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Hospital Social Workers' Boundary Work in Paediatric Acute Wards—Competitive or Collaborative?

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Abstract

Recent research suggests that the notion of boundary work can improve our understanding of interprofessional tension and collaboration in health care, yet hospital social workers (HSWs) have not received sufficient attention in this area. Using boundary work as a theoretical framework, this article investigates HSWs' boundary work in interactions with other health care professionals in paediatric acute wards. The data were based on in-depth interviews with nineteen HSWs at hospitals in Norway about their experiences with interprofessional collaboration. Based on their situated narratives, abductive analysis was performed, using the conceptually distinct but inter-related forms of competitive and collaborative boundary work that are grounded in Abbott's framework of jurisdiction. The findings demonstrate how HSWs construct, defend and extend boundaries to create distinctions between themselves and others, and how they sometimes adapt and downplay boundaries in order to achieve common goals and perform their work. As a facilitator of this process, the HSW might be viewed as a boundary subject. This, in turn, can result in optional and intentional ways for HSWs to carry out boundary work. There is reason to believe that, the less specific educational requirements and role guidelines, the more important these mechanisms become.

Keywords: boundary subject, boundary work, hospital social worker, interprofessional collaboration, social work

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Introduction

Interprofessional collaboration is widely recognised as an important means of strengthening health care and improving health outcomes (Reeves *et al.*, 2009). In recent years, the roles of hospital social workers (HSWs) have developed such that they now face unique challenges and opportunities in a rapidly changing environment (Kim and Lee, 2009). Several factors have triggered this development, such as an increasing demand for efficiency, more complex health conditions and a stronger emphasis on how social determinants affect physical health outcomes (Craig and Muskat, 2013). The bulk of the research on interprofessional collaboration has investigated HSWs' perceptions of the barriers to, and facilitators of, collaboration with other professionals. For example, Ambrose-Miller and Ashcroft (2016) found that, from the perspective of social workers, issues around role clarification, communication and power dynamics acted as either barriers or facilitators. Others have detected a lack of supportive opportunities for teamwork between social work staff and medical care teams (Albrithen and Yalli, 2015) or a lack of understanding of social work theory and practice on the part of other professionals (Kvarnström, 2008; Glaser and Suter, 2016).

Most of these studies of collaboration between HSWs and health professionals, however, are mainly focused on the collaborative experiences, outcomes and consequences of social work, and not on boundary work itself (Mizrahi and Abramson, 2000; Reese and Sontag, 2001; Glaser and Suter, 2016; Emprechtinger and Voll, 2017; Zerden *et al.*, 2019). Lately, the research on boundary work in interprofessional collaboration has developed towards exploring how professionals, in their discourse and practice, influence the social, symbolic or material distinctions affecting groups, occupations and organisations (Langley *et al.*, 2019). This research on boundary work has gained increasing attention because it has consequences for the dynamics of collaboration which, in turn, may influence the work practices, learning and effectiveness within and among organisations (Langley *et al.*, 2019).

To the best of our knowledge, however, there is a lack of research on boundary work from the perspective of HSWs. Little is known about how they cooperate and compete with other health professionals, in particular when addressing crucial issues and claiming responsibility for providing interventions that enable patients and families to cope with acute and critical illness. A limited body of boundary-work literature from the perspective of social work, especially within health settings, supports the need for further studies in order to support social work within

multi-boundary contexts. The purpose of this study is, therefore, to understand the boundary work in paediatric HSWs' experiences of interprofessional collaboration within the context of acute and critically ill children and families. The main research question in this article is thus: 'What types of boundary work do HSWs perform and what means or strategies do they employ'?

