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Professional Boundaries in-Action: Using Reflective Spaces for Boundary Work to Incorporate a New Health Care Role

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Abstract

Prior research on professional boundary work emphasises the importance of subtle interactions among affected individuals when a new role is inserted into an established professional setting, which inevitably changes the prevalent division of labour. Thus, managers may set reflective spaces for professionals to collaboratively arrange their boundaries and make room for the new professional. This ethnomethodologically oriented study examines boundary arrangements in work development meetings in a university hospital, while professionals made room for a new role, a hospitalist. Examining professionals' naturally occurring interactions in reflective spaces, the findings depict seven categorisations for the hospitalist. Elaborating on the dynamics of these categorisations, we propose that technically based categorisations sustain stability and context-bound categorisations allow change in work practices, whereas their combination enables transformation within the institutional context. Accordingly, the study adds to the literature on the transformative potential of reflective spaces by illuminating the intertwining of engaged professionals' boundary talk-in-interaction with the consequences of configurational boundary work in relation to a new professional role.

Keywords: boundary work, boundary arrangement, configurational boundary work, health care, new role incorporation, new role insertion, professional boundaries, reflective spaces

Introduction

Presenting a new professional role into a well-established professional setting changes the division of labour between the professions and may be felt as a threat (Currie et al., 2012). Division of labour between professions is a process of social interaction (Strauss, 1978), in which professionals constantly engage in *boundary work* to defend, arrange, create, maintain or disrupt their professional jurisdictions or the relationships between occupations or professions (Langley et al., 2019). Accordingly, previous studies focusing on incorporation of a new professional role have

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addressed the microprocesses through which the division is (re)negotiated, constructed and legitimated (Allen, 2000; Allen, 2001; Reay et al., 2006).

In addition, recent studies have started to consider configurational boundary work, through which managers or other institutional entrepreneurs aim to modify others' boundary landscapes (Langley et al., 2019). These studies tend to focus less on boundary work itself and emphasise the potential of various spaces – what we call reflective spaces – to influence professionals' interactions, mobilisation of action and appreciation of the need for change (Langley et al., 2019). Reflective spaces provide possibilities for professionals' collective experimentation, inclusion and reflection that would be impossible in normal work settings, thereby promoting change and new ways of thinking (Zietsma and Lawrence, 2010; Nylén, 2013; Bucher and Langley, 2016). However, we currently lack fine-grained accounts of the actual interactive boundary work that occurs in such reflective spaces (Langley et al., 2019), and hence have limited understanding of their transformative potential.

To address this gap, we present an analysis of boundary talk-in-interaction in reflective spaces during new professional role insertion, and recorded boundary negotiation. Drawing on ethnomethodology, we capture boundary-organising work actualised in the naturally occurring interactions involved (Cooren and Fairhurst, 2004). We consider professional boundaries as things-in-action that are under ongoing, mutual accomplishment, and boundary work as professionals' practical reasoning, i.e., their shared sensemaking practises (see Whittle and Housley, 2017). In particular, we focus on professionals' categorisation processes because sensemaking occurs when streams of experience are stabilised and enacted in practice through categorising when communicating (Weick et al., 2005). Hence, we investigate how professional boundaries are accomplished in reflective spaces through professionals' practical reasonings about categories.

We focus specifically here on observations of professional boundaries in-action in the work development meetings in a university hospital in which a new role, a hospitalist, was collaboratively

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constructed by the personnel. The work development meetings formed reflective spaces for configurational boundary work to incorporate the new professional role. The meetings were video-recorded and transcribed for analysis, allowing us to examine, *in situ*, the (re)arrangement of professional boundaries through mutual categorisations of the new role. Hospitals provide particularly interesting contexts for examining configurational boundary work because demarcations between professions in hospitals are well established (Abbott, 1988), but hospital organisations increasingly strive to influence professional boundaries to enhance quality of care and services' effectiveness (Powell and Davies, 2012) and to facilitate medical innovation (Mørk et al., 2012).

The ethnomethodologically oriented research provides the following main contributions. First, our situational study of the real-time interactions of professionals in new role insertion allows detailed exploration of microprocesses involved in construction of a new professional role in an established setting (Allen, 2000; Allen, 2001; Reay et al., 2006). The professionals' practical reasoning manifests seven categorisations of the new professional role that capture boundary arrangement as talk-in-interaction (Langley et al., 2019). Second, our study extends understanding of reflective spaces' transformative potential (Zietsma and Lawrence, 2010; Nylén, 2013; Bucher and Langley, 2016) by differentiating between technical and contextual knowledge bases, which reproduce the social order, foster change in it or enable transformation. Moreover, we illustrate how reflective spaces deliberately established by the management to make room for a new professional can reveal conflicting expectations as an important cultural resource for the organisation but complicate the professional role from individuals' perspectives. Overall, the study refines conceptualisation of professional boundary work in new role incorporation through reflective spaces.

The following sections review literature on professional boundary work, particularly in relation to new role incorporation and reflective spaces. The value of the chosen

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ethnomethodologically oriented approach is demonstrated, then the research methods are described, the findings are presented, and finally their implications are discussed.

Professional Boundary Work – From Demarcation to Boundary (Re-)arrangement

Professional boundary work comprises rhetorical strategies to establish boundaries around professions and occupations to distinguish them from one another (Gieryn, 1983; Allen, 2001). Boundaries are seen as markers of difference and boundary work concerns the jurisdiction and technical aspects of professions, which are understood through associated bounded roles and knowledge-bases (Llewellyn, 1998; Lamont and Molnár, 2002). Through professional boundary work different professionals aim to assert authority within a particular field (Abbott, 1988; Welsh et al., 2004) or over the scope and content of their work practices (Arndt and Bigelow, 2005). However, professional boundary work includes not only the demarcation of boundaries but also negotiations that destabilise relationships between different professional or occupational groups (Oliver and Montgomery, 2005; Apesoa-Varano, 2013). Studies that focus on the everyday mundane interaction at workplaces particularly emphasise the negotiable nature of professional boundaries (Allen, 1997).

Boundary work becomes particularly apparent when a new professional or occupational role is inserted into a well-established professional setting (Allen, 2000). For example, during jurisdictional change in occupational roles, nurse managers have been shown to distinguish nursing work from other kinds of work by emphasising and valuing nurses' holistic expertise (Allen, 2000). In contrast, nurses have been shown to use 'atrocity stories' to sharpen demarcation between nursing and medicine during new professional role incorporation (Allen, 2001). Professionals may also use their knowledge of other actors and their institutional context while enacting subtle strategies to implement desired change in established work patterns to legitimise a new professional role (Reay et al., 2006). However, introducing a new professional role into a professional setting is

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typically challenging because it often threatens elite professionals' privileged positions and they have potential to discreetly resist such changes (Currie et al., 2012). Hence, new role insertion inevitably requires boundary re-arrangements, in which expertise, intentional strategies and storytelling about the professions may all be involved.

However, to make room for a new professional, others must appreciate the need for change, act accordingly and modify their practices. For these purposes, previous studies indicate that spaces established by management outside normal work settings may allow the negotiation, integration and collaboration needed to arrange, and re-arrange, professional boundaries (Zietsma and Lawrence, 2010; Bucher and Langley, 2016). Following Langley et al. (2019), we regard such spaces for configurational boundary work as '*small-scale settings within a community or movement that are removed from the direct control of dominant groups, are voluntarily participated in, and generate the cultural challenge that precedes or accompanies political mobilization*' (Polletta, 1999: 1). Such spaces may provide solidarity for involved actors that further facilitate action, and enable professionals or occupational groups, particularly those in dominated positions, to transcend the prevailing common sense that typically keeps them passive (Polletta, 1999). We also note the conceptual relevance of elements of the relational spaces described by Kellogg (2009: 657): areas of isolation, interaction, and inclusion that allow reformers and subordinate employees to develop a '*cross-position collective for change'*.

