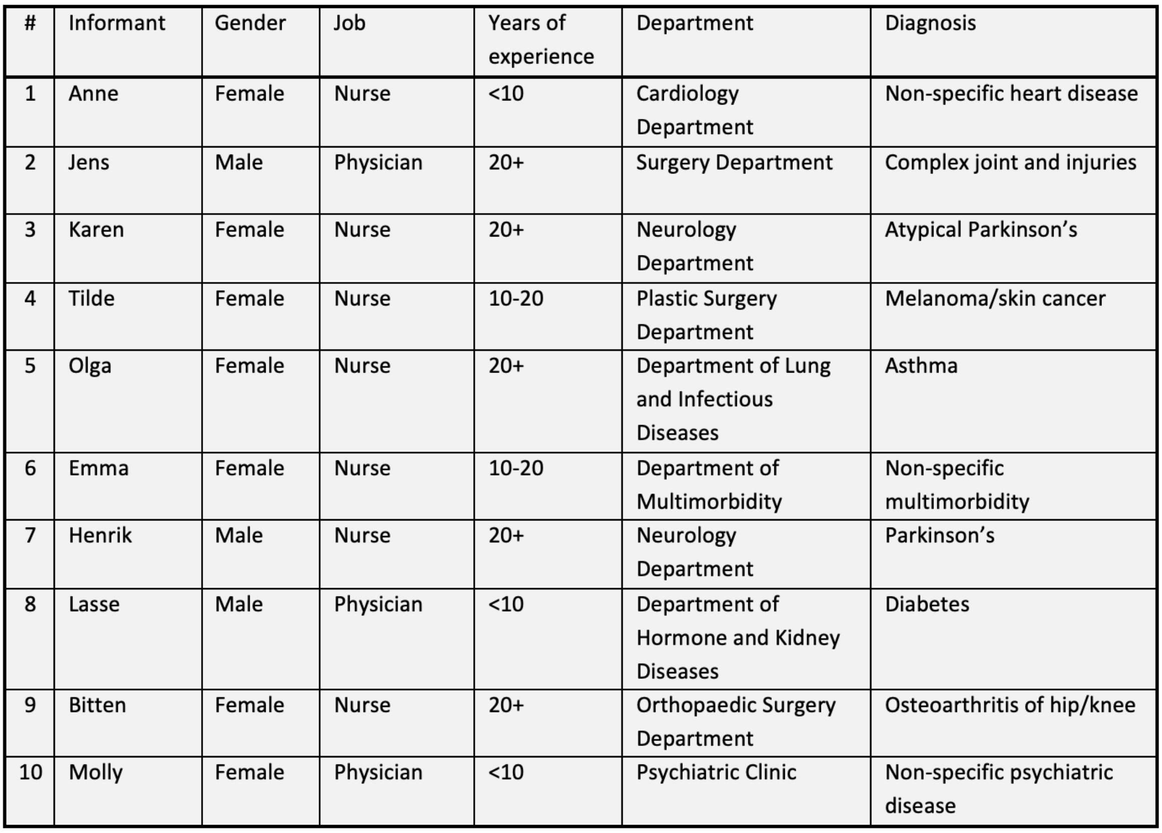
Ethics

Our study was conducted in compliance with the standards of the Helsinki Declaration (World Medical Association, 2013). Informed consent was obtained from all participants prior to their participation in the study. The participants were assured of their confidentiality and the anonymity of their responses, and pseudonyms were used to protect the identity of the respondents in all research outputs. The data collected from the interviews was securely stored and accessible only to the research team.

The project is registered in the Research Project Registry of the Capital Region (no. P-202-764) in accordance with Article 30 of the General Data Protection Regulation and was registered in Clinical Trials.

Table 1

Respondents



#	Informant	Gender	Job	Years of experience	Department	Diagnosis
1	Anne	Female	Nurse	<10	Cardiology Department	Non-specific heart disease
2	Jens	Male	Physician	20+	Surgery Department	Complex joint and injuries
3	Karen	Female	Nurse	20+	Neurology Department	Atypical Parkinson’s
4	Tilde	Female	Nurse	10-20	Plastic Surgery Department	Melanoma/skin cancer
5	Olga	Female	Nurse	20+	Department of Lung and Infectious Diseases	Asthma
6	Emma	Female	Nurse	10-20	Department of Multimorbidity	Non-specific multimorbidity
7	Henrik	Male	Nurse	20+	Neurology Department	Parkinson’s
8	Lasse	Male	Physician	<10	Department of Hormone and Kidney Diseases	Diabetes
9	Bitten	Female	Nurse	20+	Orthopaedic Surgery Department	Osteoarthritis of hip/knee
10	Molly	Female	Physician	<10	Psychiatric Clinic	Non-specific psychiatric disease

Findings

We identified three main themes that capture the key findings of our analysis, illuminating the evolving relationship between healthcare professionals and patients, especially regarding responsibility distribution and decision-making involvement:

1. Informed consent in practice. This theme explores the different practices of informed consent among healthcare professionals across different departments, highlighting the factors that influence these variations and the implications for patient engagement.

2. Objectives of patient information sharing. This theme explores the motivations and reasoning behind sharing information with patients, focusing on how healthcare professionals perceive the role of patient knowledge in healthcare decision-making and the challenges they encounter in communicating "effectively."

3. Ambiguities in responsibility assignment. This theme addresses the ambiguities surrounding the delineation of responsibility in patient care, examining how healthcare professionals and patients negotiate their roles in the decision-making process and the implications for collaborative engagement.

1. Informed consent in practice

Across departments, healthcare professionals had widely different approaches to *patient-centered care*, and there was no systematic approach in the healthcare professionals' enactment of patient choice. While physicians were the ones with jurisdiction over clinical decision-making, this was often done in union with the group of nurses. When healthcare professionals distributed information to patients, it depended on both the healthcare professional's belief in terms of the right type and amount of knowledge, as well as what they assessed the patient wanted in terms of information. However, a common practice among all respondents was a stated intention for the patient to leave the department well-informed and ready to make decisions and act upon them.

1.1 Information conveyed in writing

The method of information delivery varied significantly not only between departments but also internally within the respective department. When asked whether a standardized brochure or information was given to patients, Anne responded: "No, it is a bit difficult to provide such one. It's not like we all do it the same way, so we don't have a guideline that everyone should be informed about this or offered that in a precise manner." Anne expressed that there is no specific way to practice informed consent, but it is instead up to the individual healthcare professional to assess whether a brochure or another oral or written offer is relevant to the patient. This indicates significant differences in how healthcare professionals handle shared decision-making. Anne explained how some of her colleagues preferred to provide large amounts of brochures for the patient to sort through themselves, while others orally conveyed information. The choice of providing a large amount of written information was something respondent Tilde had doubts about:

> We often discuss whether we hand out too many brochures, but patients say that they would rather have everything and then sort through it themselves. We don't hand out any brochures until we have a final diagnosis. When we have patients in the outpatient

> clinic before they receive the diagnosis, we also try to advise them not to go out and Google everything.

Tilde had an idea that knowledge distribution to the patient should be individualised. She sought a collaborative relationship with the patients, considering their needs and offering guidance where necessary. Furthermore, her suggestion to advise patients not to rely solely on internet searches shows an understanding of patients' challenges in interpreting (medical) information. While there are different viewpoints on patients seeking information independently, Tilde acknowledged the difficulty in determining what is right for everyone. This recognition of individual needs and circumstances reflects a deliberative approach that values individual autonomy by tailoring information to suit each patient's specific situation. The dilemma of providing too many brochures versus allowing patients to sort through information themselves aligns with deliberative democracy theory, emphasizing patient autonomy and the right to access information.

1.2 Information conveyed orally

Contradictory approaches to knowledge sharing became particularly evident when the respondents discussed orally delivered information. Jens stated that his practice primarily relied on oral delivery methods. When asked if he expected patients to remember the information provided orally, he responded: "Never believe what a patient says, the doctor said, because [...] they can't, they can't process that much." Jens expressed doubts about patients' ability to grasp the orally provided information. However, he also explained his method of practicing shared decision-making with young, physically active patients making decisions about returning to football post-surgery: "Yeah, I set up scenarios for if they go back (to playing football), there are these risks, and what is the consequence if they do it anyway. [...] As much as possible with a small percentage." Contradictions arise in these quotes; Jens doesn't believe patients can process large amounts of information, yet engages them in decision-making involving complex risk assessments. Understanding options in this context requires significant health literacy, which can be demanding for many patients—something Jens acknowledged, as many preferred him to make the decision. From Dent's perspective on choice, Jens' approach to knowledge sharing may be disempowering. In contrast to the nurses interviewed, he appeared to have elevated expectations regarding patients' ability to comprehend and act on the information, concluding: "Well...mixed. I expect that they understand it." Although unsure whether patients truly understood the information, he nonetheless expected them to do so. This tension between professional expectations and patient understanding contributes to the complexities of responsibility distribution.

Karen reinforces this issue by discussing the difficulty patients face when they disagree with physicians, especially regarding treatment decisions. She states:

> And it is really hard when you have to say no to a doctor, who offers you treatment for a UVI. Even though we have had the conversation here, and our patient has said, when that time comes, I do not want treatment, because I want this to end.

This suggests that patient expression of their own needs can be particularly challenging when interacting with authoritative figures in healthcare. According to Karen, this can lead to disempowerment, forcing a sense of responsibility onto patients about physician recommendations that may not align with their desires.

Interestingly, while some respondents illustrated disempowering knowledge-sharing practices, empowering approaches also emerged. According to the respondents, when healthcare professionals provided detailed information about patients' upcoming choices and adapted their practices to better meet individual patient needs, they effectively empowered patients in the decision-making process. Emma described her patients as positive when receiving specific instructions, even if they didn't intend to follow them: "I also think that those who wish not to follow the instructions are positive about the knowledge sharing or recommendation, and when one explains why." Emma's emphasis on explaining the reasoning behind recommendations demonstrates respect for patient autonomy and supports empowering decision-making regarding health outcomes.

2. Objectives of patient information sharing

The consensus among all respondents was that patients should have the necessary information to make informed decisions and act accordingly. While there was a clear desire for patients to be well-informed, some uncertainty remained regarding how to ensure this is consistently achieved.

2.1 A well-prepared and autonomous patient

One objective of achieving a highly informed patient was ensuring they were prepared to make independent decisions about future treatments. As Karen stated: "So if someone wants to eat everything because it brings the most quality of life, then that's what they should do. But then they need to be equipped to make that choice by knowing the consequences." However, it remained unclear how to define a well-informed patient and whether this could be achieved through straightforward communication, regardless of the patient's wishes, or through communication tailored to their preferences. Most respondents expressed uncertainty about balancing comprehensive information delivery—often meant to safeguard their practices—against being attuned to individual patient understanding. Tilde voiced this struggle:

> No, because they can't, they can't receive that. There is just too much, they are overwhelmed, and they have been told that they have a cancer diagnosis. Yeah. So, I don't think it does any good. Except that I can check it off my list and say I have lived up to my obligation of providing information.

Tilde described the difficulty of finding a balance between being honest and adapting the amount of information provided. While there is a desire to check off the information provided on the list to cover her practice, Tilde believed that the patient's condition and receptiveness take precedence over this need. Anne also acknowledged this dilemma but addressed the necessity for the patient to understand the situation in a different manner:

> If you sense that they haven't fully grasped the seriousness of it, it's important to talk about this being "a really serious, uhm, what's it called, illness you have," and you can say, "now you're getting some medication, and you've had a balloon angioplasty, but there are also some things you need to do to prevent this from happening again."

These diverse approaches to defining and achieving a well-informed patient reflect the underlying power dynamics in patient-professional relationships, where healthcare professionals ultimately determine the flow of information.

2.2 The health literacy-information link

The interviews also underscored the considerable influence of a patient's health literacy on various aspects of healthcare professionals' interactions with them, ranging from communication method selection to the patient's comprehension and adherence to treatment. This impact was especially pronounced in specialized departments such as Neurology, which focuses on Atypical Parkinson's disease, emphasizing how thorough knowledge of one's diagnosis can enhance the treatment journey. When patients displayed signs of lacking understanding about the diagnosis progression and the recommended interventions, inadequate health literacy regarding the diagnosis emerged as a contributing factor:

> I actually think for the most part, it's about the difficulty understanding because neurology is hard to grasp, the brain is difficult to comprehend. And the symptoms are hard to understand. [...] It requires a lot of knowledge. It requires extremely extensive knowledge.

In the quote, Karen emphasized the importance of high health literacy in the patient's understanding of the disease. By understanding the nature of their condition, it could become easier for patients to accept its progression and, thus, act in accordance with the current recommendations. A proactive attitude towards one's own health also proved to be significant. The patients' willingness to invest in their own health was positively acknowledged by several respondents and was linked to the responsibility placed on the patient. When Jens was asked whether patients needed to take the lead in managing their illness, he responded: "Yes, you have to take initiative. Absolutely. And what we really emphasize is that the patient is interested in managing their own situation." Jens explained that a patient's initiative and engagement in their own health are crucial for how the illness progresses. While it is difficult to interpret specifically what this entails, it carries positive connotations. However, the fact that some patients may lack the means to take on this role may contribute to deteriorating communication and treatment outcomes.

