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Contestation about Collaboration:

Discursive Boundary Work among Professions

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Abstract

We examine how professions responded to a potential change in jurisdictional boundaries by analyzing the written submissions of five professional associations in reaction to a government proposal to strengthen interprofessional collaboration, relating these responses to the professions' field positions. We identify four foci for framing used by the professions, represented by their professional associations, to discursively develop their boundary claims: (1) framing of the issue of interprofessional collaboration (that we call issue framing), (2) framing of justifications for favored solutions (that we call justifying), (3) framing of the profession's own identity (that we call self-casting), and (4) framing of other professions' identities (that we call altercasting). We find that professions employed these foci differently depending on two dimensions of their field positions – status and centrality. Our study contributes to the literature by identifying distinctive ways through which the foci for framing may be mobilized in situations of boundary contestation, and by theorizing how field position in terms of status and centrality influence actors' framing strategies.

Keywords

Boundary work, professions, framing, health care

Introduction

Professions engage in boundary work (Gieryn, 1983) to maintain, change or broaden their practice domains. Boundaries between professions are negotiated (Thomas & Hewitt, 2011) and the stakes are high: Boundaries define a profession's access to material and non-material resources such as power, status, and remuneration (Abbott, 1988). While boundary work between professions can occur at the individual or organizational level, our focus here is on the field level (DiMaggio & Powell, 1983; Fligstein & McAdam, 2011). Fields are defined as the set of “organizations that, in the aggregate, constitute a recognized area of institutional life” (DiMaggio & Powell, 1983, p. 148); they span diverse constituents – macro-actors such as government, professional associations, regulatory agencies, suppliers, and consumers. They are also generally stratified, with some actors occupying higher or lower status or more or less central “field positions” than others (Abbott, 1988; Leblebici, Salancik, Copay, & King, 1991).

A number of studies have explored the strategies that professions employ in their attempts to construct, defend or contest professional boundaries (Abbott, 1988; Allen, 2000; Lawrence, 2004; Suddaby & Greenwood, 2005) either in ongoing work or in response to particular events, and scholars have suggested that higher status professions tend to defend existing boundaries while lower status professions strive to change them (e.g., Abbott, 1988; Battilana, 2011). However, we currently lack a systematic account of how professions discursively construct their boundaries, and in particular how differences in professions' field positions influence the use of different discursive strategies in response to events that raise questions about existing boundaries (Battilana, 2011; Lockett, Currie, Finn, Martin, & Waring, 2014).

A focus on the discursive manifestations of professions' boundary work in relation to field positions is both theoretically interesting and practically important because professions do much

of their negotiating and positioning with government and other field actors through the creation and distribution of official documents. A deeper understanding of how field positions are reflected and played out in discursive strategies within such documents can enhance reflexivity concerning the boundary claims of different groups. In an era of government-led initiatives to alter professional jurisdictions and behaviours as part of efforts to improve efficiency and effectiveness (Martin, Currie, & Finn, 2009; Thomas & Hewitt, 2011) struggles around boundaries are likely to become increasingly common, and are likely to be played out through texts. We therefore ask: *How do professions engage in discursive boundary work in response to initiatives aimed at reshaping professional practice?* and *How do the field positions of professions influence the types of discursive boundary work they engage in?*

The health care field is a particularly interesting context for examining how professions negotiate boundaries. Demarcations between health care professions are well-established; they are also numerous given the high stratification of the field, with multiple professions striving to maintain or extend jurisdictions (Abbott, 1988; Finn, 2008). Events that impact practice domains are therefore likely to trigger discursive boundary work. In this paper, we analyze the texts created by professions (represented by professional associations) in response to a government document proposing interprofessional collaboration (IPC), a move that would restructure professional practices in Ontario, Canada. In particular, we studied the texts produced by five professional associations, focusing on their discursive boundary work in relation to their field positions. We draw on the notion of “framing” popularized in the social movements literature (Cornelissen & Werner, 2014; Snow & Benford, 1988) to capture these discursive strategies.

Our study revealed four main foci for framing in the profession’s written reactions to the initiative: – framing of the issue of IPC (that we call issue framing), framing of justifications for

avored solutions (that we call justifying), framing of the profession's own identity (that we call self-casting), and framing of other professions' identities (that we call altercasting). It is by engaging with these foci in different ways that the professions defend or contest existing boundaries. We find that variations in how the different professions mobilize the different foci for framing are related to two dimensions of their field position: status and centrality. Our study thus contributes to the literature by identifying different patterns and foci for framing associated with boundary work at the field level, and by theorizing the relationships between professions' field positions and their patterns of framing.

