Complex Problems in Need of Inter-Organizational Coordination: The Importance of Connective and Collaborative Professionalism within an Organizational Field of Rehabilitation1

Tone Alm Andreassen

Centre for the Study of Professions, OsloMet – Oslo Metropolitan University

toaa@oslomet.no, +47 91158160

Abstract

Rehabilitation processes of working-age citizens involve several organizations and professions, and require inter-organisational and inter-professional coordination and collaboration across hospitals, community healthcare, and employment services. Institutional perspectives on organizations and professions can contribute to understanding the conditions that facilitate or impede coordinated services. This analysis of Norwegian rehabilitation hospitals, community-based rehabilitation and employment service, suggest that the services belong to a joint organizational field of rehabilitation, which, according to institutional perspectives, will underpin inter-organizational collaboration and coordinated services. However, both knowledge-sharing and joint action are apparently hindered by infrastructure deficits, knowledge transfer from hospitals that does not meet the needs of frontline professionals, and 'pure' forms of professionalism. Connective and collaborative forms of professionalism, including boundary-spanning tasks, seem necessary to ensure smooth transitions, undisrupted pathways, and coordinated services for injured citizens.

[1] This analysis is based on the project 'Transitions in rehabilitation: Biographical reconstruction, experiential knowledge, and professional expertise' (Norwegian Research Council, grant no. 229082). I would like to thank the project group for valuable discussions, and am especially grateful to Mirela Slomic and Ole Kristian Håvold, who have undertaken large parts of the data collection, as well as Bjørg Christiansen, Per Koren Solvang, and Ivan Harsløf, who, like me, have also contributed in this task.

10.1 Introduction

Rehabilitation processes of working-age citizens comprise various health and welfare services and professions and involve several organizations and disciplines, requiring inter-organizational and inter-professional coordination and collaboration (Wade and de Jong 2000). How to organize provision of coordinated services to citizens with chronic conditions or complex problems crossing professional, organizational, and sectoral boundaries has been a major issue in European welfare policy (Gröne and Garcia-Barbero 2001; Nolte et al. 2008), as this means integration between different levels of healthcare system and also integrated care across health and social care (Antunes and Moreira 2011; Mur-Veeman et al. 2008). This chapter derives presumptions from institutional perspectives on organizations and professions to contribute to the understanding of conditions that facilitate or impede coordinated services.

From the perspective of institutional theories of organizations and professions, professionals who provide rehabilitation services are institutionally embedded. Their values, interests, and practices are partially determined by the institutional logics that structure the organizations in which they work (Garrow and Grusky 2012; Thornton and Ocasio 2008; Thornton et al. 2012). Organizational fields are presumed to be significant sources of pressure for institutional conformity (DiMaggio and Powell 1983). Hence, inter-organizational coordination and collaboration will take place more easily between organizations *within* an organizational field than between organizations situated in separate fields. The first presumption thus is that, if healthcare and social welfare services, including employment services, resemble a joint organizational 'field of rehabilitation', accomplishing coordinated services will be easier than if these services belong to separate organizational fields.

Furthermore, in organizations populated by professionals, not only will institutional logics of organizations guide the actions taken, but also logics of professionalism (Freidson 2001). However, professionalism and organizational logics intertwine in diverse ways and subsequently professionalism can take on different forms (Evetts 2003; Muzio and Kirkpatrick 2011; Noordegraaf 2011). The second presumption thus is that the forms of professionalism in operation, and the extent that professionalism includes organizing and connective capacities, will impact on inter-organizational coordination and collaboration. Hence, the existence of boundary-spanning tasks and workers (Aldrich and Herker 1977; Williams 2002) will facilitate inter-professional and inter-organizational cooperation and collaboration.

I explore these presumptions with empirical data, and previous analyses of these data, from three types of services involved in rehabilitation processes in Norway: (1) hospital-based rehabilitation programmes, (2) community-based rehabilitation services in the municipalities, and (3) the frontline offices of the Norwegian Labour and Welfare Service (NAV) providing employment assistance to citizens in the margins of the labour market.

10.2 Theoretical Perspectives

A core assumption in institutional theories of organizations is that the interests, identities, values, and assumptions of individuals and organizations are embedded within prevailing institutional logics (Friedland and Alford 1991; Garrow and Grusky 2012; Thornton and Ocasio 2008; Thornton et al. 2012). The concepts of embedded actors and embedded action turn attention to the influence of institutions on actors' behaviour, and to how the means and ends of individuals' and organizations' interests and agency are both enabled and constrained by prevailing institutional logics (Battilana and D'Aunno 2009; Phillips et al. 2000). The postulation is that institutional logics shape individual preferences and organizational interests as well as the repertoire of behaviours by which they may attain them (Friedland and Alford 1991). However, the institutional logics themselves have to be maintained and can be disrupted and transformed by institutional work (Lawrence and Suddaby 2006; Lawrence et al. 2009). Through processes of de-institutionalization and institutional change – among others, through the work of professionals (Greenwood et al. 2002) – patterns of action and interaction can be transformed.

Institutional logics operate at the level of organizations, as well as on the level of the organizational field. An organizational field (or 'institutional field') consists of organizations with different but related functions that, in the aggregate, constitute a recognized area of institutional life (DiMaggio and Powell 1983). Key features are interaction among organizations in the field, inter-organizational structures of domination and patterns of coalition, an information load with which organizations in a field must contend, and a mutual awareness among participants in a set of organizations that they are involved in a common enterprise (DiMaggio and Powell 1983).

