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RESEARCH ARTICLE

An interprofessional perspective on healthcare work: physicians and nurses co-constructing identities and spaces of action

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Abstract

In this article we develop a theoretical perspective of how professional identities in multi-professional organisational settings are co-constructed in daily interactions. The research reported here is located in a healthcare context where overlapping knowledge bases, unclear divisions of responsibilities, and an increased managerialist emphasis on teamwork make interprofessional boundaries in healthcare operations more complex and blurred than ever. We thereby build on a research tradition that recognises the healthcare sector as a negotiated order, specifically studying how professional identities are invoked, constructed, and re-constructed in everyday work interactions. The perspective is employed in an analysis of qualitative data from interviews and participant observation at a large Swedish hospital, in which we find three main processes in the construction of space of action: hierarchical, inclusive, and pseudo-inclusive. In most of the interactions, existing inter-professional divides and power relations are sustained, preventing developments towards integrated interprofessional teamwork.

Key words: healthcare management; organisational culture; power and dependence; social construction; public sector management

Introduction

In this paper we develop a theoretical perspective of how professional identities in multi-professional organisational settings are co-constructed in daily interactions. The research reported here is located in a healthcare context where overlapping knowledge bases, unclear divisions of responsibilities and an increased managerialist emphasis on teamwork make interprofessional boundaries in healthcare operations more complex and blurred than ever (Chreim, Langley, Comeau-Vallée, Huq, & Reay, 2013; Currie & White, 2012; Rovio-Johansson & Liff, 2012). Similar multi-professional settings are also under development in other sectors such as consulting, law, etc. (cf Ackroyd & Muzio, 2007; Nordegraaf, 2011). For future studies of such contexts, it is of importance to develop a theoretical language whereby interactions between professions and their consequences for professionals, organisations, and clients can be understood (Bucher, Chreim, Langley, & Reay, 2016; Fitzgerald, 2016).

The proposed theoretical perspective views professional identities not only as institutionalised on a societal level, nurtured in intra-professional settings, and brought into interactions with others (Chreim, Williams, & Hinings, 2007), but also as co-constructed in these very interactions. We thereby build on a research tradition that recognises the healthcare sector as a negotiated

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order (Allen, 1997; Comeau-Vallé & Langley, 2019; Finn, 2008; Lokatt, 2019; Mitchell, Parker, & Giles, 2011; Nugus, Greenfield, Travaglia, Westbrook, & Braithwaite, 2010; Salhani & Coulter, 2009; Svensson, 1996), specifically studying how professional identities are invoked, constructed, and re-constructed in everyday work interactions (Liff & Wikström, 2015; Rovio-Johansson & Liff, 2012). The perspective is here employed in a study of physicians and nurses at a Swedish university hospital. While the relations between physicians and nurses have indeed been studied before as they are the two professions that dominate healthcare, few studies have attended to these relations at an interactional level (Fitzgerald, 2016).

Earlier studies have shown that such interprofessional negotiations usually tend to sustain extant professional divides and thereby spaces of action (cf Holmer-Nadesan, 1996). In everyday work interactions, the strategic adoption of different protective routines (Liff & Wikström, 2015), distinct interpretive repertoires (Finn, 2008; Hall, 2005), differing institutional logics (Andersson & Liff, 2018; Wikström & Dellve, 2009), and ways of promoting one's own profession at the expense of others (Bucher et al., 2016; Butler, Chillas, & Muhr, 2012) may inhibit interprofessional knowledge sharing and sustain existing practices – which will ultimately bring about problematic consequences for hospitals and their patients. By analysing these interactions and the identity work taking place in terms of spaces of action (Crevani, Lindgren, & Packendorff, 2010; Holmer-Nadesan, 1996; Packendorff, Crevani, & Lindgren, 2014) – i.e. what professional actors find appropriate, legitimate, and thinkable in their work situations – we show how traditional distancing power relations between physicians and nurses are indeed often sustained. However, at times they identify with similar lines of action and the possibility of an interprofessional space of action emerges in which professional belongings are to some extent left behind. By developing a theoretical perspective that describes how professional discourses are invoked in the ongoing production of professional spaces of action, it should be possible to better understand and analyse the preconditions for, and consequences of, new forms of interprofessional teamwork in healthcare and other multi-professional settings.

The paper starts by referring to existing research literatures on multi-professional work in healthcare settings, focussing specifically on the changes that have taken place in the relationship between physicians and nurses. We then outline an interprofessional perspective on multi-professional work, in which professional identities and spaces of action for physician and nursing professionals are seen as co-constructed in interaction as actors draw upon various discursive resources. The perspective is employed in an analysis of qualitative data from interviews and participant observation at a large Swedish hospital, in which we find three main processes in the construction of space of action: hierarchical, inclusive, and pseudo-inclusive. The paper concludes with a discussion on these processes and the possibilities of establishing a multi-professional space of action in which ingrained professional identities are downplayed and to some extent replaced by a common organisational identity.

Towards an Interprofessional Understanding of Identity Dynamics in Healthcare Work

As one of the most long-established professions in society, physicians have throughout the years been trained to independently perform complex working tasks and to trust their own experience when handling unforeseen situations without interference from others (Agevall & Jonnergård, 2007; Dent, 2008). In the words of Bucher et al. (2016), physicians have been able to sustain their superior status and centrality in the healthcare system by asserting that they have the knowledge and skill to control the work of other professions, and also by their natural dominance of the core activities taking place (von Knorring, Alexanderson, & Eliasson, 2016). This is not necessarily played out in open and explicit conflict, but rather through subtle discursive reductions of aspiring professions into 'technicians' or 'assistants' (Currie, Lockett, Finn, Martin, & Waring, 2012) by characterising them as 'practical' or 'a-theoretical' (Dahle, 2012), by limiting access to knowledge and information (Gadolin & Wikström, 2016) or through silently ignoring them (Sanders & Harrison, 2008).