Drawing on the above conceptual ideas, we define reflective spaces as small-scale bounded social settings where professionals can interact in different ways than in normal work settings to explore new ideas by distancing themselves from everyday work practices. Reflective spaces may dispel the unequal power relations between different professionals — such as nurses and physicians (Currie et al., 2012) — that may affect whether they can influence and change established practices or participate in '*solidified ways of interacting*' (Nylén, 2013: 117). They may allow professionals time to develop new ways of acting, and thus extend and modify boundaries (Nylén, 2013). The

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interplay between interactions in reflective spaces and actual work settings through boundary work by involved professionals plays crucial roles (Bucher and Langley, 2016), by providing means to overcome actors' embeddedness (Zietsma and Lawrence, 2010) in taken-for-granted work practices, and thus change them (Langley et al., 2019).

Hence, previous research on professional boundary work acknowledges boundaries' negotiable nature and the need for purposeful action when a new profession is to be inserted into an established professional setting. Configurational boundary work in reflective spaces has particular potential for intentionally transforming professional boundaries. However, as research has mainly focused on organisational or institutional level processes, we seek here to extend understanding of the microprocesses of professional boundary work by ethnomethodological examination of the interactions between professionals *in situ* during insertion of a new role in a hospital setting.

Boundary (Re-)arrangement as Practical Reasoning about Categorisation

Ethnomethodologically based study builds on assumptions that social interactions are ordered and context-bound (Garfinkel, 1967). With the help of practical reasoning, defined as shared sensemaking practices (see Whittle and Housley, 2017), people orient themselves towards mutual action (Garfinkel, 1967). The practical reasoning is manifested in accounts through which professionals explain actions or things to other people (Garfinkel, 1967). The common-sense knowledge required for practical reasoning about actual practical problems is always local and situational (Whittle et al., 2015; Whittle and Housley, 2017).

Practical reasoning structures the interpretation and understanding of a situation, i.e., how professionals make sense of it (Weick, 1995; Larson and Lundholm, 2013). Here categories are important because sensemaking occurs when the flow of organisational circumstances is enacted in practice through categories (Weick et al., 2005). Categorisation refers to the classification of objects into groups, and it is an important activity for the prevailing social reality's stability (Leiter, 1980).

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Categories are shared and made available for meaningful, mutual action through communication (Cooren et al., 2006; Larson and Lundholm, 2013; Whittle et al., 2015). Thus, categories are flexible linguistic resources for practical use in social actions (Edwards, 1994; Whittle et al., 2015). This does not, however, mean that professionals are always conscious of their practical reasoning (Whittle and Housley, 2017). On the contrary, practical reasoning is typically taken for granted and a key task for any researcher exploring associated phenomena and processes is to detect and explain the taken-for-granted practical reasonings used by members of focal social groups (Whittle and Housley, 2017).

Accordingly, ethnomethodologically oriented research applies a bottom-up approach to study organisational phenomena by examining how members of social groups establish accountable order through their everyday taken-for-granted practices (Whittle and Housley, 2017). For professionals, social action centres on particular tasks associated with their respective professions (Heritage, 1997). Studies on, for example, police and social service work have shown, *inter alia*, that social action is bound to specific identity categorisations (Heritage, 1997; Stokoe, 2009; Stokoe and Edwards, 2009), such as categorisations of nurses or physicians in hospital settings. Changes in prevailing role dynamics can be analysed in terms of agency, culture, structure, institution, habits, power or routines (Rawls, 2008; Whittle and Housley, 2017). However, ethnomethodologically oriented research considers these dynamics in terms of the ongoing accomplishment of professional boundaries and social order by the knowledgeable participants using practical reasoning and categorisation in the social situations (Rawls, 2008; Stokoe, 2009; Whittle and Housley, 2017).

Although social action is seen as endogenously generated, ethnomethodological research does not ignore wider social structures, but redefines them as ongoing social accomplishments (Whittle and Housley, 2017). The ongoing negotiation and re-arrangement of professional boundaries, and hence social order, does not mean that ‘everything goes’ (Whittle and Housley, 2017). Quite the opposite, social order and institutional structures are seen as being formed and continuously

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sustained or changed in, and through, social action (Housley and Fitzgerald, 2002). Thus, an ethnomethodologically oriented boundary work perspective allows consideration of the complex combinations of divisiveness, permeability, rigidity and fluidity of professional boundaries, which warrant more attention (Glimmerveen et al., 2019).

Main premise of our analysis is the notion that professional boundary work involves social action in a local and situational context. Professional boundary (re)arrangements can be facilitated by reflective spaces that enable new role insertion through collaborative inquiry, reflection and inclusion of various professionals. The realisation of professional boundaries depends on the practical reasonings about categorisations used by the professionals. By attending to actual interactions of the professionals in their sensemaking of the situation, we delve into their use of categorisations during the configurational boundary work.

The Empirical Study

Research setting

To explore professional boundary work as a mutual activity in detail, we immersed ourselves in a work development process in a Finnish university hospital, a leading public hospital in its area with more than 4500 employees. Due to stratification and professional hierarchy, hospitals have complex divisions of labour (Abbott, 1988; Bucher et al., 2016), which make them particularly interesting organisations for examining professional boundaries. Historically, different health care professionals, particularly physicians, have enjoyed professional autonomy (Collier, 2012) and typically take the boundaries between professions seriously (Bucher et al., 2016). Hence, they are generally aware of their professional boundaries and the differences among professional groups (Powell and Davies, 2012). However, governments and healthcare organisations increasingly strive to regulate health care professionals and their boundaries to enhance patient care quality and health services' effectiveness (Martin et al. 2009; Bucher et al., 2016). Thus, they increasingly promote

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new practices that emphasise patient orientation and interprofessional co-operation. Clearly, these expectations increase needs to foster boundary-modifying transformations that enhance the development of desirable new work practices (Cregård, 2018).

To acquire empirical material for our study, we followed a development project in a surgical ward for nine months when the role and position of a new medical specialist, a hospitalist, were constructed. A hospitalist is a specialist physician who works in a surgical ward but is not a surgeon, primarily to ensure that patients receive holistic medical care, and thus enhance the quality of care and patient orientation within the ward (Wachter and Goldman, 2016). Hospitalists have proven ability to enhance in-patient care, thereby reducing patients' average length of stay and total hospital costs (White and Glazier, 2011).

While hospitalists are commonly employed, for example, in the USA (Wachter and Goldman, 2016), the hospitalist considered here is believed to be the first in a Nordic country. In a highly specialised university hospital, such as the focal hospital, patients in the wards are typically cared for by specialists with narrow areas of expertise, for instance, hepatobiliary surgery. The hospital management's idea of employing a hospitalist was triggered by the increasing complexity of the clinical circumstances of patients requiring hospital care and the need for dedicated clinicians to oversee their care.

As a new professional specialist in the focal context, the hospitalist's role was developed in collaboration with the ward's personnel, including the recruited person, in facilitated work development meetings. The idea was that the hospitalist's role and job description in surgical wards at the hospital would continue to develop after the piloting, and hence remain fluid during the recruitment and subsequent developmental processes (including the meetings described and analysed here). These meetings were used to enable and enhance dialogue between the hospitalist and the personnel, providing space and time for the health care professionals to talk about the hospitalist's work in relation to their work practices.