In the next section, we review the literature on boundary work and field positions and explain in more detail how the notion of framing offers a promising approach to studying discursive boundary work at the field level.

Boundary Work, Field Positions and Framing

Professional boundaries and field positions

Boundaries are “distinction[s] that establish categories of objects, people or activities” (Lamont & Molnár, 2002; Zietsma & Lawrence, 2010, p. 191) and that regulate interactions between them (Scott, 1994). In particular, professional boundaries distinguish “special” occupations from other workers based on expert knowledge that professions use to solve problems (Abbott, 1988). In contrast to other occupations, professions often hold exclusive rights to perform work associated with that knowledge (Abbott, 1988), which accords them considerable autonomy (Pickard, 2009). These exclusive rights are exerted through professional licensing bodies and government legislation. Specific areas of knowledge and practice also demarcate different professions and sub-professions from each other. Similarly, differences in professional identities develop as a consequence of particular education and socialization

processes (Chreim, Williams, & Hinings, 2007; Goodrick & Reay, 2010) and each profession's common values, approaches to problem-solving, and language (Hall, 2005). Professions may occupy different positions in the field based on two important dimensions – *status* and *centrality*.

Professional *status* is related to authority, or the capacity of a profession to control the work of other professions (Abbott, 1988; Freidson, 2001). In professionalized fields, this capacity and related status increases with the exclusiveness and specificity of the domain of knowledge controlled by a profession (Suddaby & Viale, 2011). In the field of healthcare, physicians are situated at the apex of the status hierarchy due to their extensive training and exclusive rights. Other professions such as nurses or pharmacists are restricted from performing certain tasks without a physician's order (Freidson, 2001). Also, professions that emerge in vertical differentiation of the professional workforce, such as health assistants, or new professions are usually lower in status than established ones (Abbott, 1988). In addition to distinguishing between high and low status groups, more recent studies have focused on actors that lie between these extremes. "Middle status" actors (Phillips & Zuckerman, 2001) are important because they often follow their own specific interests and engage in different practices from high or low status actors. In terms of field level developments, middle status actors may not only be more inclined to change than high status actors, but also have more resources than lower status actors to achieve change (Lockett, Currie, Waring, Finn, & Martin, 2012).

While status hierarchy is an important characteristic of professionalized fields, it is different from a second important dimension of field position, which distinguishes between central and peripheral positions (Greenwood & Suddaby, 2006; Leblebici et al., 1991). The concept of *centrality* draws attention to the distribution of practices in a field and actors' embeddedness in prevailing practices. For example, Greenwood and Suddaby (2006) categorized

more established accounting firms as central to their field, while the smaller and newer firms were viewed as peripheral. With regards to health care, Abbott (1988) distinguished two areas: the “medical area” composed of physicians, nurses and other lower status groups; and, important to our study, the “psychotherapeutic area”, with psychiatrists at the top, followed by psychologists and then other groups like social workers. With a majority of health care interventions addressing the physical dimension and only a smaller segment addressing mental illnesses (CAMH 2015), professions in the medical area can be characterized as more central to the health care field, while those in the psychotherapeutic area are more peripheral.

In summary, boundaries demarcate professions from other professions and sub-professions with distinctive status and centrality in the field; however these boundaries are not fixed. In the following sections, we discuss how professions discursively negotiate their boundaries by engaging in boundary work and then how field positions influence such boundary work.

Boundary work and framing

Boundary work consists of strategies used to establish, obscure or dissolve distinctions between groups of actors (Gieryn, 1983). Professions continually negotiate boundaries, but can also be pushed to engage in boundary work by events that affect demarcations between them, such as state interventions that respond to public opinion or economic pressures (Dingwall, 2012; Micelotta & Washington, 2013; Muzio & Ackroyd, 2005), as is the case in our study. Rather than merely reacting to such pressures, professions can actively shape events to pursue their own interests (Currie, Lockett, Finn, Martin, & Waring, 2012; Micelotta & Washington, 2013). Put differently, professions can use such events to open up “discursive opportunity structures” (McCammon, Sanders Muse, & Newman, 2007; Werner & Cornelissen, 2014) that allow them to defend or contest boundaries and maintain or change their jurisdictions.