2.3 Patient engagement through coproduction

In exploring patient engagement in health choices using Dent's concept of coproduction, the interviews revealed both empowering and disempowering approaches. All respondents demonstrated an awareness of empowering methods to promote specific health behaviours and shared how they attempted to apply this understanding. This was accomplished through mutual knowledge exchange: health professionals shared their expert insights on the patient's situation while aligning with the patient's actual needs and capabilities for implementing the recommendations. However, a challenge emerged as written information often proved ineffective, resulting in health professionals struggling to ensure that their communicated recommendations were both comprehensible and feasible for the patient. Henrik highlighted this issue when discussing interdisciplinary collaboration:

> When a doctor prescribes something as if it were chiselled in stone, acting like a puppet master directing the patient to the pharmacy, that way of working is not acceptable in my opinion. You must have motivational talks with the patient to understand where they are and whether they even think this is important.

Henrik prioritized understanding the patient's unique circumstances and rejected prescribing treatments without certainty about their relevance to the individual. He advocated for motivational discussions to endorse treatment recommendations, emphasizing the importance of tailoring treatment based on the patient's preferences. Henrik's approach can be viewed as empowering the patient's voice, aligning with Dent's concept of patient participation, where listening to the patient's desires takes precedence over assuming educational needs. The interdisciplinary challenges were further corroborated by nurse Emma, who highlighted the complexities arising from differing professional perspectives:

> It is easy to write that a patient should do (health instructions), and then you think, why hasn't this been streamlined? There is just a long way from it being written in a doctor's note, to a patient who does not want to do (health instructions).

Our respondents highlighted interprofessional differences in the approach to prescribing treatments. Physicians tended to focus on issuing prescriptions with the expectation that these would be understood and followed, whereas nurses emphasized motivational dialogue and considered the patient's individual circumstances.

Despite the intent to uphold an empowering collaborative approach evident in all interviews, the reality did not always align as perceived. Some respondents assessed past recommendations and reflected on why they might not have been effective for the patient. This evaluation often hinged on the extent of patient compliance with the prescribed treatment, potentially leading to a disempowering dynamic in patient care. A tendency towards paternalistic attitudes can surface when healthcare providers overly emphasize patient compliance.

3. Ambiguities in responsibility assignment

Patients and healthcare professionals, respectively, engaged in the negotiation of responsibility assignments. It was clear throughout that ambiguities surrounding the holders of responsibilities and the boundaries in-between actors were present and complicated the process of achieving shared decision-making.

3.1 Assuming responsibility: Patients as primary responsibility holders

According to all the respondents, the patient was seen as a major holder of responsibility, both in terms of making decisions regarding treatment and following treatment instructions. However, navigating the recommended body investments and prioritizing them can be challenging for a patient who does not have the necessary resources. Anne stated that it is largely up to the patient to decide what makes sense for them:

> […] medication is not enough, you also must make changes in your lifestyle if you don’t want this to happen again. It’s...you could say it’s a choice they have to make, whether they want to do it, whether they think it’s important enough or whether they think it doesn’t matter.

Anne expressed that the patient is responsible for determining what is important. In this quote, the patient is told that they must follow recommendations if they do not want to be admitted again for the same heart condition or symptom. The patient is assigned the responsibility for preventing future illness, which is extensive and requires significant lifestyle changes. The patient may end up in a situation where the responsibility is imposed, but managing that responsibility can be difficult. However, Anne also expressed her own role in the dilemma and how she was unsure about the boundaries of her involvement in the patient’s adherence to body investment recommendations:

> But sometimes you also wonder how much you should...how much should you? We shouldn’t persuade them, I mean, it’s just about informing them why it’s relevant for them to quit smoking and what it can mean to continue smoking, and based on that, the patient must make a choice about what they prefer.

This can be understood as the healthcare professional feeling uncertain about when their guidance with the patient has been sufficient. The boundaries between the patient’s responsibility for their own treatment and the healthcare professional’s responsibility to convey and support the recommendations may seem unclear. The healthcare field the patient must navigate has implicit values, and patients who know the rules are better able to manage the received knowledge. The enforced responsibility could, in the case of a resourceful patient, be seen as a personal advantage, when having the capability to handle it. This was clear when

Bitten reframed the word responsibility when discussing the patient's rising responsibility as a result of accelerated patient courses: "Yeah, responsibility or also, you know, freedom." A resourceful patient may perceive the increased responsibility associated with accelerated patient courses as a form of freedom, thereby giving the patient a sense of empowerment. However, when a patient lacks the capacity to manage this responsibility, it may result in responsibilization and disempowerment.

3.2 Shaping responsibility: The role of healthcare professionals

Every informant reflected on their own role in the distribution of responsibility, and Jens, Anne, and Karen expressed uncertainty about the allocation of responsibility. The uncertainty often stemmed from their desire for patients to make choices regarding the various body investments, but with the understanding that their professional influence greatly influenced the outcome:

> Yeah, some people say, "oh, you just put the responsibility on me, right?" (imitates patient). And it's like, yeah, I do, because it's your knee, so it's you who must make the decision, right? There are probably many people who want you to make the decision for them, and to some extent you do. It's not that you make the final decision because they have to say yes to it, but you recommend something, and they usually listen, especially if you appear reasonably trustworthy, they usually follow your recommendation.

In this quote, Jens illustrated a dual reality in which, on one hand, it is expected that the patient shows independence and takes responsibility for deciding whether to undergo surgery. On the other hand, Jens explained that he often assumed a guiding role in the direction the decision took and that he almost determined it in his guidance. While the intention to achieve shared decision-making can be observed, the healthcare professional's perspectives appear to significantly impact the final decision. Thus, there is a push for responsibilization, but where the idea of *choice* is transformed into a mere rhetoric. This dynamic can create confusion for patients as they navigate between a healthcare professional with a clear agenda and their own desire to demonstrate initiative and willingness in making health-related decisions. Thus, the quote illustrates uncertainty regarding the allocation of responsibility between the patient and the healthcare professional. Similar uncertainty was also observed between departments. Anne stated: "And sometimes we just have to do the best we can and hope that...that someone picks it up at the other end or that they themselves gather the things they need when they go home, right?" In addition to uncertainty between the patient and the healthcare professional, there can also be uncertainty about which department is responsible. Anne explained that although lifestyle changes were a significant part of the Cardiology department's treatment, they did not provide guidance on it. They hoped that the cardiology outpatient clinic would address lifestyle changes, but she did not have confirmation that they did.

Discussion

We found that the approaches to informed consent (Theme 1) impact the objectives of patient information sharing (Theme 2) and subsequently influence the assignment of responsibility (Theme 3). Based on our findings, we will discuss the nuances of risk communication, variability in patient knowledge, and the broader challenges faced in fostering meaningful patient involvement in decision-making.

Pursuing shared decision-making in clinical practice

It was evident that the practice of presenting treatment options and asking patients to make a choice is commonplace. However, the interviews also revealed that the level of guidance by healthcare professionals is often underestimated. For instance, physicians explained that when the risk of not pursuing treatment is significant, they would specifically emphasize risks, especially if the patient appeared inclined to decline treatment. Such risk communication is—according to Edwards & Elwyn (2009)—part of clinicians' everyday practices and lie at the heart of helping patients make informed choices between treatment options. Dent (2006) argues that the idea of *choice* is transformed into a mere rhetoric and a series of management practices, which certain individuals within the profession perceive as undermining their role as independent, authoritative, and knowledgeable health advisors.

We also found that the kind of knowledge patients brought to these shared decision-making encounters varied from that of the health professionals. De Swaan's concept of "proto-professionalization" suggests that patients and their families undergo a process of being socialized into a certain professional culture within the clinic or consulting room. As a result of this, some patients learn to internalize medical norms previously confined to the professional domain, and they learn to express their concerns using a limited range of terms derived from the professional vocabulary. Professionalism has been "responsibilized" within the new managerial rhetoric, becoming more of a disciplinary framework than a result of autonomous expertise. According to Dent (2006), proto-professionalism may indicate systematically distorted communications between patients and health professionals and should not be mistaken for a broader loss of confidence in the medical profession or health care services in general.

When patients as consumers are faced with responsibilization, they are confronted with the task of acquiring a wide range of knowledge. The healthcare system, built on providing expertise to healthcare providers, has developed entrenched professional power within this expert-based service system (Anderson et al., 2016). Even when patients as consumers are motivated to learn, formal educational structures may be necessary to assist them in their participatory processes. Access to resources, such as additional time with healthcare providers to enhance consumer expertise or the ability to access and understand medical knowledge, becomes crucial. In our data, it was clear that time pressure prohibited this. The lack of readily available information and effective methods for its implementation highlights an additional area of expertise that patients, as consumers, must acquire without a structured support system to guide them. Moreover, as seen in the interviews, limitations in understanding the disease may constrain the types of self-experimentation that patients as healthcare consumers attempt (e.g., when continuing to play football despite increased risk of joint diseases), as their own understanding of behaviours that could impact their health determines the focus of their self-experimentation efforts.

Establishing common ground in patient-professional collaboration

An emphasis on the wishes of patients as *users* is seen as a means to the end of good quality care (Dent 2006). We found that patients' social support in consultations, according to our respondents, also has an impact on shared decision-making, which aligns with the study of Holmes-Rovner and colleagues (2000). Shared decision-making in the present Danish healthcare system faces conceptual, normative, and practical challenges. In its truest sense, shared decision-making occurs only when real choices are available, and the physician involves the patient in the decision-making process. However, it may not always be suitable to employ shared decision-making, particularly when the available options are limited (Edwards & Elwyn, 2006; Whitney et al., 2004). Fragmentation within the healthcare system and the presence of multiple and conflicting discourses from providers can overwhelm patients as they navigate this process. They may lack the ability to compare and manage the extensive amount of information coming from various sources, making it challenging to determine what to test to evaluate its effects on their well-being.

When examining the driving forces behind these changes, it is essential to underscore the agency of professions, as well as the role of external forces: "opening and losing areas for jurisdiction and by existing or new professions seeking new ground" (Abbott, 1988, p.90). Furthermore, the evolution of regulatory frameworks, such as deliberative democracy, has the capacity to reshape divisions of labour independently of the influence of professions. Consequently, these forces have the potential to undermine the positions of professions, ultimately leading to a loss of status and autonomy (Kirkpatrick et al., 2011).

In our study, we discovered that while health professionals offer information resources, knowledge, perspectives, and action strategies, the information shared between patients is often more experimental than the information provided by clinicians. This means that the shared information may or may not be consistent with each other. Another challenge patients face in their efforts towards taking responsibility for their health is that even with access to health information, they frequently find themselves lacking the necessary expertise. Anderson et al. (2016, p.270) refer to this ability as "appropriation," which involves health consumers' capacity to handle vast amounts of information, transform it into expertise, and effectively apply those resources to enhance their well-being. Without the appropriation of knowledge from experts within the healthcare system, patients as consumers are less likely to achieve their desired well-being outcomes. Our findings included cases in which patients were portrayed as giving precedence to personal values and preferences, as argued in existing literature (Lehane & McCarthy, 2007; Náfrádi et al., 2017; Wroe, 2002), emphasizing the value of achieving shared decision-making and thus aligning patient-needed and professional- recommended care.

Communication approaches and interprofessional variations

The literature on treatment decision-making (Franklin et al., 2019; Say et al., 2006) often conceptualises physicians' interaction styles as situated along a continuum from paternalism to the promotion of patient autonomy, with the former frequently regarded as less desirable. However, in our study, the health professionals did not explicitly question the problematic aspects of the patient-physician relationship encouraged by current decision-making practices. Health professionals' narratives revealed that patients with varying perspectives on the physician-patient relationship may approach the common practice of presenting treatment options and asking the patient to decide in different ways. Furthermore, our study revealed differences between nurses and physicians in their approach to patient treatment choices. Nurses tended to prioritize motivational talks and suiting treatment to the patient's individual circumstances, whereas physicians often had high expectations regarding the patient's knowledge and ability to both choose and adhere to the prescribed treatment. While all respondents demonstrated an understanding of empowerment-focused approaches, there was a notable tendency for these ideals to be challenging to implement in practice with barriers as time limitations and unclear role assignment, which have been identified as barriers to improve shared decision-making (Rose et al., 2017). The interprofessional variations were particularly highlighted by the group of nurses, who explicitly acknowledged the differing approaches to achieving shared decision-making, whilst commenting upon the negative impact of working with paternalistic physicians.

As argued by Whitney et al. (2004), the core of informed consent lies in a meaningful dialogue between physician and patient about the proposed treatment, alternative treatment options, nontreatment, as well as the associated risks and benefits. Unlike a mere form-signing activity, informed consent is an ongoing process that unfolds over multiple encounters between the physician and the patient. In our study, we also found that it is possible to build up such a dialogue in the departments where patients see the same health professional several times. However, patients are mostly allocated short times with health professionals, which makes the encounter where shared decision-making takes place a stressful encounter.

Limitations

This study has several limitations. First, it focuses exclusively on the perspectives of healthcare professionals, thereby excluding valuable patient insights that could provide a more comprehensive understanding of treatment recommendations and the perceived value of resources. Second, with the research was conducted in a specific healthcare setting, so the findings may not be generalizable to other contexts. Nevertheless, considerations of generalizability must be understood as an epistemological condition in research grounded in more fluid ontological assumptions, where knowledge is conceived as situated, contingent, and context-dependent rather than universally transferable.

While we opted for semi-structured interviews due to their flexibility and ability to allow participants to elaborate on their experiences, this method hinges on the interviewer's skill in facilitating open dialogue. On the other hand, participant observation would be advantageous for capturing real-time interactions and behaviours, providing a richer understanding of how healthcare professionals practice patient choice and responsibilization. Observing both doings and sayings (Bourdieu, 1990; Garfinkel, 2023) would enrich the analysis, offering insights into the complexities of these encounters. Unfortunately, this study did not have access to such observations, but incorporating them would certainly be a valuable avenue for future research.