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Data

The primary data applied in this study were acquired by video-recording and transcribing interactions during eight work development meetings using the transcription system introduced by Jefferson (1984) (see Table 1) to illustrate the manifested accounts in detail. Rather than collecting a large dataset from short and routinised, similar interactions – such as issuing tickets (Llewellyn and Hindmarsh, 2013) – we used another common strategy in ethnomethodologically-oriented studies: *extended sequence analysis from a case* (Rawls, 2008; Whittle et al., 2015). This allowed us to examine the development of the situated interactions that were not routine or repetitive in nature (Whittle et al., 2015), which was crucial because of the recognised importance of such interactions in the boundary (re-)arranging processes facilitated by reflective spaces.

< Table 1 around here, please >

The work development meetings were held monthly at the hospital and facilitated by an external consultant who was not a member of our research group but used to work as a nurse in a hospital and had expertise in co-ordinating meetings, and hence was both 'distant' and 'near' to the setting (Polletta, 1999). The meetings involved the hospitalist and health care professionals with various organisational positions on the ward where she was to be employed: medical director, nursing director, nurse managers of the ward, nursing staff (practical nurses and surgical nurses) and surgeons. Altogether, 16 individuals actively participated in the meetings, which lasted from 1.5 to 3 h. All the meetings were captured in video-recordings. In addition, the first author of this paper observed the first meeting and the second author the second meeting.

We used semi-structured interviews with involved health care professionals, key persons' reflective diaries, questionnaires and data from various secondary sources (see Table 2) to form an overall picture of the focal development process. The secondary data were collected primarily for purposes of another study, and were not analysed for this study *per se*, but allowed immersion in the organisational life and acquisition of broader contextual understanding about the case and the

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manifested interactions in the video-recorded work development meetings. The semi-structured interviews concerned participating professionals' experiences of the development process. The diaries provided insights into employees' thoughts and concerns about the process. A questionnaire sent to the participating personnel via email provided information about employees' attitudes towards the process. The consultant's emails provided a timeline of the development process and detailed information about the meetings' contents, while the hospitalist's presentation materials illuminated the perceptions of a hospitalist's role in a surgical ward generally and her own perception of her new role specifically.

There were also informal discussions between the authors, consultant and key persons involved in the development process. In addition, two authors of this paper have overall responsibilities for medicine and nursing in the health care organisation that includes the focal hospital. The former was the main active agent in the hospitalist's introduction to the hospital.

< Table 2 around here, please. >

Before collecting the empirical data, we obtained permission to conduct the research from the focal hospital organisation. During this phase, ethical aspects of the research process were evaluated. No separate ethical board statement was needed because the study focused on personnel, not on patients or minors. Ethical concerns related to the hospital employees were addressed as part of the hospital district authorities' standard research assessment and authorisation process. All participants in the study were also informed of the voluntary and anonymous nature of their participation and their right to withdraw from it at any point during the research process (Denzin and Lincoln, 2011). These practices are consistent with the established norms of scientific research in Finland.

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Analytical process

In the analytical process, we drew on membership categorisation analysis (Housley and Fitzgerald, 2002; Stokoe, 2012). Although category analysis is often intertwined with conversation analysis, these two ethnomethodological methods have distinct foci (Stokoe, 2012). Conversation analysis pays particular attention to sequential, structural features and patterns in participants' conversation, whereas category analysis primarily focuses on categorial features of talk and interaction (Stokoe, 2012). Because categories are largely mediated through spoken communication, we concentrated on the spoken interaction in the work development meetings. The video-recordings enabled us to capture nuances of this interaction and helped us to identify persons who were speaking.

The focal concerns in the analysis of the spoken interactions were the practical reasonings and categorisation processes of everyday life and the ways the practical reasonings about categorisations constantly produce and re-produce social order. We explored how the people themselves described people, things or happenings in the social world – which they came to categorise within these descriptions. However, our main concerns were not the categorisations *per se*, but the practical reasonings used to make sense of the categories within the social situation (Rawls, 2008; Whittle et al., 2015). Practical reasonings and categorisations occur in the professionals' mutual action within social situations rather than through classification or labelling by a researcher (Schegloff, 2007). This kind of performative categorisation results in seeing language as the mutual action of people within a social situation that produces reality rather than describing it (Potter and Wetherell, 1987).

The analysis started with familiarisation with the material. After obtaining an overall understanding of the focal development process, we concentrated on the health care professionals' mutual action in the work development meetings. During this phase, we watched the video recordings and read the transcriptions simultaneously. We then identified parts of the transcriptions in which the hospitalist was explicitly discussed to build collections of mentions of the hospitalist and hospitalist-related accounts (Stokoe, 2012). We then detected the categorisations of the

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hospitalist by considering how actors in the work development meetings used categories in their accounts regarding the hospitalist. To discern related professional boundaries, we identified categorisations of the hospitalist used in accounts of each professional or occupational group or applied in relation to such a group. We then located the position of each categorisation within the ongoing interaction captured in the transcription (Stokoe, 2012).

To capture associated practical reasonings, we analysed the action orientation of the text in which each category appeared (Stokoe, 2012). We recorded the roles of, and situations from which, participants discussed their views. Various rights and obligations as well as beliefs manifested in the categorisation processes were explored to obtain an understanding of the reasoning in the context (Samra-Federicks, 2010; Whittle et al., 2015). We examined how the professionals oriented, built, and resisted categorisations, and the interactional consequences of the category use (Stokoe, 2012). In this way, we were able to tap into the social processes through which the professional boundaries were constantly constructed. Using our contextual understanding as an analytical resource, we were able to identify how the practical reasoning about categorisations sustained the established social order in some cases and challenged it in others. Hence, we detected ways in which the practical reasonings in the mutual categorisation processes actualised professional boundaries around the hospitalist.

The following simple example of a conversation in which participants in a work development meeting discussed the hospitalist's role within the ward and the work tasks it should encompass illustrates the analytical process:

Consultant: have you identified tasks for the hospitalist? (1)

Nurse 2: well (1) at least (.) like X said (.) at some point there are no surgeons [in the ward], for example (1) all of them are in operations and such (.) and then (1) well (1) if like ↑questions arise [about patient care] (.) or something urgent (.) or patient transfer (.) like a need to write a

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medical case summary (2) then maybe (.) blood tests were mentioned at some point (.) I mean a hospitalist could take care of these [issues] (4)

The extract explicitly concerns the hospitalist. The nurse explicitly states that surgeons are not always present in the ward because they are engaged in operations and indicates that this sometimes leads to a lack of guidance about patient care. The nurse categorises the hospitalist as an available medical professional who would be present in the ward. The negotiated professional boundary concerns the boundary between nurses and the hospitalist. Engaging in practical reasoning regarding rights and obligations, the nurse makes sense of the hospitalist's role by describing her as someone who can collaborate with nurses in provision of patient care during shifts. In the extract, the categorisation process arose from contextual reflection about work practices (issues raised about patient care while surgeons were engaged in operations) rather than technical aspects of the medical profession. Regarding consequences of the manifested categorisation process, we suggest it had potential for changing prevailing work practices. Instead of the nurses waiting for the surgeons to return from operations, the hospitalist could solve some issues instantly with them.