Collaborative processes are more complex when they involve interaction of multiple sets of institutional rules and standards that may be in conflict with one another. A critical factor affecting the dynamics of collaboration involves the range of institutional fields in which participants are located (Phillips et al. 2000). Coordination and collaboration are presumed less complex within an organizational field than across fields because organizational fields are characterized by increasing homogenization instigated through processes of 'isomorphism' (DiMaggio and Powell 1983).

Professions can be important sources of isomorphism; in particular, professionals can contribute to what DiMaggio and Powell (1983) term 'normative isomorphism'. This is due to the legitimacy of formal education and a cognitive base produced by university specialists, as well as to professional networks that span organizations. Professional networks across organizations contribute to rapid diffusion of normative rules about organizational and professional behaviour. Recruitment of professionals who possess comparable orientations and dispositions to occupy almost similar positions across a range of organizations contributes to similar practices in a range of organizations.

Institutional theories of organizations emphasize professions as important agents in processes of creation, maintenance, or disruption of institutions (Muzio et al. 2013; Scott 2008). Professionals are institutional carriers or facilitators of institutional change, and organizations are sites and vehicles for professional action (Muzio et al. 2013).

Professionalism, in the 'pure' sense (Noordegraaf 2007), means exclusive ownership of an area of expertise (jurisdiction), jurisdictional autonomy and discretion in work practices, collegial control and accountability to one's peers, grounded in expertise based on abstract, theoretical knowledge and practical skills applied in diagnosing, reasoning and taking action in individual cases (Abbott 1988; Freidson 2001). The assumption is that when jurisdictional autonomy is achieved, professionals will protect their core task domains, and resist inter-professional and inter-organizational collaboration if this challenges their jurisdictions (Kellogg 2014). Professionals' boundary maintenance will be a barrier to collaboration across disciplines and organizations (Lindsay and Dutton 2012).

In contrast to such 'pure' professionalism, new notions of the concept aim to grasp the increasing importance of organizations to professional work and of professionals' orientation to the work of the organizations in which they are employed. Notions of reconfigured, hybrid, or collaborative professionalism (Adler et al. 2008; Carvalho 2014; Noordegraaf 2007, 2013) point to forms of it in which professionals take up tasks and develop knowledge and skills outside their core activities.

This means that the traditional concept of professionalism becomes reconfigured (Noordegraaf 2013). Reconfiguration occurs through reorganization due to new circumstances that call for coordinated services and interdisciplinary approaches. 'Organized professionalism' denotes 'professional practices that embody organizational logics' (Noordegraaf 2011, p. 1351). Professionals take up organizing roles and professionals develop organizational capacities in order to face changing work circumstances. Professionalism becomes increasingly 'connective', linked to other professionals and to the outside world. In the context of the present study, this professionalism includes the crossing of specialist boundaries and organizational borders in order to support chronic patients effectively, and involves professionals who apply not only skills within their own specialized field of expertise but also connective capacities, communication, cooperative and learning skills.

The concept of 'collaborative professionalism' indicates a professionalism taking place in network communities characterized by constructive diversity rather than unity, and by transdisciplinary forms of working (Adler et al. 2008). According to Adler et al. (2008), when professionals learn to work in heterogeneous teams and learn to see other professionals as sources of learning and support, assumedly also professional self-identities are transformed.

Hence, when reconfigured forms of professionalism are present in service-providing organizations, inter-professional or inter-organizational activities and collaboration across organizational boundaries will be supported. In particular, this will take place if professionals take up 'boundary-spanning roles' that link between an organization and important outside organizations (Aldrich and Herker 1977). By understanding how issues are differently defined, influenced by the involved organizations' different values and interests, competent boundary spanners can facilitate inter-organizational cooperation (Lindsay and Dutton 2012; Williams 2002). By buffering between different professions, 'brokerage professions' can facilitate cooperation across professional and organizational boundaries (Kellogg 2014).

Based on these perspectives, I will investigate whether hospital-based rehabilitation services, community rehabilitation services, and employment services constitute a joint organizational 'field of re-

habilitation', because, if not, identification of a common ground for collaboration would be more difficult. Indicators of the field status of rehabilitation services are inter-organizational structures of domination and coalition that delineate divisions of labour and responsibilities and ascribe mandates in the rehabilitation process, an infrastructure of coordination and collaboration, and an awareness among the participants that they are involved in a common rehabilitation enterprise. Furthermore, the analysis will look for signs of professionals being carriers of homogenization processes, such as similarities in the ways that the healthcare and the employment services respectively approach persons with traumatic injuries.

Second, acknowledging that the professionals' actions will be influenced by their professional identity and the forms of professionalism that guide their perception of the problems in need of rehabilitation and their approach to easing these problems, the analysis will examine indicators of 'pure' professionalism focused on diagnosing, reasoning, and taking action in the individual cases, and on relationships to a collegium of peers. The analysis will also look for indicators of more collaborative, communicative, and cooperative forms of professionalism, which may include boundary-spanning tasks, and for the existence of brokerage professions crossing professional and organizational boundaries.

10.3 Field of Study, Empirical Material, and Analytical Approach

10.3.1 Field of Study: Services Involved in Trauma Rehabilitation in Norway

This analysis studies the rehabilitation processes of people experiencing multi-trauma with or without traumatic brain injury (TBI). Rehabilitation processes of TBI/multi-trauma patients are exemplary cases for in-depth investigation of the organizational and professional dynamics enabling or hindering coordinated services. These disabling conditions affect many different aspects of everyday life, including social and vocational participation (Andelic et al. 2009). This causes rehabilitation processes of long duration involving many different healthcare and social welfare services, and, according to the injured persons themselves, several unmet needs (Andelic et al. 2014).