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Over recent decades, economic, political, and technological factors have all come to challenge this well-established order. One such transition is the emergence of New Public Management in the Western Hemisphere (Kelliher & Parry, 2015; Leonard, 2003; Levay & Waks, 2009) that has resulted in regulations and work procedures that infringe on physicians' traditional medical autonomy (Agevall & Jonnergård, 2007; Armstrong & Ogden, 2006; Briggs, Cruikshank, & Paliadelis, 2012; Walshe & Rundall, 2001). Physicians have often resisted these developments, claiming superior knowledge of what is best for the patient (Liff & Andersson, 2011), and rejecting non-medical perspectives (e.g., economic and political ones) as irrelevant to clinical decision-making (von Knorring, Alexanderson, & Eliasson, 2016).

In parallel, nurses have achieved increased influence in interprofessional communication (Banham & Connelly, 2002), and entered organisational arenas that were previously reserved for physicians (Dent, 2008). For example, nurses have taken over some routine medical tasks and also taken on a range of influential positions within hospital management. This implies that nurses may be part of setting the practical boundaries for physicians' professional autonomy in clinical work (Bolton, 2005). At the same time, nurses assigned to managerial positions find it difficult to retain respect from colleagues who do not perceive managerial tasks as appropriate for nurses (Gaskin, Ockerby, Smith, & Russell, 2012; Rosengren & Ottosson, 2007).

As suggested by Bucher et al. (2016), conflicting expectations from external stakeholders have forced healthcare professions to engage in a continual negotiation for their boundaries, status, and centrality. Similarities (and sometimes even overlapping) in knowledge bases as well as changes in what is considered as desired medical practice result in a competition for centrality and status. An example is a study by Salhani and Coulter (2009) which acknowledges how micro-politics between nurses and physicians become critical in the (re)construction of new professional boundaries. In the same vein, Finn (2008) and Liff and Wikström (2015) describe how power struggles between nurses and physicians come to impede efficient multi-professional teamwork and efficient knowledge sharing between the different professions. Instead, both professions come to engage in typical protective routines that allow them to 'protect their special knowledge and established position from review and criticism' (Liff & Wikström, 2015: 268).

Our understanding of professional identities is built on a social constructionist understanding whereby identities can be understood as 'negotiated meanings of experiences arising from membership in social communities both in professional education and working-life' (Parding, Abrahamsson, & Berg-Jansson, 2012: p. 300). Following this logic, Clarke, Brown, and Hope Hailey (2009) describe professional identities as constructed within 'organisationally based discursive regimes which offer positions, or epistemological spaces, for individuals and groups to occupy' (p. 325). Social structures enable certain subject positions to become accepted, and the legitimisation of these very positions in turn reinforces the social structures, which again sustain established subject positions. These identity construction processes take place in a cultural context, where notions of professions and legitimacy are inter-dependent on notions of expertise, influence, formal rights, responsibilities, and gender (Butler, Chillas, & Muhr, 2012; Witz, 1990), and where the specific issue or context determines what is legitimate and what discursive resources are possible to invoke. Professional identities should thus be understood as discursive products that limit and set expectations on individuals (Czarniawska, 2013) in the form of pre-conditions for professional identity negotiation, which are here understood as *spaces of action* (Holmer-Nadesan, 1996). We have summarised the above description of the core concepts of this perspective in Table 1.

Power Dynamics in Interprofessional Negotiation: Construction of Spaces of Action

The 'space of action' for an individual actor refers to what is appropriate, legitimate, and thinkable in a situation, given the existing cultural conditions (Crevani, Lindgren, & Packendorff, 2010; Packendorff, Crevani, & Lindgren, 2014). As cultural conditions alter with time and place

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Table 1. An interprofessional perspective on health care organising: summary of core concepts

Research interest and rationale	Overlapping knowledge bases, unclear divisions of responsibilities, and increased managerialist emphasis on teamwork make interprofessional boundaries in health care operations more complex and blurred (Bucher et al., 2016; Gadolin & Wikström, 2016; Liff & Wikström, 2015; Rovio-Johansson & Liff, 2012). Important to develop a theoretical language whereby not only the traditional divide between nursing and physician professions but also their interaction can be understood.
Profession	Professions are occupations that are organised, autonomous carriers, and disseminators of abstract knowledge systems sanctioned by society. Professionals have the ability to employ these knowledge systems in performing actions that are perceived as difficult, skilful, and valuable by clients and/or the public (Witz, 1990).
Professional identity	Discursively negotiated meanings of experiences arising from membership in institutionalised professional communities, providing individuals and groups with legitimated subject positions (Chreim, Williams, & Hinings, 2007; Clarke, Brown, & Hope Hailey, 2009; Parding, Abrahamsson, & Berg-Jansson, 2012).
Interprofessional negotiation	Co-construction of professional identities taking place as professionals from different professions draw on professional discourses including their status and centrality in everyday work interactions (Bucher et al., 2016; Fitzgerald, 2016). Several power bases may be brought into interaction, such as sub-profession, gender, age etc.
Space of action	What is constructed as appropriate, legitimate, and thinkable by actors, based on their interprofessional negotiation. All everyday work interactions can potentially reinforce spaces of action or change them (Crevani, Lindgren, & Packendorff, 2010).
Possible outcomes of inquiry	Characteristics of power processes in micro-interactions in which professional identities are constructed. Understandings of how professions co-construct and affect each other in interprofessional work, and the consequences thereof.

