Does the doctor know best?
A study on inter-professional identity negotiation within an era of new professionalism

Erika Lokatt
KTH Royal Institute of Technology
Department of Industrial economics and management
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1. Introduction

“Training is to teach the nurse to handle the agencies within our control which restore health and life, in strict obedience to the physician’s or surgeon’s power and knowledge.”

– Florence Nightingale, 1882

1.1. A new era of professionalism

Institutionalised professions have for many centuries enjoyed considerable privileges in our society. The possession of exclusive knowledge bases, closely linked to societal values and needs, has throughout the years granted these closed communities power, prestige and autonomy over their own work (Sarfatti Larson, 1979). Distinct ethics and an altruistic drive to serve society rather than personal interests have historically legitimised this privilege of self-regulation, where loyalties to the own profession often have been stronger than those to an employer or an organisation (Morgan & Ogbonna, 2008). Members of a profession have typically been focused on raising standards within their own discipline rather than conforming to bureaucratic standards (Morgan & Ogbonna, 2008). The superior position becomes highly visible in the quotation above, where physicians and surgeons, belonging to the well-established profession of medicine, are naturally associated with power and knowledge and should therefore be served by their assistants. The conception that nurses blindly should obey the doctors’ orders has historically been unquestioned in society, where the important issue of societal health has been in the hands of medical expertise and judgement.

As an active agent in societal development, professions do not operate in isolation but are part of a larger complex landscape where political, economical, educational and social trends all interact and continuously shape the conditions for professional work (Butler et al., 2012). Although many people would probably still associate physicians, lawyers and pilots with power and prestige, professional practice has been subject to extensive reforms during the last decades (Parding et al., 2012). Muzio & Ackroyd (2007) describe an “increasingly hostile ideological, institutional and economic environment in which professions operate”. This description refers to contemporary social, political, cultural, economic, geographical and epistemological influences (Butler et al., 2012) that have all come to challenge previous unopposed ways of directing work within the professions. As a result of these new trends, the altruistic motivation within professions has been questioned (Ackroyd et al., 2007),
with the result of professional practice becoming less autonomous and more scrutinised from outside.

1.2. From heroes to laymen

The new conditions for professional practice have shown substantial implications for the health care sector (in this thesis referring to hospitals). Especially, the two professions of medicine (physicians) and nursing have faced major changes that have come to challenge professional identities within these communities. Making up one of the most established professions in society (von Knorring, 2012), medical doctors have historically been trained to independently perform complex working tasks and to trust their own experience and judgement in handling unforeseen situations without interference from other occupational groups (Agevall & Jonnergård, 2007; Dent, 2008). Responsibility for society’s health has granted the profession its own control over health care practice (Aili & Nilsson, 2007). This privilege of self-regulation has however been circumscribed as a consequence of the New Public Management-reforms that reached health care in the 1990s (Levay & Waks, 2009; Leonard, 2003). These new logics, which introduced management models from the private sector into hospitals (Parding et al., 2012), advocated patient-centred leadership, cost-efficiency and a focus on market mechanisms. As a result of these changes, physicians now find their autonomy threatened by standardisations, non-medical managers and increased external scrutiny. External changes have forced the medical profession to reconsider their professional identities, as the very core of what it entails to be a physician has become contested (Parding et al., 2012). What could earlier be understood as undisputed codes of conduct within the medical profession has now changed with new discourses on health care practice that legitimise competing notions of professional autonomy.

1.3. From white dresses to white collars

Increased standardization and scrutiny over medical work is not the only source for contemporary power struggles within the health care organisation. Resulting from an on-going professionalization, nursing has during the last decades gained considerable influence over medical practice. This trend of professionalization does in part derive from the new market logics introduced with New Public Management, but is also a result of education reforms and an augmented gender debate.

While physicians always have enjoyed the privileges from being one of the most strongly institutionalised professions in society (Lindgren, 2000; Gleeson & Knights, 1

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1 Although there are competing notions of whether nursing should be legitimised full professional status in society, I will throughout the thesis refer to this occupation as a profession.
nursing was long considered a semi-profession. This limited access to the professional community was not solely based in a lack of full autonomy and distinctive knowledge bases, but could also be traced to the nursing occupation’s feminine character (Bolton & Muzio, 2008; Chua & Clegg, 1990, Dent, 2008). Emerging within a strong patriarchy discourse (Holmer-Nadesan, 1996), nursing work was historically carried out by young, unmarried women within organisations characterised by strong institutionalised male powers (Chua & Clegg, 1990). Although the excess of unqualified nurse practitioners during the First World War resulted in a fear among ‘proper’ nurses to lose their social and economic rewards to untrained personnel, and thus encouraged them to request standardised training, nursing was long considered being nothing more than a natural extension of womanhood. In the 1960s -70s, when women began to claim their equality with men and advocate independency, the occupation finally reached initial professionalization (Banham & Connelly, 2002).

While physicians have defended their profession against economic and administrative considerations in diagnosing and treatment decisions by emphasising the importance of medical and scientific knowledge (Iedema et al, 2003; Waring & Bishop, 2013), nurses have applied a multitude of strategies to increase their autonomy within certain knowledge fields and areas of decision-making (Salhani & Coulter, 2009; Traynor et al., 2010). This process is still on-going, and there are different opinions on whether nurses have reached full professional status in society yet. What is clear, however, is that the profession has become more involved in medical work. From only having the responsibility to subtly communicate recommendations without interfering with the physician’s right to take all initiatives (Stein, 1967), nurses today possess the formal right to perform tasks and make decisions previously strictly limited to the doctoral workforce (Dent, 2008). In the beginning of the 21st century, so called ‘nurse practitioners’ within the British health care system started to take over parts of the physicians’ routine work (Banham & Connelly, 2002). This new division of responsibilities was not only a result of specialised nursing training, but was also a way to unburden physicians and thus make the organisation more efficient in the spirit of New Public Management. Today, nurses have reached specialisation within additional medical areas and assist their physician colleagues in everything from triaging and outpatient consultations to anaesthetics and surgery work (Dent, 2008). Discourses within New Public Management have also induced substantial changes into nurses’ position within hospital management. Where the former emphasis on leadership and support of nursing work allowed for full focus on caring, extended requirements in terms of financial constraints, budgeting and efficiency have now forced many nurses to take on a complex set of (sometimes conflicting) perspectives in their occupational positions (Bolton, 2005).
1.4. From clear-cut borders to foggy battle fields