The analysis was performed by the first author, who has a background as a health care professional and many years of experience of the focal organisation, albeit not of the surgical field. In ethnomethodological study, being close to the research setting is regarded as advantageous rather than disadvantageous (Whittle et al., 2015). In this case, for example, the first author's nuanced understanding of work practices in health care generally and the focal hospital particularly facilitated interpretation of the social activity. In addition, the nursing and medical directors' inclusion in the research group enabled closer interactional analysis of the development meetings and enhanced sensitivity to cultural nuances in participants' practical reasonings regarding categories and professional boundaries (Larsson and Lundholm, 2013). We acknowledge that the researchers' presence in the first and second meetings might have influenced the professionals'

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interactions. However, we detected no difference in the interactions in terms of transparency or extent between these and the other meetings.

Professional Boundaries in-Action in Reflective Spaces

Since hospitalist was a new type of medical specialist not only in the focal university hospital but also in the entire Nordic region, the hospitalist's role in the ward had to be jointly constructed. When this study commenced the hospitalist had just been recruited. Initially, she contacted the medical director and inquired about a position to finish her general specialist degree. At this point, the medical director got to know her professionally and subsequently thought that she would be suitable for piloting the hospitalist working model. Hence, no formal process was followed in the hospitalist's recruitment, and no clear job description was set in advance. Instead, she was chosen because she had the required formal qualifications (general specialist) and was regarded as a suitable person to develop the partially envisaged role in collaboration with the ward's personnel.

At the time of the study, the ward had 90 staff, about 66 percent of whom were nurses and practical nurses, 20 percent surgeons and 14 percent administrative personnel, including managers and secretaries. The ward had up to 55 patients, staying up to 4.6 days on average (with substantial variation), and there were ca. 25 operations weekly. The work development meetings were arranged by management to allow the personnel to collectively make room for the new specialist. Participation in the development meetings was voluntary, but ultimately participants were selected by management in efforts to obtain roughly even representation of all the professionals and occupational groups in the ward.

Although the medical director knew the hospitalist in advance, the personnel in the ward (and, hence, work development meetings) did not. Thus, we believe that the professional acquaintance between the medical director and the hospitalist did not affect the professionals' interactions in the meetings, particularly since the medical director did not take part in the meetings. However, the

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other participants' knowledge that the medical director approved of her and thought that she was suitable for the role could have had have some influence of their initial judgement. It should be noted that personal characteristics of the hospitalist (she was well-liked) presumably also affected aspects such as the tone of interactions. However, analysis of the dynamics of the manifested categorisations (as presented later in the text) suggests that the personnel's categorisations and associated practical reasonings were rooted in professional boundary concerns rather than their personal relations with the hospitalist.

Situated interactions manifesting categorisations in the work development meetings

To illustrate our fine-grained and detailed analysis, we present five extracts of the interactions that exemplify manifested categorisations and practical reasonings by the professionals.

Extract 1 – Hospitalist as a new medical specialist

The hospitalist's role in the ward was expected to develop while the recruited person familiarised herself with work practices within it. During this process, she engaged in various tasks. In the work development meetings, the involved professionals, including her, discussed the tasks that should be within her remit in the ward, as illustrated by the following extract:

Nurse 2: Yes, so the hospitalist can't be like a trash bin that all the tasks are thrown at.

Surgeon 3: I think (1) I mean, of course surgeons have operations (.) and if there's some long-lasting resection or such like then a surgeon's stuck in the operating theatre for the whole day=but if there are like three tasks [operations] then there an hour and a half gaps between [them] (1) so, I wouldn´t (.) like to consider [the] hospitalist as, like, a rectifier of others' work.

Consultant: Mmm,

Surgeon 3: There should be an independent role [for a hospitalist].

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((polyphonic utterances and nodding))

Surgeon 3: I mean (1) because our hospitalist is a specialist physician (2) so (1) we have these [tasks that are] traditionally done by an assistant physician (1) or by medical interns when they still knew how to do these tasks (1) these [tasks] *that were not finished [by surgeons]* ((laughter))

These accounts manifest knowledge of the intraprofessional hierarchical relationships between internal physicians, general physicians and medical specialists. They concern the boundaries between the hospitalist and other physicians. The surgeon's comment 'because our hospitalist is a specialist physician, (2) so (1) we have these [tasks that are] traditionally done by [the] physician assistant' expresses the common-sense knowledge of the hierarchical social relationship between a specialist physician and physician assistant. In addition, the nurse declares that the hospitalist cannot be a 'trash bin' who does tasks typically done by medical interns, and the surgeon states that the hospitalist cannot be a 'rectifier of other [surgeons'] unfinished work'. The tasks should be sufficiently demanding to correspond to the training required for a medical specialist. The surgeon continues by explicitly categorising the hospitalist as *a new medical specialist* who should be given an adequate, independent role in the ward. The accounts manifest common-sense knowledge of the medical specialist and tasks that are regarded as suitable for the role. However, the hospitalist had already engaged in tasks that were 'traditionally done by an assistant physician'. This is justified, or made sense of, by referring to the incompetence of current medical interns. In summary, the practical reasonings in these accounts maintained the prevailing intra-professional hierarchical social order.

Extract 2 – Hospitalist as a labourer and real-life medical worker

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In the following extract, the independent role for the hospitalist was discussed, negotiated and clarified using the common-sense knowledge of the need for an appropriate division of labour, and the accounts embody typical practical reasoning of the organisation:

Consultant: Mmm…this (2) rectifier (1) is a rather good word (1) I mean, it may quite easily get out of hand.

Assistant ward nurse: I have a fear (2) I mean what I have now heard (1) nobody´s job description can be like that.

((three seconds taking out of turn))

Head nurse: I would rather think (1) that she [the hospitalist] mainly takes the ward round, checks the big picture [considering patients] (.) the operations are different issues.

Hospitalist: It's not quite like that (1) like (1) the point is not that the hospitalist does other people's unfinished tasks but has their own role and in practice = it can't be said that unfinished work [the hospitalist] is not allowed to do = I'm not saying that – (.) of course, if I'm there and I don't have anything to do (.) why on earth wouldn't I write (.) an epicrisis or something (.)

Surgeon 3: But anyone could write that.

Rather than categorising the hospitalist as a specialist medical professional, these accounts categorise her as *a labourer* in the ward whose work description had to be adjusted in a reasonable manner in relation to other labourers' work. The consultant's comment that 'it may easily get out of hand' embodies concern about the work distribution, which is supported by the head nurse's comment that 'nobody's job description can be like that'. The consultant and head nurse do not deny or comment on the surgeon's previous expression, *per se*, but rather orient themselves in the discussion differently by discussing the 'rectifier' metaphor used previously during the conversation. Thus, in the combination of structure and content, expressions in this conversation maintained vertical, hierarchical professional order.

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As the conversation proceeded, the practical reasonings related to the hospitalist´s job description and tasks emphasised a need for flexible rather than strict division of labour. The head nurse suggested a simple division between the hospitalist's and the surgeons' roles in the ward. The hospitalist rejected this proposed categorisation as too simplistic. In this way, she categorised herself as *a real-life medical worker*, and in real-life the division of the roles and tasks is complex. Her account shows that she made sense of her work through her own experiences in the ward, where the situations were far more complex than the head nurse's proposed division implied.

Extract 3 – Hospitalist as an autonomous expert

Hospitalist was a new professional role in a highly specialised professional setting, where surgeons have particularly strong professional authority and are typically highly respected. The following extract illuminates the subtle negotiations regarding the professional boundary between surgeons and the hospitalist, conducted by a nurse and hospitalist. The conversation occurred while personnel were discussing the kinds of patients that should generally fall within the hospitalist's jurisdiction.