The notion of “framing” has been applied in other field-level studies (Benford & Snow, 2000; Lefsrud & Meyer, 2012; Werner & Cornelissen, 2014) to describe discursive strategies relating to boundaries. In general, “framing” involves assigning meanings and interpreting conditions and events in ways aimed at achieving specific goals (Granqvist & Laurila, 2011; Snow & Benford, 1988); through framing, field-level actors “legitimate or delegitimize the acceptance of a particular program of change” (Suddaby & Viale, 2011, p. 434).

Scholars have typified framing strategies by which actors legitimize change or the status quo in a variety of ways. For example, Werner and Cornelissen (2014) suggest that faced with a particular discursive opportunity structure, actors may engage in “frame blending” (employing conjunctive language to link desired meanings to pre-existing ones), or “frame shifting” (using disjunctive language associated with contrast and difference to suggest changes with respect to pre-existing understandings). Frame blending and shifting strategies may be more or less moderate or radical depending on the narrowness or openness of perceived opportunities.

Others have typified framing in terms of different modes of justification. For example, Suddaby and Greenwood (2005) drew attention to different types of theorization in a boundary dispute between accountancy and law firms; and Vaara and colleagues identified different strategies for legitimating mergers, acquisitions and alliances in the media (Vaara & Tienari, 2002; Vaara, Tienari, & Laurila, 2006). These authors distinguished a variety of justifications including rational argument, recourse to norms and values, and “naturalization” (where assumptions replace explicit justifications).

Different types of framing have also been identified in the social movements literature. Benford and Snow (2000) discuss diagnostic, prognostic, and motivational aspects of framing. The first two aspects relate to the issue itself – identification of the problem and desirable

solutions; the third (motivation) is closely related to justification. Lefsrud and Meyer (2012) drew on these three types of framing to examine the climate change debate, and how experts discursively positioned their own and others' identities, implicitly constructing boundaries between groups. This suggests that there may be interesting linkages between the framing of issues and the framing of identities (see also Cornelissen & Werner, 2014) in the context of boundary work that warrant further development.

Overall, the literature suggests that attention to various types of "framing" offers a promising approach to understanding discursive strategies in response to new opportunities. However, these have not yet been explored in the context of professions' discursive boundary work. Moreover, this leads to the question of how field positions might influence framing.

Boundary work, framing and field positions

Various empirical studies have shown that different professions appear to have different perspectives on the roles of other professionals in their work, but few have attempted to relate boundary work systematically to field positions, especially at the field level. Finn (2008), for example, found in a workplace study that physicians viewed "teamwork" within an operating room setting in terms of efficiency, while nurses constructed "teamwork" as involving more egalitarian structures. Similarly, Lockett et al. (2014) observed that physicians within a high status primary care service displayed less "allocentrism," (i.e., recognition that change is contingent on other professionals' thoughts and actions) than physicians or nurses in lower status positions. These findings suggest that status is important to boundary work; however it remains unclear how the relationships between framing strategies and field position play a role.

In fact there is some confusion concerning the role status plays in boundary work. For example, some studies suggest that high status professionals tend to defend boundaries against

incursion by emphasizing the exclusiveness of their abstract knowledge and training, and by constructing the role of aspiring actors as “technicians” or as “non-experts” (Abbott, 1988; Allen, 2000; Currie et al., 2012; Lefsrud & Meyer, 2012). Yet other studies found the contrary. For example, Sanders and Harrison (2008) observed that in contrast to lower status professionals, the highest status professionals *did not* explicitly claim their competence as a legitimization strategy to shape boundaries. Rather “silence” appeared to express “a taken-for-granted assumption of their own technical superiority” (Sanders & Harrison, 2008, p. 297). In other words, “claiming competence” seemed to be necessary only when it was questionable.

Overall, the question of what influences different patterns of framing in relation to boundary work at the field level, and in particular what role field position plays in this regard, remains under-explored. If we assume that macro-actors in different positions have different interests and will therefore try to influence field-level developments in different ways (Currie et al., 2012; Meyer & Höllerer, 2010; Zietsma & Lawrence, 2010), then we need to consider in more detail how *different positions* translate into *different framing strategies* at the field level. To examine these issues, we study the way in which multiple professions engaged in a public discussion relating to the (re)shaping of professional boundaries in health care.