(Halford & Leonard, 2005), different contexts typically enable different spaces of action for the same profession. What is legitimate to say and do in one context might not even be imaginable 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 continual discursive construction of spaces of action determines how different power bases inherent to a profession can be invoked, and affect the results of professional negotiation in different social contexts. It is important to remember that different professions have different possibilities to influence the interprofessional negotiation processes; in fact, the possibility to influence is part and parcel of the perceived space of action.

The concept of space of action has earlier been employed in analysing how members of single occupations have constructed notions of what is appropriate, legitimate, and thinkable – such as cleaners (Holmer-Nadesan, 1996), engineers (Crevani, Lindgren, & Packendorff, 2010), and project managers (Packendorff, Crevani, & Lindgren, 2014). Here, we apply the concept to the analysis of how two professions relate to each other and how boundaries between the two spaces of action are constructed. As individuals invoke professional identities as well as expectations of other individuals' professional identities in daily interaction, both spaces of action are discursively co-constructed. When, for example, a physician invokes a hierarchical notion of his/her profession in interaction with a nurse by exercising authority, they are both reinforcing the physician's superiority and existing space of action as well as the nurse's inferiority and more limited space of action. The nurse's perspective on matters and any information s/he may have on the process and result of medical treatments are thus likely to be suppressed. Given the traditional power relations between physician and nursing professions, it is also to be expected that physicians have a wider range of possibilities to define and articulate what is appropriate, legitimate, and thinkable for nurses than the other way around (Eriksson & Müllern, 2017).

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There are indications in recent research of what discursive mechanisms are to be found in such interprofessional negotiation. In their study of how professional associations respond in writing to government initiatives proposing interprofessional collaborations in healthcare, Bucher et al. (2016) find four main discursive aspects. The first two, *Issue Framing* and *Justifying*, are mainly concerned with launching a specific interpretation of the issues at hand – i.e. constructing the specific context of interprofessional negotiation – and making references to basic principles in healthcare that befit the arguments. The two remaining framing strategies are employed by the associations to describe their own identity (*Self-casting*) and also the other involved professions in relation to the initiative (*Altercasting*) (cf. also Lingard, Reznick, DeVito, & Espin, 2002). For example, the physician associations frame themselves as the natural leaders of healthcare operations, carefully pointing out 'team coordination' as a less significant administrative task that is best dealt with by nurses within the bounds of what is acceptable to physicians. At the same time, nursing associations cast themselves as unacknowledged and devalued, altercasting physicians as obstacles to interprofessional teamwork through their privileging of pure medical perspectives on healthcare.

While Bucher et al. (2016) offer a useful conceptual framework for the analysis of interprofessional negotiation and co-construction of action space, they do not study actual micro-interactions including the ongoing co-construction of professional identities. The study reported by Liff and Wikström (2015) is more relevant for the purpose of this paper. They identify different protective routines employed by multi-professional teams. One example is how discussions of specific patient issues as well as treatment methods are avoided in cases where the reputation of superior medical knowledge runs a risk of being damaged. The authors also note how physicians use the team setting as a way of reinforcing their dominant role within the organisation, while nurses think that this authority should be shared between the professions. While the results of the study stress the importance of applying an interprofessional perspective in the exploration of professional identities, they also open up for questions regarding the political gameplay within the actual negotiations.

A conceptual model describing the power processes behind negotiated professional spaces of action could allow for an improved understanding of not only how interprofessional professionalism is constructed in relations, but also of how social constructions of legitimate medical practice set the preconditions for successful interprofessional work. The analytical concepts of this model, developed mainly from the above discussions on Liff and Wikström (2015); Packendorff, Crevani, and Lindgren (2014) and Bucher et al. (2016), are summarised in Table 2.

Methodology

The complex nature of language is a central concern when studying the interplay between discourses and spaces of action. Language is here understood as ambiguous and constitutive rather than representational (Alvesson & Deetz, 2000). This implies that it is not possible to refer to external objects through communication of fixed meanings, since the space of action is constructed in reference to underlying discourses. As discourses set the limits for what can be done, said and imagined, they also reinforce established spaces of action by concealing alternative notions that challenge dominant conceptions.

The central part of the study was, therefore, to investigate how the two professions interacted through language; that is, how they talked *about* as well as *with* each other in different situations. What they talked about in their respective communities is also important for the continual negotiation. This involves posing questions such as: What is possible to say and what is not possible to say? Who is entitled to say what about whom? What discourses are present where? What discourses are drawn upon in which issues or situations? What spaces of action are possible for each profession in a certain issue or situation?