Nurse 2: If I may still comment (.) about [the] hospitalist (.) Last week I had (1) an experience (1) there are certain general medical issues (1) in which surgeons do not, they don´t have, I mean, after all, surgeons are surgeons (.) so, [they don't] have an opinion and we had, for example, this patient who had (2) after surgery (1) really low blood pressure and all the blood pressure medicines were on hold, so (1) we were able to use her [the hospitalist's] professional know-how, meaning, what medicine should be given and the schedule = it isn't necessary to consult (1) [the] internal medicine specialist ↑ anymore (1)

Hospitalist: It went well

Nurse 2: It went really well ((both nurse and hospitalist are talking over each other))

Hospitalist: I believe the medication (.) the assessment of the medication overall (1) in some cases (.) not all of them (.) there are such weird medicines today (.) I mean, like, even general

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physicians or general specialists aren't aware of all of them (.) but I think that the medication is (2) for the patient (.) I think that's something (1) at least in some cases (1) *if not the hospitalist but for someone (1) to pay attention to*

In this extract, the practical reasoning was rooted in the autonomy of professionals, particularly medical professionals and specialists, in hospitals and categorises the hospitalist as *an autonomous expert*. The nurse emphasised the hospitalist's knowledge of medical issues, applied the category pair 'surgeon-general specialist' and manifested the boundary between these two medical specialists. Rather than making sense of their boundary through the intra-professional hierarchy of the medical profession, the nurse's account actualises the hospitalist as a special physician in her own right. The statement "After all, surgeons are surgeons" embodies the taken-for-granted understanding within the institutional context that surgeons are skilful experts in operations rather than internal medical issues, such as issues related to medicines.

Although the hospitalist agreed with the nurse, her account showed how subtle the negotiation of categories can be. The hospitalist discussed the complexity of modern medicines and how difficult it was to keep track of them, even as a general specialist. In this way, the hospitalist weakened the distinction between surgeons and a general specialist manifested in the nurse's account and emphasised the autonomy of surgeons who have their own territory to tend and defend.

Extract 4 – Hospitalist as an authority

Since the new medical specialist had started working in the ward, the boundary between the nurses and hospitalist came under scrutiny. Some conversations manifest perceptions that the nurses' role in the ward was 'exceptionally broad', meaning that nurses were considered to have stronger professional autonomy than nurses in some other wards in the hospital. The following extract is part of the discussion concerning a patient's case that was followed and video-recorded by the

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consultant. The recordings were watched together and collaboratively considered by the involved health care professionals in one development meeting.

Surgeon 1: This case emphasised rehabilitation. (.) so, there were not many strictly medical issues to address (.) but I still think that the hospitalist's input was valuable here (.) It brought in [a] kind of (1) medical (1) backbone for this case. (.) so it was like ↑ it worked very well in this [situation]

Assistant ward nurse 2: And it was like (1) it engenders trust (1) that [the] physician takes [a] stance; it is not only, like, [the] nurse.

Nurse 3: Yes ((talking out of turn)).

Surgeon 1: But this is the work that you [nurses] do. (.) This is exactly your expertise, like (6)

Consultant: Yes, I wonder why this was put on the hospitalist ['s work list].

Hospitalist: This was (.) because ↑ in my opinion, the nurse gave it to me (.) because there was a misunderstanding in this case (.) there was a dilemma (.) [the] patient wanted to go home (.) but in practice (.) he needed home care (.) which was refused by his wife (.) So, in principle like, that

Ward nurse: The support was sought

Hospitalist: Yes

Ward nurse: So, sometimes, if you think from [the] nurse's perspective (.) there is (.) [a] blocked situation (.) like here as it was (2) it is in a way like (1) to support and help (.) I mean (2) the collaboration with the hospitalist (.) nurses do not necessarily (1) *yeah, well I don't know.*

These accounts evoked the taken-for-granted understanding that physicians have authority, particularly from the patients' perspective. The accounts related to the boundary between the hospitalist and nurses, and manifested concern about whether the hospitalist should get involved in similar situations from a medical perspective. The surgeon's account merely categorised the

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hospitalist as a medical specialist, while the assistant ward nurse's reply rather explicitly categorised the hospitalist as *an authority*. The surgeon expressed concern that the situation where the hospitalist intervened did not require medical knowledge, but he continued that the 'medical backbone' provided by the hospitalist was beneficial in it. The assistant nurse replied to the surgeon's account of the hospitalist's input by stating that a physician might engender 'trust' between the patient and the staff by 'taking a stance'.

However, the surgeon did not take this proposed categorisation for granted. He continued by pointing out that the competence required in the situation was the core expertise of nurses. This highlighted, more explicitly, the need to negotiate the boundary between the hospitalist and nurses, and the consultant wondered how the case ended up on the hospitalist's work list in the first place. The hospitalist started to explain the situation from her perspective, and the ward nurse contributed to the discussion. By stating that 'support was sought', the ward nurse maintained the evoked authority categorisation, and continued by arguing that a position with such authority in the ward was required, to provide support for nurses if challenges arose.

This extract shows that 'physician-nurse' was a strong categorisation in the institutional context, where physicians give orders and nurses implement them. Moreover, physician is a strong cultural categorisation that embodies authority outside of its institutional context. The categorisation of the hospitalist as an authority actualised the interprofessional hierarchy and maintained the hierarchical professional social order.

Extract 5 – Hospitalist as a medical specialist pioneer and available specialist

Because the hospitalist was (we believe) the first in a Nordic country, there were high expectations that she would innovate and develop unforeseeable, ground-breaking work practices. The following extract is part of a discussion concerning this matter.

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Surgeon 3: And when you're hired as a hospitalist (.) you need to write reports (.) you need to develop so you need to have time (.) like days and days while you don't have anything concrete to do so that you can think and write

((laughing))

Hospitalist: §usually I don't think anything§

Surgeon 3: And not to run around doing this and that (.) I mean you can't create this hospitalist thing if you don't have time to think.

Surgeon 1: And it's exciting (.) like it's such a new position (.) So how do you manage to create a job description for yourself, a job description suitable for a strong medical professional (.) Like if I think, for example, of [name] (.) so he has his own job description and he's like a great expert who is regarded as a saviour in the ward and he fixes this and that all the time, and the patient usually starts to get better (.) Something like that, not exactly the same, I mean he's a cardiologist and you're a general specialist, but something (.) I mean conservative [non-surgical or otherwise invasive] medical expertise would be an excellent thing in certain issues [in the ward]

Assistant ward nurse 2: [A] nurse often misses conversational help (.) [A] nurse might feel that this patient is not feeling well (.) and when you express your concern to [the] surgeon, [s/he says] 'Well, the patient looks fine to me' and walks away (.) If the hospitalist would have [time for saying something like] 'What gave you that impression?' Well [the patient's] heart is beating fast (.) It's not right (.)

Here, the practical reasoning is rooted in both the knowledge of the medical specialist and the understanding that the hospitalist's work falls outside the traditional role of the medical professional, involving creation of something new rather than simply engaging in standard tasks. In this way, the account specifies the categorisation of the hospitalist as a *medical specialist pioneer*. At the beginning of the extract, surgeon 3 stated that the hospitalist needed time to 'think and

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write', not 'run around', so that she could 'create' something new. Surgeon 1 continued this theme by noting that the creation of 'such a new position' was 'exciting' and the challenges of creating a new kind of 'strong medical professional'. These accounts actualise a new kind of identity for a medical specialist, which may open possibilities for transformation in the social order.