Furthermore, this study's reliance on only 10 respondents limits the breadth of perspectives, as it may not fully represent the diversity of experiences within the healthcare profession.

Conclusion

Our analysis sheds light on the challenges present in the implementation of patient-centered care and informed consent among Danish hospital-based healthcare professionals. The concept of responsibilization, which emphasizes shared responsibility between healthcare professionals and patients, is often overshadowed by uncertainties surrounding the allocation of responsibility and the boundaries of healthcare professional involvement. The notion of proto-professionalism further complicates these dynamics, as healthcare professionals navigate their roles in guiding patients while striving to respect their autonomy amidst time constraints, potentially leading patients to acquire forms of knowledge that diverge from the intended treatment goals.

The implications of these findings are significant for both the study of patient-centered care and the sociology of professions. First, they underscore the need for a more nuanced understanding of how responsibility is distributed and perceived within healthcare settings, suggesting that effective patient engagement requires more consistent practices and frameworks that account for varying professional interpretations. Additionally, our findings highlight the discrepancies between the ideals of patient-centered care and the realities faced by healthcare professionals, particularly for patients with fewer resources who may struggle to engage meaningfully in their care.

This research emphasizes the importance of closing the gap between theory and practice by fostering an environment that enables healthcare professionals to implement shared decision-making effectively. Enhancing training and support for professionals may better equip them to communicate with and involve patients, ensuring that the principles of patient-centered care become a lived reality rather than an aspirational goal. Ultimately, our study contributes to ongoing discussions about the evolving roles of healthcare professions, advocating for greater adaptability and responsiveness to patient needs in increasingly complex healthcare landscapes.

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Professionals’ Working Conditions and Turnover Intentions in Norwegian Child Protection Institutions: A Comparison Across Ownership Models

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Abstract

This study compares the working conditions and turnover intentions of professionals in Norwegian residential child protection institutions across public, for-profit, and non-profit ownership, using survey data from 870 professionals. Apart from work-family balance, professionals in for-profit institutions report less favourable conditions across key risk dimensions—notably, weaker collegial support, lower-quality professional leadership, and greater work pressure. Turnover intentions are significantly higher in for-profit institutions, which is largely attributed to a more limited scope for professionalism. These findings are discussed in light of institutional theory. In sectors where organisations compete for users, investment in professional expertise may be a strategy to enhance attractiveness. By contrast, in contexts where users are allocated providers, as in residential child protection, competition for public contracts may incentivise cost-cutting, flexible staffing, and selective bids for target groups that place particular demands on staff—dynamics that potentially heighten work pressures while reducing investment in professional competence.

Keywords

Child protection, scope for professionalism, working conditions, ownership models, Norway, turnover intentions

Introduction

Recent decades have seen structural changes in the mix of state, market and civil society involvement in the delivery of social services in most Western welfare states (Bode, 2008, 2024; Martinelli et al., 2017). Coming out of a tradition from the mid-1950s of strong state provision, this shift is also evident in Norway. From the 1990s onwards, there has been a growing trend towards public competitive tendering to secure contracts with private providers—non-profit as well as for-profit—for the delivery of publicly funded welfare services, as well as developments in other financing and regulatory mechanisms that in different ways increase the role of private services (Bjøru et al., 2019).

Notably, the Norwegian child protection sector has experienced substantial growth in private for-profit providers—a development that has sparked some controversy (Bogen & Grønningsæter, 2014; Wangberg et al., 2019). Norwegian trade unions have, from the outset, raised concerns about working conditions under for-profit ownership models (Shanks et al., 2021). However, some argue that private providers offer more career opportunities, with benefits such as greater flexibility and autonomy (Shanks & Lundström, 2023). At stake here is the scope for professionalism. In this article, drawing on institutional theory, we conceptualise the scope for professionalism as a normative ideal. As such, it comprises certified expertise, peer regulation and commitment to a service ideal (Thornton & Ocasio, 2008). As an empirical condition, it may be manifested in the extent to which professional education, collegial collaboration and autonomous judgement are supported in practice (Eraut, 1994).

In light of critical turnover problems in the sector, working conditions for professionals have become a key area of concern (Johansen, 2014). Yet, whilst extensive research exists on child protection workers’ psychosocial working conditions (Beer et al., 2021; Geirdal et al., 2024; Jacobsen, 2021; Olson et al., 2022), there is a notable lack of research that systematically compares working conditions across models of ownership (NOU 2020:13, p. 29). This gap is unfortunate, as how organisations interact with their employees is regarded as a key process in explaining employee well-being in the child protection field (Baldschun, 2014).

This study aims to advance our understanding of turnover intentions among child protection professionals by assessing the role of ownership-related organisational factors. Public-private distinctions in welfare services are more nuanced than traditionally assumed, as even formally private providers operate within a dense framework of public regulation (Bay & Røiseland, 2025). This implies that working conditions may not hinge on ownership alone, but also on how services are embedded in institutional and regulatory arrangements. In particular, an important distinction lies in how users gain access to services: in many private welfare sectors, such as private schools or health clinics, users or their families actively choose the provider. In others, such as in residential child protection institutions, placement decisions are made by public authorities. This difference in access mechanisms may have implications for how market-oriented principles ultimately influence conditions for professionals working in these organisations. Derived from a survey conducted among a larger population of professionals in Norwegian child protection, we analyse a sub-sample of 870 employees working in residential settings (Norwegian Directorate for Children, Youth and Family Affairs, 2022), examining turnover intentions and working conditions across several dimensions, including work time, pay, training, and leadership, professional environment and collaboration, and staff skill adequacy.

Background

Since the 1990s, Norway has seen a marked increase in the establishment of private residential institutions for child protection (Nordstoga & Støkken, 2018). The use of for-profit providers increased particularly during the Conservative-led government (2016–2018), with staffing levels rising sharply before later stabilising at a slightly lower level. The use of non-profit providers also increased during this period, although at a more moderate pace (Statistics Norway, 2024). Today, child protection is one of the most profitable areas for for-profit welfare organisations in Norway, and of the four largest private providers in residential child protection, three are commercial and controlled from abroad (NOU 2020:13).

Upon taking office, the current Social Democratic government pledged to take measures to phase out for-profit organisations, partly due to concern about the working conditions (Meld. St. 4 (2023–2024)). However, observers have recently detected considerable ambivalence in the government's general position concerning commercial actors in the welfare state (Slettholm, 2024). Moreover, recent changes in the financial framework of child protection—decentralising the choice of providers to the financially strained municipalities—are likely to encourage more purchases from cheaper for-profit actors (Alsos et al., 2019).

There are notable differences between institutional types. Employees at for-profit institutions tend to be younger, with around 45 per cent under age 35, compared to roughly 30 per cent in public institutions. As Bengtsson (2020) notes, younger social workers are generally less ideologically resistant to employment in the for-profit sector, which may partly explain this pattern. The share of staff with relevant professional education has increased in for-profit institutions over recent years. Still, it lags behind public and non-profit providers by close to ten percentage points. The proportion of employees without any tertiary education is one in three in the for-profit institutions, compared to a little more than one in five in the public and non-profit institutions (Statistics Norway, 2024).

Proponents argue that for-profit organisations are less bureaucratised, and can offer more personalised care—for example, in the form of workers staying day and night for more extended periods of time (Omdal, 2023). Furthermore, their ability to scale their activities according to varying needs is appreciated—particularly in a Norwegian context, which is characterised by many small municipalities and fluctuating needs. Recently, the authorities gave priority to the acquisition of "flexible capacity" without purchase guarantees—a segment largely dominated by for-profit providers (Norwegian Ministry of Children and Families, 2022). This flexibility, however, also entails rapid adjustments and quick recruitment by for-profit organisations, thereby implying less-than-optimal conditions for the staff.

Non-profit institutions appear to cater more to the part of the target group that is struggling with substance abuse. Non-profit organisations are known for offering advantages in social service provision, particularly for this target group, as their non-profit roots provide greater trust and legitimacy in the eyes of users (Harsløf, 2003). Although quasi-market regimes may exert pressure on non-profits to adopt business-like practices and compete on similar terms as for-profit providers (Mosley, 2020), the deeper institutional context of non-profit organisations, which will be discussed in the next section, may still create a better interplay between users and staff, as well as between staff and management.

These sectoral differences in staffing and specialisations are particularly consequential in residential settings, where the intensity of care demands can amplify the effects of poor working conditions on turnover and the professional environment (Simmons et al., 2022). High turnover can lead to increased workloads for remaining staff and may deplete the organisation of professional knowledge (Svensson, 2008). As such, working conditions and turnover also have wider implications for the scope for professionalism—a theoretical perspective that we shall now consider.

Institutional theory and scope for professionalism

Experiencing limited scope for professionalism is linked to turnover intentions among social workers (Astvik et al., 2020). To understand how such constraints may emerge, this section examines institutional theories on the relationship between public, private and non-profit ownership models and working conditions for professionals.

The theoretical perspective of new institutionalism relates the functioning of organisations to institutional orders based on their anchoring within specific societal sectors, each associated with distinct logics (Thornton & Ocasio, 2008; Thornton et al., 2012). In this perspective, public institutions tend to be governed by bureaucratic and regulatory logics that emphasise stability, equity and accountability, prioritising adherence to rules and standardised procedures (Sirris, 2020). For-profit institutions, on the other hand, are driven by market logics that emphasise competition, efficiency, profitability and customer satisfaction (which in child protection primarily concerns the commissioners of services). These logics prioritise cost-effectiveness and responsiveness to shifting demands. Although children in public institutions are seen as cost-bearers, they represent a revenue source in market-based settings, which may incentivise efforts to maximise occupancy (Wiborg, 2010, pp. 25-26). A critical perspective on how for-profit institutions affect the scope of professionalism is found in the work of Derber (1983). His analysis emphasises how professionals may lose control over both the processes and objectives of their work as they are compelled to align their practices with institutional priorities, which, in commercialised contexts, may be shaped by the demands of securing and maintaining state contracts:

> Profit-making organizations seek to institute […] client selection practices and client processing and case procedures that are profit-maximizing. Since salaried service professionals, while they may maintain autonomy in exercising technical skills with clients, typically do not formulate organizational policies, they are routinely faced with contradictions between service goals and the commercial interests of their employers. (Derber, 1983, p. 322)

Non-profit residential institutions are expected to be influenced by a community-oriented logic rooted in civil society. This logic emphasises mission-driven goals, social impact and civic engagement. Although staff in such organisations are salaried, their motivation may also stem from a sense of calling or collective identity. In this view, the non-profit institution can function as a "moral community" (Sirris, 2020, p. 68), foregrounding participatory service delivery and responsiveness to user needs.

However, the institutionalist framework also emphasises processes that may alter and align such logics within and across organisations. In this literature, such processes are conceptualised as institutional isomorphism, encompassing pressures stemming from state regulation, competition between organisations and broader societal culture that impose homogeneity in organisational practices (DiMaggio & Powell, 1983).

This phenomenon has significantly shaped the evolution of governance in welfare systems, particularly in challenging the traditional roles of public-sector professions. Scholars have noted that these professions have been increasingly subjected to criticism for being monopolistic and inefficient, and have faced pressures to conform to market-driven norms that prioritise responsiveness and efficiency (Freidson, 2001). These isomorphic pressures align with trends that have been observed in the Nordic countries, where the alleged statist institutional landscape has faced dual critiques: first, a social critique from the left invoking civil society values, followed by a liberalistic critique from the right, invoking market values, both converging on the notion that state dominance hindered innovation and user empowerment (Kaukonen & Stenius, 2008). Åkerstrøm Andersen (1996, p. 63) demonstrates how, in the 1990s, commercial actors seeking to develop the emerging market for public services in Denmark adopted argumentative frameworks that tapped into the values that were associated with social movements. These arguments emphasised freedom and human dignity, aiming to demonstrate how outsourcing public services could counteract disempowering statist monopolies. Hence, whilst different types of service providers may suggest different practices, ultimately reflected in distinct working conditions, institutional convergence may have reduced these differences.

In summary, we have examined a set of institutional and organisational dynamics that may reinforce, counteract or obscure one another, thereby complicating any straightforward interpretation of observed differences in turnover intentions or professional working conditions. Although institutional logics provide valuable insight into how different ownership models may shape the organisational environment, they should be understood as underlying tendencies rather than as fixed determinants (Fleetwood, 2005).

Even so, it is possible to formulate expectations based on the combination of structural conditions, staffing patterns and institutional affiliations. For-profit institutions, where staff are on average younger, less experienced and more likely to lack relevant professional education, and where organisational priorities often emphasise flexibility and cost-efficiency, are expected to offer weaker conditions for professionalism. In contrast, public institutions, which operate under bureaucratic logics that promote standardisation, legal compliance and formal accountability, are more likely to offer stable conditions for professionalism. Although these conditions may be highly formalised, they nonetheless support core features of a professional environment, such as consistent role expectations, institutionalised training routines and predictable oversight. Non-profit institutions are anticipated to fall somewhere in between. Although they are not immune to the pressures of competitive tendering, their mission-oriented values, participatory ethos and closer ties to civil society may foster a more supportive environment for professional judgement and peer collaboration.

In this article, we broadly consider constraints on the scope of professionalism to involve both a quantitative reduction in the proportion of staff with relevant education and experience and a qualitative shift in the dominant logic of professionalism—from occupational forms based on peer regulation and discretion to organisational forms characterised by a relatively poor professional-collegial environment and poor professional management (Evetts, 2009).