A boundary-work perspective on interprofessional collaboration

In the last decade, the concept of 'boundary work' has received increasing attention in studies of professions in general and, specifically, in relation to interprofessional collaboration in health care (Langley *et al.*, 2019). Inspired by the works of Abbot (1988), an influential scholar within the sociology of professions, these studies explore the social dynamics in health care provision, that is, the ways in which practitioners negotiate work roles and status hierarchies as boundary work (Lamont and Molnár, 2002). Within highly specialised organisations such as hospitals, the formal structure and division of labour are marked by organisational, professional and disciplinary boundaries (Meier, 2015). These boundaries, in turn, determine the jurisdictions of the different professions. Abbott (1988) defined jurisdiction as a profession's legitimacy to control an area of work. This legitimacy of jurisdiction plays out in three different arenas: the legal arena, the public arena and the workplace. However, 'There is a profound contradiction between the two somewhat formal arenas of jurisdictional claims, legal and public, and the informal arena, the workplace' (Abbott, 1988, p. 66). Workplaces are often characterised by the establishment and structuring of boundaries through negotiations and habits. These boundaries are changeable and situation-specific, implying a continual process of professionals defending their occupational rights and expanding their jurisdictions by laying claim to adjacent areas.

This is the process described as boundary work. Boundary work refers to the 'purposeful individual and collective effort to influence the social, symbolic, material, and temporal boundaries, demarcations, and distinctions affecting groups, occupations, and organizations' (Langley *et al.*, 2019). It is the key social process that constitutes professional jurisdictions (Abbott, 1995; Liu, 2018). Boundaries are formed, negotiated and changed through a dynamic interplay among professionals (Abbott, 1995), which Liu (2018) described as 'a site of conflict and cooperation between two or more professional or nonprofessional actors seeking to establish jurisdictions over similar work' (Liu, 2018, p. 46). With its origin in Gieryn (1983), who used the term to describe the discursive strategies used by scientists to demarcate science from non-science (Langley *et al.*, 2019), the notion of boundary

work later gained influence in various disciplines (Lamont and Molnár, 2002).

According to an integrated synthesis of the literature (Langley *et al.*, 2019), research on boundary work has investigated conceptually distinct but inter-related types, or forms, of boundary work. Two of the most common forms are 'competitive' and 'collaborative'. C*ompetitive* boundary work proposes that agents construct, defend or extend boundaries to distinguish themselves from others in order to 'maximize their social position and status, obtain resources, and reproduce or contest existing power relations' (Langley *et al.*, 2019, p. 54). C*ollaborative* boundary work, in contrast, focuses on how agents accommodate, mobilise and overcome obstacles to pursue collective aims and get their work done (Langley *et al.*, 2019).

The typical means of competitive and collaborative boundary work described in the literature are discursive boundary work (i.e. discursively constructing oneself as distinct from other professional groups in relation to certain tasks or dimensions), boundary work practices (i.e. practices instantiating and enhancing one's claim or position), and the materiality of boundary work (i.e. using technologies or spatial placement to communicate a certain professional position). Furthermore, the way in which the types of boundary work are intertwined in practice reflects important points in the literature: that boundary work is rarely wholly competitive or wholly collaborative (Allen, 2000; Meier, 2015; Langley *et al.*, 2019) and that one type of boundary work may influence and generate situations demanding the other type (Liao, 2016; Grodal, 2018). Boundaries are constantly in flux through social interactions (Langley *et al.*, 2019).

Studies of professional boundary work in health care organisations have mostly centred around the nurse–physician boundary (Allen, 1997; Johannessen, 2018). Some of these studies focus on how boundaries are defended or created. For instance, through field observation and interviews, Allen (2000) discovered how nurse managers influenced the boundaries between physicians and nurses/nurse assistants by taking control, establishing expertise and doing identity work. Similarly, Reay *et al.* (2006) identified practices such as the pushing back of boundaries, which entails fitting roles into existing systems, cultivating opportunities and providing values. Other studies have focused on how boundary work may contribute positively to collaboration, which happens by the downplaying of boundaries (Meier, 2015) and the deconstruction of differences (Ybema *et al.*, 2012). Allen (1997), Liberati (2017) and Lindberg *et al.* (2017) show, in different ways, that the process of negotiating boundaries is an integral part of achieving collaboration.