Assistant ward nurse 2's practical reasoning, in turn, embodied real-life experiences and contextual knowledge and her practical reasoning was rooted in the notion of collaborating to provide the best possible care for the patient. She made sense of the hospitalist as *an available medical specialist* who might have time to discuss nurses' concerns regarding patients. Her expressions provided a way to renegotiate the boundaries between nurses and physicians in the work context by emphasising a need for flexibility.

Dynamics of the manifested categorisations

In the process of mutual construction of the hospitalist's role, the participating professionals used seven distinct categorisations with practical reasonings that varied among the professional groups. The most prevalent categorisation in the interactions was of *a new medical specialist*, which was used by surgeons to maintain the status of a medical specialist profession. Nurses used categories of *an autonomous expert* and *available medical specialist* to make room for a medical specialist who would help them and provide advice for the benefit of the patients. Less frequently, nurses also used the categorisation of *an authority* to highlight the potential importance of the presence of someone like a hospitalist to facilitate their work. To some extent, the consultant and directors used the category of *a labourer* in attempts to create a clear division of labour in the ward, but the hospitalist and surgeons used the categorisation of *a real-life worker* to show how difficult it is to set clear lines and rules for everyday work practices. On a few occasions, surgeons used the categorisation of *a medical specialist pioneer* — a highly professional, but novel medical specialist.

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Creating a new role in an established professional setting may threaten the status of elite professionals, such as surgeons (Currie et al., 2012). In our case, however, the surgeons seemed eager to integrate the new specialist into their workplace and clearly wanted her to have high professional status. Thus, through the categorisation processes surgeons sought to maintain the overall status of medical professions, but also demarcate hospitalist from their own profession as someone whose role was to work with patients and nurses in the ward and tackle tasks of little apparent interest to surgeons. In a similar vein, nurses expressed high hopes and expectations that the hospitalist would clarify, or alleviate, their work in the ward. The hospitalist, in contrast, tried to make sense of her role through real-life experiences in the ward. Hence, the reflective spaces were used for discussing encountered practical problems that could not easily be raised during standard working hours when interactions centre on patients' care. The professionals could also collectively evaluate the appropriateness of realised divisions of labour in these spaces by considering different professional viewpoints.

As a result of the professionals' collaborative work in the meetings, a preliminary model of the hospitalist's role was formed, including co-management of the treatment and care of patients that required a more holistic approach than any single medical specialist could provide. This included: planning, coordinating, defining and summarising care of multi-morbidity patients in the ward, as well as planning follow-up treatment and evaluation of their medication. This would enable to surgeons to concentrate on operations and other tasks regarded as within their specific professional remit. Hence, the reflective spaces allowed professionals to negotiate boundaries of the new professional role and identify associated tasks, but the emerging role with various categorisations was complex.

Finally, we found that the recorded boundary work processes had different emphases on, and consequences for, the social order (see Table 3). Practical reasonings related to four categories (a new medical specialist, an authority, an autonomous expert, and a labourer) concerned the position,

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jurisdiction and control of the new role and were frequently manifested in the work development meetings. These reasonings resonated with the traditional idea of a profession as an externally defined role. As such, the categorisations around the hospitalist showed that the professionals largely used practical reasoning rooted in notions of the technical knowledge-base of professionals, including notions of professional hierarchy (both horizontal and vertical) and autonomy. In this manner, the practical reasoning processes sustained horizontal and vertical professional order, and with the categorisations drew lines between professions that were defensive and competitive in nature.

< Table 3 around here, please >

However, the practical reasoning processes related to categorisations of an available medical specialist and a real-life medical worker involved the work context and emphasised the notion of the professional as a reflective practitioner. These less frequently recorded processes were rooted in understandings of the everyday work practices within the ward, and through them professional boundaries around the hospitalist were negotiated with attention to the local context. They manifested reflection on the negotiated situation, and embodied professional identity through which the situation was made sense of (Weick, 1995). These categorisations within the practical reasoning processes were rooted in contextual orientations towards work practices. Drawing from a contextual knowledge base, the expressions of professionals manifested the wisdom and capability required for professionals to overcome situation-related, practical problems involved in work practices. While the professionals' technical orientation maintained stability in professional boundaries and work practices, expressions of the contextual orientation allowed change in them.

The practical reasoning related to the category of medical pioneer involved two rather contractional categorisations, as a new medical specialist and a pioneer. The practical reasoning behind categorisation as a new medical specialist was rooted in the traditional position-based view of professionals, whereas the categorisation as a pioneer allowed inquiry and reflection in relation

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to the institutional context. Thus, this categorisation manifested practical reasonings that resonated with both technical and contextual perspectives of professionals, providing potential for conflicting practical reasoning processes to merge into something new. The observed dynamics of this professional boundary showed the difficulty in coherently integrating conflicting reasoning processes, but such categorisation may still enable transformation of the medical profession's orientation. However, the hospitalist was rarely categorised as a new medical pioneer in the recorded meetings. Shorter extracts that capture various views related to each categorisation and their emphasis on jurisdiction, position, control or practical needs are presented in Table 4.

< Table 4 around here, please >

Overall, the study indicates that although hospitalist was a new professional role in the hospital, and work development meetings were organised to collaboratively (re-)arrange professional boundaries to make room for this new professional, the categorisation processes largely reinforced the existing vertical and horizontal boundaries. Figure 1 illustrates the categorisation processes in reflective spaces, and establishment of social order, identified in the study. Practical reasonings associated with categorisations rooted in common-sense knowledge regarding technical or contextual dimensions of professions manifested professional boundaries generated through social interaction of the participating knowledgeable professionals. Practical reasoning rooted in technical orientation towards professions maintained stability in professional boundaries, whereas contextual practical reasoning allowed change in both them and work practices. The consequent interactive combination of technical and contextual practical reasoning generated role dynamics capable of transforming the social order within the institutional context.

< Figure 1 around here, please. >

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Discussion

Organisation scholars have been increasingly interested in diverse microprocesses that occur during insertion of a new professional or occupational role into an established setting (Allen, 2000; Allen 2001; Reay et al., 2006). Recent configurational boundary work literature emphasises the potential of reflective spaces to facilitate interactions of professionals, mobilise boundary (re)arrangement and promote change (Zietsma and Lawrence, 2010; Nylén, 2013; Bucher and Langley, 2016). There has been little attention to the interactive nature of such microprocesses, particularly in situations that are deliberatively arranged by management to make room for a new professional. Our ethnomethodologically oriented study of actual boundary talk-in-interaction (Langley et al., 2019) in work development meetings aiming to incorporate a new role in the hospital setting illuminates these interactive processes.

The ethnomethodologically oriented notion of boundary work incorporates elements that are essential for professional boundaries to form initially and endure over time (Whittle and Housley, 2017). More specifically, this approach enabled us to analyse in detail the practical reasoning about categorisations whereby actors (re)arrange professional boundaries through their mutual social action. Hence, our study's first contribution centres on the scrutiny of the actual interactions between professionals in terms of their shared sensemaking practices. This allows us to depict a repertoire of categorisations in relation to a new professional role involving definition of the new professional boundaries, emerging categorisation of the new role, underlying practical reasonings and consequences for the prevailing social order.