An advantage in centring the study on a specific patient group, rather than coordination in general, is the opportunity to investigate approaches towards specific problems and situations instead of generalized presentations of overarching procedures and intentions. The Transitions in Rehabilitation project aimed to grasp conditions surrounding two critical transitions in the rehabilitation processes of individuals: (1) between hospital-based specialized rehabilitation and community-based rehabilitation (within municipal health care), and (2) between healthcare services and employment services.

In Norway, specialized hospital-based rehabilitation is the responsibility of the state and the Ministry of Health and Care Services via four regional health authorities. In this research, hospital-based rehabilitation includes two inpatient clinics and one outpatient clinic. One of the inpatient clinics serves patients in a subacute phase; the other – like the outpatient clinic – serves patients later in their rehabilitation process, with a specific rehabilitation programme oriented towards patients who have been living at home for a while. From these services, patients are discharged to community-based rehabilitation services and/or employment offices.

Community-based rehabilitation services are the responsibility of Norway's politically autonomous municipalities. Legal regulations set some standards that the local governments have to fulfil, but, due to their autonomy and the variations among the municipalities in size, geography, and centrality, the services vary in organization, volume, and character.

Employment services for citizens in the margins of the labour market are provided by the frontline offices of NAV, a responsibility of the Ministry of Labour and Social Affairs. Besides employment service provided by the frontline offices, NAV also administers national insurance benefits to all citizens in Norway and social welfare to those in need but not entitled to national insurance benefits, as well as assistive technology to compensate for impairments. Thus, for citizens as well as professionals from other services, NAV is associated with more than just employment services.

10.3.2 Empirical Basis of the Analysis

The empirical material from hospital-based rehabilitation was collected through observation of team meetings and subsequent interviews with some of the participating professionals. The sample comprised three different inter-professional teams from three rehabilitation programmes, allowing for interviews with 16 professionals and observation of an additional 25 professionals – in total, 41 professionals. Eight one-hour inter-professional meetings were observed.

The empirical material from the community-based rehabilitation and from the employment services was collected through group interviews. The interviews in relation to employment services involved eight frontline offices and, in total, 27 professionals. The interviews conducted with representatives of community-based rehabilitation services involved eight municipalities and, in all, 34 professionals. Table 10.1 presents the educational backgrounds of all the professionals interviewed.

Table 10.1 Educational backgrounds of the interviewed professionals

	Health sciences[a]	Social work/ social education	Pedagogy/ social sciences	Other
Hospital-based rehabilitation (*n* = 16)	11	3	1	1
Community-based rehabilitation (*n* = 34)	27	4	-	3
Employment service (*n* = 27)	4 (+ 1)[b]	7	9	7[c]

[a] Primarily nursing, occupation therapy, or physiotherapy, but, for the hospital-based rehabilitation professionals, also psychology and medicine.

[b] One social worker was also a psychologist.

[c] Primarily internal training from the former National Insurance Administration merged into NAV, but also education in law.

The community-based rehabilitation services and the employment offices were selected from a list, prepared by the hospitals, of municipalities that, during the previous year, had had patients discharged from the hospital. This was done to increase the likelihood that the frontline professionals will have had experience with traumatic injuries. The sample comprises small and large municipalities in both central and peripheral areas.

While hospital-based rehabilitation is specialized in relation to specific target groups (here, trauma patients), frontline services in municipalities are generalists, in the sense that their services in principle cover every kind of illness, injury, or impairment. Therefore, studying trauma patients in hospital-based rehabilitation meant observations and interviews about the daily life of the professionals. In generalist-oriented frontline services, the case of trauma patients had to be introduced by a vignette describing a trauma patient at discharge from hospital-based rehabilitation, similar to a discharge summary in the kind of information given. The vignette was developed by two researchers with background as a physician and as a trauma patient respectively, and discussed with clinicians in hospital-based rehabilitation and with a panel of citizens with personal injury experience.

The patient/client in the vignette is a 34-year-old male carpenter with a wife and two small children. He is diagnosed with traumatic brain injuries, cerebral haemorrhage, and temporary paralysis in the left extremities due to an accident. The focus groups were introduced to his situation 12 months after injury, the point at which a patient stops receiving sickness absence benefits and approaches the crossroads of either permanent disability benefit or a process aimed at returning to work supported by a temporary benefit. At that time, the study's patient is still suffering from reduced muscular strength, some problems in daily activities due to a lack of fine motor skills in his hands, balance problems, memory loss, strong headaches, light to moderate depression (for which he receives psychological treatment), and a loss of energy. Further training is recommended by the hospital. The wife has 50% unpaid leave from her job to be his carer at home. He considers his wife to be of very valuable support, and he himself would like to have more energy to play with his children. His motivation for employment is low, and his general practitioner (GP) has declared him 100% disabled for the time being. Although the vignette case was not a typical case for the frontline services, in all interviews, at least some of the participants stated that they have had similar cases, which they also referred to during the discussion.

Data were collected during autumn 2014 and spring 2015. Two PhD students[2] have previously analysed parts of the empirical material. The current analysis draws on the findings from their analyses. Their publications are referred to within the analysis below.