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Table 2. Analytical concepts: Discursive foci, possible power processes and consequences for the construction of space of action in interprofessional work

Discursive focus	Possible power processes in interprofessional negotiation	Possible consequences for the construction of space of action
Framing of situation or issue (including expectations on future similar issues and situations)	Restricting issues to one profession or stretching issues to encompass several professions. Compartmentalising situations into several single-profession situations, or constructing situations as new and in need for interprofessional knowledge creation.	Removing issues from some professions' spaces of action or locating them in several or all involved professions' spaces. Constructing situation as single-, multiple- or interprofessional space.
Justification	Absent (no need to discuss relation between professions), normative (self-evident what the relation is) or rational/experiential (persuasion based on issue or situation at hand).	Constructing what arguments and ways of reasoning that are imaginable and/or legitimate for the different professions in certain situations and for certain issues. Spaces of action may be divided, or overlapping.
Self-casting	Framing of own professional identity, e.g. in terms of authoritative leader, capable but under-recognised participant, involved or distanced actor.	Constructing the role and responsibility of the professional in the current issue and situation, i.e. what is appropriate, legitimate, and thinkable.
Altercasting	Framing of the other involved professions, in terms of assuming power (reinforcing differences in hierarchy, status, and centrality), or unmasking power (problematising unjustifiable differences in power and status).	Constructing what are the roles and responsibilities of other professionals' in the current situation, i.e. what one interprets as appropriate, legitimate, and thinkable for the 'others'.

A case study was performed by the first author of this paper at one of Sweden's largest university hospitals, an organisation that requires consistent teamwork between physicians and nurses resulting in much direct communication between physicians and nurses in everyday clinical work. After an initial round of semi-structured interviews aimed at understanding the organisation and current developments, extensive in-depth participant observations were carried out at seven different clinics, including emergency care, gynaecology/childbirth, heart medicine, kidney medicine, and surgery/urology. One staff member at each clinic was shadowed throughout their working days and also interviewed in action. Some observations took place during night shifts, although the majority were performed during the day. Observations ranged from 8 to 12 h in length and included everything from meetings, rounding, and standardised drug administration to different forms of surgery and critical situations in delivery rooms. The researcher also spoke regularly to different people within the wards and had lunch together with nurses and physicians. In this way, it was possible to see what topics were brought up in non-clinical situations, further adding to the understanding of what discourses were invoked in organisational jargon.

The observations took the form of what Czarniawska (2007) refers to as shadowing, where the researcher preserves 'an attitude of outsideness' while gaining first-hand access to organisational practice (p. 56). As instances of interaction are productively assessed by shadowing professional practitioners in their daily work, it is important to stress that an exploration of identity work centres on social interaction. While individual physicians and nurses were being shadowed, the unit of analysis thus remained the direct and indirect interaction between (these two) professions that took place through verbal communication and other forms of interaction including bodily gestures and silence. For ethical reasons, observations could not be recorded, as this would go against

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the fundamental tenet of patient confidentiality. Instead, detailed field notes were taken, in which activities, participants, utterances, and other actions were summarised situation by situation – usually micro-episodes during which a clinical matter was discussed and/or resolved. Each observation resulted in about 5–10 such situations being described.

All authors of this paper independently identified critical negotiation situations in the transcribed field notes, i.e. a subset of the documented situations in which professional identities and spaces of action were invoked in the everyday flow of activities. These situations were analysed by focusing on (1) what discourses are/are not drawn upon by physicians and nurses when framing issues and situations and justifying ways to handle them; (2) how the two professions construct identity through self-casting and altercasting; and (3) how these discursive processes and spaces of action delimit each other. Thereafter, the author team collectively assessed how power processes set the preconditions for physicians' and nurses' spaces of action in each situation. The limited material presented in subsequent sections is not representative of all interactions at the hospital, but should be regarded as significant interactions where important aspects of interprofessional negotiation can be observed. Hence, this represents an analysis of some and not all of the discursive processes of the construction of professional spaces of action in this organisation.

In the next sections, utterances and conversations from interactions show how discursive constructions of physicians and nurses result in different limitations and possibilities for these two professions in the interprofessional rooms. Two main types of discursive processes were identified; hierarchical processes and inclusive processes. Hierarchical processes build on a divisive logic, whereby the segregation and hierarchisation between the professions are sustained through unidirectionalism (physicians being the sole profession involved in self-casting and altercasting in the professional rooms) and exclusion (physicians' construction of judgment and sarcasm towards others as intraprofessional matters). Within the inclusive processes, there were indeed examples of constructing issues and situations as interprofessional work, but also several occasions of 'pseudo-inclusive' processes where professional divides were temporarily dissolved in certain situations and/or settings.

Hierarchical Interprofessional Processes: Sustaining Professional Divides

The general impression from the empirical material is that the traditional hierarchical discourse still dominates the interprofessional dynamics within many rooms and situations at the hospital. This discourse has been constructed and reinforced through years of formal power imbalances between physicians and nurses. By invoking a hierarchical discourse in their interaction, physicians and nurses sustain notions of spaces of action for the two professions that are both different and distanced in relation to each other.

Issue framing and absent justification

Standardised routines and conversation patterns reinforce the hierarchical power structure in the interprofessional room, which implies that everyday medical issues are framed as 'owned' by physicians and that this 'ownership' is not in need of justification. At the surgery ward, surgery team members had the routine of presenting themselves to each other in a systematic order before surgery, starting with the lead surgeon and ending with the nurse anaesthetist. During surgery, it was further noted how the two physicians in the room (operator and assistant operator) were constantly talking about everything and anything. Recommendations on surgical cuts, jokes, and gossip about friends and colleagues followed one after the other. At the end of the operating table, the surgical nurse was autonomously carrying out her standard tasks in silence. She only spoke when she needed the nursing assistant to provide more material. Meanwhile, the anaesthetist

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quietly monitored the data appearing on her screen and administered drugs upon order from the physician.