Method

This research used data from the 2022 Employee Turnover Survey (Norwegian Directorate for Children, Youth and Family Affairs, 2022). The survey was designed to capture a wide range of determinants related to employee turnover and was distributed electronically to all employees within the national child welfare services, encompassing both front-line services and institutional care settings. Invitations to participate in the survey, along with information about the study's purpose and the anonymity of responses, were distributed via email. Two reminders were sent.

As it is not known how many actually received or noticed the email with the survey link before the deadline, it is not possible to determine the exact response rate. However, it can be calculated that the number of respondents from child welfare institutions represents 25 per cent of all registered full-time equivalents (Norwegian Directorate for Children, Youth and Family Affairs, 2022). This must be considered a relatively low response rate, and it should be noted that full-time and permanent staff are over-represented.

The survey was conducted anonymously, and the background questions were formulated to avoid indirect identification; however, this also entailed that key background variables, such as ethnic background, were excluded. This is an important limitation, as previous research suggests that workplace stressors may be more strongly associated with turnover intentions among minority ethnic professionals (Deery et al., 2011). Despite the anonymity, the fact that data were produced under the auspices of the Norwegian Directorate for Children, Youth and Family Affairs may have influenced how some respondents chose to answer.

This article uses a subset of the survey data, with 870 respondents working at residential child protection institutions, which were: state-owned (547), non-profit (190) or for-profit (133). To determine the professionals' own intention to leave the job, this study used the question: "I'm likely to actively search for a new job during the next year" (as a dummy variable where those who fully agreed with the proposition were coded as "1" and the remaining group as "0"). This single item for measuring an employee's inclination to find new employment has proven to be a valid predictor of actual turnover (Sousa-Poza & Henneberger, 2004). Further questions concerned working conditions that were likely to be associated with turnover intentions. These concerned satisfaction with structural employment conditions, relations with management, professional working environment and psychosocial working environment. Pertaining to all questions concerning such determinants, respondents could answer on a 5-point Likert scale ranging from "not at all" to "to a very great extent." To explore how various determinants of turnover cluster into broader identifiable dimensions, while preserving as much of the original variance as possible, we first ran a principal component analysis with varimax rotation (MacCallum et al., 1999). We then compared the means of each factor (component) across the three types of service providers using Ordinary Least Squares (OLS) regression. Finally, we estimated the professionals' inclination to leave the organisation as a function of the type of organisation they were employed in, again using OLS regression (Hellevik, 2007). To assess the importance of professional leadership—a key factor in a field that is inherently tied to high emotional stress (Wiborg, 2010)—we created an interaction term between the level of strain experienced by the professionals and their evaluation of the quality of leadership at their institution, as a composite factor based on the items listed in Table 2.

Findings

Table 1 provides the descriptive statistics for the background variables used in the analyses. We observed that there were major differences in the composition of the workforce. There were fewer employees with a relevant educational background (child protection/social work) in the for-profit institutions, and there were also fewer employees with continuing educational courses/supplementary training of relevance to the field. Respondents from for-profit institutions were about half as likely to hold a master’s degree as their counterparts in the other types of institutions. Similarly, relevant work experience was markedly lower among for-profit staff. These findings suggest important differences in the levels of professional qualifications across the various institutional types. We observed that the professionals in for-profit institutions were much more inclined than their counterparts in the other types of institutions to state that they were likely to actively search for a new job in the coming year.

Table 1

Descriptives

	Public (n 547)	Non-profit (n 190)	For-profit (n 133)
Age			
Below 30 years of age	19%	23%	27%
30–45 years of age	42%	41%	37%
Above 45 years of age	40%	36%	36%
Gender			
Male	38%	36%	39%
Female	62%	64%	61%
Education			
Upper secondary education	12%	16%	19%
Bachelor’s degree	71%	67%	71%
Master’s degree	13%	15%	7%
Educational background in child protection/social work	82%	78%	74%
Completed continuing educational courses/supplementary training relevant to the field	49%	52 %	40 %
Work experience within the field of child protection			
Below one year of work experience	6%	11%	14%
1–3 years of work experience	17%	21%	24%
1–4 years of work experience	23%	21%	24%
More than 8 years of work experience	54%	46%	38%
Characteristics of current employment			
Permanent employment	91%	91%	89%
Management role	17%	23%	20%
Full-time employment	79%	87%	92%
Part-time employment	21%	13%	8%
Likely to actively search for a new job next year	22 %	17 %	34 %

n = 870

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Table 2 presents the results of the principal component analysis using all questions regarding reasons to consider leaving the job. The analysis identifies seven factors (Kaiser-Meyer-Olkin = 0.912, minimum eigenvalue > 1, accounting for 64% of the variance), emphasising features of the professional and psychosocial working environment. One can regard the identified factors as distinctive risk dimensions, representing empirically grounded tendencies that, when negatively evaluated, may contribute to professionals’ turnover intentions.

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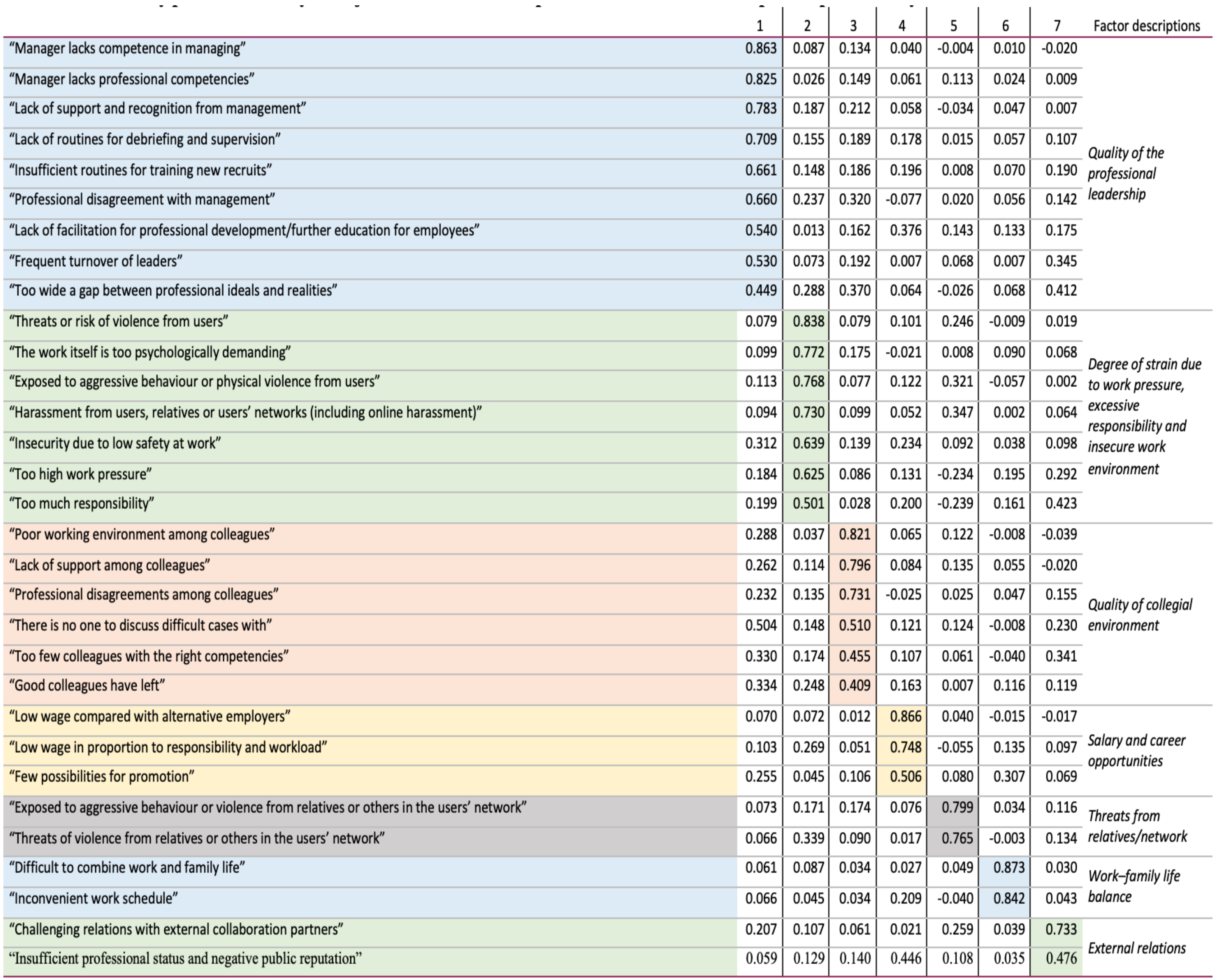
Table 2

Reasons why professionals may leave jobs in residential child protection institutions: Principal component analysis results with varimax rotation



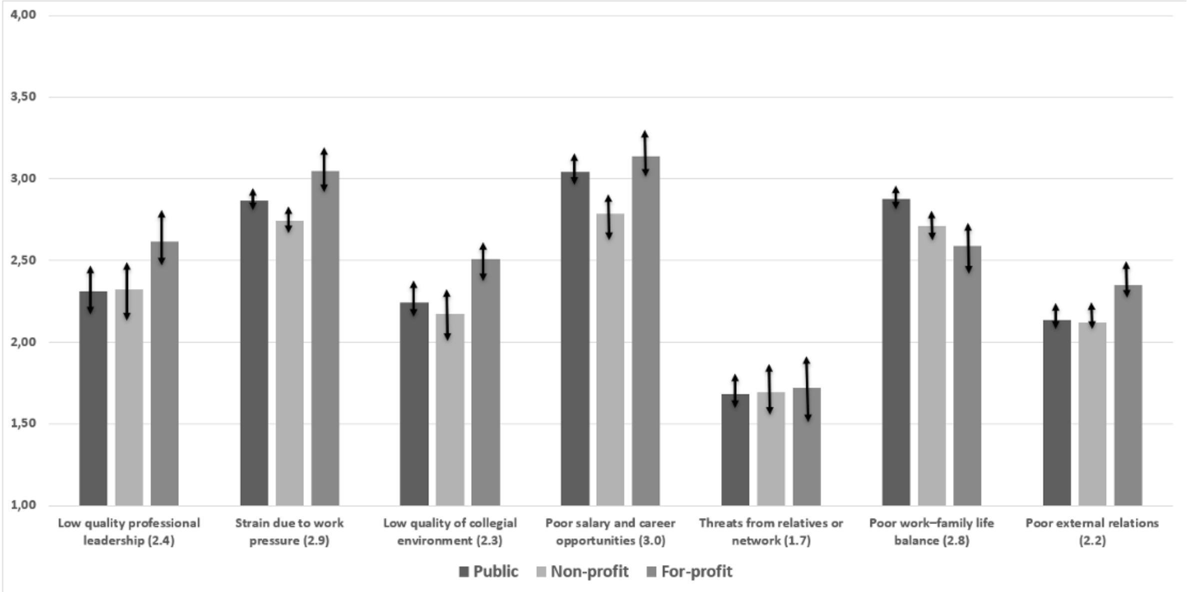
	1	2	3	4	5	6	7	Factor descriptions
“Manager lacks competence in managing”	0.863	0.087	0.134	0.040	-0.004	0.010	-0.020	*Quality of the professional leadership*
“Manager lacks professional competencies”	0.825	0.026	0.149	0.061	0.113	0.024	0.009	
“Lack of support and recognition from management”	0.783	0.187	0.212	0.058	-0.034	0.047	0.007	
“Lack of routines for debriefing and supervision”	0.709	0.155	0.189	0.178	0.015	0.057	0.107	
“Insufficient routines for training new recruits”	0.661	0.148	0.186	0.196	0.008	0.070	0.190	
“Professional disagreement with management”	0.660	0.237	0.320	-0.077	0.020	0.056	0.142	
“Lack of facilitation for professional development/further education for employees”	0.540	0.013	0.162	0.376	0.143	0.133	0.175	
“Frequent turnover of leaders”	0.530	0.073	0.192	0.007	0.068	0.007	0.345	
“Too wide a gap between professional ideals and realities”	0.449	0.288	0.370	0.064	-0.026	0.068	0.412	
“Threats or risk of violence from users”	0.079	0.838	0.079	0.101	0.246	-0.009	0.019	*Degree of strain due to work pressure, excessive responsibility and insecure work environment*
“The work itself is too psychologically demanding”	0.099	0.772	0.175	-0.021	0.008	0.090	0.068	
“Exposed to aggressive behaviour or physical violence from users”	0.113	0.768	0.077	0.122	0.321	-0.057	0.002	
“Harassment from users, relatives or users’ networks (including online harassment)”	0.094	0.730	0.099	0.052	0.347	0.002	0.064	
“Insecurity due to low safety at work”	0.312	0.639	0.139	0.234	0.092	0.038	0.098	
“Too high work pressure”	0.184	0.625	0.086	0.131	-0.234	0.195	0.292	
“Too much responsibility”	0.199	0.501	0.028	0.200	-0.239	0.161	0.423	
“Poor working environment among colleagues”	0.288	0.037	0.821	0.065	0.122	-0.008	-0.039	*Quality of collegial environment*
“Lack of support among colleagues”	0.262	0.114	0.796	0.084	0.135	0.055	-0.020	
“Professional disagreements among colleagues”	0.232	0.135	0.731	-0.025	0.025	0.047	0.155	
“There is no one to discuss difficult cases with”	0.504	0.148	0.510	0.121	0.124	-0.008	0.230	
“Too few colleagues with the right competencies”	0.330	0.174	0.455	0.107	0.061	-0.040	0.341	
“Good colleagues have left”	0.334	0.248	0.409	0.163	0.007	0.116	0.119	
“Low wage compared with alternative employers”	0.070	0.072	0.012	0.866	0.040	-0.015	-0.017	*Salary and career opportunities*
“Low wage in proportion to responsibility and workload”	0.103	0.269	0.051	0.748	-0.055	0.135	0.097	
“Few possibilities for promotion”	0.255	0.045	0.106	0.506	0.080	0.307	0.069	
“Exposed to aggressive behaviour or violence from relatives or others in the users’ network”	0.073	0.171	0.174	0.076	0.799	0.034	0.116	*Threats from relatives/network*
“Threats of violence from relatives or others in the users’ network”	0.066	0.339	0.090	0.017	0.765	-0.003	0.134	
“Difficult to combine work and family life”	0.061	0.087	0.034	0.027	0.049	0.873	0.030	*Work–family life balance*
“Inconvenient work schedule”	0.066	0.045	0.034	0.209	-0.040	0.842	0.043	
“Challenging relations with external collaboration partners”	0.207	0.107	0.061	0.021	0.259	0.039	0.733	*External relations*
“Insufficient professional status and negative public reputation”	0.059	0.129	0.140	0.446	0.108	0.035	0.476	