Methodology

Research context

The health care field is an ideal setting for addressing discursive boundary work given the large number of professions active in the field and their high degree of stratification (Abbott, 1988; Finn, 2008). Events that impact practice domains hold particular significance because professions regard their boundaries very seriously, and governments increasingly strive to regulate professions in their efforts to increase the effectiveness of health services (e.g. Martin et

al., 2009). One common initiative around the world concerns the promotion of workforce flexibility through inter-professional collaboration (Kuhlmann & Saks, 2008). The specific context for this study reflects these developments. Specifically, we explore the boundary work of professional associations in the health care field in Ontario, Canada, in response to an Ontario government initiative aimed at “improving access to seamless, effective, patient-centred care” (HPRAC, 2008, p. 1) by supporting and facilitating interprofessional collaboration (IPC).

In Ontario, government initiatives usually follow a multi-step process, starting with the consultation of advisory bodies by the responsible government department (in this case the Ministry of Health and Long Term Care, the “Ministry” in what follows), research on the issue, presentation of proposals to the government, consultation of key stakeholders, and further rounds of consultations and amendments that may be ultimately transformed into new laws or regulations. Our study focused on the first phase of the IPC initiative – the multi-step consultation between the Ministry, the Health Professions Regulatory Advisory Council (HPRAC; labelled “Advisory Council” in what follows) – a lay body established in 1991 that advises the Minister of Health on issues relating to the health care professions – and various professional associations. The process led to the production of a report and proposals to the Minister by the Advisory Council and submissions by members of the public, the private sector and professional associations in response to the proposals.

In its interim report to the Minister in 2008, the Advisory Council presented IPC as part of a “trend toward breaking down the exclusive control or monopolies that some health professions have had in the delivery of care, to allow overlapping scopes of practice” (HPRAC, 2008, p. 2). The initiative’s goal was to strengthen IPC by proposing regulatory adjustments to practice domains and inviting collaboration among professional bodies. According to the Council’s

document, “overlapping scopes of practice better enable collaboration by allowing substitution of available providers to perform certain activities” (HPRAC, 2008, p. 2). This move, if established in regulation, would require the existing boundaries around certain practice domains to be opened. The Council’s “Invitation to comment” on the matter of IPC can be interpreted as a discursive opportunity structure that professions used to engage in boundary work in order to maintain or change their jurisdictions.

Our study focuses on the responses of professional associations to the Council’s report. Due to their important role in the health care field in general and the IPC initiative in particular, we focus our analysis on Physicians, Registered Nurses and Psychologists together with their junior professions of Registered Practical Nurses and Psychological Associates (capital letters indicating reference to their respective associations).

Overall research strategy and data

We were interested in two research questions. First, we wanted to examine how professions employed framing to discursively (re)draw boundaries in a chain of publicly available texts. Consistent with our view that boundaries are negotiated and socially constructed we used an interpretive approach to analyze discursive data (Heracleous, 2004; Jørgensen & Phillips, 2002). Second, we strived to better understand how differences in framing by each of the professions was related to their field positions. We characterized the five professions’ field positions by drawing on extant literature on health professions; in addition, we consulted context-specific documents on the Ontario professions to validate general descriptions found in literature as being appropriate in Ontario (see Appendix for a list of key sources).

Our main dataset consisted of texts issued within the discursive space that was opened up by the IPC initiative. This included the Advisory Council’s “interim report” to the Minister

containing a Discussion Guide with 43 questions around IPC (http://www.health.gov.on.ca/en/common/ministry/publications/reports/hprac_08/2_hprac_interpro_20080300.pdf). This Council document was addressed to professional bodies, private and public organizations as well as the general public. This document set the tone of the discussion and pre-structured the topic to some extent. More importantly, we attended to the subsequently issued submissions of several professional associations. We collected these texts from the official Advisory Council page (http://www.hprac.org/en/projects/Interprofessional_Collaboration_DG_Responses.asp) set up to gather the written submissions in 2008. Due to their importance in the overall development of the professional field and the IPC initiative, we focused our analysis here on the submissions of five specific professional associations. Table 1 provides an overview of these texts, their composition and length.

Insert Table 1 here

Data analysis and interpretation

Data analysis included two broad stages. First, we examined the professions' field positions. Drawing on documents from Ontario and general literature on health professions, we distinguished the five focal professions according to their status – based on a profession's authority over others, and centrality – based on a profession's embeddedness within prevailing practices in the field (see earlier definitions). Second, we inductively analyzed the discursive boundary work strategies used by the professions, and related these to field positions.