The physicians' dominance in this case is well in line with traditional hierarchical discursive notions of physicians as not only in command, but also entitled to dominate the social interaction in the work situation (Eriksson & Müllern, 2017). There are, of course, arguments for this order, but it nevertheless reinforces the hierarchical power relation between physicians and nurses in the interprofessional room. While the nurses also have specific tasks and responsibilities to attend to, their discursively constructed space of action not only delimits them to performing these tasks and responsibilities according to instructions from the physicians – it is also not legitimate or even thinkable for them to engage in non-patient-centred conversations with other professionals. The physician's feeling of entitlement to take centre stage in the interprofessional room thus results in the physician profession's space of action increasingly being open for a range of possible behaviours, while the nurses' space of action remains limited to silently carrying out routine tasks and following doctors' orders.

Self-casting and altercasting by generalisation

The physicians also criticise the nursing profession in front of everybody and allow themselves to make sweeping claims about the quality of nurses' clinical work without any apparent hesitation. The following utterance shows how a physician reacts when an operation is delayed due to a too-low blood value:

> 'Yesterday when it [the Hb-value] was down to 69 they [the nurses] should have made a call… but of course they have just taken the test and not checked the results…' (Female surgeon)

The interesting part here is not how the physician blames the nurses for a delayed operation, but rather how she is able to sarcastically state that nurses in general do not take responsibility for following up their test results and assume that this has now occurred once again, to everyone's dismay. A further example of how physicians depict nurses as a profession lacking competence could be observed after a completed operation, where nurses were responsible for reporting the total blood loss:

> 'Bleeding 600 [ml], yeah right. That sounds like a lot…' (Female gynaecology physician. Nods her head, laughs, implying that she does not trust the value given).

The physician here certainly acknowledges that nurses are indeed responsible for carrying out the specific task, but that they are inept and cannot be trusted. While reinforcing physicians' superiority in terms of competence and analytical ability, she also delimits the nurse's space of action to carrying out a task only under surveillance, rather than autonomously. The specific incidents here are again formulated in terms of a general pattern, which extends the identified differences between professional spaces of action into other rooms and episodes as well.

Unidirectional self-casting and altercasting through emotional display

The differences and also distances between spaces of action for physicians and nurses are also visible when it comes to what emotions can be displayed in social interaction, and who can be exposed to these displays. Whilst anger, hostility, and sarcasm are normally seen as illegitimate emotions in most workplaces, it may in some rooms be possible and even expected to show professional status and power in this way (Butler, Chillas, & Muhr, 2012; Coe & Gould, 2008; Empson & Alvehus, 2019). Physicians thus appears to be self-casting an intraprofessional

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entitlement to share their frustration and criticisms with surrounding colleagues (Comeau-Vallé & Langley, 2019), while their interprofessional altercasting of nurses makes it both illegitimate and unthinkable for subordinate professionals to do the same thing. Both these processes are unidirectional, i.e. emanating from physicians but without any questioning, counter-casting or resistance from anyone else. An example of this was for example observed in the following conversation during surgery work:

> 'What are you doing?' (Female head surgeon, in a sharp tone)
> 'We're taking the blood out of the bucket in order to measure how much there is' (Female surgery nurse)
> 'But you shouldn't include that'. (Female head surgeon)
> 'Exactly, so we're emptying it in order to measure the total'. (Female surgery nurse)
> 'But compound bleeding is not included in the total bleeding, I'm telling you (irritated)! You cannot include that!' (Female head surgeon)

Here, the physician does not hesitate to tell off the nurse in an irritated and aggressive manner, effectively silencing the nurse. Directly criticising a colleague in front of everyone appears to lie within physicians' space of action, and every time it goes unquestioned it also reinforces both their space of action and the difference/distance to that of nurses. This should be compared to how another nurse in the same room, when noticing that her colleague seems offended, stays silent and just makes irritated grunts while walking over to the other corner of the room. Within the nurse's space of action, it seems unthinkable to utter a single word of annoyance even when a fellow nurse is under attack, which could be linked to the already discussed construction of nurses as silent assistants, void of competence, and influence.

The physician demonstrates self-casted superiority in terms of medical knowledge, which in traditional hierarchical notions of healthcare makes physicians even more powerful and increases their space of action. Nurses are, in relation to this, altercasted as less competent, which not only reinforces their limited space of action but even diminishes it. Next time, the nurses will probably listen to the physician right away and trust their own judgement even less. While lashing out at nurses could be seen as a reminder of who possesses power, physicians' intraprofessional criticism does not have the same implications for interprofessional power relations. Rather, the hard comment and the equally hard counter-comment are a sign of a wide space of action, where physicians are allowed to make mistakes without losing legitimacy amongst their peers. By reinforcing a culture where physicians' mistakes (as well as interventions) are respected, the physician profession's space of action is further widened.