10.3.3 Analytical Approach

The analysis is theoretically informed, guided by perspectives from institutional theories of organizations and drawing on organizational discourse analysis (Phillips and Oswick 2012) to examine the social construction of the institutions that characterize a particular empirical case. Organizational discourse analysis sees organizations as linguistically shaped and studies how language, broadly defined, constructs social phenomena, and how language in use is an expression of the social context in which they occur. This suggests that the talk and actions of the interviewed professionals should be treated as expressions of institutionalized perceptions of the organizational context of their work, of their role as professionals, and of the problems of the injured individuals.

In the analysis, not only the utterances are important, but also how the professionals relate to one another in group interviews and team meetings. Accordingly, both the observed team meeting in the hospitals as well as the group interviews were instances of observation. Moreover, the focus is not just on the topical content of the talk, but also on the ways of talking, and on the interaction among the participants, such as signs of consensus or disagreement.

In contrast to the observed meetings at the hospitals, which are instances of actual work performance, in the group interviews in community-based rehabilitation and in the employment service, the professionals talk about what they *would* do or should have done, but do not necessarily do – omissions to which they sometimes admit, as do the hospital professionals in the interviews. One example is a professional who, in the interview, speaks about several kinds of consequences of the traumatic injuries that regularly are discussed in team meetings, yet the related observation demonstrates that none of these consequences have been explicitly discussed.

The analysis involved the following steps: first, a case description of each team, office, or service was developed; second, a comparison across the cases of each service was performed, in order to understand if it made sense to describe them as unified services; and, third, a comparison between the three services was undertaken, in order to shed light on (a) whether the services could be seen as part of a common organizational field, and (b) the extent that the professionalism expressed by the professionals included organizational tasks and boundary-spanning roles.

In the analysis below, the professionals of the three services appear as a collectivity or community – as a unified 'they'. This is in accordance with the informants' own talk. In the interviews, they often spoke of a 'we' taking action in a patient's or client's case. During the analysis, I have carefully noted to whom a 'we' refers, and whether any significant divergence or disagreement appears in the group

[2] Mirela Slomic and Ole Kristian Håvold.

discussions. Their use of 'we' underlines the professionals as organizational members, but is also in keeping with the fact that they were invited to be interviewed as members of the organizations that employ them.

10.4 Analysis

Considering the field status of the services involved in rehabilitation, the fact that the sectors of health care and of employment services belong to different bureaucratic hierarchies, and are regulated by different laws, indicates that dissimilarities between the sectors are significant. Furthermore, the sectors are given different political mandates (cure, care, and rehabilitation versus activation towards labour market participation and self-support). On the other hand, healthcare services and employment services are both part of a politically governed welfare state (in a small country of around five million people). Furthermore, many citizens are users in both sectors; healthcare and social service professionals share a common aim and professional ethics of providing help to people in need; and, to some extent, the same occupations populate both sectors. This is illustrated by the educational backgrounds of the interviewed professionals (see Table 10.1). Furthermore, during their work careers, several of the interviewed professionals had moved between services. Hence, from a broader perspective, the services could be seen as belonging to the same organizational field.

10.4.1 Inter-Organizational Structures of Divisions of Labour and Responsibilities

Across the sectors of health care and labour and welfare services, inter-organizational structures exist that delineate divisions of labour and responsibilities and ascribe mandates to the different services involved in the rehabilitation process. This appears both in the professionals' interpretation of their organizations' mandates and in their understanding of and relationships to the other services involved.

The hospital-based rehabilitation teams are constructed to treat multi-problem cases holistically. They operate according to a common goal of providing interdisciplinary interventions to rehabilitate patients in relation to all areas of life. To the professionals, employment is one such area of a patient's life. Social workers or occupational therapists could therefore communicate with the employment service and/or with the patient's employer.

The hospital-based rehabilitation teams and their organizations are set up to perform the task of rehabilitating an injured patient sufficiently to discharge the patient from hospital, and to produce clinical information and recommendations to the frontline services. The end of the treatment period instigates a conclusion about possible needs for further rehabilitation, summed up in a report prepared for the frontline services; in particular, a discharge summary sent to the patient's GP. In the present study, the professionals in the community rehabilitation services and the employment offices, for their part, seemed well aware of the kind of services provided by the hospitals.

Likewise, across the frontline offices of the employment service, a shared understanding of the mandate – return to work and income security during this process – seemed present. In all offices, the professionals appeared internally coherent, and, across offices, locations, and sizes, consistency in the approach towards the clients was widespread. The professionals described many of the same kinds of measures and procedures to be applied in the vignette case, and they presented a shared understanding and evaluation of his problems (Håvold, in press). According to the employment professionals, their environment seemed to hold the same conception of their mandate – except for a lack of knowledge about the opportunities offered by the employment service.

The community-based rehabilitation services differed. In some municipalities, the professionals presented well-established procedures for needs assessment, as well as programmes for rehabilitation and other forms of service provision to the person in the vignette case. In others, the professionals revealed uncertainty, and apparently approached this kind of situation on an ad hoc basis. In several municipalities, the professionals talked about a lack of adequate services.

The professionals searched for opportunities in the services offered by the municipality (Slomic et al. 2017). Some stated that they could provide an adequate rehabilitation programme to an injured young man. Others concluded that neither their resources nor their expertise sufficiently covered his need for long-term, specialized rehabilitation. Correspondingly, compared to the hospitals and the employment services, community rehabilitation services seemed more diffuse.

The employment offices described 'work' as their mission, and work was a question in hospital-based rehabilitation (in particular, in late-phase rehabilitation programmes), but, in community-based rehabilitation, work was mostly out of the scope of the professionals. To them, the frontline offices of NAV were associated with benefits and irrelevant as collaborators in rehabilitation.