Field position of professions: Within the medical area, which accounts for more than 85% of interactions in the health care field in Ontario (CAHM 2015) and therefore comprises actors at the field's *center*, Physicians are clearly the *highest status* actors (Abbott, 1988; Freidson, 2001), followed by Registered Nurses (RN) and then Registered Practical Nurses (RPN), a junior

profession subordinated to the Registered Nurses. Physicians hold a number of exclusive rights such as communicating a diagnosis (Medicine Act 1991) and in many cases need to authorize other professions to perform their work. Practical Nurses hold lower levels of education than RNs, their senior profession (diploma vs. university degree). We therefore position Practical Nurses as *low status* in the medical hierarchy, and Registered Nurses as *middle-status* actors.

The psychotherapeutic area comprises actors more at the *periphery* of the health care field. This positioning is also reflected in Ontario legislation which defines a total of 12 so called controlled acts, only one referring to the psychotherapeutic area. Psychotherapeutic professions in our study included Psychologists, who hold lower status than Psychiatrists (not included in our study as there was no separate submission to the Advisory Council), as well as Psychological Associates (PA). PAs are less educated than Psychologists (a masters vs. a doctoral degree). PAs therefore hold a *lower status* position than Psychologists who we characterize as *middle-status*.

Discursive boundary work strategies and relations with field positions: Our analysis of discursive boundary work strategies followed four steps. First, we identified *themes* that were indicative of boundary work by looking for explicit or implicit aspects related to professional roles and practices, capabilities, relationships, and hierarchy employed by each profession in relation to itself and other groups with whom it interacted. Initially, there were a large number of different themes, some of them specific to individual texts; by moving back and forth between data and the literature presented earlier, these were gradually condensed into four more abstract themes or “foci for framing,” common across the five texts. We call these “foci for framing” because each deals with a different specific element or object around which framing occurs, but with all four contributing collectively to constituting an understanding of how professional boundaries are constructed within the discourse of that profession. The four foci for framing are:

(1) framing the “issue” of IPC itself, expressed in how the professions referred to the topic of IPC, its problems and solutions (labeled “issue framing” in what follows); (2) framing of justifications for favored boundary configuration solutions where actors draw on different forms of knowledge to substantiate their claims (we call this “justifying”); (3) framing of the profession’s own identity where the profession who authored a document referred to “self” as a profession and as a discussant of IPC (labeled “self-casting”); and (4) framing of other professions’ identities, referring to the (re)positioning of other groups in relation to one’s own (labeled “altercasting” following Weinstein & Deutschberger, 1963).

In a second step, we focused on each of the professions. We explored in-depth their particular use of the four foci for framing in relationship to their field positions, extracting the most salient similarities and differences between professions’ strategies across the different foci. We iteratively considered extant literature to better ground our distinctions. For instance, in line with Vaara et al. (2006), we distinguished between the use of rational resources where actors refer to “utility or function of specific actions or practices” (Vaara et al., 2006, p. 800), normative resources where actors mobilize values or norms about how things “should” be done. We also identified experiential resources as a separate category where actors referred to elements based on local experiences in laying their claims.

In a third step, we looked across the particular uses of framing for the five professions, for patterns in the way field positions manifested themselves in framing strategies. We identified distinctive field position-framing relationships associated with the dimensions of status and centrality. In a final step, we returned to the literature and to our data in an effort to better understand the theoretical mechanisms underlying the relationships discovered in the previous steps, and to identify their boundary conditions (Eisenhardt, 1989; Langley & Abdallah, 2011).

The tables in the findings sections provide extensive examples of our coding of the four foci for framing and the five professions' particular framing strategies within and across these categories. The authors worked separately and then jointly on the analysis and interpretation of the findings. In the next section, we present our first order findings, showing the profession-specific strategies adopted in relation to the four foci for framing. In the following section, we abstract from the first order findings to theoretically relate framing strategies to field positions.

First Order Findings: Discursive Boundary Work Strategies across Four Foci for Framing

We now present the four foci for framing that we identified in the professions' texts – *issue framing, justifying, self-casting, and altercasting* – and show how the five macro-actors mobilized these categories differently as they responded to the Advisory Council's report. In the context of our study, the distinctive ways in which the professions mobilized the different foci for framing can be interpreted as strategies of boundary work aimed at discursively defending or contesting jurisdictional demarcations in the field.