Professionals’ Working Conditions and Turnover Intentions in Norwegian Child Protection Institutions

We constructed seven indexes from the principal component analysis to capture the different risk dimensions. Figure 1 shows how professionals at the different institutions scored on these risk indexes. We observe that professionals in the for-profit institutions reported significantly worse working conditions than those in public institutions on four of these indexes. They more frequently had issues with low-quality professional leadership within the organisation; they reported more strains due to work pressure; they found the quality of the collegial environment to be poorer, and they more frequently reported challenging relations with external actors and inferior status in the public. There were no significant differences with regard to the factor of salary/career and experiencing threats from users’ relatives or network. On the important issue of work-family life balance, we observe the opposite pattern; professionals in for-profit institutions found it easier to combine work and family life. For all parameters but work-family balance and threats, professionals in non-profit institutions reported working conditions that were significantly better than those enjoyed by their counterparts in for-profit institutions.

Figure 1

Differences in mean scores on seven negative risk indexes by institutional affiliation



	Professional leadership	*Work strain*	*Collegial environment*	*Salary/career*	*Threats*	*Work–family life balance*	*External relations*
For-profit vs. public	***	***	***	NS	NS	***	***
Non-profit vs. public	NS	***	NS	***	NS	**	NS
For-profit vs. non-profit	***	***	***	***	NS	NS	***

Annotation: Index scores range from 1 (low risk) to 4 (high risk). 95% confidence intervals are indicated with arrows. Mean scores for each affiliation are shown in parentheses. *** $p < 0.001$; ** $p < 0.01$; * $p < 0.05$; NS = not significant; n = 870.

Professionals’ Working Conditions and Turnover Intentions in Norwegian Child Protection Institutions

We subsequently analysed turnover intentions as determined by the type of service provider, individual characteristics of the professionals and their scores on the identified risk dimensions. In the latter respect, we omitted the factor of threats from relatives or network, as it was not significantly correlated with the dependent variable, neither in the bivariate nor the multivariate model. Table 3 presents the results. The first model shows that, compared with those employed in public institutions, there was a stronger inclination among professionals working in for-profit institutions to agree to the proposition that they intended to search for a new job. This propensity was lower among newly employed workers (those with less than one year of work experience), permanent employees and employees who indicated that they had some kind of management role.

The second model introduces the index measuring strain due to work pressure. As expected, scoring high on this risk dimension was associated with increased turnover intention. This association, however, diminished when, in Model 3, additional risk dimensions covering other aspects of working conditions were added. This finding suggests that inadequate management practices within a given residential institution and poor professional environment among colleagues were more important determinants of professionals’ turnover intentions than the experience of work strain in itself. We observe that the explanatory power of the for-profit variable diminished when the working condition variables were included in the model. This indicates that the elevated turnover rate was partly attributable to for-profit institutions providing a poorer professional environment in terms of leadership and collegial community. A somewhat peculiar association between what we have termed poor external relations and turnover was observed. This suggests that, when accounting for the other risk dimensions, those who found it challenging to collaborate with external partners, such as the municipal child protection services, were *less* inclined to search for a new job.

Underscoring the importance of management, we find that professionals who both experienced their job as a strain and reported poor professional leadership were particularly inclined to declare intentions to search for a new job (Model 4). Figure 2 illustrates this point. Despite these findings, one discerns that the full model only has a moderate ability to explain the variation (16.5 per cent). This indicates that other unmeasured factors are likely to have played a significant role in professionals’ intentions to search for a new job.

Professionals’ Working Conditions and Turnover Intentions in Norwegian Child Protection Institutions

Table 3

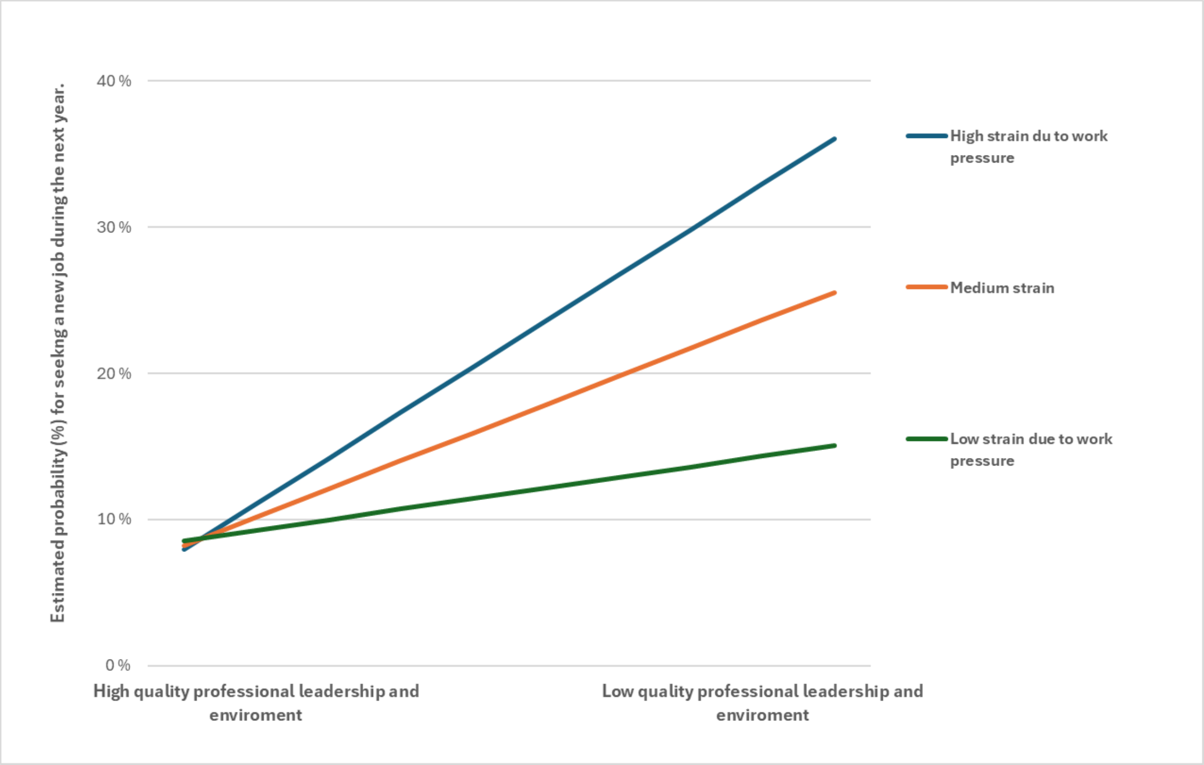
OLS regression analysis of intent to search for a new job

	Model 1			Model 2			Model 3			Model 4		
	B	S.E.		B	S.E.		B	S.E.		B	S.E.	
(Constant)	0.179	0.051		0.16	0.050		0.147	0.048		0.141	0.048	
Operational model (ref: public)												
Non-profit	-0.052	0.036		-0.042	0.035		-0.033	0.034		-0.039	0.034	
For-profit	0.155***	0.041		0.133**	0.041		0.105*	0.041		0.103*	0.040	
Male (ref: female)	0.026	0.030		0.027	0.030		0.049	0.029		0.048	0.029	
Age (ref: 30–45 years)												
< 30 years	-0.025	0.045		-0.037	0.044		-0.024	0.043		-0.025	0.043	
> 45 years	-0.065	0.034		-0.056	0.034		-0.045	0.033		-0.047	0.033	
Education (Ref: Bachelor)												
Upper secondary school	0.017	0.046		0.025	0.046		0.024	0.044		0.018	0.044	
Higher university	0.077	0.046		0.082	0.045		0.057	0.044		0.059	0.043	
Completed continuing educational courses (ref.: no)	0.017	0.031		0.02	0.031		0.014	0.030		0.014	0.03	
Education child protection/social work (ref.: no)	0.084*	0.036		0.094**	0.036		0.086*	0.035		0.081*	0.034	
Work experience (ref: > 8 years)												
Below one year of work experience	-0.166*	0.065		-0.149*	0.064		-0.146*	0.062		-0.145*	0.062	
1–3 years of work experience	0.057	0.048		0.071	0.048		0.069	0.046		0.065	0.046	
1–4 years of work experience	-0.034	0.039		-0.022	0.039		-0.011	0.038		-0.014	0.037	
Part-time (< 90%) (ref: full-time)	0.039	0.043		0.024	0.043		0.017	0.041		0.021	0.041	
Has management role (ref.: no)	-0.152***	0.039		-0.143***	0.039		-0.085*	0.038		-0.086*	0.038	
Temporarily employed (ref: permanently employed)	0.168**	0.055		0.193***	0.054		0.183	0.052		0.178**	0.052	
Strain due to work pressure (z)				0.073***	0.014		0.019*	0.016		0.022	0.016	
Low quality of professional leadership (z)							0.079***	0.02		0.077***	0.020	
Low quality of collegial environment (z)							0.052**	0.02		0.053**	0.020	
Poor salary and career opportunities (z)							0.023	0.016		0.027	0.016	
Poor work–family life balance (z)							0.026	0.015		0.027	0.014	
Poor external relations (z)							-0.044**	0.015		-0.041**	0.015	
Interaction work pressure x low-quality leadership (z)										0.032*	0.013	
Adjusted R2	0.067			0.095			0.159			0.165		

Dependent variable: “I am likely to actively search for a new job during the next year” “Yes” = 1; “No” = 0*** p < 0.001; ** p < 0.01; * p < 0.05; B = unstandardised coefficient; S.E. = standard error; Z = standardised. Sig. F Change: p < 0.001 for each successive model. n = 830.

Figure 2

Interaction between assessed leadership quality and work strain on the likelihood of intending to search for a new job



Discussion

Our findings show systematic variation in self-reported working conditions across ownership types. The analysis indicates a reduced scope for professionalism in for-profit institutions, as reflected in the respondents' reports of significantly poorer collegial environments and poorer professional leadership. They further link professionals' turnover intentions to these specific risk dimensions. Although the analysis does not directly measure organisational strategies, these differences can be interpreted in light of broader patterns discussed in the literature.

Research comparing working conditions for professionals across public and private sectors has linked private settings to better working conditions for certain professionals, including doctors (Heponiemi et al., 2011) and schoolteachers (Brady, 2020). However, it can be argued that the influence of market logics is not uniform but varies with the nature of the service context—that is, whether professionals operate in environments that are characterised by user choice, such as health clinics and schools, or in settings where users are allocated. In the former context, where more resourceful users actively select services, organisations may prioritise the recruitment and retention of professional expertise to enhance their attractiveness to users. Conversely, in the latter context, the market logic may assert itself as private organisations compete for public contracts by positioning themselves to serve users with particularly high needs, offering flexible service arrangements and prioritising cost-minimising strategies.

The apparent specialisation among for-profit institutions in serving users referred on the grounds of behavioural problems is observed in both Norway and Finland (Toikko, 2017; Statistics Norway, 2024). This pattern may reflect a deliberate market-segmentation strategy, targeting a niche with particularly complex needs. Such a high-stakes niche arguably requires especially high levels of professional competence and stable staffing—a requirement that stands in contrast to the lower scores for professional leadership and collegial environments identified in this study.

Social workers most often work in contexts characterised by users having little choice of provider. In this regard, our analysis of such a context aligns with that of Healy and Meagher (2004), which highlights how the privatisation of social services contributes to the employment of less-qualified workers, thereby increasing the potential fragmentation of social work professionalism. In line with this, we find lower levels of staff with relevant education, Master's degrees and tenure in for-profit institutions compared to other institutions with other ownership. However, the study cannot determine whether this reflects management decisions in for-profit institutions or professionals' preference to work elsewhere.

Following the theory of institutional isomorphism, as institutions across ownership models are essentially subject to the same regulation, including norms for staffing, one would expect only minor differences in this regard. The fact that we observe significant differences may be explained by a decoupling between formal standards and day-to-day practices, rooted in the underlying institutional logics that prevail within residential institutions (Suddaby et al., 2010). For example, the state's specific competency standards for staff in leadership roles apply to all, but the propensity for seeking exemptions may be higher among for-profit institutions. International studies have even found for-profit institutions to be more likely to violate legal requirements regarding staffing (Sen et al., 2024).