The issues outlined above have certainly come to change the preconditions for political gameplay within the health care organisation, as decisional power seems to become decentralised from the medical profession. Both physicians and nurses are currently facing new discursive worlds, where administrative and economic logics as well as performative notions of managership disturb established power relations between these two professions. Following the introduced market logics, a focus on efficiency and cost-effectiveness has in one sense reduced the significance of professional boundaries and overthrown the traditional organisational culture with strong professional hierarchies. From a managerial view, it becomes less important who performs different tasks and more important that the tasks are taken care of in a way that makes the organisation efficient. Simultaneously, it can be argued that an understanding of professional boundaries has become more important than ever, as an overlap in knowledge and working tasks now has complicated the process of professional identification for physicians as well as nurses. Important to stress is that what historically qualified as good professional practice has to be reconsidered within the new market logics. Where earlier notions of medical autonomy as indispensable for societal health traditionally have granted physicians unlimited decisional power, this professional autonomy is today considered more of a challenge to market-efficient organisations, as change initiatives from non-medical discourses tend to encounter ‘control-maintaining strategies’ from the physicians (Lokatt & Sack, 2013). Still, more traditional conceptions of professional boundaries remain encouraged through medical and nursing education, where a ‘production of producers-logic’ in most cases still dominates the agenda. These contrarious expectations on professionals inevitably give rise to a cultural clash and create major confusion within the health care organisation. What is actually expected from the different professionals? It is easily noted how a negotiation for physicians’ as well as nurses’ identities and organisational places becomes more relevant and complex than ever.

It also becomes apparent that the quest for new professional identities and organisational positions takes place within a continuous inter-professional negotiation. The recognition of nursing’s increased autonomy and legitimacy becomes slowed down by the medical profession’s continuing fight for superiority (Banham & Connelly, 2002). As the nursing profession has encroached upon medical territories, however, physicians now not only have to defend their power-legitimising knowledge from outside scrutiny, but also from a profession with adjacent, and sometimes even over-lapping, knowledge bases. Nurses have to reconsider core values of their professional identity while defending their increasing autonomy to the physicians, whose historical superiority is being challenged by new
structures of responsibilities. Nursing’s increased organisational standing as a more independent entity has thus constructed unclear professional boundaries in the providing of patient care and resulted in a ‘turf-war’ (Banham & Connelly, 2002). In an organisation where professional identity has always played the leading part, new organisational logics now push the standing tension between nurses and physicians to its limit and change the preconditions for professional collaboration.

Banham & Connelly (2002) note how preconditions for successful inter-professional work currently become challenged by competing notions of communication between nurses and physicians. Physicians seem to expect (and accept) little nursing input, which can be coupled to a professional tradition of unquestioned expertise, autonomy and responsibility rather than interdependence and dialogue. In a health care organisation characterised by attenuated professional hierarchies and inter-professional teams, it therefore becomes important to stress how problems in teamwork and inefficiency can be understood in terms of underlying inter-professional struggles for new identities. In order to secure efficiency and patient quality within the health care organisation, it thus becomes critical to better understand the underlying power struggles that constitute inter-professional identity construction. Although efforts have been put into understanding mechanisms of professional adjustment to different forms of external pressure, thereby touching upon the concept of professional identity reconstruction, this understanding builds almost exclusively on a single-profession approach. While insights about how physicians and nurses make sense of, and react to, new organisational preconditions have been provided (Fox, 1993; Banham & Connelly, 2002; Bolton, 2003; Rosengren & Ottosson, 2007; Currie et al., 2008; Dent, 2008; Bolton et al., 2011), an understanding for how the professional identities are reconstructed in relation to other professions appears somewhat neglected. Salhani & Coulter (2009) touch upon the inter-professional perspective by investigating the ‘complexity and robustness of micro-political dynamics in the constitution of professional and collaborative interprofessional work relations’. However, their contribution is limited to strategies that are consciously undertaken by nurses and consideration is not taken to how the social context constructs pre-conditions for inter-professional negotiation. Moreover, while stressing the importance of micro-political dynamics between professions, also Salhani & Coulter come to rely on a single-profession logic.

1.5. Research aim and contributions

Acknowledging the need for a more dynamic understanding of professional negotiation within health care, this thesis addresses the issue of professional identity construction from an inter-professional perspective, where consideration is taken to the simultaneous reproduction of nursing and physician identities. In doing so, it builds further on a research tradition that seeks to understand professional power
politics by recognising the health system as a negotiated order (Svensson, 1996; Allen, 1997; Salhani & Coulter, 2009; Nugus et al., 2010). Within an era where overlapping knowledge bases and unclear divisions of responsibilities make inter-professional boundaries more complex than ever, the thesis aims to increase the understanding for how the medical and nursing professions reconstruct their professional identities in relation to each other. By establishing a conceptual model that describes the inter-professional power struggles between these two professions, it will be possible to determine what mechanisms lie behind negotiated professional identities and how these influence preconditions for inter-professional teamwork. This kind of understanding will also make it easier to define responsibilities, sources for underlying conflict and critical negotiation points. With gained insights about what actually happens in, and determines the outcome of, inter-professional interactions, it becomes easier to avoid unwarranted battles and increase the chances for patient quality in tomorrow’s health care organisation.
2. Theoretical background

Before engaging in the study on professional negotiation, this chapter introduces the theoretical standpoints from which the thesis takes departure. It starts out with an introduction to professions as a concept. It further outlines how history, organisation, and the surrounding context all become factors that interoperate in a discursive construction of professional identities. An inter-professional perspective for understanding the reconstruction of professional boundaries is thereafter established by discussing how professional identities become negotiated through external pressures as well as through stronger competition from adjacent professional communities. The chapter concludes with a discussion on the established inter-professional perspective applied within the health care organisation.

2.1. Introducing professions

While acknowledging how the concept of professions is frequently used in contemporary research as well as in everyday speech, a major disconsensus on how to define it can still be noted (Butler et al., 2012). Some basic characteristics that distinguish professions from other occupational groups are suggested to be (Lindgren, 2000, p. 68):

1. Systematic theory (a shared knowledge base grounded in a distinct science)
2. Authority (formal legitimisation)
3. Occupational autonomy (legitimised self-regulation of the work tasks)
4. Distinct ethics (a shared system of norms for professional practitioners).

Acknowledging the autonomous aspect of professional work, professionalism has (next to free market and bureaucracy) been considered a third ideal type for how work is organised (Freidson, 2001). It can be defined as “an ideal type where the organization of, and control over work is realized by the occupation instead of by the market or by an hierarchy” (Van der Krogt, 2007). Professionalism in its traditional form thus emerges in the belief that some areas of work are too specialised to be performed by individuals lacking extensive education and experience, while also being too complex to become standardised, rationalised or commercialised. Distinct ethics and an altruistic drive to serve society rather than personal interests have historically legitimised this privilege of self-regulation, where loyalties to the own profession often have been stronger than those to an employer or an organisation (Morgan & Ogbonna, 2008). Professional autonomy naturally results in a phenomenon of closure (Morgan & Ogbonna, 2008), which grants power to the profession in a gatekeeping way as outside scrutiny is rebuffed (Brint, 1993).