Exclusionary altercasting through humour and sarcasm

With the physician profession's discursively constructed power comes the right to use humour and sarcasm in conversations with oneself and colleagues from different professions (cf Butler, Chillas, & Muhr, 2012; Lokatt, 2019). The sarcasm can be directed towards one's own profession but also towards other professions and patients:

> 'Yeah there really are a lot of UFOs here! [Referring to other physicians at the clinic.]' (Female head gynaecologist)
> 'Hostages too!' (Male assisting gynaecologist)
> 'Ha-ha, yes UFOs and hostages working here!' (Female head gynaecologist)
> 'If something goes wrong, it's [the assisting surgeon's] fault, ha-ha [laugh]!' (Female head surgeon)
> 'Look, they [the nurses] have written 8.000 here [laugh]! Aren't they funny [sarcastic voice]?' (Female head gynaecologist)

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These sarcastic conversations reinforce the physicians' privilege of joking about everything and everyone. Their space of action is even strengthened, as they are being perceived as laidback individuals with self-distance, openly accepting jokes about their own profession. It is interesting to note how the hierarchical discourse does not allow for nurses to use the same kind of humour and sarcasm as their physician colleagues. Nurses' non-actions reinforce their profession as the subordinate one, strengthening the expectations on them to work in silence and avoid taking too much place in the interprofessional room – which is not least a problem where detection of mistakes and quality improvement are concerned.

Inclusive and Pseudo-Inclusive Interprofessional Processes

In the material, there are a few instances of how physicians and nurses reconstruct their spaces of action as less different and less distanced to each other. This evolves through the mutual confirmation of competence and trust, but also seems to be limited to a set of similar contextual conditions rather than being representative of the organisation as a whole. In our material, we find *inclusive processes*, that is, situations and issues that are constructed as interprofessional ones and where professional divides are played down. We also find what we have termed *pseudo-inclusive processes*, that is, situations and issues in which physicians' and nurses' self-casting indeed implies shared spaces of action but which are achieved by altercasting others in negative ways.

Inclusive processes: constructing issues and situations as interprofessional work

If the hierarchical discourse was strongly associated with nurses working in silence without interfering with the dominant physician profession, the inclusive discourse allows for nurses to claim space in the interprofessional room. For example, during a problematic childbirth, physicians, and nurses together engaged in medical decisions:

> 'I know I'm not allowed to ask this but would you mind…?' (Female midwife nurse)
> 'Absolutely, no problem [presses gently downwards on the mother's stomach]' (Female head gynaecologist)

While self-casting her subordinate position using the words 'I know I'm not allowed to ask this but…', the midwife nevertheless takes a medical initiative, which within hierarchical framings would be strictly limited to the physicians' space of action. Already here, it becomes obvious that the nurse's space of action is wide enough to overlap the physician's space of action in some aspects (that is, framing the situation as one in which she may issue medical recommendations). When the gynaecologist chooses to follow the midwife's recommendation without any objections, the situation is framed as an interprofessional one in which professional divides are not present and the nurse's medical competence is acknowledged. This should be contrasted to how the hierarchical processes implied a discursive construction of nurses as an unreliable profession with inferior competence.

At the childbirth unit, in contrast to many other units and clinics at the hospital, nurses, and physicians show genuine interest in each other's private lives, such as children and relationships. Communal coffee breaks and invitations to each other's parties also show evidence of mutual respect and a more equal professional standing Within these inclusive framings, nursing's place in the interprofessional room will not only increase the nursing profession's space of action, but also reduce the distance between physicians and nurses.

Pseudo-inclusive processes: altercasting others within one's own profession

At the surgery ward, physicians and anaesthetic nurses talk sarcastically about other aspects of nursing, which are more involved in direct patient care:

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'Well, could you mention some theories on 'caring' [sarcastic laugh]?' (Female head surgeon)
'No way, then I would throw up. We aren't that into 'caring' here'. (Female anaesthetic nurse)

Through partaking in physicians' ways of joking, nurses are confirmed as colleagues on an equal level. Their space of action is widened in the sense that they are included in the interaction; they can voice opinions and concerns while being listened to. They are constructed as peers in the immediate situation, with potential to continue as such, but it comes at a price. By making sarcastic remarks on caring ('*omvårdnad*' which is the main conceptual and ideological base of the Swedish nursing associations' professionalisation projects), nurses devalue aspects of their own professional integrity. In this way, the widening of their space of action in the current situation simultaneously threatens other aspects of the possibilities they have to talk and act in a general sense.

Pseudo-inclusive processes: overlapping self-casting and altercasting

While hierarchical framings allowed for physicians to openly express irritation and dissatisfaction with others, the pseudo-inclusive discourse invites nurses to partake in this practice. This may happen through overlapping self-casting and altercasting, in which nurses are allowed to actively lend support for physicians' altercasting of other sub-professions. Physicians and nurses may thus – at least temporarily – cast themselves and others in the same way in certain situations or contexts. An example is when a physician and a nurse from the cardiology clinic discussed the lack of humour amongst the visiting surgeons performing operations on their patients:

It's problematic, where are we supposed to laugh then?! I mean, you're not allowed to go behind the door and laugh. (Female cardiac physician)
We have to come here [to the conference room] to laugh! (Female cardiac nurse)
Ha-ha! No, you and I have to go outside [to the balcony] and laugh. (Female cardiac physician)
Yes! The next step will be to install infrared heaters so that we can go out and laugh in the winter, ha-ha! (Female cardiac nurse)
It's gonna get cold for us, ha-ha! (Female cardiac physician)

As can be noted, inclusive processes sometimes allow for physicians and nurses to include each other in emotional reactions and behaviour. The physicians' space of action, which allows them to set the social agenda, is through these practices acknowledged and reinforced. Simultaneously, the physicians also confirm the use of similar utterances and reactions by nurses in their space of action, increasing this as nurses see more possibilities to talk and act. Although a distinction between professions and spaces of action still exists, this difference becomes less marked and less important to stress. Professional belonging is less important to uphold *in situ* than drawing on the same discourses and engaging in the same practices. This interprofessional community is however often a result of distancing colleagues within other units (or sub-specialities) of the same profession through altercasting. In this way, the validity of 'nursing inclusion' becomes limited to a set of similar cultural conditions, rather than a sign of reduced distance between physicians and nurses in the organisation as a whole. Power imbalances thus construct mutual spaces of action locally but not always generally.