While we present the foci for framing separately, in the submissions, they were sometimes overlapping. We present direct quotes from the texts with italics and underlining as reflected in the original; we add bold type where we wish to draw attention to particular words or passages in the texts. Further illustrative data on the strategies adopted for each profession within each of the categories are provided in Tables 2 to 6.

Insert Tables 2 to 6 here

Issue Framing: Narrowing vs. Stretching

The Advisory Council launched the process described here by publishing their document encouraging interprofessional collaboration. This served as a mechanism to potentially open up the boundaries between professions, and created an opportunity for each profession to respond.

The document elaborated on a number of “obstacles” and “barriers” to IPC that created or reinforced “silos” between professional groups rather than fostered collaboration. The Council claimed that one way to reduce interprofessional barriers was through changes in regulation including “revis[ing] professional scopes of practice as necessary” and “redefining who can provide care.” The following excerpt illustrates these proposals:

The [Advisory Council] proposes that any initiatives should be directed to finding ways to: Assist health regulatory colleges and their members to work **collaboratively, rather than competitively**, and to learn from and about each other through a process of **mutual respect and shared knowledge** to... [among others] improve patient care and facilitate better results for patients.

In the five response submissions we analyzed, the professions referred to the focal issue of IPC as put forth by the Advisory Council. *Issue framing* involved framing IPC as the topic of the discussion, referring to problems with the current understanding and practice of IPC, and proposing solutions. While we found that each of the professions amended the label and understanding of IPC put forth by the Council, we further distinguished between *narrowing* and *stretching* the discourse around IPC as salient variants of issue framing.

Narrowing the discourse was characterized by ascribing IPC a meaning very similar to existing models of work between professions, implying a need to strengthen the status quo. This variant was clearly associated with the **Physicians** holding the field position of central, high status actors as mentioned earlier. Their document was entitled “Achieving patient-centred collaborative care.” In their definition of “collaborative care”, the Physicians emphasized their own central role in the model:

*Collaborative care entails **physicians and other providers** using **complementary** skills, knowledge and competencies and working together to provide care to a common group of patients based on trust, respect and an understanding of each other’s skills and knowledge.*

Note that they use their own terminology (“collaborative care”), and rarely take up the term “interprofessional collaboration” proposed by the Advisory Council. According to the

Physicians' definition of collaborative care, responsibilities or decisions were never meant to be shared among team members, but rather to be "divided" and skills were to "complement" each other with physicians standing out in this complementarity in their distinctiveness from "other providers." Accordingly, Physicians resisted proposals that would involve expanding other providers' scope of practice. They stated:

We want to reinforce the notion that **collaboration is not contingent upon the expansion of scopes of practice** for certain provider groups.

Building on this, the document signaled the Physicians' concern that they might become dispensable if there were changes in the scope of practice. They stated that they "don't believe that successful collaborative arrangements can be achieved through regulation or legislation" and argued that "[c]larity of roles... and communication is at the heart of any newly established interprofessional collaboration." Thus, Physicians framed the problems surrounding IPC as having less to do with a need for change than for "clarifying" the present system (see Table 2).

The four professions other than Physicians, all with a relatively lower status, *stretched* the meaning of IPC as put forth by the Council, clearly indicating their aim to move away from the status quo and thus open boundaries. The **Registered Nurses** deviated somewhat from the Council's notion of "patient-centred" IPC, claiming the need to discuss "**authentic** client-centred" IPC, thereby already pointing to perceived deficiencies in current IPC practice. They also responded to the Physician's document by challenging the validity of several statements in it. For instance, the RNs contrasted what they thought the physicians said with what physicians did, reframing the physicians' perspective as incompatible with "authentic" IPC:

Although many physicians support interprofessional collaboration in theory, in reality many also see themselves as the 'leaders' or 'final decision-makers' of the 'team'. This attitude undermines the very essence of interprofessional collaboration.

In contrast to the Physicians' framing, the RNs perceived interprofessional care to be “grounded in mutual respect and **shared** knowledge” between care providers and enacted by a “health-care **team**.” While the RNs did not assume that legislation would guarantee IPC, they regarded legislative structures as important “facilitators” in achieving it (see also Table 3).