There has for many years now been an on-going discussion on what occupational
groups should qualify as professionals (Noordegraaf & Van der Meulen, 2008). While some authors stress the importance of “identifiable work that can be standardized” (Whitley, 1989; Mintzberg, 2004), others contend that professions emerge in the formation of strong occupational identities (Grey, 1997; Davies, 2006). It has thus been discussed whether the concept of professions should be explained through inherent characteristics or as a result of power processes (Van der Krogt, 2007). While early definitions of professions tend to focus on characteristics acquired through institutionalised control and autonomy, more recent takes on the concept stress context-dependency and influence of social structures in the construction of professional identities.

2.2. Acknowledging professions as social constructions

It is widely acknowledged that high-valued knowledge grants professions power and status in organisations as well as in society. How this power is constructed has however been debated over the years. During the 1950s and 60s, a trait approach to understanding the concept of professionalism could be seen as dominating (Brint, 1993; Saks, 2012). This view departed from the notion that the very possession of high-level knowledge and expertise, accompanied by factors such as rationality, ethical standards, public altruism and educational credentials was what separated professional practices from other occupations in society. However, this rather uncritical understanding soon became object to criticism by scholars stressing how the process of professional emergence should be considered the source to acquired and sustained power within these closed communities (Brint, 1993). Bloor & Dawson (1994) note how the process of professionalization is nowhere simple or straightforward, but rather “comprises a complex and dynamic series of processes involving many players at different levels over a long period of time” (p. 282). Following the work of Wilensky, Caplow and Abbott, professionalization can be understood as including the following six characteristics (Bloor & Dawson, 1994):

1. The formation of a professional association
2. Attempts by members of the profession to gain control over the particular area of work
3. The development of minimum standards of professional training and the establishment of training facilities
4. The pursuit of a professional knowledge base
5. The development of a code of ethics
6. Political agitation to gain public support for the claim to professional status and for affiliation with, and regulation by, the state.

The professionalization process takes the form of a self-regulated production of producers. By controlling entrance to the profession through standardised
professional training and shared ethics, a closed, ‘normalised’ community is constructed. This community becomes characterised by identity, commitment and loyalty to the own group (Sarfatti Larsson, 1979). While acknowledging how processes of professionalization exert major impact on professional values and logics through internal mechanisms of control, it becomes important to stress how the issue of professional identity construction also holds an aspect of external impact. As pointed out by Bloor & Dawson (1994), ‘Individuals in organizations do not ‘sense-make’ in isolation, but rather, they rely heavily upon observing the behaviour of others in social settings and upon the shared meanings others give to that behaviour.’ (p. 278). Building on the same relational logic, Iedema et al. (2003) describe professions as socially constructed through performances:

”... the boundary between profession and organization is seen as an effect of specific interactants’ performances, rather than as inherent to professionalism as such.”

This relational understanding implies that professional identities are never chosen by the professions themselves (and forced upon new entrants through professionalization processes), but rather become the negotiated products of social structures and values within the surrounding organisation and society.

2.3. Exploring the concept of professional identities

Building on this social constructionist approach, identities can be understood as “negotiated meanings of experiences arising from membership in social communities both in professional education and working-life” (Parding et al., p. 300). Identities are under continuous reconstruction and should therefore be understood as processes rather than products. As Lindgren and Packendorff (2008) stress:

“The individual is an active part of the ongoing construction of her/himself.”

Continuous processes of identification can be explored in terms of power struggles between different subject positions, where the specific context (time and place) determines which of these should be considered legitimate and possible to draw on. Subject positions should here be understood as discursive products that limit and set expectations on individuals (Jorgensen & Phillips, 2000, p. 48) by locating them within hierarchies inherent to specific discourses (Holmer-Nadesan, 1996 p. 57). Organisations thus enable and repress identities through mechanisms of underlying power. Following this logic, Clarke et al. (2009) describe professional identities as constructed within ‘organizationally based discursive regimes which offer positions, or epistemological spaces, for individuals and groups to occupy’. While the social structures enable certain subject positions to become accepted, the legitimisation of these very positions in turn reinforces the social structures, which again reinforce the
acknowledged subject positions. This inter-relationship couples back to how Iedema et al. choose to describe the boundary between organisation and profession as emerging in ‘interactants’ performances’.

It becomes important to stress how not only organisational, but also societal, values and expectations set their mark on the process of professional identity construction (Lindgren & Packendorff, 2008). Individuals tend to position themselves in relation to normalised values, religious beliefs and political ideologies. An illuminating example of this is how perceptions of gender in the broader society as well as in the individual organisation exert major control over how individuals position themselves in relation to different discourses. Leonard (2003) notes how societal perceptions of gender difference come to define individuals as ‘in’ or ‘out’ of certain positions. How individuals locate themselves relative different subject positions thus depends on how social and cultural practices within the surrounding context have constructed established notions of certain (gendered) qualities as desirable or undesirable in different settings. As a direct result of the patriarchy discourse, which can be understood as ‘a traditional system of hierarchical male authority based in piety toward tradition and toward the master’ (Holmer-Nadesan, 1996, p. 53), women tend to be over-represented in low power/status positions where they are more vulnerable to authority and lack immediate control over work processes (Holmer-Nadesan, 1996, p. 56). This makes it hard for women-dominated occupations to draw on subject positions that infer authority and control, as there is an institutionalised conception that women are not desirable in these positions. This should be a contributing factor to why many nurses feel uncomfortable in their new occupational roles as clinical managers (Bolton, 2003; Rosengren & Ottosson, 2007; Dent; 2008). Lindgren (2010) describes how professions traditionally have been male-dominated communities, constructed within the realms of patriarchal norms. Women in established, male-dominated professions are therefore often absent (undesired) within sub-proessions that infer high status. This is an interesting insight to bear in mind when studying gender divisions within different specialities in for example medicine and law. Organisational and societal expectations naturally make women draw on subject positions that yield little status and rewards, making gender becoming a power relation where superiority and subordination are highly present. Manifestations of a still prevailing patriarchy discourse can be found in how diminished standing for a profession (lower salary and status) often readily is connected to an increase of women within it (Lindgren, 2000, p. 70). It becomes obvious that societal perceptions of gender difference have considerable implications for how different professions/sub-professions perceive their possibility to draw on different subject positions in the construction of identities. The same logic also holds true for organisational and societal expectations coupled to class, ethnicity, etc.
Building on a constructionist approach, I claim in my thesis that professional identities are social constructions, emerging in the complex interplay between historical paths, organisational structures and expectations from the surrounding society. It is the underlying power struggles between competing notions of what it entails to be a professional that construct and constrain possibilities to act, thereby enabling certain subject positions that in turn position individuals relative different discourses and form professional identities. Professional identity can thus be understood as a complex result of internal as well as external dynamics, where normalisation processes and power struggles between organisational discourses enable, constrain and reinforce certain subject positions. Not only the controlled production of producers, but also disciplining forces from organisation and surrounding society, contribute to how professions make sense of their occupational role and construct professional boundaries.