Pseudo-inclusive processes: overlapping self-casting and altercasting non-professionals

While the hierarchical framings give physicians a great deal of leeway in talking about colleagues and patients in a sarcastic way, inclusive framings at the childbirth unit allow midwives to engage

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in sarcastic discussions with their physician colleagues. By altercasting non-medical actors in diminishing and ironic ways, physicians and nurses may again temporarily indulge in overlapping self-casting as medical experts:

> 'Oops, now there is a real piece of action in number 4 [laugh]!' (Female midwife nurse)
> 'Yeah, really unexpected [sarcastic laugh]'. (Female head gynaecologist)
> 'Yep, she can lie there and bear down. Won't help a bit. Now she wants morphine as well [laugh]'. (Female midwife nurse)
> 'Ha-ha, but she can forget about that'. I told her several times that inducing the delivery was a really stupid idea. This is what happens next. We are heading for a C-section now [laugh]. (Female head gynaecologist)

In some interprofessional rooms, the pseudo-included is thus even allowed to initiate the emotional reactions, which could almost be equated with how the superior is allowed to 'express emotions'. Taking part in emotional reactions, the pseudo-included is often engaging in sarcastic conversations with the superior, further illustrating how different social practices interfere with each other. These insights should be compared to historical notions of the doctor-nurse game (Stein, 1967), where nurses who wished to give recommendations on medical treatments had to phrase their ideas in a well-established subtle manner. In line with how the nurses in this way safeguarded the honour of the medical profession, it could be argued that included professions who 'disguise' medical recommendations by incorporating phrases such as '*I know I'm not allowed to ask*' or '*maybe*' actually are safeguarding the honour of the superior profession. This suggests that a similar social game as the one described by Stein (1967) still permeates the healthcare context, where it informs the continuous negotiation for influence.

Concluding Remarks: Interprofessional Negotiation and Spaces of Action

In this paper, we set out to establish a theoretical perspective that describes *how professional discourses are invoked in the ongoing production of professional spaces of action in interprofessional negotiation.* The perspective details how professional discourses operate in the ongoing production of professional spaces of action, and should enable scholars to better analyse the consequences of professional teamwork in healthcare. In this concluding section, we will thus discuss the implications of these different interprofessional processes in terms of spaces of action for physician and nursing professionals and reflect on the possibilities of interprofessional collaboration in healthcare organisations.

Interprofessional construction processes and spaces of action

Hierarchical interprofessional processes reinforce the power imbalance between physicians and nurses, sustaining almost limitless notions of spaces of action for physicians and constructing what is appropriate, legitimate, and thinkable for nurses as both limited and as subject to limitations by physicians. Right from the start, physicians discursively construct a space of action where they are allowed to take centre stage, show emotional reactions, be sarcastic and draw ungrounded conclusions about the competence of other professionals. Through these very practices, the space of action also increases as the physician profession's superiority becomes more institutionalised in the prevailing discourse (cf. Liff & Wikström, 2015). While physicians enjoy more possibilities, nurses are bound to a limited space of action where they are expected to work in silence and to be ignored. Physicians practicing their privileges also become a constant reminder of who possesses the power, with the result that nursing's space of action becomes increasingly diminished and the distance between the professions becomes increasingly enlarged. This is not only to the

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detriment of work satisfaction and teamwork, but also to the possibilities of detecting and alleviating quality problems in medical treatment (Table 3).

Within the inclusive processes, on the other hand, physicians and nurses experience the same space of action in some aspects. They openly share criticism about their colleagues, make sarcastic jokes about colleagues and patients, and respect each other's suggestions for medical interventions. Not only does this result in a more equal standing between the professions, it also constructs an *interprofessional space of action*, within which physicians and nurses temporarily draw on the same discourses and enjoy the same privileges.

It is important to stress is that this space is neither general for the whole organisation, nor permanent or inherent to professional identity bases. Also, nursing's entrance into this interprofessional space of action comes at the cost of losing other aspects of their possibilities to talk and act. The result of the inclusive discourse is thus a continual reconstruction of nursing's space of action, where the initial power imbalance between physicians and nurses stays more or less constant. We have termed these instances of local/temporal interprofessional negotiation pseudo-inclusive, as they seem rather to sustain than reshape the traditional divides between the two professions.

Towards interprofessional professionalism – mission impossible?

As has been noted, the physician profession's space of action becomes dominant regardless of what process of interprofessional negotiation is analysed. This seems to give physicians a constant advantage in interprofessional negotiation with nurses. Since spaces of action set the limits for what discourses can be invoked, the increasingly growing gap between nurses' and physicians' possibilities to act within the hierarchical discourse will further reinforce the traditional notions of medical superiority. In turn, the imbalanced spaces of action will be even more institutionalised.