10.4.2 Traces of Normative Isomorphism

Despite the differences above, the analysis revealed a similarity in the ways that the healthcare and the employment services respectively addressed individuals with multi-traumatic injuries – how they understood the problem and how they approached the situation. In hospital-based rehabilitation, the professionals stated that they are holistically oriented towards the whole person, attentive to the patients' individual goals, and adjust their services to each individual situation. As one said, 'In the end, it is their goals that define the focus of our work'. They meet patients whose lives have been dramatically transformed, but, for a patient to realize the need for a radical reorganization of their life, the professionals have to apply a gradual and soft approach.

In community-based rehabilitation, the professionals' approach to the vignette case was to stimulate motivation of the person – 'to implant in him a confidence that the situation will improve' and 'help him realize that, with such an injury, one year is not very long'. They wanted to approach lack of motivation 'from every possible angle', and 'take the backdoor' if necessary. In doing so, they will search for the patient's personal goals, and start there. They considered the vignette patient's recov-

ery process to be of a long duration and emphasized that a long-term perspective would be necessary. Hence, despite municipal variation in the range of services available to injured people, the professionals' approach to injured patients was strikingly similar.

In the employment offices, the professionals' approach was also to stimulate motivation (Håvold 2018). They described their focus as being on 'opportunities despite health problems'. Their job is to try out any possible route that may lead to a return to work. Relating to the vignette case, the professionals considered individuals with brain injuries to be complicated cases, and they assumed a long-term perspective regarding his return to work process. It was important to stimulate a move in the right direction – towards hope and a future. They talked about 'being careful, not too pushy' and about having to judge when to introduce the question of job and employment.

Across the different services, the professionals' approach was quite similar. In all services, the professionals stated that their point of departure is a person's individual situation, wishes, and goals, and that these are their basis for enhancing motivation. They will listen to a person's opinions and wishes, but not fully accept wishes that contradict what they perceive to be in the person's best interest. Rather, they will motivate for stepwise changes, which during the process could initiate motivation and goals that are more 'constructive' from the professionals' point of view.

Despite different sectors, organizations, and ownership (municipalities and ministries), policies and professional knowledge seem to travel across organizational boundaries, and contribute to shared approaches to the problems that the services deal with. The similarities in professional approaches across a range of organizations in the healthcare services and the frontline employment offices show traces of normative isomorphism. They indicate that processes of homogenization have taken place through professionals who possess similar orientations and understanding of the problems of injured individuals.

10.4.3 An Infrastructure of Interaction and Awareness of a Common Enterprise

Across the different service organizations, an infrastructure of interaction, coordination, and sharing of information seemed to be in operation. In this infrastructure, the GPs seemed to hold a key position in terms of their receiving discharge summaries from hospitals. While both the community rehabilitation services and the employment offices stated that differences between GPs existed, in general, the GPs often appeared distant and difficult to involve in collaboration.

In community-based rehabilitation, the GPs seemed seldom involved in interdisciplinary assessments of an injured individual's needs. The responsibilities and tasks linked to GPs concerned medication and referrals to specialist health care, such as psychologists. When in doubt about assessment of a patient, the municipal medical officer could be consulted.

In employment services, the professionals depend on medical declarations, but they make their own judgements about job requirements and aspects of the employer that will affect the opportunities for returning to work. In the vignette case, they did not take on face value the GP's statement that

the client is 100% incapacitated (Håvold et al. 2017). According to the professionals, the employment service has many measures and programmes that can enable an individual to return to work, and, for a young man like the one in the vignette case, only after every opportunity is tried out will permanent disability benefit be the conclusion. If in doubt, the workers will consult NAV's own medical or neuropsychological expertise.

To both frontline services, the hospitals seemed more important than the GPs as providers of specialized diagnostic information about an injured person as in the vignette case. A shared understanding across the interviewed services was that, in the infrastructure of interaction, the hospitals have a position as providers of specialized services, and the community-based rehabilitation and the employment services, for their part, are in the position of receivers of patients, information, and advice.

In some municipalities, the professionals were certain that they would receive a discharge report from the hospitals; in others, they stated that they would not know about the existence of an injured young man unless his GP or the employment office reported a need for further rehabilitation. From the point of view of the municipal rehabilitation services, the hospitals' recommendations for further rehabilitation and assistance were given without sufficient insight into the available services in the municipalities (Slomic et al. 2017). Therefore, from this perspective, hospital recommendations were challenging.

In relation to community-based rehabilitation, the hospital professionals described efforts to recommend a patient's need for follow up. They tried to write 'explicit instructions', such as 'the patient needs ...' an occupational therapist, or a support person to motivate towards an activity, or contact with a psychiatric nurse or a psychologist for help with coping with their life. Hospital professionals framed the needs of the patients as needs for specific professionals, rather than as descriptions of injury implications, prognosis, or functional ability. Apparently, they acted as if the discharge summary sufficiently provided this kind of information. Nothing in the hospital professionals' discussions pointed to the knowledge needs of the frontline services. The professionals named the kind of professionals that the patients needed, but not the kind of problems for which professional help was required. In line with their expressed patient centeredness, their focus was primarily on the patient's needs, not on the frontline services' needs for sufficient information to serve the patient after discharge from hospital. When municipal services lacked the professionals named, the hospital recommendations did not help the frontline professionals to identify alternative ways to meet that patient's needs.