2.4. Professions under pressure: Reconstructing professional identities

It is widely acknowledged that the preconditions for professional practice have come to change substantially during the last decades. Social, political, cultural, economic, geographical and epistemological influences have all introduced new external expectations on professions and challenged unopposed ways of directing work within these communities (Butler et al., 2012).

It has already been stressed how organisational and societal expectations on the profession enable and constrain specific subject positions through discursive power struggles. As long as discourses co-exist beside each other without legitimising a set of subject positions that put contrarious demands on what it entails to be a professional, established professional identities are reinforced through organisational values, as described above. Complexity arises when competing discourses enable contrarious subject positions that hinder each other. In these cases, the subject faces over-determination (Jorgensen & Phillips, p. 49) and the struggle between conflicting discourses results in antagonism (Jorgensen & Phillips, p. 55). Since identity construction can be understood as the process whereby antagonism is reduced, the rise of contrarious subject positions puts pressure on established identities. By acknowledging competing expectations as legitimate, antagonism opens up for identity reconstruction.

Following last decades’ external influences on professional practice, a rise of conflicting discourses has resulted in the subject becoming increasingly over-determined. Developments within technology, production and organisational structures construct new preconditions for professional practice, where legitimate notions of behaviour, attitudes and skills within these communities become contested (Parding et al., 2012). An illustrative example is how decisional rights in
many organisations have moved from a professional to a managerial level, at the
same time as operational procedures have become more standardised (Parding et al.,
2012). These new conditions put pressure on professions to act less as self-regulated
societies and more as integral parts of organisational communities. As autonomy
hereby is reduced, notions of professional power and influence become contested.
Subject positions that earlier enjoyed unchallenged legitimacy among practitioners
now face opposition from previous hidden notions of what it entails to be a
professional. These are notions that, because of prevailing societal and organisational
norms, not until now have been allowed to establish themselves as legitimate.
Nevertheless, today’s increasing antagonism between different notions of
professionalism inevitably fosters a reconstruction of professional identities. It
becomes evident that external changes have made professional identities more
unstable and contested than before. As pointed out by Butler et al. (2012), ‘what
counts as peripheral to a profession is constantly being modified by institutional
reform, political restructuring and wider economic trends’. Noting how last decades
have given rise to major discursive antagonism between different stakeholders’
expectations on professional practice, professions have been forced to start
negotiating for their identities.

2.5. Inter-professional power struggles

Society today stands for an increase in professional communities. Ackroyd & Muzio
(2007) note how “the development of new forms of knowledge and the rise of new
knowledge occupations are offering a serious challenge to the traditional or
established professions”. Ever since the 1950s, there has been an on-going
specialisation in terms of complex scientific knowledge (Freidson, 2001, p. 21). This
trend can today be considered more distinguishable than ever, noting how
universities are currently increasing their scope of scientific education to include
programs such as tourism, coaching, leisure studies, food science and fashion studies
(Brante, 2010). While Brante stresses how this education hype calls for stronger, more
excluding, definitions of professional knowledge, I would rather argue that the rising
amount of scientific communities inevitably results in an increased number of
professions with their own identities. This increase in professional communities
consequently comes to result in more inter-professional contact but also in more
overlapping professional boundaries. Noting differences in levels of power and
influence between different professions, organisations come nevertheless to face
more situations where different professional identities interact in the daily
operations.

These inter-professional relations add another aspect to the dynamics of professional
identity construction. While conflicting expectations from external stakeholders have
forced professions to engage in a continuous negotiation for their boundaries, the increasing professionalization creates closed communities with adjacent (and sometimes overlapping) knowledge bases. The similarities in knowledge result in a competition for the same organisational positions. An increased professionalization has also given rise to new structures for authority and responsibility. Where institutionalised professions earlier have constructed their identities without interference from other occupations, professionalised communities now encroach upon positions that were earlier controlled by distinct institutionalised professions, resulting in a continuous power struggle.

What then affects the outcome of this inter-professional negotiation? It has already been acknowledged how social and cultural practices within the surrounding context construct pre-established expectations on gender, class, ethnicity etc. These factors (gender, class, ethnicity) can thus be understood as power bases that are (consciously or unconsciously) drawn upon in the inter-professional struggles for identity. By analysing what power bases seem to give legitimacy and in what relations these are used (consciously or unconsciously) in negotiations, it becomes possible to establish a conceptual model that describes inter-professional power struggles. The inter-professional perspective can be summarized with the following assumptions /dimensions of key concepts:

Table 1: The inter-professional perspective

| Professions | Social constructions  
|             | Constructed through performances in a larger social context |
| Professional identities | Dependent on social (material and cultural) context  
|             | Continuously under negotiation/reconstruction |
| Professional borderlines | Complex/blurry negotiation arenas where the reconstruction of professional identities takes place |
| Professional boundaries | Temporary (discursive) results of (re)constructed professional identities |
| Power bases | General characteristic inherent to a profession  
|             | Decisive forces that determine the results of professional negotiation |
2.6. The health care case

The health care organisation holds a unique composition of occupational groups in a close internal network (Ackroyd et al., 2007). Dynamics between these groups have historically been established within a strong professional hierarchy, where society’s conceptions of high-valued knowledge combined with a strong patriarchy discourse have positioned nurses as subordinate to physicians’ orders and agendas. External forces in terms of new market logics, increased professionalization, restructured education and gender consciousness are currently challenging these dynamics, reconstructing inter-relational dynamics between the professions and forming new professional identities.