Moreover, by investigating professional boundaries as constantly becoming, as in-action, the approach provided a way to capture ongoing stabilising activity as well as professional boundary-changing processes in new role insertion. In line with Reay et al. (2006), our analysis suggests that professionals can use their embeddedness in the context to incorporate a new professional role into a well-established professional setting. We, however, take this further by specifying the influences

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within the institutional context from the different types of technical and contextual reasonings that respectively tended to reinforce boundaries' rigidity and increase their fluidity. Moreover, our study stresses the transformative potential that emerges from the practical reasoning combining these knowledge bases. This extends understanding of the nature of professional boundary work that is characteristically both rigid and fluid (Glimmerveen et al., 2019).

Our study's second main contribution is extension of understanding of the configurational boundary work in reflective spaces (Zietsma and Lawrence, 2010; Bucher and Langley, 2016). It showed that reflective spaces allowed professionals to (re)arrange their boundaries and articulate a new professional role. However, in the examined case a complex landscape of expectations regarding the new professional emerged, which might be difficult for a new person to navigate in an established professional setting, such as a hospital. Hence, the observations highlight needs for resolution in reflective spaces, in the sense of a collective understanding of a new role that does not incorporate unfeasibly diverse or conflicting categorisations. The notion of the consequences of the boundary talk-in-interaction in a reflective space from the viewpoint of the new person is an important addition to previous research, which has mainly addressed organisational and institutional level processes.

Furthermore, our findings reinforce the view that reflective spaces can be used to motivate professionals in various work positions to collaboratively elaborate, assess and question existing work practices (Polletta, 1999; Kellogg, 2009; Zietsma and Lawrence, 2010). While previous studies have demonstrated the transformative potential of reflective spaces (Zietsma and Lawrence, 2010; Nylen, 2013; Bucher and Langley, 2016), our fine-grained analysis provides an important contribution by illuminating how change actually occurs through boundary talk-in-interaction in these spaces. As noted above, we defined technical and contextual practical reasonings about categorisations with differing consequences for the boundaries between professions and the social order. As the stability-enhancing technical reasoning was more frequently used, our study suggests

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that although they may allow collaborative boundary renegotiations, reflective spaces may easily provide arenas for professionals' boundary enactments that defend the established boundaries. Hence, multi-professional collaboration and interaction in reflective spaces *per se* do not produce change but the dynamic of social (inter)action plays a crucial role and the dynamic should be traced beyond the emerging boundaries to the bases of change.

Studies on professional boundary work often exclude the wider institutional context from analysis of micro-level action (Langley et al., 2019). In contrast, the ethnomethodologically oriented approach intrinsically encompasses the wider contexts of situated boundary work in the practical reasonings about categorisations. For example, the captured practical reasoning associated with the technical categorisation processes emphasised the position, jurisdiction and control of the new professional, thereby manifesting the distinct institutional context in the professionals' interactions. In future studies, the ethnomethodologically oriented approach may facilitate analysis of other novel dimensions of professional boundary work, for example, structural inequalities (Whittle and Housley, 2017), such as gender inequality. It should be noted that the ethnomethodological perspective does not take sides but rather focuses on unequal opportunities of different professionals in producing accounts that are accepted by others (Whittle and Housley, 2017). Nevertheless, ethnomethodologically based research enables movement beyond the often-problematic dualism of micro- and macro-level.

This study also makes a methodological contribution. In previous research, professional boundary work has typically been studied through interviews and observations (Langley et al., 2019). In our study, the video-recordings allowed us to investigate the delicate interactional nature of the boundary work in reflective spaces. Through video-recordings, we could capture the naturally occurring interactions of professionals *in situ*. They also allowed us to transcribe subtle nuances of the interactions (Jefferson, 1984). Such recording is also particularly important when there are more

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than a few participants in order to identify speakers and the people they are specifically addressing, which is crucial for understanding the interactive situations.

Along with theoretical and methodological contributions, the study has practical implications. Overall, previous literature on professional boundary work has increased practitioners' conceptual understanding of processes of integration and collaboration (Langley et al., 2019). Since reflective spaces are often utilised by practitioners to enhance participation, collaboration and integration across different professions to engender change (Nylén, 2013; Buchen and Langley, 2016), our findings might enhance practitioners' understanding of the facilitation of interprofessional collaboration in such spaces. Thus, acknowledging that context-bound practical reasoning in reflective spaces may contribute to change within established contexts might help practitioners to embrace contextuality and avoid falling into the 'universality trap'.

Although ethnomethodologically oriented analysis is highly empirical, its context-bound nature limits the results' generalisability. Rigour in ethnomethodological research is provided by fine-grained analysis of naturally occurring interactions rather than generalisability (see Whittle et al., 2015). However, we have provided a detailed description of the case, research setting and methods to enable readers to assess the transferability of our observations and conclusions (Lincoln and Guba, 1985). Moreover, although the reported categorisations of boundaries are context-specific, the logic underlying the practical reasonings, and both their stability-enhancing and change-inducing knowledge bases, are likely to be influential in any professional settings in which a new role is inserted into an existing social order. Similar knowledge bases may underpin practical reasonings in reflective spaces when, for example, a new administrative role is introduced into a longstanding academic research unit. Furthermore, the discernment of both stability- and change-enhancing reasonings is clearly essential for elucidating the rigidity and flexibility of boundaries, the processes involved, and the transformative potential of reflective spaces.

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Our study is not without limitations. We ignored materiality involved in the work development meetings and, for example, paid little attention to the possible influence of written material in accomplishment of the professional boundaries. Written material arguably generates more durable professional boundaries than boundaries that are only orally enacted and may inspire further negotiations of the professional boundaries. However, written material regarding the hospitalist's role played a marginal role in the observed work development meetings. No final decision had been taken by the hospital to hire more hospitalists to create a broader functional tier, and the introduction of the hospitalist in the pilot ward was intended to provide experience. Hence, the oral communications in the development meetings were particularly important in this case. However, further studies could focus on the impact of documents on practical reasoning by professionals about professional categories, and how various documents are used in professional boundary arrangements (Whittle and Housley, 2017). Furthermore, we have treated the hospitalist, the holder of the new professional role, as one person among others in the social interaction. In the future, it would be interesting to investigate new role insertion from the perspective of the new professionals, for example, by focusing particularly on their boundary work and identity work processes.

Conclusion

Our study provides an illuminating account of the dynamics of professional boundary work — particularly the mutual (re)arrangement of boundaries associated with insertion of a new role — in reflective spaces. Adopting an ethnomethodologically oriented approach, the study illustrates how analysis of boundary categorisations can fruitfully capture the delicate interactive nature of professional boundary work in reflective spaces and the ongoing processes involved in both stabilisation and change of established social order. Thus, we argue that elucidation of

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categorisation processes has high utility for understanding the dynamics of professional boundaries in established professional and institutional settings, such as hospitals.

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Table 1. Symbols used in the transcriptions and their descriptions.

Symbol	***Description***
(.)	A micropause - a pause of no significant length
(0.7)	A timed pause - long enough to indicate a time in seconds
> <	Arrows showing that the pace of speech has quickened
< >	Arrows showing that the pace of speech has slowed
( )	Unclear section
(( ))	An entry requiring comment but without a symbol to explain it
↑	Rise in intonation
↓	Drop in intonation
→	Entered by the analyst to show a sentence of particular interest. Not usually added by the transcriber
CAPITALS	Louder or shouted words
=	Indicates no pause between the end of one sentence and start of the next.
*	Silently spoken
§	Smiling while speaking

Table 2. Data acquired and considered in the study.