Moreover, the interaction between the state as commissioner and service providers shapes not only the latter but potentially also the former. In line with system-theoretical perspectives (la Cour, 2012; Åkerstrøm Andersen, 1996), such interaction may induce public authorities to adopt elements of market logic themselves. In contexts where the state relies on external providers to fulfil statutory responsibilities, authorities may have practical incentives to grant exemptions or overlook regulatory breaches in order to ensure service continuity, contain costs or avoid political liability. From this view, decoupling between formal standards and actual practice may emerge not only from providers' strategies but also as a mutually sustained configuration shaped by interdependent interests. Empirical examples of such dynamics can be found in adult social care in the UK, where regulators have been observed to systematically overlook providers' violations so as to sustain service capacity (Goodair et al., 2024). However, such mechanisms may only be at play to a limited extent in Norway, where the licensing of residential care in child protection places great emphasis on professionalism and professional methods, also in comparison with the Nordic countries of Sweden and Finland (Pålsson et al., 2022).

The findings reveal an interesting pattern when comparing non-profit and state-owned institutions. Despite operating within the same competitive tendering market as for-profit institutions, non-profit institutions align closely with state-owned institutions in key dimensions that are indicative of the scope for professionalism, such as the quality of professional leadership and the professional collegial environment. This parity is notable, given that non-profits report significantly higher work strain and poorer salary and career opportunities compared with their public counterparts. These differences suggest that non-profits face unique operational and resource-related challenges, yet their civil-society-oriented logic appears to sustain professional environments that rival those of state-owned institutions.

It is notable that the analysis did not find professionals in for-profit institutions scoring higher on the risk dimension regarding threats from relatives, given that these institutions have a higher proportion of placements based on behavioural issues, as discussed above. Somewhat unexpectedly, professionals in for-profit institutions reported a better work-family life balance. We know that there are notable differences in the regulation and practice of working hours across for-profit, non-profit and public child protection institutions, with the latter much more likely to work extended shifts, or shifts exceeding 24 hours (NOU 2024:17). Self-selection into these institution-specific work-time regimes, based on individual family circumstances that were not accounted for in our analysis, may lie behind this finding.

Another unexpected association was that professionals who reported greater difficulties in collaborating with external partners were, when other factors were accounted for, less likely to express intentions to leave their jobs. It is possible that experiencing the surrounding environment as hostile, or as critical to one's methods or approach, brings about a sense of entrenchment or defensiveness, making professionals feel compelled to remain in their current position.

Conclusion

Using survey data, this study has compared working conditions and intentions to look for a new job across public, for-profit, and non-profit residential child protection institutions. The study offers insights into important contrasts between them. We have highlighted the relevance of distinguishing between contexts where users choose service providers and contexts, as is the case in residential child welfare, where allocation is controlled by the authorities. This distinction helps to interpret how market logics in for-profit settings, where providers compete for state contracts rather than for users, may reduce the scope for professionalism by potentially weakening incentives to invest in staff qualifications, professional collegial structures, etc. This dynamic may occur even in Norway's relatively stringent regulatory environment, where licensing procedures place strong emphasis on professionalism and professional methods. Although we can only point to plausible mechanisms suggested by theory and extant literature, this perspective adds nuance to new institutionalism and contextualises our empirical finding that the level of professional qualifications, broadly understood, is substantially lower in for-profit residential institutions. This finding is in itself notable, as research on work environments suggests that workplaces with a stable and higher proportion of professionally trained staff are more likely to develop a collective, participatory environment. This is because professions tend to develop shared standards and norms, a stronger sense of occupational identity and greater engagement, all of which contribute to a supportive psychosocial work environment (Knudsen et al., 2011). High staff turnover, in contrast, can erode these collective dynamics.

Indeed, the study finds that professionals in for-profit institutions are more likely to express intentions to leave their jobs. This is consistent with research in other social service fields that has found that, where users are allocated by the authorities, working conditions appear to be worse in for-profit settings (Kröger, 2011). Two risk dimensions seem to be particularly important in explaining professionals' turnover intentions. First, the quality of management, in terms of leadership and professional competencies within child protection as well as routines for attending to the strain involved in this form of intensive care work, stands out as important. Second, our findings indicate that the quality of the collegial working environment plays a significant role in shaping turnover intentions. This risk dimension, concerning informal social norms and support among workers, is known from classical workplace sociology to act as a buffer against poor management (Lysgaard, 2001 [1961]). In line with findings from other social service fields, where collegial mechanisms are crucial for managing high workloads (Berlin et al., 2022), our study also highlights the importance of the professional-collegial environment in residential child protection institutions. On one aspect, the for-profit institutions stood out positively—the study suggested that the work-time arrangements provided at these institutions often align with their employees' preferences.

The study underscores the importance of management quality and the professional-collegial environment. With regard to management, we highlight structural factors such as the level of professional competence and relevant experience. In this sense, our analysis differs from Tham's (2007) Swedish study, which emphasises affective and relational aspects of management—such as employees feeling "rewarded," "valued," and "taken care of by management." Although important, we suggest that these factors should be situated within the broader structural-institutional conditions that make meaningful professional support possible. Despite regulations aimed at ensuring uniform professional standards across different types of service providers, as well as sociocultural processes that may work to further the convergence of management strategies, the contrasting institutional logics discussed in this paper still seem to play a significant role. At a time when the group of users placed in child protection institutions is presenting increasingly severe challenges, particularly in terms of mental health (NOU 2023:24), it becomes crucial to address the structural conditions of turnover associated with ownership models, with their implications for continuity of care and the erosion of professionalism.

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"When You Feel Like There is No Trust in the Profession"—Midwives and Obstetricians Facing Complicated Cases

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Abstract

This study examines how two collaborating professions, midwifery and obstetrics, are influenced by women requesting caesarean sections. The empirical material consists of semi-structured interviews with Swedish midwives (n=6) and obstetricians (n=6). Analysed through Tilly's terms, the categorical pair and triad, midwife and obstetrician function as complementary categories in a triad with the women they encounter. Midwifery is a profession with connotations of closeness, understanding, and a unique connection to birth. It is challenged when women reject support or the idea of vaginal birth as empowering. Obstetrics, as a profession, relates to medical expertise, distance, and overview. It is challenged when their knowledge and authority are rejected. Both professions rely on each other's complementary roles for support. The midwife draws on the obstetrician's authority, while the obstetrician draws on the midwife's empathic knowledge of the woman. When strongly challenged, they uphold their defined positions by questioning the woman's judgement and rationality.

Keywords

Professional roles, maternity care, midwives, obstetricians, categorical pairs, caesarean sections

Introduction

Midwives and obstetricians, the two primary professions in maternity care, have been argued to define themselves as each other’s opposites. Midwives have traditionally been women and associated with female-coded values, such as intuition, care, and low-risk, “natural” births. Meanwhile, physicians have traditionally been men and associated with historically male-coded values of distanced professionalism, biomedical expertise, and use of instruments in complicated cases (Hildingsson et al., 2016; Reiger, 2008; Öberg, 1996). As we will show, these perceptions of the two professions are prevailing but not unchallenged. In Sweden, midwives have a comparably strong position, currently and historically. Still, maternity care has a hierarchical structure with the obstetrician as the authority (Hildingsson et al. 2016; Öberg, 1996). This article will shed light on how these two professions, midwifery and obstetrics, define and negotiate their roles in a context that provides unique challenges when they encounter women who request a caesarean section (CS). The request for a CS without a medical indication provides a scene to study the interplay between midwives, obstetricians, and patients when the roles and hierarchies of maternity care are challenged. While the roles of midwives and obstetricians in Swedish maternity care have been described in generic and rather consistent terms in previous research, focusing on a specific situation provides new perspectives.

Historically, midwives were women with an informal expertise in birth who lived and worked close to their patients. Thus, they also functioned as gatekeepers for the first provincial doctors when they entered the scene. By the mid-1800s, the balance had shifted, and physicians had a broadly accepted authority (Johannisson, 1990). This was also the time when the idea of physicians’ using the best evidence in making decisions about the care of individual patients started to develop (Sackett, 1997). The professionalisation of educated midwives has its starting point around 1870. Initially, it re-strengthened midwives’ positions, but by the early 1900s, physicians had control over midwife education as well as over their professional jurisdiction. Swedish midwives organised and strived for longer education with more theory, for less responsibility for nonmedical labour in the hospitals, and for the right to use instruments during complicated births (Öberg, 1996). Swedish physicians worked on keeping their own profession exclusive, keeping the number of active physicians low in comparison to most of Europe (Carlhed Ydhag, 2020; Öberg, 1996). Midwives were expected to handle acute complications in the physician’s absence, especially in the sparsely populated areas of northern Sweden. If complications occurred in the physician’s presence, the midwife stepped back. This may in part explain the strong position and independence of Swedish midwives and the fast hospitalisation of birth during the early 1900s, as it made it possible for physicians to be accessible for many births managed by midwives simultaneously (Öberg, 1996).

Research on midwives’ professional position has taken different normative standpoints. Some emphasize the empowerment in close midwife-patient relationships (Hildingsson et al., 2016; Larsson et al., 2019; Wulcan & Nilsson, 2019), while others argue that midwives perserve their subordination by toning down their professional skills, allowing obstetricians to claim technical expertise as their arena (Reiger, 2008). Swedish midwives do not have a history of readily accepting their niche. Still, physicians monopolised the expertise in complicated births over time, partly by controlling midwife education. Birth complications were initially something all physicians were expected to handle (Öberg, 1996), and obstetrics became a speciality only in the 1950s (Carlhed Ydhag, 2020). Öberg (1996) argues that, by then, physicians had won the battle over the birth clinic and were the widely accepted profession in charge. The two professions have since proceeded by carving out their respective niches in cooperation.

Women’s preferences have also shaped the development of birthing practices and reproductive healthcare. Öberg (1996) has argued that women’s preferences were an important factor driving the hospitalisation of birth around 1900 and an accurate measure of the quality of care. When the number of deaths was higher in hospitals, most women preferred home birth with a known midwife. When antiseptics were discovered and hospital births became safer, they also became more popular.

Viewed as a study of professions, this work examines the interplay between a classic profession built on basic, generally recognised, robust scientific knowledge that unites and standardises practices, and a semi-profession, with less autonomy and more emphasis on communicative methods (cf. Brante, 2013). Although the professions of midwifery and obstetrics have been studied individually and comparatively, negotiations of their roles in concrete, real-life situations remains less studied. A few studies have focused on how women requesting CS perceive their encounters with healthcare and are perceived by professionals. By investigating how professions interplay when encountering them, this study provides an important link between studies of the professions in maternity care on an aggregated level and studies focusing on patients.

Professional perspectives on birthing

In this study, the power dynamics between the professions in maternity care were analysed through interviews with Swedish midwives and obstetricians about working with women who request CS. In Sweden, a woman who wants a CS without a medical indication can apply for it on maternal request, which is called “by psychosocial indication.” The final decision is made by an obstetrician, but a midwife is involved in providing counselling and information for the woman (Svensk förening för Obstetrik och Gynekologi, 2011; Wulcan & Nilsson, 2019).

Research consistently shows that the power balance between midwives and obstetricians has a substantial impact on how birthing and maternity care is understood (Hildingsson et al., 2016; Panda et al., 2018a; Lyckestam Thelin et al., 2019). Obstetrician domination is associated with standardised, evidence-based maternity care where birthing is seen as a medical event, and risk and safety on an aggregated level are in focus (Reiger & Morton, 2012). Midwives are seen as involved in the longer process from pregnancy to motherhood, where giving birth is part of a transition in life, and as advocates for individualised, autonomy-focused care and natural birth (Reiger & Morton, 2012; Öberg, 1996). Discussions on patient autonomy regarding mode of birth are an arena for expressing professional norms and ideals. In Sweden, there has been a heated debate on whether CS on maternal request should be added to the few exceptions from the ground rule that a patient cannot demand surgery, as stated in Swedish healthcare legislation (Health and Medical Services Act, 2017). If that were accepted, the third category, the birthing women, would step into the field where the two professions have divided their responsibilities.

CS is regarded as an exception in Sweden. The general levels have been slowly rising since at least the 1970s, but are still low by international comparison (National Board of Health and Welfare, 2015). The Swedish system, which is tax-funded and mainly a public healthcare system, has been shown to correlate with low levels of CS on maternal request (Loke et al., 2019; Panda et al., 2018b). The presence of a “normal birth culture” in the public and medical discourse has been argued to strongly influence professional decision-making about CSs and dominate in Sweden due to the strong position midwives hold (Hildingsson et al. 2016; Panda et al., 2018a). International research on the influence of maternal preference on CS levels is inconclusive (Begum et al., 2021; Panda et al., 2018b). In Scandinavia, 6–8 percent of women prefer CS to vaginal birth (Løvåsmoen et al., 2018). Women requesting CS challenge the Swedish discourse that vaginal birth in a hospital is the ideal mode of birth (Lindgren, 2006) and are thus considered difficult to work with (Eide et al., 2019; Johansson, 2023). Research on women giving birth shows that some experience vaginal birth as a rite of passage into true womanhood (Lyckestam Thelin et al., 2019) while others describe it as an expected rite of passage that creates unreasonable judgment when rejected (Lindgren, 2006).