2.6.1. The ‘new’ medical profession

As one of the most established professions in society, medical doctors have throughout the years been trained to independently perform complex working tasks and to trust their own experience in handling unforeseen situations without interference from other occupational groups (Agevall & Jonnergård, 2007; Dent, 2008). As a consequence of the autonomous medical profession, the 20th century was long characterised by physicians enjoying almost complete control over the health care organisation (Domagalski, 2008). During recent decades, economical, political and technological factors have all come to challenge the previous well-established medical discourse. Many changes have emerged as results of the market economy influences that affected health care during the 1990s, commonly known as the wave of New Public Management (Levay & Waks, 2009; Leonard, 2003). Within this logic, an increased focus on patient quality and cost-effectiveness has induced new standardisations, regulations and evidence-based working procedures, that have all come to reduce the ability for physicians to make independent decisions (Walshe & Rundall, 2001; Armstrong & Ogden, 2006; Agevall & Jonnergård, 2007). The introduction of quality registers (Hansen, 2007) and evidence-base medicine (Rosenberg & Donald, 1995; Bernstein, 2004) as means to evaluate and control clinical activity has demystified medical practice and increased the scrutiny of physicians’ former autonomous work. Another strategy for making health care organisations more efficient can be found in the British health care system, where a restructuring of medical training has been implemented in order to shift the power balance from the medical profession to management and government (Bolton, 2011). This new system (referred to as MMC) can be argued to constitute a threat to the medical profession, which no longer is in charge of ‘the production of professional producers’. Physicians also fear that a fragmented education will impair professional unity and destroy a shared sense of belonging.
2.6.2. The ‘new’ nursing profession

Health care has also experienced an increased professionalization within nursing during the last years. This is partly an effect of a more conscious gender debate, where the strong patriarchy discourse has been challenged by increased female autonomy and a push towards more open communication between the sexes (Banham & Connelly, 2002). Nursing has always been a women-dominated occupation (Lindgren, 2000), long considered ‘a natural extension of women-hood’. Historically, nurses were expected to play their part in the ‘doctor-nurse-game’ (Stein, 1967), which was developed as a way to increase patient security while safeguarding the medical profession’s honour within an organisational structure where nurses, despite their possession of unique information about patients’ health status, were expected to blindly obey the doctor’s order (compare with quotation in the beginning of Chapter 1). If a nurse wished to give recommendations on either a treatment or a discharge that could have critical implications for the patient’s health, this should be done in a well-established, subtle manner. The recommendation would need (1.) to appear as coming from the physician and (2.) not to be perceived as a critique against the physician’s own judgement. When phrasing a recommendation in this ‘mystique’ way, the physician would understand what was implied and use authority in commanding the nurse to carry out the treatment. The doctor-nurse game was however overturned in the 1960s -70s, when women began to claim their equality with men and advocate independency (Banham & Connelly, 2002). An augmented debate on gender difference resulted in an increased organisational standing for nurses, where they no longer strictly had to obey the doctor’s order. It was now organisationally accepted if a recommendation came directly from the nurse.

Nurses have also entered organisational arenas that were previously exclusive to the medical profession to occupy (Dent, 2008). These changed divisions of responsibilities are not only a result of conscious gender discussions, but also stem from education reforms and market logics introduced with the entrance of New Public Management. As the focus on patient quality and cost-effectiveness with increased standardisations and control has incorporated more administrative work into the medical profession’s responsibilities, nurses have decreased physicians’ workload by taking over some of their routine medical tasks. However, educational reforms resulting in increased nursing specialisation have also allowed nurses to engage in more complex medical tasks, including anaesthetics and surgery work (Dent, 2008).

Discourses emerging within New Public Management logics have also induced substantial changes into nursing’s position within hospital management. Even if nurses for a long time have played a natural part in the management function, it was earlier questioned whether they should be included in senior management teams or
solely take on line management responsibilities (Bolton, 2003). During last decades, market logics and reconstructed notions of nursing expertise have resulted in the nursing profession taking on more diverse and influential positions within hospital management. Where former emphasis on leadership and support of nursing work allowed for full focus on caring, extended requirements in terms of financial constraints, budgeting and efficiency have now forced many nurses to take on a complex set of (sometimes contrarious) perspectives in their occupational positions (Bolton, 2005), where they also exert influence over decisions that lie in the medical profession’s interest to control.

2.6.3. An inter-professional reconstruction of professional identities

As a consequence of the many external pressures outlined above, the organisation structure where control over work becomes realized by an occupation instead of a market or an hierarchy is inevitably about to change. By introducing new discourses as legitimate within a previous profession-centred organisation, new preconditions for medical practice have now inferred a discursive antagonism that challenges professional identities for both physicians and nurses. All these external influences have made professional boundaries more contested and unstable than before. Physicians and nurses have been forced to negotiate for their professional identities, as the new market logics have introduced alternative discourses on medical practice as legitimate.

Research has addressed the issue of how physicians react to the external changes forced upon them, noting how the profession applies strategic methods to maintain control over their superior position within the organisation. Currie et al. (2008) describe how physicians, at the cost of individual autonomy, practise strategic evidence-based decision-making in order to maintain control over medical knowledge. In a similar way, Fox (1993) shows how the doctoral workforce maintains control over patient consultations by consciously steering conversations in specific medical-centred directions, focusing on medical core knowledge rather than alternative topics of interest for the patient. Studies have also shown how unsatisfying incident reporting sometimes can be reformulated to a question of insufficient financial resources for the medical profession (Currie et al., 2008). Going against research that suggests a contemporary depersonalization of institutionalized professions (Agevall & Jonnergård, 2007), these insights indicate that medical influence has not been reduced but rather reconstructed. Efforts in finding strategies addressing the issue of how leaders without a medical background can gain increased legitimacy (Walshe & Rundall, 2001; Davies, 2006) further strengthen the notion of medical dominance within the health care organisation. This is in line with Freidson’s idea that ‘new forces of regulation are changing the structure of control in the professions, but not the scope
of professional control’ (Brint, 1993, p. 266). In the negotiation for professional identities, professional boundaries nevertheless become reconstructed. An example of this is how physicians, by strategically acting and talking about medical work in ways that protect their own agenda while sacrificing the patient perspective, become viewed as less altruistic than before. Although the medical profession still can be expected to exert major control over the health care operations, this control is the result of a continuous underlying negotiation between different logics of medical practice.