One of the few studies of boundary work that include HSWs is Apesoa-Varano's (2013) study of five occupational groups negotiating boundaries at the bedside of the patient. Her findings illuminate how

boundaries are crossed and reinforced at the same time by all the occupational groups in the negotiation process. In previous studies of boundary work from the perspective of social workers, the Swedish study of Isaksson and Larsson (2017) is an example of a study on social workers' boundary work in schools. In a conceptual paper, Oliver (2013) frames social workers as boundary spanners, that is, as those in the go-between position that links clients and services, which constitutes an alternative response to identity challenges. However, there is a lack of research on boundary work from the perspective of HSWs, which this study aims to address.

Data and methods

This article is based on a descriptive exploratory study where nineteen HSWs were interviewed about their experiences of working in paediatric hospital wards in Norway. Even though treating acutely ill children is organised by the state, there is a lack of common state guidelines for hospital social work, which leads to differences in organisational matters, in the way the role is performed and in the expectations around HSWs' services and educational requirements other than a bachelor's degree in social work.

Twenty-four HSWs were identified according to the inclusion criteria: educated social workers who are in direct practice roles in paediatric acute wards. The participants were informed about the project by an information letter and gave written consent at the beginning of the interview. Their superiors were informed of the project but, to ensure the participants' confidentiality, the HSWs responded directly to the first author, who was responsible for the entire process of collecting and processing data. Out of twenty-four HSWs invited to participate in the study, nineteen responded positively, three rejected the invitation and two did not respond. The participants, representing twelve Norwegian hospitals, were all women, with an average age of 49.5 years (35–68 years), and of Scandinavian origin. The average duration of their seniority was 24.6 years (13–42 years) and their hospital seniority was 12 years (1–35 years) on average. Seventeen of the nineteen social workers held a master's degree or had additional training beyond a bachelor's degree in social work. The study was approved by the Norwegian Social Scientific Data Service and conforms to internationally accepted ethical guidelines and professional ethical guidelines.

Based on the premise of social interaction as a way to generate data, the method of individual interviews was used to explore in depth the unique experiences (Charmaz, 2006). The interviews were conducted between May and October 2019, mainly at the participants' workplaces. One participant was interviewed by phone for practical reasons. The participants were

asked to reflect around themes such as 'the families' needs and characteristics for the acute situation', 'interdisciplinary collaboration in the acute stage' and 'the HSW's knowledge base and articulation of knowledge'. Each interview lasted between fifty-six and ninety minutes, with an average of seventy-two minutes. The interview quotes were translated from Norwegian to English by the first author and reviewed by a colleague. The software NVIVO 12 Pro was used to manage the data.

Analysis

An inductive analytic text condensation (Malterud, 2012) was conducted to identify the basic themes in the data. The text condensation process was completed by the first author and consisted of four main steps: (i) identifying eight associated themes after familiarisation with the data; (ii) a coding process, in which identified meaning units potentially related to the preliminary themes were coded into four groups; (iii) abstracting by condensation of content in each code group; and (iv) making generalised descriptions of the code groups. This study is based on one of the codes, called 'interprofessional collaborations and boundaries'.

In order to ensure a proper critical distance from the data, we sought to ground our analysis by performing a theoretically informed analysis of the interview excerpts subsumed under the selected code (Braun and Clarke, 2006; Timmermans and Tavory, 2012). Here, we employed as the tools of analysis Langley *et al.*'s (2019) concepts of competitive and collaborative boundary work, along with their delineation of discourses, practices and spatial boundary work strategies. For coding, we used an abductive approach as we moved back and forth between observations and theoretical concepts (Timmermans and Tavory, 2012). First, the data set was approached by the first author looking for content and answers to the question 'how do HSWs do boundary work?' Instances in the excerpts of what HSWs say to other health professionals (and others) were initially coded as a 'discursive' means of boundary work, while instances of what HSWs do when interacting with others were coded as boundary work 'practices'. Lastly, accounts of where HSWs place themselves spatially in their interprofessional collaboration were coded as the 'materiality' of boundary work.