In relation to the employment service, the hospital professionals considered it within their mandate to give an accurate picture of a patient's situation, including a judgement on whether the patient at discharge was ready for a (gradual) return to work or whether a workable everyday life was the only achievable goal. In the employment offices, assessing a client's work capability is important in judgements about opportunities for returning to work. The professionals reported that they received medical declarations from the GPs, or discharge summaries from hospitals, and sometimes hospital professionals made direct contact. They relied on medical expertise about the health conditions and on recommendations for further treatment ('presumably, the specialists know what they are talking about'), but they found the vignette's discharge summary too focused on injuries and impairments.

They complained about medical declarations regularly lacking useable information about a client's functional ability and prognosis (Håvold et al. 2017).

The analysis of hospital-based rehabilitation to some degree confirmed the opinion of employment professionals that healthcare professionals' primarily pay attention to problems and deficits, which is understandable given their mandate of rehabilitating impairments. Still, it is worth noting that, in the hospital teams' discussions about discharging patients' opportunities for returning to work, the professionals (ostensibly experts on the implications of injuries) seldom made judgements about how the impairments their tests revealed affected a patient's ability to match the requirements of their job. Rather, they discussed work capacity and work stress in general.

The analysis of employment services to some extent confirmed the hospital professionals' opinion that employment professionals lack sufficient knowledge about the implications of traumatic injuries, which is understandable given their generalist character of serving clients with all kinds of health conditions or social problems. Hospital professionals reported that some of their patients found collaboration with the employment service difficult. However, they also emphasized that, when they explained the health problems of an individual to the employment service, the professionals understood and accepted these explanations.

This analysis points to an inter-organizational structure of domination and dependencies, in which the hospitals, as providers of specialized services, are in position to set premises for the work of the frontline services – in deciding the point of time for discharge and in holding the professional expertise on the traumatic injuries. The frontline services – as receivers of patients, information, and advice – although they can ask for further information and advice, seem not to be in a position to require of the hospitals that their knowledge transfer answers to the needs of frontline professionals.

Although the professionals pointed to several insufficiencies and missing links that impeded a well-functioning collaboration (Slomic et al. 2017), and despite relationships of dominance in the infrastructure of interaction, all three services seemed to hold an awareness of being part of a common enterprise of contributing to the rehabilitation of injured people. This indicates a shared organizational field across the sectoral divide between healthcare services and the labour and welfare services.

10.4.4 Professionalism and Boundary Work

The forms of professionalism guiding the professionals' work appear in their discussions about their work, but must be understood in light of the organizational structures in which they work.

The hospital-based rehabilitation services are organized in inter-professional teams with working relationships on a daily basis. The professionals talked about their inter-professional teams as 'we' and 'us' understood as units of professionals connected by common goals and shared knowledge (Slomic et al. 2017). In team meetings, this was demonstrated through frequent confirming with a 'yes' or nodding. The professionalism of the hospital professionals seemed extensively linked to the team's

organizational task of providing specialized rehabilitation services. Furthermore, their inter-professional collaboration was facilitated by brokerage professionals – team coordinators who are mostly passive in the inter-professional discussions, but who are the 'oil in the machinery' and arrange for the teams and their external responsibilities to function. Here, the classic 'pure' professionalism is transformed, underpinned by dedicated brokerage professionals. Subsequently, reconfigured patterns of action and interaction can take place.

The employment offices are organized in teams, units, or departments. The interviews identified an organizational structure in which clients are assigned to one professional, and, although the professionals are organized in teams, they most often assess and follow up clients on their own. Still, close collegial relationships based on being members of the same organizations seemed prevalent. During the interviews, the professionals added to or even concluded one another's statements, or they confirmed each other's accounts by nodding. They used the terms 'we' and 'us' with reference to the organization. Their professionalism related to the mandate of the organization.

The community-based rehabilitation services are organized in a purchaser–provider-like model in which one unit assesses the patients' needs, whilst other units provide the services granted to the patients. In addition, physiotherapy and occupational therapy services are often organizationally separated from nursing homes and homebased care. This organizational divide was manifested as a sort of fragmentation. While the professionals knew or knew of each other, they did not operate or talk as unified teams (as in the hospitals) or colleagues in working relationships (as in the employment service). They worked in parallel, each professional individually, rather than together (Slomic et al. 2017). Their professionalism related mainly to their respective occupations, as did the 'we' in their statements. While the professionals would perform an interdisciplinary assessment of the vignette case, the actual rehabilitation measures would be autonomously undertaken by each professional or service.

The professionals in the hospitals and in the employment service seemed to operate with a professionalism linked to the mandate of the organizations in which they worked, resembling a form of 'organized professionalism'. In contrast, in community-based rehabilitation, the professionalism seemed linked to occupational groups, rather than to a municipal responsibility of providing rehabilitation services, and thus was more aligned to a 'pure' professionalism. Rather than this being an effort to protect their professional domain against challenges from inter-professional or inter-organizational collaboration, it appeared to be a withdrawal into a collegium of peers, which was possibly due to the fragmented organizational structure in the municipalities, and, in several of the municipalities, no coordination stimuli from the management.

The hospital-based rehabilitation teams and the employment offices both included professionals who took up boundary-spanning tasks of establishing links from their organization to relevant actors in the outside world. In hospitals, social workers and occupational therapists performed boundary-spanning tasks in conveying to the patients' employers and the employment service any adjustment requirements in respect of a reduced work capacity, opportunities for self-support, and needs for public income security. In the employment service, seemingly, all professionals could take up the boundary-spanning tasks of collecting information from the healthcare services and of involving employers in discussions of opportunities for the patient to return to work. Through such information

processing, these professionals enacted a form of 'connective' professionalism aimed at influencing their environment.