In the striving for increased legitimacy and full professional status, nurses have always negotiated for their position within the health care organisation. The recent introduction of market logics, however, makes the struggle for professional nursing identity becoming more complex than ever. Research has delved into the issue of how nurses make sense of their new medical careers, where caring no longer is the only aspect of good professional practice. Both Bolton (2003) and Dent (2008) note how these professionals sometimes tend to disassociate themselves from the term ‘manager’ as they consider this being something outside the institutionalised discourse of caring. It has further been noted how nurses assigned managerial positions experience a challenge to retain respect from their colleagues, who do not perceive managerial tasks as appropriate for nurses to take on (Rosengren & Ottosson, 2007). Following this intern opposition, nurses in managerial positions now often combine their administrative tasks with clinical work, resulting in an increased workload. Also the entrance into medical tasks earlier carried out by physicians has affected the way in which the nursing profession perceives its standing within the organisation. Although the engagement in clinical examinations should enable higher status, the excess of tasks that are carried out in order to ‘reduce costs’ or ‘diminish the physicians’ working hours’ makes the nursing profession feeling devalued. As concluded by Banham and Connelly: ‘Nurses do not wish to be cheaper doctor substitutes or people who perform tasks that ‘bore’ doctors’ (p. 262). These very issues highlight the power struggles about what should belong to nursing practice. By taking over medical areas previously held by physicians, and reluctantly incorporating managerial tasks into the professional role while still holding on to clinical work, nursing identities become continuously reconstructed.

While these insights about how health care professions react to external pressures shed light on reconstructed professional identities, the inter-professional perspective appears rather absent in this understanding. Salhani and Coulter (2009) acknowledge how the micro-politics between nurses and physicians become critical in the construction of new professional boundaries. They describe how nurses within mental health form political alliances and informal arrangements in their work with psychiatrists. While stressing the scope of inter-professional power struggles, the
authors’ understanding becomes nevertheless limited to strategies consciously undertaken by the nurses. Consideration is not taken to how organisational and societal expectations construct the pre-conditions for inter-professional negotiation or how the physicians counter-act to the nurses’ political actions. So what can actually be said about the inter-professional power struggles that determine the outcome of identity negotiation? It has already been acknowledged how the quest for new professional identities and organisational positions takes place within a continuous inter-professional negotiation, where nursing’s expected increase in autonomy and status becomes challenged by physician’s seemingly successful efforts to maintain a superior position within the health care organisation. Nevertheless, external pressures have resulted in overlapping knowledge bases and a competition for the same subject positions, which now forces physicians to defend their organisational position to an increasingly influential nursing profession. So what then decides the outcome of professional negotiation between physicians and nurses? Within the quest for new forms of control, other factors than sole professional belonging seem to affect reconstructed identities. Pratt et al. (2006) note how resident physicians adapt their identity creation processes to the working tasks during specialist training. As both physicians’ and nurses’ working tasks today have become highly diversified (as a result of increased specialization and market logics), identity construction can be expected to vary between different disciplines within medicine as well as nursing. Furthermore, both Dent (2008) and Domagalski (2008) observe a difference in professional attitude towards New Public Management, where young physicians who have not experienced the medical golden age seem to accept the market economy logics to a larger extent than their more senior colleagues. It has also been stressed how external as well as internal conceptions of gender, class and ethnicity determine how sub-(professions) are allowed to position themselves within discursive hierarchies. All these factors then constitute potential power bases that together with historical notions of professional practice determine outcomes of inter-professional negotiation.

Acknowledging how the new era of professionalism has threatened professional identities and given rise to a turf war between nurses and physicians, efficient management of the health care organisation presupposes an increased understanding for what actually goes on in the inter-professional power struggles.

*Which identity belongs to which profession in the new era of professionalism?*

*What subject positions can be “stolen” from other (competing) professions?*

*Which negotiation positions are possible for the different professions to draw on?*

*What power bases seem to give legitimacy in negotiation and determine the outcome of inter-professional power struggles?*
In what relations are these power bases (consciously or unconsciously) drawn upon?

By delving deeper into these questions, it should be possible to increase the understanding for how the medical and nursing professions reconstruct their identities in relation to each other, forming new preconceptions for inter-professional teamwork within the health care organisation.

3. Methodology

In establishing the methodological framework for this thesis, an introduction to how reality and knowledge are being understood as context-based, discursive constructions of underlying power struggles is initially provided. Thereafter follows a discussion on how discourses and spaces of action are continuously enabled and constrained through the practice of language, often delimiting each other. The research design is further outlined, presenting the case-study conducted at a large Swedish emergency hospital. The chapter concludes with a brief discussion on methodological considerations.

3.1. A constructionist understanding of reality and knowledge

Having noted how professional identities are perceived as always being constructed within the realms of organisational and societal contexts, this thesis naturally comes to depart from the notion that reality is socially constructed. Within this view, no such thing as objective knowledge exists. As pointed out by Steedman: “knowledge cannot be separated from the knower” (Alvesson & Sköldberg, 2009, p. 1). Building on Michel Foucault’s theories, knowledge is here understood as being produced in a close interplay with power through the practice of discourse. It is never innocent, since it cannot be cleansed from power (Alvesson & Willmott, 2003, p. 2).

3.1.1. The concept of discourse

Although conceptions of discourse have shown to proliferate significantly between different schools of thought, a common understanding of the concept builds to a certain extent on Foucault’s fundamental ideas that “discourses are something rather steady that set the limits for what can be understood as meaning” and that “the truth is produced within the discourse” (Jorgensen & Phillips, 2000, pp. 19-20). Commonly accepted ideas are always infiltrated with history, and discourses can therefore only become temporarily steady constructions moulded by social notions prevailing at specific places over specific time frames.
Building on Laclau and Mouffe’s critique to the Foucauldian view, which states that only one discourse can prevail at any time, several discourses should always be considered co-existing beside each other, constantly competing for acceptance (Jorgensen & Phillips, 2000, p. 34). Just as important as understanding historical rules shaping conceptions and interpretations (Bevir, 1999, p. 348, Jorgensen & Phillips, 2000, p. 19), becomes thus the identification of alternative interpretations that, on the basis of reigning social norms, have not been allowed to establish themselves as obvious (Howarth, 2007, p. 85). Conceptions that become “ignored” can be seen to constitute a discursive field, in relation to which the dominating discourse is always being shaped and re-shaped (Jorgensen & Phillips, 2000, p. 34). The “weaker” conceptions are, despite their perceived invisibility, in fact what enables the “stronger” conceptions to become accepted, since no phenomenon can be ascribed meaning without being understood in relation to a competing notion of itself. This is what the French philosopher Jacques Derrida stresses when pointing out how the constant contradictions making up mankind’s very existence become concealed through rationalization processes, where unity is rewarded over differentiation (Cooper & Burrell, 1988, pp. 99-100, Hassard & Parker, 1993, p. 10). The co-existence of different conceptions lies also in line with how scholars have been able to conclude that “free and autonomous expressions often suppress alternative representations, and thus hide the monopoly of existing codes” (Deetz, 2003, p. 24). A discourse could therefore be understood as a (hidden) reduction of possibilities with the aim of creating unambiguousness (Jorgensen & Phillips, 2000, p. 34).