Furthermore, the concepts of competitive and collaborative boundary work were used as sensitising concepts to collate these initial codes into emerging themes describing different types or forms of boundary work performed by HSWs. In doing so, the roles of discourses, practices and materiality in the various forms of boundary work could be identified. Subsequently, and in line with Braun and Clarke (2006), the initial codes were sorted and categorised as exemplifying potential themes. All the relevant coded extracts were collated within these themes. Using mind-maps,

and in a close dialogue between the first and the second author, a process of combining different codes to find potential themes led us forward to see the contours of the overarching boundary work themes. The first draft of the thematic map was created and reviewed with the second author in relation to the coded extracts, to ensure internal homogeneity within the themes and external heterogeneity between them (Braun and Clarke, 2006). There were no major disagreements concerning theme validity; however, a few minor changes were made, and some of the themes were combined and subsumed under one of the overarching themes. Finally, the map was refined and discussed between the first author and all co-authors, including the definitions and names for each theme, reflecting the content and theoretical framework of the study (Braun and Clarke, 2006).

Findings

Two overarching themes and five sub-themes emerged as a result of the abductive analysis. Corroborating Langley *et al.*'s (2019) conception, the first theme was called competitive boundary work, describing how HSWs worked for boundaries, attempting to create distinctions between themselves and others. We identified three different modes of competitive boundary work, namely constructing, defending and extending boundaries. These three sub-themes will be presented in the following sections, after which the second theme, collaborative boundary work, will be discussed.

Competitive boundary work

Sub-theme 1: constructing boundaries

The first mode of competitive boundary work identified in the analysis was labelled 'constructing boundaries'. Constructing boundaries has to do with HSWs' attempts to position themselves as a valuable professional group in the ward, representing a distinct competence. The most frequently used strategy to construct boundaries is explanatory discourse: the HSWs engaged in different kinds of verbal activities in order to explain and distinguish their competencies from those of others. Hospitals regularly arrange sessions with presentations from a diversity of occupations, intended to provide information to interns. The majority of the HSWs used this opportunity to advocate for a wider perspective of health-promoting measures, to highlight their competencies and to establish a more distinct domain from other professional groups. The participants characterised these formal presentations as one-way presentations

to inform the audience, get other health professionals' attention and promote their occupational jurisdiction.

Other participants provided presentations for smaller and more specific groups, such as nurses or physicians, customised to the specific needs of the ward. Based on their education, training and experiential knowledge to meet the daily work challenges, HSWs sought to clarify how their specific competence could accommodate particular needs.

A third avenue for conducting boundary work through discourse occurred in collaborative situations with other health professionals. In these situations, in order to take responsibility for ensuring that social and psychosocial conditions were discussed and put on the agenda, HSWs asked questions like: 'Are there any social issues? Is there anything? I feel a little fussy sometimes, but I still ask' (HSW 7). Several participants also invited other health professionals to join them in meetings with patients or families in order to make them more aware of HSWs' competencies and agendas. These collaborative situations with other health professionals represent an important arena for discursive boundary work among the participants.

Several participants stressed the importance of communicating the social work perspective and assessments in an understandable way that is backed up by facts and concrete examination, so that 'they [physicians] will not think that what I am doing is unfounded' (HSW 19). Speaking or writing simply, without unnecessary internal jargon or terminology, was recognised as a vital communication skill. Furthermore, established formal routines for collaboration were regarded as a way of strengthening and bringing to the forefront the HSWs' role and competencies. Taking responsibility for formalising the routines on the wards, therefore, seemed to be a crucial aspect of constructing boundary work.