In contrast, the boundary-spanning task of coordinating an individual care plan (to which citizens with complex problems have a legal right) seemed often avoided by the professionals in community-based rehabilitation. While the professionals considered such a plan to be beneficial with respect to the vignette case, they were reluctant to initiate a joint plan process. They regarded the coordination task burdensome, and seemed to apply an approach of 'self-targeting', leaving the initiative to the patients or the families (Harsløf et al. 2017). No brokerage professionals existed to assist with coordination tasks. Apparently, 'connective' professionalism was absent, which might be due to a lack of organizational incentives to take up organizing tasks.

10.5 Conclusion

This analysis has demonstrated that, across the sectors of health care and labour and welfare services, inter-organizational structures exist that delineate divisions of labour and responsibilities and ascribe mandates to the organizations involved in rehabilitation processes. Between these organizations, differences exist in political 'owners' (ministries and municipalities), organizational mandates, and professional focuses. However, there are also significant similarities in professional approaches across organizations and sectors, specifically regarding how the professionals understood traumatic injury and how they would support the injured person's rehabilitation process. These similarities can be understood as traces of normative isomorphism. The organizations seemed incorporated in an infrastructure of interaction, coordination, and sharing of information, and the professionals appeared to have an awareness of being part of a common rehabilitation enterprise. These are all manifestations of a joint organizational field of rehabilitation, which, according to the introductory presumption derived from institutional perspectives on organizations, should support collaboration and coordinated services.

Furthermore, the analysis has revealed deficits in the infrastructure of coordination and collaboration, such as the key position but lack of involvement of GPs, knowledge transfer from hospitals that does not answer to the needs of frontline professionals, who, on their part, are not in a position to place requirements on the hospitals.

However, not only infrastructure deficits impede coordination and collaboration: the lack of a professionalism anchored in the mandate of the organization and including boundary-spanning tasks seems further to hinder knowledge sharing and joint action. A 'pure' professionalism focused on diagnosing, reasoning, and taking action in the individual case seems insufficient to meet complex, sector-crossing problems. Connective and collaborative professionalism including boundary-spanning tasks seems necessary to ensure smooth transitions, undisrupted pathways, and coordinated services being provided for injured individuals. Ostensibly, such professionalism involves professionals acting as members of an organization, understanding professional work as part of a totality of services, and seeing rehabilitation services not merely as a contribution of their own discipline, but

as the contribution of the organization and the organizational field of rehabilitation. Puzzlingly perhaps, this means a professionalism that pays attention not merely to the needs of the injured individuals, but that also, in order to ensure coordinated services, meets the needs of the services that serve these individuals.

References

Abbott, A. (1988). *The system of professions: An essay on the division of expert labor*. Chicago, IL: University of Chicago Press.

Adler, P. S., Kwon, S.-W., & Heckscher, C. (2008). Perspective–professional work: The emergence of collaborative community. *Organization Science*, 19(2), 359–376.

Aldrich, H., & Herker, D. (1977). Boundary spanning roles and organizational structure. *Academy of Management Review*, 2(2), 217–230.

Andelic, N., Hammergren, N., Bautz-Holter, E., Sveen, U., Brunborg, C., & Røe, C. (2009). Functional outcome and health-related quality of life 10 years after moderate to severe traumatic brain injury. *Acta Neurologica Scandinavica*, 120(1), 16–23. doi:10.1111/j.1600-0404.2008.01116.x.

Andelic, N., Soberg, H. L., Berntsen, S., Sigurdardottir, S., & Roe, C. (2014). Self-perceived health care needs and delivery of health care services 5 years after moderate-to-severe traumatic brain injury. *PM&R*, 6(11), 1013–1021.

Antunes, V., & Moreira, J. P. (2011). Approaches to developing integrated care in Europe: A systematic literature review. *Journal of Management & Marketing in Healthcare*, 4(2), 129–135. doi:10.1179/175330311X13016677137743.

Battilana, J., & D'Aunno, T. (2009). Institutional work and the paradox of embedded agency. In T. B. Lawrence, R. Suddaby, & B. Leca (Eds.), *Institutional work: Actors and agency in institutional studies of organizations* (pp. 31–58). Cambridge, England: Cambridge University Press.

Carvalho, T. (2014). Changing connections between professionalism and managerialism: A case study of nursing in Portugal. *Journal of Professions and Organization*, 1(2), 176–190.

DiMaggio, P. J., & Powell, W. W. (1983). The Iron Cage revisited: Institutional isomorphism and collective rationality in organizational fields. *American Sociological Review*, 48(2), 147–160.

Evetts, J. (2003). The sociological analysis of professionalism: Occupational change in the modern world. *International Sociology*, 18(2), 395–415. doi:10.1177/0268580903018002005.

Freidson, E. (2001). *Professionalism: The third logic*. London, England: Polity Press.

Friedland, R., & Alford, R. R. (1991). Bringing society back in: Symbols, practices, and institutional contradictions. In W. W. Powell & P. J. DiMaggio (Eds.), *The new institutionalism in organizational analysis* (pp. 232–263). Chicago, IL: University of Chicago Press.

Garrow, E. E., & Grusky, O. (2012). Institutional logic and street-level discretion: The case of HIV test counseling. *Journal of Public Administration Research and Theory*, 23(1), 103–131.