3.1.2. The interplay between power and knowledge

It becomes important to stress the constantly on-going power struggles between different conceptions, where time and place determine which of these should be considered legitimate. Drawing on Willmott’s (2013) critique to uncritical perspectives on power, which tend to see the concept as an attribute to be possessed by individuals or groups, power is here understood as a relational phenomenon:

“… power does not reside in things, but in a network of relationships which are systematically interconnected.”

– Burrell, 1988, p. 227

Within the power struggles constituting discourse formation, knowledge plays a central part, and thus becomes a direct source to power (Börjesson & Rehn, 2009, p. 89). Power and knowledge are intertwinedly produced (Wilson, 2013, p. 46), reinforcing each other through a continuous feedback process (Hörnqvist, 2012, p. 98). While power sets the limits for what can be perceived as knowledge, the resulting notions of what constitutes knowledge in turn reinforce prevailing power relations. Furthermore, the discursively constructed knowledge sets the limits for
what is understood as “the truth”. In this way, truth also becomes a discursive construct directly linked to prevailing notions of knowledge, never definitive or objective. As Foucault puts it:

"The problem with knowledge is not that it conceals/distorts the truth, it creates it”.

The conception of discursive constructions as temporarily representations of underlying domination struggles can thus be related to a complex of power/knowledge, where discourses constitute the very core of “power execution”. The discourse becomes an instance where knowledge, truth and power merge together (Howarth, 2007, pp. 79-80). Power can be argued having a productive, defining role that emerges in the co-existence of different discourses competing for accepted notions of knowledge. The power creates and constrains possibilities to act in the continuous struggle for dominance (Christensen et al., 2011, p. 87), and has by Jorgensen & Phillips (2000) been considered the positive source for social reality (p. 20).

3.2. Analysing the reconstruction of professional identities

If discourses constitute the very core of power execution, an analysis of what discourses are drawn upon within the health care organisation should provide valuable understanding of power struggles between physicians and nurses. Valuable insights about this political play should also be obtained by studying the very interaction between these two professions in different organisational contexts.

3.2.1. The continuous interplay between discourses and spaces of action

It has already been stressed how professional identities are constructed within ‘organizationally based discursive regimes which offer positions, or epistemological spaces, for individuals and groups to occupy’. Inspired by the work of Regnö (2013), I understand the preconditions for professional negotiation as a result of material and cultural conditions prevailing within the organisation at any time. Material conditions here refer to hierarchical structures, division of powers and responsibilities, structures for how work is organized and distributed between professions, the nature of financial and non-financial rewards, etc. Cultural conditions should instead be understood as the dominant conceptions of professions in relation to factors such as expertise, importance, rights and gender. Material conditions come to exert a major influence on cultural conditions. An example of this is how low salaries often yield little power and influence within an organisation, as the financial compensation signals that the performed working tasks are not critical enough to be rewarded higher. Conversely, dominant conceptions of different professions often determine how power and responsibilities are distributed within the organisation. Material and cultural conditions thus come to result in the
preconditions for professional negotiation, which are here understood as *spaces of action* (Holmer-Nadesan, 1996).

As material and cultural conditions often alter with time and place (Regnö, 2013), different rooms typically come to enable different spaces of action for the same profession or sub-profession. What is legitimate to say and do in one room one day with one constellation of people might not even be thinkable in another context. Spaces of action thus set the limits for what discourses can be drawn upon in different social contexts by restricting the professionals to certain subject positions, within which they are allowed to strive for freedom (Holmer-Nadesan, 1996). Conversely, discursive socialisation processes can delimit the professional’s perceived space of action, in turn reinforcing the dominant discourses. The continuous interplay between discourses and spaces of action determines how different power bases inherent to a profession can be drawn upon and affect the results of professional negotiation in different social contexts. In order to better understand the inter-professional power struggle between physicians and nurses, it therefore becomes critical to study how material and cultural conditions construct spaces of action and allow professionals to draw on different discourses in the reconstruction of professional identity.

### 3.2.2. Language as a tool for studying underlying power struggles

Acknowledging the complex nature of language becomes a central factor in studying the interplay between discourses and spaces of action. While much conventional research has assumed language to mirror an objective external world, the recent linguistic turn within social science has instead stressed the context-dependent side of language (Alvesson & Deetz, 2000, p. 132; Alvesson & Kärreman, 2011, p. 29). Within this perspective, language is understood as ambiguous and constitutive rather than representational (Alvesson & Willmott, 2003, p. 19), implying that references to external objects through communication of fixed meanings is never possible, as every single utterance is being constructed within the realms of underlying discourse.

Language should thus be understood as a constitutive force (Alvesson & Deetz, 2000, p. 132). While discursive conceptions and spaces of action set the limits for what can be uttered (and how) through language, the language is in turn reinforcing established notions by operating as a disciplinary force, concealing alternative notions that challenge dominant conceptions. In this way, language comes to be both enabling and constraining. As opposed to Laclau and Mouffe, who perceive all social practices to be discursive, this thesis builds on the notion that only linguistic practises (communication and texts) should be seen as discursively constructed. This, since also ‘non-linguistic practises’ become linguistic when noting how nothing can
be ascribed meaning without building on conceptions constructed through texts or language in the first place.

In negotiation situations between physicians and nurses, it thus becomes central to study how these two professions interact through language; that is, how they talk about as well as with each other in different situations. However, also what they talk about in their respective communities becomes critical for the continuous negotiation. What it possible to say and what is not? Who is entitled to say what? What discourses are present where? What discourses are drawn upon in what situations/rooms? What spaces of action are possible for each (sub-)profession in a certain setting/room? All these communication patterns enable and constrain discursive notions of what it entails to be a professional doctor or nurse, thereby constructing legitimate subject positions for the two professions to draw on in the continuous inter-professional power struggles.

3.3. Research design

In exploring inter-professional power struggles within the health care organisation, a case-study is currently being performed at one of Sweden’s largest emergency university hospitals. This large-size hospital was chosen for two main reasons. To start with, it holds many sub-professions within medicine as well as nursing. These sub-professions are united by general professional logics but also separated by their distinct knowledge bases and values that contribute to closed communities within larger closed communities. Moreover, the organisation is structured in a way so that a large amount of direct communication between physicians and nurses occurs in everyday operations. Critical medical conditions, quick decisions and complex interventions require a continuous teamwork between the two professions and open up for political power struggles where the complex division of responsibilities and legitimate knowledge come to a head. The plethora of professional identities and the many direct contact arenas result in critical negotiation situations, where professional boundaries are reconstructed relative each other.