Sub-theme 2: protecting boundaries

The second competitive boundary work mode that emerged from the analysis is termed 'protecting boundaries'. This mode refers to protecting HSWs' social work perspectives and defending their involvement in the treatment of families and children. While the mode of constructing boundaries involves explanatory discourse, the discourse applied in the second mode is more of a delineating kind, serving to distinguish health social work from other types of practice. For instance, due to what the HSWs perceived as objectionable routines compromising their professional ideals, they refused to accept what they viewed as unreasonable demands from others. Instead, they requested satisfactory conditions and did not compromise in order to meet the demands and expectations of other health professionals.

- When a problem occurs, they [the nurses] call us
- And ask if you can help?
- Yes, and we can usually do that. [. . .] So, then I answered that we can talk with them [the parents] but it will require an interpreter. [. . .] They understood that the discharge had to be postponed (HSW 4).

The HSWs also insisted on adequate resources and routines surrounding patient prioritisation. In this regard, the participants mentioned instances of failures in the ward's routines, resulting in urgent and often misjudged decisions. As one HSW put it:

> If we see that a patient has been hospitalised for a month, and then we get a referral in red because the patient is to be discharged the same day, then it does not get priority over others. No (HSW13).

To refuse a referral was by the HSW expressed as one way to educate the ward, to increase the cautiousness of the ward regarding the routines.

This was also a way of raising awareness of the social and psychosocial issues among the staff and was consistently expressed by other participants in various ways. For example, one HSW stated: 'To take my space and say, this is really something I can take care of' (HSW 1). The continuous nature of this task was emphasised by another HSW: 'Because always, in every context, you have to promote yourself, or stand your ground, or convince, or show that this is also important, right, what we contribute' (HSW 17).

Sub-theme 3: expanding boundary work

Expanding boundary work involves efforts to broaden the acknowledgement of HSWs' skills and competencies beyond the common image of their profession in order to help them secure a more central role in interprofessional collaboration. This sub-category represents those participants who experienced that their specialised competencies were not satisfactorily valued or even apparent to health professionals. The mode of expanding boundary work was expressed through intentional actions to challenge various barriers to interaction. Typical means used in this mode were spatial placement and presence in certain arenas. For instance, being present in the ward and making themselves available to other health professionals, as well as patients, was expressed as a valuable and effective strategy for interaction. Possible strategies to compensate for the decentralised location of their offices could be spending more time in the ward, eating lunch with physicians and nurses, attending prerounds and participating in physicians' daily meetings.

Most of the HSWs referred to the experience of 'standing along the wall while the physicians sit around the table' during prerounds. Despite these conditions, several chose to sign up for and attend these meetings. The simple act of showing up could work as a reminder for the physicians to include the HSW and ask for their services. Sometimes, it also provided the opportunity to ask questions or elicit comments from a social work perspective. For some, this participation led to being included and being offered a seat at the table. Moreover, interaction with physicians and nurses could also take place at the patient's bedside, in the corridor, in the physician's office or in patient meetings.

Refusing to be hindered by physical barriers and, instead, actively seeking the attention of physicians seems to increase the interaction between physicians and HSWs and, thereby, to promote their role as equal counterparts.

Collaborative boundary work

Theme 2 is called collaborative boundary work, in line with Langley *et al.* (2019), referring to HSWs' work *at* boundaries, in settings where interactions among different occupations are necessary to achieve a common goal. In this study, there were two prominent patterns among the participants in relation to collaborative boundary work. The two subthemes are labelled 'adapting' boundaries and 'downplaying' boundaries.

Sub-theme 1: adapting boundaries

Adapting boundaries was a way of performing collaborative boundary work amongst the HSWs, thus demonstrating the everyday ambivalence of boundary work in the wards. This mode involves adapting to others' expectations of one's role when the expectations are not in accordance with one's own perception of competence. Even if the adaptation could cause personal tensions, the HSWs handled the tensions by absorbing them. A typical example of the latter could arise when health professionals seemed to devalue the HSWs' competencies, as when a physician entered the ward, expecting a psychologist rather than a social worker to handle parents' demand for psychological support, and expressed: 'We asked for a psychologist and here comes a social worker'. Even though the participants perceived being devalued by health professionals as frustrating, they generally handled these situations not by reacting but, rather, by providing attention to the patients' or the families' needs. None of the participants talked about why they chose to deal with it the way they did. One HSW used a metaphor—'to be the oil in the machinery'—to explain how she evaluated her role in general. This view that