Within the more inclusive processes, it has been shown how nurses and physicians sometimes occupy the same spaces of action, experiencing more or less the same advantages and limitations. Some sub-professions of nursing have the potential to achieve more equal standing with their physician colleagues, but the interactions often tend to sustain the initial power imbalance between the two professions. And even if a sacrifice has to be made, this sacrifice does not threaten their own sub-profession but rather nursing in general. Noting this, it seems problematic to talk about nursing as one universal profession. Rather, in interprofessional negotiations, some sub-professions of nursing have succeeded in reaching specialisation within areas that are constructed as legitimate within the superior physician profession. These nurses play a key role in the interprofessional negotiation between physicians and nurses, because, while widening their own space of action, they simultaneously close a door on other nurses.

While the hierarchical processes reinforce medical professions as autonomous and separate, the more inclusive processes stress the importance of recognising professional boundaries as more fluid and unstable constructs, that sometimes overlap each other in interprofessional spaces of action. Since collaborative practices exert a major influence on interprofessional negotiation, future inquiry into professionalism in healthcare needs to acknowledge not only the pre-NPM notions of professionalism, but also the consequences of interactions between professions. Bearing in mind how discursive constructions allow for physicians and nurses to talk and act in the interprofessional room, it should be possible to better understand the complex conditions for interprofessional teamwork in healthcare organisations.

Limitations and future research

There are certainly limitations to this study that future research may ameliorate. Extended empirical material would enable a further understanding of what possible interaction processes and

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Table 3. Interprofessional processes: Discursive characteristics and consequences for spaces of action

Process type	Discursive construction of professional identities	Consequences for space of action
Hierarchical	Sustaining professional divides through: • Division of issues and/or situations into single-professional ones • Justification of decisions and practices by reference to physicians' logic • Self-casting of physicians as dominating (exclusion). Nurses ignored or altercasted as inferior. • Nurses not being engaged in self-casting or altercasting (unidirectionalism).	Physicians' status and centrality in medical practice sustained, and valid across situations and issues. Nurses' general incompetence sustained. What is appropriate, legitimate, and thinkable in everyday work issues and situations is defined and justified by reference to physicians' professional logic. Physicians' space of action limitless and non-negotiable, other professions' spaces of action limited and subject to further limitations depending on situation.
Inclusive	Dissolving professional divides through: • Framing issues and situations as interprofessional ones • Justification of decisions and practices by mixing professional principles and inventing new ones • Overlapping self-casting • Downplayed altercasting.	Creeping sustenance of interprofessional rooms, i.e. recurring issues and situations in which professional divides beyond what is seen as necessary are not appropriate, legitimate or even thinkable. Involved professions share an almost common space of action, division of influence and responsibilities justified by reference to the task at hand.
Pseudo-inclusive	Temporarily dissolving professional divides through: • Framing parts of issues and aspects of situations as inter-professional ones • Justifying decisions and practices by reference to mixed situational and local experiences • Overlapping self-casting • Altercasting others; other sub-professions, non-medical actors or other members of own profession.	Opening and closing down inter-professional rooms in which professional divides are played down. Divides in relations to actors 'other' to the situation or issue instead emphasised, sometimes with the consequence of circumscribing ones' own space of action. What is appropriate, legitimate, and thinkable in this situation or issue may not be transferred to other situations and issues across time and space.

power bases are potentially involved in interprofessional work also in relation to additional occupational categories in healthcare organisations (cf. Bucher et al., 2016; Comeau-Vallé & Langley, 2019). Data from additional hospitals would also make it possible to discern the effects of local organisational cultures from those inherent in the professions. One possible study would be to investigate the contents and conditions for interprofessional professionalism in more detail, i.e. how teamwork in health care can be approached without sustaining professional divides (Fitzgerald, 2016; Gadolin & Wikström, 2016; Liff & Wikström, 2015; Wei, Webb Corbett, Ray, & Wei, 2019), and what it may mean for a multi-professional team to become 'professional' as such (Mitchell, Parker, & Giles, 2011). It should also be of interest to study physicians and nurses on a sub-profession level, in order to achieve a more detailed understanding of how different parts of a profession relate discursively to each other and what the consequences are for both intra- and interprofessional teamwork (Comeau-Vallé & Langley, 2019; Halford & Leonard, 2005; Pratt, Rockmann, & Kaufmann, 2006). A third possible avenue for future research

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is to consider the gendered dynamics of interprofessional negotiation, viewing gender as a central power base in profession-based work (cf Dahle, 2012; Stein, 1967; Witz, 1990)[1].

On a wider note, the theoretical perspective can also be applied to other multi-professional organisational settings. As earlier noted (cf. Friedson, 2001; von Knorring, Alexanderson, & Eliasson, 2016), physicians have for many decades been referred to as the prototypical profession, and is still closer to the ideal type of profession than any other occupation. As the phenomenon of interprofession-based organising has found recognition throughout society, similar trends of restructuring have thus been noted in different fields of professional service. In the most typical case, the previously unquestioned autonomy of an established profession (e.g., medicine or law) has recently been challenged by new discourses on professional practice, where structural reconfigurations now allow up and coming professions (e.g., nursing or business advisory) to formally occupy more influential positions in interprofessional work arrangements. Research in such contexts is important, not only to advance forms of collaboration between professionals, but also to improve the conditions for quality improvements for patients and their relatives and preserving societal trust in professional experts.

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[1]In the Swedish healthcare system there were in 2014 according to Statistics Sweden about 37,000 employed physicians (of which 51% were women) and 104,000 employed nurses (of which 90% were women). The professions are thus different both in size and in terms of gender composition. Moreover, the physician profession exhibits significant gender differences across specialisations – many surgical specialities have less than 10% women while geriatrics have about 60%.

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