Greenwood, R., Suddaby, R., & Hinings, C. R. (2002). Theorizing change: The role of professional associations in the transformation of institutionalized fields. *Academy of Management Journal*, 45(1), 58–80. doi:10.2307/3069285.

Gröne, O., & Garcia-Barbero, M. (2001). Integrated care: A position paper of the WHO European Office for Integrated Health Care Services. *International Journal of Integrated Care*, 1(2), e21.

Harsløf, I., Håvold, O. K., & Slomic, M. (2017, December). *Establishing individual care plans for rehabilitation patients: Traces of self-targeting in the Norwegian, universal welfare state*. Paper presented at a parallel session of the 2017 social research seminar of Norwegian Labour and Welfare Administration (NAV), Norway. Abstract retrieved from https://www.nav.no/no/NAV+og+samfunn/Kunnskap/arrangementer/trygdeforskningsseminaret/parallelle-sesjoner. Accessed 00 Month Year.

Håvold, O. K. (2018). Opportunity talk, work talk and identity talk: Motivating strategies used by the Norwegian labour and welfare offices. *Nordic Social Work Research*, 8(2), 158–170. doi:10.1080/2156857X.2017.1405836.

Håvold, O. K. (in press). All roads lead to Rome: Discretionary reasoning on medically objective injuries at the Norwegian Labour and Welfare Offices.

Håvold, O. K., Harsløf, I., & Alm Andreassen, T. (2017). Externalizing an 'asset model' of activation: Creative institutional work by frontline workers in the Norwegian Labour and Welfare Service. *Social Policy & Administration*, 52(1), 178–196.

Kellogg, K. C. (2014). Brokerage professions and implementing reform in an age of experts. *American Sociological Review*, 79(5), 912–941. doi:10.1177/0003122414544734.

Lawrence, T. B., & Suddaby, R. (2006). Institutions and institutional work. In S. R. Clegg, C. Hardy, T. B. Lawrence, & W. R. Nord (Eds.), *The SAGE handbook of organization studies* (2nd ed.) (pp. 215–254). London, England: SAGE.

Lawrence, T. B., Suddaby, R., & Leca, B. (2009). *Institutional work: Actors and agency in institutional studies of organizations*. Cambridge, England: Cambridge University Press.

Lindsay, C., & Dutton, M. (2012). Promoting healthy routes back to work? Boundary spanning health professionals and employability programmes in Great Britain. *Social Policy & Administration*, 46(5), 509–525.
Mur-Veeman, I., van Raak, A., & Paulus, A. (2008). Comparing integrated care policy in Europe: Does policy matter? *Health Policy*, 85(2), 172–183. doi:10.1016/j.healthpol.2007.07.008.
Muzio, D., Brock, D. M., & Suddaby, R. (2013). Professions and institutional change: Towards an institutionalist sociology of the professions. *Journal of Management Studies*, 50(5), 699–721. doi:10.1111/joms.12030.
Muzio, D., & Kirkpatrick, I. (2011). Introduction: Professions and organizations – a conceptual framework. *Current Sociology*, 59(4), 389–405.
Nolte, E., Knai, C., & McKee, M. (Eds.). (2008). *Managing chronic conditions: Experience in eight countries*. Brussels, Belgium; Copenhagen, Denmark: European Observatory on Health Systems and Policies; World Health Organization.
Noordegraaf, M. (2007). From 'pure' to 'hybrid' professionalism: Present-day professionalism in ambiguous public domains. *Administration & Society*, 39(6), 761–785. doi:10.1177/0095399707304434.
Noordegraaf, M. (2011). Risky business: How professionals and professional fields (must) deal with organizational issues. *Organization Studies*, 32(10), 1349–1371. doi:10.1177/0170840611416748.
Noordegraaf, M. (2013). Reconfiguring professional work: Changing forms of professionalism in public services. *Administration & Society*, 48(7), 783–810. doi:10.1177/0095399713509242.
Phillips, N., Lawrence, T. B., & Hardy, C. (2000). Inter-organizational collaboration and the dynamics of institutional fields. *Journal of Management Studies*, 37(1). doi:10.1111/1467-6486.00171.
Phillips, N., & Oswick, C. (2012). Organizational discourse: Domains, debates, and directions. *Academy of Management Annals*, 6(1), 435–481.
Scott, W. R. (2008). Lords of the dance: Professionals as institutional agents. *Organization Studies*, 29(2), 219–238.
Slomic, M., Soberg, H. L., Sveen, U., & Christiansen, B. (2017). Transitions of patients with traumatic brain injury and multiple trauma between specialized and municipal rehabilitation services – professionals' perspectives. *Cogent Medicine*, 4(1). doi:10.1080/2331205X.2017.1320849.
Thornton, P., & Ocasio, W. (2008). Institutional logics. In R. Greenwood, C. Oliver, R. Suddaby, & K. Sahlin (Eds.), *The SAGE handbook of organizational institutionalism* (pp. 99–129). Los Angeles, CA: SAGE.
Thornton, P., Ocasio, W., & Lounsbury, M. (2012). *The institutional logics perspective: A new approach to culture, structure and process*. Oxford, England: Oxford University Press.
Wade, D. T., & de Jong, B. A. (2000). Recent advances in rehabilitation. *British Medical Journal*, 320(7246), 1385–1388. doi:10.1136/bmj.320.7246.1385.
Williams, P. (2002). The competent boundary spanner. *Public Administration*, 80(1), 103–124.