her role required a sensitivity towards her surroundings in terms of how she needed to act in a specific situation was held in common with several other participants. Similar episodes were reported in which the HSWs' special competencies were unknown to the staff. Adaptation, thus, served to demonstrate a competence beyond the jurisdiction that is common to all HSWs, which is more oriented to practical assistance.

Another example of adapting boundary work is the acceptance of existing routines, even if they are not optimal for the HSW. For example, the existing routines could prevent them from using their skills or present barriers in accessing information. Some HSWs experienced that participating in prerounds did not give room for other issues besides medical ones to be addressed. Thus, the role of the HSW would be more as an observer than a participant, despite the fact that prerounds, in many cases, constituted the only formal meeting point between HSWs, other subordinates and physicians. According to the participants, when physicians defined content and form in a way that did not include the HSW's perspective, the avenues of collaboration were reduced. Furthermore, the physical arrangement of the meetings did not invite interaction. The participants talked about how HSWs and other subordinates were placed in a row behind physicians such that it sometimes was difficult to hear what was being said. In internal discussions among the HSWs, however, the main question was whether or not they should attend, rather than how they might change the content or the preround concept. Moreover, attending these meetings could bring forth valuable information about in-patients and their special social needs, which could assist them to initiate the necessary processes earlier. A way of adapting to the existing format is reflected in the following excerpt:

> Everything is faster, more case-focused, I have to be quicker when I present issues. I really need to practice that. It's another language altogether (HSW 17).

This HSW reflected on how she adapted her way of speaking to the terminology, topics and pace of the physician as a way to engage in collaboration.

Sub-theme 2: downplaying boundaries

In contrast to the previous section, downplaying boundaries denotes HSWs' efforts to include other professional groups in a sense of shared identity, despite occupational differences. The importance of a shared identity was articulated through their use of 'we' to emphasise a form of alliance among the different groups. As one HSW put it:

> We work coordinated. Send notes to each other to keep others up to speed, cooperate in that way (HSW 13).

This statement illustrates that this participant downplayed the divide between 'us' and 'them' by emphasising 'we'. Her way of describing interprofessional collaboration was in line with other participants, who also expressed the importance of being acknowledged and included by other health professionals:

> I think there are a lot of informal meetings about how did we get through this, or what is a good idea to do now, or how do you feel in relation to this now? What are you doing in relation to this, what do you think we should do, what could we do together? (HSW 1)

Some participants emphasised that going through stressful situations together strengthens the feeling of team belonging. These situations can lead to downplaying the boundaries among them by sharing their experiences of shortcomings and vulnerability when they experienced mutual support. Taking care of one another and expressing concern for colleagues can, thus, enhance the experience of 'we'.

Downplaying boundaries was also performed in cases in which the ordinary division of labour did not work well. This was expressed, for example, in contexts in which the relationship between the HSWs and the patients or parents, for various reasons, prevented the HSWs from performing the tasks themselves. One solution could be to hand over their tasks to other occupational groups who might be in the position to implement them. Some HSWs did not differentiate among occupational groups and referred to them, instead, as the treatment team around the patient; others referred to subordinates, such as occupational therapists or nurses. Alternative solutions appeared as a result of knowing one another's skills and personal qualifications. Considerations of efficiency and available resources, rather than professional determinations, seemed to guide the decisions as to who would perform the tasks. Finally, the desire to help the patients seemed a prime reason to cross borders as well as a consequence of it.

Discussion

As described above, HSWs' boundary work can be characterised as both competitive and collaborative. Where the former focuses on different ways of HSWs distinguishing themselves from others through constructing, protecting and expanding boundaries, the latter describes modes of collaborative boundary work, that is, adapting and downplaying boundaries, that are aimed at achieving common goals and getting the work done.