This discourse is also present in Swedish research. A preference for CS is predominantly connected to fear of childbirth and presented as a problem in need of explanation and solution. Medical research has focused on fear of childbirth as a psychiatric condition related to anxiety and depression (c.f. Nieminen, 2016; Sydsjö et al., 2015; Zhang et al., 2021). Nursing studies have focused more on low self-efficacy regarding birthing, which has been related not only to mental health but also to a medicalisation that makes women expect a medical professional to take charge. This medicalisation is argued to harm women’s trust in their natural ability to give birth, which is in turn connected to a lack of bodily awareness and connection between body and mind in a broader sense (c.f. Larsson et al., 2019; Sahlin, 2020; Wigert et al., 2020).

Aim

The aim of this study is to understand how two collaborating professions, midwifery and obstetrics, are influenced by the patients they are working with. We study this in a critical context, where women request caesarean sections. It provides an example of how the two professions redefine themselves and relate to each other, as well as to the birthing women, in a challenging situation where general ideals and goals for the professions’ collaboration cannot follow ordinary routines. This study will hence deepen the understanding of the intraprofessional dynamics. With the help of Charles Tilly’s understanding of durable inequality, we discuss the results through his terms, categorical pair and triad. This framework provides a new lens to view the intraprofessional interplay in maternity care, compared to the more traditional organisational theories previously used to understand their positions in Sweden (see Öberg, 1996; Carlhed Ydhag, 2020). It is well-suited to understand how hierarchical relationships between groups—in this case, professional groups—develop over time.

Methods and materials

The analysis emerged from an interview study conducted at two clinics between April 2021 and March 2023. The clinics were selected through a purposive sampling method, based on three factors: the size of the clinic’s catchment area, distance to the closest neighbouring clinic, and geographical placement. Clinic 1 serves a mid-sized region as its sole birth clinic in the mid-parts of Sweden. Clinic 2 is one of five birth clinics in a geographically small but densely populated southern region. The clinics represent the two most common combinations of the factors used. All interviewees but one midwife work in specialist maternity care teams for fear of childbirth, where all requests for CS on maternal request are processed. Most also work at the generic maternity ward concurrently. Request for CS is an exception, also in the teams for fear of childbirth, thus the professionals mostly meet women who prefer vaginal birth or are unsure of mode of birth. At clinic 1, two midwives and two obstetricians were interviewed, all women. At clinic 2, four midwives, all women, and four obstetricians, three women and one man, were interviewed. This mirrors the gender division of obstetricians and gynaecologists in Sweden (National Board of Health and Welfare, 2021), and male midwives are so few that they disappear entirely in the national statistics (National Board of Health and Welfare, 2024).

All participants were informed both verbally and in writing about the project, the confidential treatment of their information, and their rights as participants. The interviews ranged from one to two hours and were transcribed verbatim. Due to the COVID-19 pandemic, clinic 1 interviews were conducted over video link. Clinic 2 interviews were conducted at the clinic, except one, which took place at the university for practical reasons. The interviews were semi-structured and focused on the work with women who prefer CS. They were guided by questions from four themes: decision-making, professional perspectives on the women, cooperation with other professions, and organisation and practical circumstances.

At the outset of the thematic analysis, three key themes stood out in the material as the interviewees focused on them the most: the roles of the obstetrician, the midwife, and birthing women as patients. All text about these themes was extracted for further thematic coding. The theme *birthing women* was by far the largest but also the most homogeneous. A thematic analysis according to Hayes (2000) was used. The first three themes were coded into categories and sub-categories at three levels, also guided by the empirical material.

In Swedish, the literal translation of obstetrician (*obstetriker*) is rarely used; most interviewees used the general term for physician (*läkare*). For this article, the term obstetrician is used when participants clearly refer to obstetricians and physicians when a speciality is not inferred. When using quotes, participants are referred to with clinic (C1 and C2) and profession in order of interview (O1/M1 for the first interviewed obstetrician/midwife at that clinic).

Social categories in maternity care

The sociologist Charles Tilly's understanding of durable inequality and social categories constituted the starting point of the analysis. Tilly (1999) has argued that categories are connected primarily to social contexts and gain stability and durability when enacted in a consequent manner by interchanging individuals. While all categories are contextual, some are more local than others. For example, patients are patients in relation to healthcare, not in relation to their family, working group, or other contexts. In Tilly's conceptualisation, *patient* thus functions as an internal category, specific to the local context of healthcare. External categories are connected to wider societal contexts. The category *pregnant woman* stays relevant when the woman leaves the hospital; thus, it is an external category, possible to use in several contexts, with varying connotations.

Tilly (1999) goes further and shows how categories are connected by larger and smaller units. The smallest unit is the categorical pair. Categorical pairs are linked categories that gain relevance through each other by presupposing each other while also being clearly different and mutually exclusive. Physician-patient is a clear example. The physician has no role to play without a patient. Their interaction is directed by local knowledge about proper enactment of categories, concretised by scripts, that is established through repetition, attrition, and habit, which in turn construct expectations. The next unit for linked categories is a triad. It consists of three categories that are all linked to each other in similar ways. Tilly considers ties between categories as stable if the gain of the tie is larger than the cost to uphold it. For a stable triad, a certain symmetry is required, but all ties must not be equal. For example, if two categories have an equal and rewarding relationship, a triad with a third category is more stable if the first two have similar relationships to the third. A triad of two groups of physicians with different specialities of equal status and a patient who also holds them equal could be an example of a stable triad. In this study, we view midwives and obstetricians as a pair of professionals. They are colleagues, and they form a triad together with patients. However, their collegial relationship contains a difference in authority, which would also require somewhat different ties to patients for the triad to be stable. Hence, if birthing women relate differently to the two professions in a way that is compatible with the division of work the professions have agreed upon, this will ensure the stability of the triad. Using Tilly (1999), midwives' historical cooperation with physicians could be connected to sorting by gender and class as external categories, and ranking, where midwives have accepted a certain amount of subordination to uphold a niche that entails a unique, femininely coded role at the birth clinic. While historically contested by midwives, this hierarchical but complementary relationship has been agreed upon between the professions over many years (see Öberg, 1996). In our analysis, we will focus on how the pair is constituted as a base for understanding how the third category, the birthing women, influences the categories in the pair when they are parts of a triad.

The three categories from the professions’ perspectives

In the following three sections, we show how the three categories are involved in the interplay around birthing in general and the specific situation where birthing women want a CS. The empirical material shows how the interviewed midwives and obstetricians reason, which we argue is based on how they perceive the professional categories they belong to and collaborate with.

The midwives: Time, closeness and depth

When the midwives were discussed in the interviews, three assets in the borderlands between personal qualities and professional abilities were stressed consistently: time, closeness, and depth. When asked about their main task, most midwives talked about providing support and ensuring that the woman has a positive birth experience. The midwife was presented as someone who has important qualities that are hers both as a person and as a midwife. These two dimensions were rarely separated.

The first asset is time for emotion. Conversation was presented as the midwife’s most important tool, and they stressed the importance of taking time to let women talk until they feel finished. In this context, listening was presented as a competence specific to the midwife profession.

> We get involved, a midwife and an obstetrician, with this woman, and she can have regular visits with the obstetrician but also see us because we often make time for longer conversations and talk more in-depth about, what is the fear about, do you have something lingering from previous births. (C1, M1)

Obstetricians also argued that midwives have more time to spend with the women. The time that midwives can give makes it possible for women to put words to their fear, which was framed as crucial for finding a solution, whether it is a birth plan for medical interventions or psychological support. Time is also a prerequisite for the midwife’s second asset: an ability to form a close bond. A male obstetrician put it as follows:

> The midwife manages the greater part of supporting the women. They often have a better emotional connection to these women; due to their professional role, they somehow have a different connection to maternity care and, to being a woman, maybe. It sounds fuzzy but, midwives have a role like a mother or an older sister. Like a woman being there for other women, and for children too. (C2, O1)

Here, the closeness between the woman and the midwife was explicitly gendered, which was unusual. Still, the notion that the midwife can relate more to the pregnant or birthing woman’s situation was predominant in stories from both midwives and obstetricians, regardless of gender. The ability to understand on an intuitive level was sometimes described as a double-edged sword that makes it easier to break through to closed-off women, but more difficult to remain professional:

> To be very emotionally engaged can be a really good way to get these women to rethink things because you become very close on some sort of professional level. But it can also blind you; you get affected and have to say to yourself, “I have to get it together; she is scared, and she is worried, but a CS is not the solution.” (C2, M3)

From the obstetricians’ perspective, an important difference between the professions was that midwives can allow themselves to form opinions about what is best for individual women based on the close, interpersonal connection, without having to articulate strong arguments. The midwives were thus understood as freer in their professionalism:

> As a midwife, you don’t have to decide on CS, and then I think it might be easier to say that we won’t do a CS, or, for that matter, that this will never work; we have to do a CS. (C2, O3)

While expressing that midwives have it easier in this aspect, obstetricians also argued that having the midwife disconnected from the decision can promote continued work with women who are denied a CS. Some midwives also mentioned that not having to say no can serve the alliance with the woman, but they did not frame it as having less responsibility or easier tasks. Rather, they argued that they have a unique perspective: a deep understanding of birth and the meaning of the birthing experience on a universal level, which is the third asset. Midwives stressed the positive aspects of natural, vaginal births with as few interventions as possible as an important part of their profession:

> As midwives, we think more [than obstetricians] about the healthy and healing aspects of giving vaginal birth, no matter what a woman has experienced. /…/ We have a strong belief that it affects a woman to give vaginal birth in a very, very positive way. (C2, M2)

The meaning of vaginal birth is presented both as a midwife speciality and as something important to women, which could be seen as an expression of how the professional mission and self-perception colour the understanding of the patient and her needs.

In sum, the midwife was presented as someone who has time, the ability to form a close bond, and a unique and deep understanding of birthing. These assets were presented as both personal and professional, built on knowledge and intuition. Implicitly or explicitly, they were connected to the midwife, embodied as an experienced woman.

The obstetrician: Knowledge, distance and overview

When the obstetricians were discussed in the interviews, they were framed as consultants who enter the process of pregnancy and birth with specific medical knowledge and an unambiguously professional role. When described in general terms, the obstetricians’ profession was understood based on three assets: knowledge, distance, and having an overview. Their competence regards the assessment of medical risk and safety. The first asset is scientific knowledge. Some argued that a CS is like any other intervention where a physician has knowledge about the human body and possible outcomes: “To become an obstetrician, you must do an internship where you have a basis in a lot of other specialities too, and you get used to thinking in terms of risk and consequence all the time” (C2, O2).

Nevertheless, obstetricians also stressed the importance of a good reception. While midwives presented interaction as a natural part of their profession, the obstetricians often described themselves as different from other physicians for endeavouring to form good relationships. Many of them had considered other specialities where interaction is important, such as psychiatry and paediatrics. Midwives also argued that “their” physicians are different as they are more sensitive to women’s psychological needs and listen to the midwives when they advocate for them:

> We all agree that women should be helped to deliver their child in the way that is best for her well-being, and for a small proportion of women, that will always be a CS. /…/ There are physicians who don’t share that point of view, but our physicians they listen to our assessments. (C1, M2)

Still, obstetricians presented listening and providing support as secondary to their primary role of providing medical expertise. They did not claim to strive for the deep connection and understanding that the midwives do. The second asset stressed is *professional distance.* Trust in the obstetrician was discussed as trust in the profession, not the specific person. The obstetrician’s authority at the clinic can provide the women with a sense of security:

> I think trust is a sense of security, at least with me, to believe what I say. About what is best medically, but even more that what I say will be followed. If we decide to give vaginal birth a try and make a plan, they can trust that the plan will be followed. (C1, O2)

“When You Feel Like There is No Trust in the Profession”

In relation to women who wish for a CS, both professions emphasised the obstetricians’ role as decision-maker, arguing that a professional distance was especially important. Obstetricians often talked about this responsibility as demanding and difficult. They are the ones the woman tries to convince and becomes angry with if she does not get her way.

> Then, [after saying no] I am the mean doctor, and they want to see someone else. We had to deal with that /…/ that some women got a no, and then they wanted a second opinion within our team. (C2, O2)

As in the quote above, many described how women do not give up but try to get a second opinion. Having the decision connected to the obstetricians as a person is considered a problem, as they become “the mean doctor.” At both clinics, the decision is made within the team for fear of childbirth, either by the obstetricians or by representatives of both professions. While one person still makes the official decision, all described this routine as a source of support and security, as well as a strategy to disconnect the decision from the individual obstetrician. Being part of a team makes the decision part of a larger agenda which is managed by both a professional agreement and administrative rules. As a result of general medical knowledge and professional distance, the third asset of the obstetrician is an overview, where the individual patient is seen in the context of public health. It was argued that the obstetricians have more responsibility for looking at the bigger picture:

> In this profession, we know that performing CS randomly, allowing those numbers to skyrocket, isn’t good for anyone. For the individual, it might work out well, but we’ll end up with a lot of complications that might not be so beneficial for the population at large. /…/ I think about public health, and I believe that when working in healthcare, there’s a responsibility to strive for good public health in the long term. (C2, O3)

While obstetricians mainly stressed their competence in understanding public health, the closeness between the midwife and the woman came back as an argument for the same division of responsibility when presented by a midwife:

> To keep the statistics on CS down, it’s a pretty high goal that the obstetricians are really focused on. If you can give vaginal birth, you should be strongly encouraged to do so, and the obstetricians are more driven than the midwife, who is closer to the patient during labour. (C1, M1)

In sum, obstetrics as a profession is strongly connected to medical knowledge, professional distance, and a general responsibility for public health. Trust is presented as crucial for obstetricians. When trusted, they can more easily use their expertise and guide their patients towards a medically safe birth, and displaying the expertise is also a tool to create trust.