Material type	***Items***	***Length***	***Timing***
Videos of change facilitation meetings (sound and pictures)	8	16 h 36 min	Jan-Sept 2017
Transcriptions of video discussions on paper	8	358 pages	Jan-Sept 2017
Semi-structured interviews	16	89 pages	Dec 2017-May 2018
Reflective diaries	5	11 pages	Jan-Sept 2017
Questionnaires sent to the employees via email	2	28 pages	Dec 2016-Jan 2017
Hospitalist presentations during the process	3	35 pages	Feb, Mar, Jun 2017
Change facilitator´s e-mails to personnel and related attachments	83	45 emails	Jan-Oct 2017
Internal report on developing nursing management work	2	30 pages	Dec 2014
Internal presentation on organising nursing management	1	19 pages	Dec 2015

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Table 3. Manifestations of boundary work in the data.

Professional boundaries between	**Categorisations of the hospitalist**	**Practical reasoning about categorisation**	**Consequence for the social order**
Medical specialists and other medical professionals	A new medical specialist	Intraprofessional hierarchy	Maintenance of hierarchical horizontal professional order
Hospitalist and nurses	An authority	Interprofessional hierarchy	
Hospitalist and surgeons	An autonomous expert	Professional autonomy	
Hospitalist and other employees within the ward	A labourer	Division of labour	Maintenance of vertical professional order
Hospitalist and nurses	An available medical specialist	Collaboration	Allowed contextual reflection and change
Hospitalist and other medical specialists	A real-life worker	Flexibility	
Hospitalist and other medical specialists	A medical specialist pioneer	Innovation	Allowed contextual reflection and transformation within an institutional context

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Table 4. Extracts illustrating technical and/or contextual knowledge base of the categorisations.

Categories of the hospitalist	Knowledge base	Emphasis	Illustrative extracts
A new medical specialist	Technical	Jurisdiction	"but that [the hospitalist] works as an assistant (.) I think that's outrageous" *Surgeon 3* "so, now [the hospitalist] has been used as a substitute of someone who's on sick leave (.) but the hospitalist cannot be used for that (.) that can't be included in the [hospitalist's] job description" *Surgeon 4* "and the hospitalist doesn't do simple paperwork (.) nor carry out other's work" *Surgeon 1*
An authority	Technical	Position	"patients' feeling of security (.) was enhanced [when the hospitalist was around] (4) … (.) and the question of liability (1) so I think it is reasonable (.) the collaboration * between the nurse and the hospitalist" *Nurse 2*
An autonomous expert	Technical	Jurisdiction Position	"a hospitalist is like (.) like a kind of (.) well (.) physician who has like more time for the patients than surgeons" *Nurse 3* "compared to surgeons the hospitalist would bring (1) more depth into patient care through her expertise" *Nurse 1*
A labourer	Technical	Control	"and [to establish a clear role for the hospitalist] we [consultant and directors] have planned (.) for the hospitalist to keep a working diary (1) < for five days (.) with five-minute accuracy >" *Consultant*
An available medical specialist	Contextual	Practical needs	"often challenges [in patient care] (1) could be sorted out if a physician was just present in the ward (1) … so you [the hospitalist] have already (.) you get to collaborate with nurses" *Ward nurse*
A real-life worker	Contextual	Practical needs	"I mean I've done this and that in the ward and thought that if I don't do this §who would?§" *Hospitalist* "[i]t doesn't work like that (.) that [I] just go there and say that this is how things are done (.) but I need to discuss it with a surgeon (.) or like today I had a discussion with an anaesthesiologist" *Hospitalist* "but merely like flexible movement by the hospitalist [in accordance with everyday challenges in the ward] (.)" *Surgeon 3*
A medical specialist pioneer	Technical and contextual	Medical position Practical needs	"a hospitalist must know something that no one else knows (.) so (.) [hospitalist] needs to add value to our system" *Surgeon 2* "a hospitalist needs to have time to write and think (.) and plan (.) to create the hospitalist's job description (1)" *Surgeon 3*

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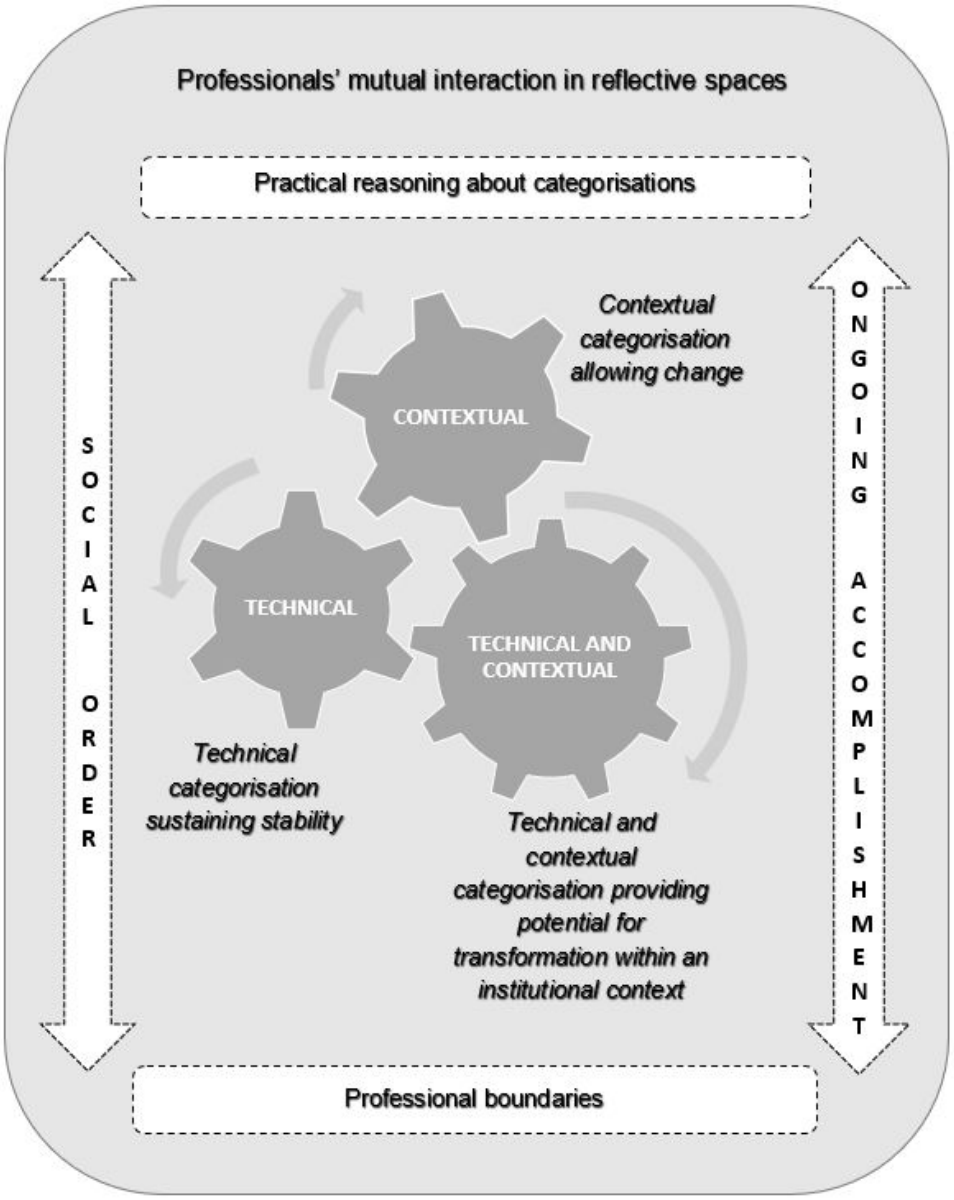

Figure 1. Professional boundaries in-action in reflective spaces.

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