A more detailed analysis of competitive boundary work evoked a picture of the three ways in which HSWs demonstrate the relevance of their professional knowledge within a hospital setting. The constructing mode of boundary work largely employed an explanatory discourse, involving different types of oral presentations on patients' and families' statutory rights and on the value of social workers' services in meeting patients' and families' social and psychosocial needs. The awareness and use of varied opportunities to make explicit and detailed arguments about their competencies and skills concurs with previous research on how subordinates defend themselves (Sanders and Harrison, 2008) and contest boundaries (Bucher *et al.*, 2016). In line with Sanders and Harrison's (2008) study, and in accordance with the HSWs' perceptions, there was also a clear tendency among physicians and other dominant groups to assume the natural rectitude of the current boundaries and, thus, to have little need to justify their positions. The previously identified distinctive boundary work tactics between subordinates and dominant groups are, thus, recognised in our study.

In contrast, a more deliberate way of acting and communicating was expressed within the category of protective boundary work. Protective boundary work transpired mainly when the HSWs demanded adequate resources and routines when they were required to respond to inquiries and demands from health professionals who failed to comply with routines or espouse a psychosocial awareness. Clarifying the responsibilities of others, by focusing on the required conditions to help meet the needs that arise in a given situation, may draw attention to the vital skills and competencies necessary to complete certain tasks. The explicit demands for resources, with direct consequences for discharge planning, are an unexpected finding, contrasting with the general impression of a subservient and humble attitude among the participants' occupational group. This finding indicates a boundary relation that provides a situationally superior legitimacy and power, which is usually reserved for dominant groups (Allen, 2000; Burri, 2008).

Finally, conducting expanding boundary work shows how some participants actively work to broaden the physicians' acknowledgement of their skills and competencies by challenging the established routines and obstacles to collaboration. Previous research supports the idea that building relationships (Ezzamel and Burns, 2005) and constructing coalitions with others (Huising, 2014; Helfen, 2015) can be more effective than mere rational arguments in influencing the boundaries shared with others. The strategy of HSWs justifying and promoting their position in relation to physicians as a dominant group is a well-known subject in the theories of professions. As pointed out in Freidson's (1970) earlier work, occupational hierarchies are based on specialised knowledge and skills that are of central importance to reaching shared goals (Freidson, 1970/2017). The function, content and character of the expertise are what

determine the authority of one occupation over others. Within occupational organisations such as hospitals, in which cooperating professionals work in parallel with one another on related tasks, the physicians seem to hold positions of authority by virtue of their specialised knowledge and skills to treat critical and acute illness. Thus, various occupational groups' seeking to build alliances with physicians—by communicating how their own knowledge and skills can contribute to reaching shared goals—may lead to a greater acknowledgement of their skills, and thus may be a useful strategy in extending their jurisdictional boundaries and establishing a clearer division of roles and responsibilities among professional groups (Abbott, 1988). However, this explanation may also be seen as a way of pursuing collaboration and may thus, as pointed out by Liao (2016) and Grodal (2018), highlight the interweaving of different types of boundary work.