The fearful birthing woman presented by midwives and obstetricians

As this is a study of the professions, the birthing women themselves were not interviewed. Still, the women are present in the professionals’ stories as they uncover how they perceive women wanting CS as well as their own view of ideal birthing. Both professions highlighted the norm of vaginal birth by talking about it as being medically best. They considered women’s stern wish for CS as an expression of some form of underlying problem that they did not fully understand:

> We have, I think, an assumption that it’s odd to want to give birth with CS. The woman wants to be cut, to have major abdominal surgery, to extract a child who could have come out another way. That it’s irrational. (C2, O1)

While the medical arguments were the most frequent from both professions, many also argued that a vaginal birth can have a psychologically positive function for the woman’s self-esteem:

> A woman with low self-esteem can generally be incredibly strengthened. If she is afraid of pain, maybe of the unknown, of losing control, and just generally of giving birth. Many women are, but especially those we meet, and they can be incredibly strengthened by finding the courage to give vaginal birth. (C1, M2)

Moreover, many also argued that vaginal birth could be empowering for women who have been abused and/or have more severe psychiatric conditions, but that there are often not enough resources to get to a point where the woman is ready. Relating to the assets of their respective professions, midwives were more prone to argue that there was not enough time, and obstetricians were more prone to argue that they did not have enough knowledge. From their different perspectives, their arguments take the starting point of CS being an abnormal way of giving birth that should be avoided.

When discussing decisions about birth mode, there was a shared ambition for a positive birth experience with as few complications as possible. Obstetricians focused more on the medical aspects and could view the experience as secondary. This position is most strongly expressed here, where the notion of the birth experience as important and transforming, often stressed by the interviewed midwives, is directly challenged:

> These days, there’s this widespread idea that it should be so wonderful to give birth. I don’t understand who came up with that or where it came from or why it has become so domineering because there’re very few who actually think that it’s this amazing experience. /…/ It hurts like hell, and it’s sweaty, and there’s blood and piss and poop and all of that, but that’s secondary to what you get for your efforts. (C1, O2)

More often, both midwives and obstetricians said that a positive birthing experience is more important than vaginal birth. “The goal can’t just be vaginal birth. The goal must be a safe and secure woman and a good birth experience where we find a reasonable way by working together.” (C1, M1).

In conclusion, a positive birth experience is the main goal for both professions. In most aspects, they reasoned in similar ways. The shared professional perspective on women with a wish for CS is that it comes from psychological or psychiatric problems or from traumas like sexual abuse or an earlier complicated birth.

The categorical pair: Midwives and obstetricians as trusted colleagues

The midwife and the obstetrician can be seen as ideal types where contrasts are used to tease out their respective professional position as classical and semi-professions. When midwives and obstetricians work together, their different expertise functions as complements. The obstetricians’ science-based procedural knowledge is combined with the midwife’s knowledge and communicative skills in a well-established role division. Thus, they are a categorical pair, as Tilly (1999) described. The categorical pair is constructed by uniting two unequal categories with well-defined boundaries, where one is subordinated to the other. Tilly (1999, p. 84) has argued that categorical inequality is not necessarily bad. It can facilitate collective production. Still, the inequality also facilitates exploitation and produces differences in individual capacities. In the interviews, the professionals talked about how they relate to each other and work together. Many spoke of how the two professions complement and trust each other. Firstly, the midwives’ closeness to the woman and the insights gained from spending time with her make her an appreciated colleague. Obstetricians spoke of the midwives as colleagues who contribute new perspectives and whom they trust to provide a solid basis for decision-making. Trust was an especially evident aspect at the first clinic, where large distances were a reason to keep the number of appointments down. The obstetrician’s role as decision maker was sometimes presented as close to symbolic:

> If the patient is 250 kilometres away, it’s really unnecessary for her to come here to see me just to decide what she and the midwife have already talked about, for example, an induction. Then it can be like, a short note from the midwife in her medical record, “Is it ok if I set her up for induction?” and then I look at her records and be like, “Sounds good, let’s do that.” (C1, O1)

Midwives expressed that while the obstetricians need access to the midwives’ knowledge of the individual woman, midwives need the obstetricians’ more specialised medical knowledge:

> It goes both ways; the obstetricians can’t make good decisions without us, and we can’t make good decisions without them sometimes if it’s a complicated birth. We

> handle the normal births, but with the complicated births, we need each other. (C2, M1)

Obstetricians presented the midwife as an ally and source of support when making difficult or unpopular decisions. In these situations, having a midwife who has worked closely with the woman on one's side was presented as a source of security. Midwives described a positive relationship in terms of obstetricians who listen to midwives and appreciate their perspective, but who can also take over when the relationship-based work has been unsuccessful, and more authority is needed. One midwife answered the question of when she involves an obstetrician:

> Most often, I have met with the woman, and maybe her partner, a couple of times, and I feel that I can't get anywhere; she insists that she wants to see an obstetrician, and she wants a CS. Then I talk to the obstetrician first. /…/ and then the obstetrician can take over. Most often, we agree. (C2, M4)

The obstetrician's professional distance can also be valued when the closeness between the midwife and the woman becomes too demanding. While the less emotional perspective of the obstetrician can be appreciated, midwives held engagement and care for patients as a standard for both professions. This was not taken for granted with all physicians, but many described the obstetricians in the teams as special, in that they think more about the holistic experience of birth and listen to the midwives:

> There are different factors that enhance the risk of CS. That you can't spend enough time in the room, that you have too many patients, etc. I think the obstetricians who come here, they want to work differently; they come from these large clinics and don't want to work like that anymore. If you involve them early, then we get on the same track and think more alike. (C2, M1)

Though midwives are excluded from explicit decision-making, they can influence the obstetricians by influencing them to take the midwife's perspective to some extent. In contrast, midwives could describe interactions with other physicians who do not listen to midwives or patients.

Cooperation within the teams was presented in predominantly positive terms, as based on mutual trust. Obstetricians trust midwives to provide valid input and take responsibility for decisions based mainly on the midwife's word. Midwives trust obstetricians to listen to and respect their competence. Both professions discussed cooperation with an awareness that the obstetrician can override both midwives and patients. Many of the midwives' positive statements were expressions of trust that this option would not be used excessively. In sum, the two professions talked about their way of functioning as a categorical pair, revealing the obstetricians' superiority without reducing the role of the midwives.

A complex triad: Midwife, obstetrician and birthing woman

When the categorical pair of professions works in relation to the birthing women, they form a triad. This triad can be related to the idea of evidence-based practice, where professional expertise is to be combined with the best available scientific knowledge and the influence of individual patients’ predicaments, rights, and preferences (Sackett, 1997). According to Tilly (1999), a triad is a social configuration that consists of three categories with ties to each other. Tilly (1999, p. 49) has argued that stable pairs tend to recruit third parties jointly, and as both professions are dependent on access to birthing women, they both include them in the triad. Yet, the birthing woman is a person, subordinated to both professions in this situation, as she is depending on the decisions made and actions taken. While the professions are internal categories in the context of the birth clinic, the woman is strongly coloured by external factors; her identity is not primarily formed by the clinic. The interaction between the professions and the women is formed by a desire to make her fit into the category properly, so that the triad can work in line with the script that is valid for the context. Within the script, the professions can improvise to position themselves and uphold their categorical identities.

When positioning themselves in the triad, obstetricians claimed to have a way of thinking in terms of risk and safety due to their medical training, a perspective that the midwives are argued to lack. Thus, they are both professions, but with different perceived competencies, which highlights that they are not one, but two categories. This was expressed by one obstetrician as follows:

> We are coloured by our other activities. When you must always weigh, if I do this, it can have these consequences, if I do that… We never have the option to do nothing. The patients only come to us when they need help, and it’s different for a midwife. (C2, O2)

As shown, midwives claimed to have a more holistic view, where giving birth is part of a longer process, and an existentially important part of a woman’s life. Some claim to be responsible for the experience and context of birthing to the extent that she can deny entrance to the obstetrician in certain situations.

> I think the midwife has a really important role as the protective shield in the room. To say: “No further with that kind of energy; you leave that outside.” /…/ If someone comes in with a stressful energy, and everyone has an adrenaline rush, then it will affect the woman and /…/ the labour wears off. (C2, M1)

Through their statements, they position both themselves and the other profession in the triad. When they reason about the third category in the triad, the woman giving birth, their professional roles can be manifested. However, it could also lead to professional disappointment if the script is not followed. In the ideal situation, the script is that the obstetricians’ medical assessment and the midwives’ expertise in supporting and encouraging are accepted by the birthing women. From that, they can improvise in line with how the situation develops and uphold their professional roles. In the cases discussed here, the women did not always act in line with the script. This caused the professions to criticise the birthing women for not taking on their role in birth-giving properly, as they challenge the professional beliefs. The midwives talked about some women who are less willing to make sacrifices before, during, and after birth as challenging the conceptions of feminism and female strength:

> It’s about beauty ideals/…/ It’s good if you’re maternal and have children, but it shouldn’t be visible on your body. There is a young ideal for women, and I find it provoking, and that it generates wishes for CS. /…/ That you think it’s your right, like a misguided feminism. (C2, M4)

While these women challenge the midwives’ professional beliefs, others challenge the midwives’ profession more directly:

> As a midwife, you come into this profession with a fascination for birth and that there is something empowering and something important in a woman’s life, in the life cycle of a woman. And to meet these women who deprive themselves of that experience, of this growth potential that birthing offers, it’s difficult, emotionally. (C2, M2)

As in previous research on Swedish birth culture, giving vaginal birth is here viewed as a rite of passage that a CS cannot replace. For the midwives, this is at the core of their communicative profession, as they regard their role as facilitating a natural process. For obstetricians, their expertise and medical responsibility are challenged, and they described the persistent women in ways like:

> Those are the worst, who are just ice-cold decisive. When you feel like there is no trust in the profession or that we know what’s best, but the patient knows what’s best. They are the most difficult, who make you feel like just giving up. /…/ No patient would just walk into the surgery ward and say that “I want my gall bladder removed /…/” No surgeon would ever accept that. But when it’s CS, it’s some sort of grey area; patients have a lot of influence, and how we ended up here, I don’t know. (C1, O1)

When the women have psychological or psychiatric problems, the obstetricians present the interaction as demanding, as they cannot use their usual tools and professional role, and are forced to become more personal:

> There’s no established best practice when it comes to this patient group, but we are working with support at the borders of therapy but without the formal education. So, you must give so much of yourself. You have to use yourself as a tool when you don’t have any other tools. (C2, O2)

While the midwife’s professional role is challenged when women do not acknowledge the value of birth, the obstetrician’s professional role is challenged when their medical authority is questioned. Midwives more often described their reaction in terms of feelings while interacting with a specific woman, such as being angry with her or saddened on her behalf. Obstetricians more frequently describe feelings of exhaustion or being emotionally drained afterwards. Regardless, it is about the expected script not being followed, which makes it difficult to maintain professional positions, as they are affected personally.

Conclusion and discussion

The aim of this study was to understand how two collaborating professions, midwifery and obstetrics, are influenced by the patients they are working with. We have contributed by using a theoretical framework that differs from previous research and highlights the dynamics between the professions and birthing women. We have also furthered the understanding of the professional roles of midwives and obstetricians by showing how the ideal types are expressed and negotiated when challenged.

Women requesting CS challenges both professions, but in different ways. Midwifery as a profession involves closeness, understanding, and a unique connection to birth as an expression of female strength, which is also shown in previous studies. The woman giving birth becomes her ally when she can provide care and protection, sometimes against insensitive physicians. When women reject care, do not share fears or emotions, or reject the idea of vaginal birth as empowering, the midwife’s professional identity is challenged. When the same idea is embraced, the birthing woman and the midwife are considered mutually strengthened. Obstetrics as a profession is connected to medical expertise, distance, and the ability to see the bigger picture and take responsibility for public health at an aggregated level, again in line with previous research. It is strengthened when women seek and trust their knowledge and judgement. When the obstetrician’s medical knowledge and authority are not accepted, and when they need to venture into areas where they do not have expertise, their professional identity is challenged. Here, the distanced professionalism may also be shaken, and the work is perceived as emotionally draining. Decision-making in a team can recreate some of the distance.

In the triad, the midwife and the obstetrician function as complementary when the script is followed by everyone involved. While they argue for vaginal birth from different viewpoints and ascribe it different values, as an important life event or the medically sound choice, they are in agreement on how the categories within the triad should act and what the desired outcome is. The triad can then be seen as a hierarchical but stable model for evidence-based practice. The obstetrician has the highest authority. The midwife has a subordinate role but also an unthreatened niche as the professional that truly understands birthing women, and obstetricians are expected to respect and listen to them. This harmony contrasts with the conflict-focused narratives in earlier studies. The woman depends on both professions. If she acts according to the script, she receives attentive care and medical guidance towards what the professions have agreed upon as a medically and psychologically safe birth. When she deviates, midwives and obstetricians sometimes find themselves in disagreement but more often in shared frustration. When challenged, they can recover by leaning on each other and the categorical pair they form. The midwife can lean on the obstetrician’s authority, for example, by sending women to them for an explicit “no” when persuasion is not enough. The obstetrician, in turn, can lean on agreement with the midwife and her empathic knowledge of the woman when they make unpopular decisions. The woman who rejects the midwife’s care and the obstetrician’s expertise with most force, by demanding a CS without accepting a dialogue with either profession, is rejected in return, as her rationality and relationship to her body are questioned. By doing so, the professions can uphold their defined positions as a pair, while the collaboration with the patient risks being lost.

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