3.3.1. Case study

At the hospital, semi-structured interviews and participant observations have been carried out in order to identify acting spaces and possible/non-possible discourses for physicians and nurses to draw on in different contexts.

The interviews not only make it possible to see how the two professions position themselves relative each other, but also show what they actually choose (consciously or unconsciously) to talk about and how they frame this. 13 semi-structured interviews have so far been conducted with physicians and nurses from different
hospital functions, including patient security, clinical pharmacology, gynaecology, obstetrics, heart medicine, kidney medicine, radiology and surgery/urology (a more detailed outline of the interviews is provided in Table 1). One group interview, where chief physicians from different clinical departments discussed the aftermaths of a lean implementation initiative, has also been performed. Interviews will continue during the spring of 2015.

The interviews have ranged from 30 to 60 minutes and been based on three main themes, within which the respondents have been allowed to talk relatively freely based on own experiences and thoughts. These themes are (1.) Organisational implications of the Lean implementation initiative introduced in 2010, (2.) New professional roles within the organisation, and (3.) Efficiency in the daily teamwork between nurses and physicians. Throughout the interviews, there was a focus on how physicians and nurses within different departments perceived their own and their colleagues’ chances to have influence in different forms of decisions. Interviews were recorded and transcribed after completion. All utterances will be anonymous.

Table 1: Conducted interviews ii

<table>
<thead>
<tr>
<th>Department</th>
<th>Date</th>
<th>Interviewee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration/Hospital management</td>
<td>June 9, 2014</td>
<td>Nurse: Patient security</td>
</tr>
<tr>
<td>Administration/Hospital management</td>
<td>October 6, 2014</td>
<td>Chief physician/Head of clinical pharmacology</td>
</tr>
<tr>
<td>Administration/Hospital management</td>
<td>August 21, 2014</td>
<td>Chief physician/Head of patient security</td>
</tr>
<tr>
<td>Gynaecology/Child delivery</td>
<td>August 22, 2014</td>
<td>Chief physician</td>
</tr>
<tr>
<td>Heart medicine</td>
<td>August 22, 2014</td>
<td>Resident physician</td>
</tr>
<tr>
<td>Kidney medicine</td>
<td>August 22, 2014</td>
<td>Chief physician/Head of department</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>August 21, 2014</td>
<td>Chief physician/Head of department</td>
</tr>
<tr>
<td>Radiology</td>
<td>October 6, 2014</td>
<td>Chief physician</td>
</tr>
<tr>
<td>Surgery and Urology</td>
<td>June 26, 2014</td>
<td>Chief physician/Head of department</td>
</tr>
<tr>
<td>Surgery and Urology</td>
<td>June 30, 2014</td>
<td>Chief physician</td>
</tr>
<tr>
<td>Surgery and Urology</td>
<td>June 30, 2014</td>
<td>Chief physician</td>
</tr>
</tbody>
</table>

ii It is easily noted that a vast majority of both interviews and observations so far has been conducted with a focus on physicians. This has little implication for the observations, where the interactions between nurses and physicians are the same independent of who is shadowed. Considering interviews, however, future focus will be on nurses within different clinical departments.
Participant observations of inter-professional work are important since they give access to the very borderline between physicians and nurses. This borderline is the place where inter-professional negotiation (sometimes conflict) takes place through communication and other forms of interaction. The observations provide insights about what material and cultural conditions are present in different contexts, thus creating a greater understanding for how spaces of action are enabled and constrained for different (sub-)professions in different rooms. As Regnö (2013) note, it is in the interaction between people that spaces of action are constructed and continuously renegotiated. It is also possible to see how physicians as well as nurses draw on different discourses depending on the setting.

Five participant observations have so far been completed at different clinics within the hospital, including emergency care, gynaecology/childbirth, heart medicine, kidney medicine and surgery/urology (outlined in Table 2). Additional observations will be performed during the spring of 2015. Some of the observations were carried out during night shifts, although the majority was performed during the day. Observations ranged from 8 to 12 hours and included everything from meetings, rounding and standardised drug administration to different forms of surgery and critical situations in delivery rooms. During observations, I also embraced the possibility to talk to different people within the wards and have lunch together with nurses and physicians. In this way, it was possible to see what topics of conversations that were brought up in non-clinical situations. Due to ethical reasons, observations could not be recorded as this would go against the fundamental tenet of patient confidentiality. Instead, field notes were taken and main themes of interest were written down the days after the observation.

Table 2: Conducted participant observations

<table>
<thead>
<tr>
<th>Department</th>
<th>Date</th>
<th>Followee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care</td>
<td>October 28, 2014</td>
<td>Resident physician</td>
</tr>
<tr>
<td>Gynaecology/Childbirth</td>
<td>September 5, 2014</td>
<td>Chief physician</td>
</tr>
<tr>
<td>Heart medicine</td>
<td>October 28-29, 2014</td>
<td>Resident physician</td>
</tr>
<tr>
<td>Kidney medicine</td>
<td>September 30, 2014</td>
<td>Chief nurse</td>
</tr>
<tr>
<td>Surgery and Urology</td>
<td>October 28, 2014</td>
<td>Chief physician</td>
</tr>
</tbody>
</table>
3.3.2. Structure of analysis

The analysis of empirical material will take its point of departure in communication and interaction through language. Looking at utterances during interviews and critical negotiation situations identified during observations, it will initially be analysed (1.) what discourses are/are not drawn upon by (sub-professions of) physicians and nurses in different contexts, (2.) how the acting spaces for these two professions alter with time and place and (3.) how discourses and acting spaces delimit each other. The obtained insights will be further analysed in relation to different forms of power bases prevailing within the professions, discussed in Chapter 2. By analysing what power bases seem to give legitimacy and in what relations these are used (consciously or unconsciously) in negotiations, it becomes possible to establish a conceptual model that describes the inter-professional power struggles between nurses and physicians.

3.4. Methodological considerations

Important to note is how interpretations and conclusions, from a social constructionist perspective, are always “contaminated” by the researcher’s own subjectivity (Alvesson & Kärreman, 2011, p. 2). Like any utterance stems from a discursive context, meaning is always constructed within the realms of personal experiences and assumptions. Acknowledging this, an analysis of communication practices in a professional organisation could never aim for conveying an objective truth about professional boundaries or identities, but should rather contribute to the understanding of professionalism by providing new perspectives on inter-professional dynamics.

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ii A context here refers to a distinct combination of present people, organisational place and time.
5. Works cited