The two modes of boundary work aimed at fostering collaboration, adapting boundary work and downplaying boundary work, further elucidate the ambivalences associated with collaboration. On the one hand, focusing on a common goal and, thereby, downplaying the differences in the occupational groups' expertise, contributes to strengthening the feeling of being a part of a team and reduces the thresholds for collaboration. On the other hand, as part of achieving smooth collaboration, the HSWs did boundary work by absorbing any difficulties. As Langley *et al.* (2019) put it while describing the duality of collaboration often found in the boundary work literature, 'collaborative boundary work is often made possible through the skilful activities of particular people managing the ambiguities of belonging to and navigating different worlds' (Langley *et al.*, 2019, p. 35). The HSW not only navigates between the patient and other health professionals, but also between different perspectives, such as the psychosocial perspective and the medical perspective (Ambrose-Miller and Ashcroft, 2016; Glaser and Suter, 2016). HSWs actively manage the navigation of the disparate social worlds to which they belong. Their subjective experiences of their positions as ones that contain both possibilities and constraints (Huzzard *et al.*, 2010) involve the conscious and reflexive regulation of their boundary-negotiating activities and standing (Azambuja and Islam, 2019). In Huzzard *et al.*'s (2010) terminology, the HSW might be viewed as an active boundary subject mediating across various groups of professionals, as opposed to being a passive boundary object. Being active subjects could also accommodate HSWs' competitive boundary work, through consciously and reflexively regulating their boundary activities in order to pursue collaboration. Thus, one type of boundary work could affect and create situations demanding another type (Liao, 2016; Grodal, 2018). A focus on boundaries and on distinctions among competencies belonging to different occupational groups is also a way of clarifying

responsibilities, which allows for the task division necessary to accomplish collaboration.

Further, being aware of oneself as a boundary subject may promote the feeling of expanding one's possibilities for action by opening up different understandings of what appropriate action in a situation entails. The notion that the position as a boundary subject allows for different perspectives is supported in the work of Azambuja and Islam (2019). In addition to understanding adapting boundary work solely as absorbing difficulties within oneself, adapting boundary work can be seen as an intentional and planned way of acting. Understanding the HSW as a purposeful and reflexive subject thus allows for the ability to choose the adaptive way of performing boundary work, based on the experience of what pays off in the long run. It may not amount to much structurally (Apesoa-Varano, 2013), but it could affect and strengthen HSWs' local jurisdictions by actively employing different modes of boundary work to achieve collaboration in workplaces.

Knowledge about these mechanisms can be useful for social workers in all settings characterised by interprofessional collaboration. However, an interesting question to be asked is whether the relevance of the boundary subject is particularly intrusive in contexts like Norwegian hospitals without formalised specialisation courses for holding the role of an HSW and without common guidelines. The study may indicate that continuing education preferences play a role in how individual HSWs fulfil their positions, which may lead to generally unclear jurisdictional boundaries and, in turn, actualises the significance of the relational aspect and the boundary subject position.

Our findings have implications for social work research. There is a need for further exploration of the interlinked work for and at boundaries from the perspective of social workers in different settings, but also of social workers' boundary work from different perspectives.

Limitations

The method used in this study exhibits a limitation in that it relies only on interviews, without being supplemented by observations that could offer additional information. The small sample, moreover, limits the level of generalisability. Future research would benefit from a greater number of participants and draw on different qualitative methods. It may also be worthwhile to note that the first author, who conducted the interviews and the first stage of analysis, once held a social worker role in a university hospital. However, despite the limitations, this study offers important contributions to an underdeveloped area of research.

Conclusion

In this article, we have argued for further knowledge about the ongoing process of HSWs' boundary work activities in order to contribute to our understanding of interprofessional tension and collaboration in health care. By analysing data from in-depth interviews with HSWs about their experiences with interprofessional collaboration, we have shown how HSWs' boundary work can be characterised as competitive through 'constructing', 'protecting' and 'expanding' boundaries, and as collaborative through 'adapting' and 'downplaying' boundaries. The discussion embraced a relational and processual view of boundary work, in which different forms of boundary work serve in collaboration towards a common goal and in creating distinctions from others in order to attain privileges and to defend or strengthen the HSW jurisdiction. Boundary work may serve several purposes simultaneously, while the actor in this process, by virtue of recognising their position as a boundary subject, can also facilitate this process. Being aware of one's position as a boundary subject can thus open up optional and intentional ways of carrying out boundary work. This might be particularly relevant in contexts where a lack of specific requirements for continuing education or common guidelines causes local developments of the HSW role. Accordingly, knowledge about the dynamics of the boundary subject position should be included in further research on HSWs' boundary work and in discussions about qualifications and jurisdiction.

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