Similar to the RNs' adjective “authentic”, we notice that the **Psychologists'** notion of “true” interprofessional care criticized current legislation and regulatory bodies that did not sufficiently consider different professions when talking of IPC:

We ... have concerns about the perspectives in some material from the Ministry of Health... that, in the past, have made reference to interprofessional collaboration but, upon further examination, **have limited these interprofessional teams to medicine and nursing alone**. We believe **true** interprofessional teams are the result of a number of professions working together for the care of their patients.

Accordingly, “true” IPC can be related to the Psychologists' call to “expand” the definition of IPC, “to ensure that it is recognized that **anyone** on an [IPC] team can be seen as the primary lead in the care of a particular patient” – an explicit claim to opening existing boundaries. The Psychologists viewed changes in legislation as a means to clarify or open boundaries by providing “agreed upon definitions of controlled acts” to reduce “confusion and negative relations between regulated professionals,” but it should also allow for “greater equity” among professionals (see Table 4).

For their part, the striking aspect of the lower status junior professions' issue framing was their expression of the need to open up boundaries not only with physicians, but also with their senior professions. The **Practical Nurses** wrote that they “believe (...) that the biggest issues for interprofessional practice... are **both inter and intraprofessional**.” They expressed concern about the “veto power” of Physicians, stating that, “if physicians do not accept a proposed change, the Ministry will not put it forth.” In relation to the RNs, they describe limitations to their own practices as registered practical nurses (under the responsibility of RNs) as mere

“excuses”: “The possible liability of one profession for the practice is often used as an excuse for why the scope of practice of one profession should not be fully implemented or expanded.” They argued that the regulators “should work to ensure that **the hierarchy of professions is eliminated** and that all professions and professionals are treated equally” (see Table 5).

Similarly, the **Psychological Associates** stated that they “support (...) the overall goal of promoting health regulatory colleges and their members to work collaboratively”, but again like the Practical Nurses added “that **intra**professional collaboration and **inter**professional collaboration are equally important”. And they specified that:

Within the College of Psychologists, [the Psychological Associates] believe... increased awareness of the scope of practice of Psychological Associates by the public and by Psychologist members would improve access to patient care, maximize collective resources, and ensure all regulated health care professionals work to their maximum competency and capability.

Thus the claim that change was needed due to hierarchical situations that hampered IPC put forth by the RNs and the Psychologists, reverberated through the Psychological Associates’ text, and, as in the case of the Practical Nurses, were extended to intraprofessional relationships (see Table 6). More strongly than the other groups, PAs recommended changes in legislation, suggesting:

...the development of **regulations to expressly state** that interprofessional collaboration is a goal or expected practice and a body to share strategies that are working successfully to achieve this goal.

Justifying: Normative vs. Rational vs. Experiential Resources to Legitimize Solutions

Professions drew on various discursive resources to justify the way they framed the issue as well as their preferred solutions in terms of professional boundaries. While the professions differed in the type of resources they referred to and the extent to which they justified their claims, a salient distinction we found across professions was between the use of *normative* vs. *rational* vs. *experiential resources*. Again, we observed a difference between the high-status **Physicians** and others, with a further nuance between middle and lower-status actors.

Physicians rarely made use of explicit justificatory resources to substantiate their claims; but if they did, the resources were mostly *normative* in kind, that is, referring to values or norms about how things “should” be done (Vaara et al., 2006) rather than formal evidence. This approach constructed their position in conformity with long-standing traditions and values that need to be protected (by maintaining and strengthening the physicians’ role). They referred to only one external study, which was on issues of medical liability, and to two internal and normative documents, one of which was their “Code of Ethics”. The Physicians first and foremost mobilized uncontested values such as the patient’s well-being and various ethical principles such as “trust” between physicians and patients. Moreover, the Physicians imbued central professional dimensions with continuity, claiming for instance that patients’ expectations of physician leadership “will not change” (for further illustrations, see Table 2).

The middle-status professions and more particularly the Registered Nurses drew on *rational justificatory resources* and did so in such a way as to suggest the need for change. This framing strategy was reflected in arguments that made recourse to the utility of IPC (Vaara et al., 2006) and drew on different forms of evidence from sources outside or inside the professions (see Tables 3-6). The *Nurses* made *extensive* use of this variant and drew on *multiple* resources to exhibit problems with current structures. They recurrently referred to professional skills not used in existing work models; they cited 30 studies such as a “Statistics Canada report” which “suggests that workplace environment, including the quality of working relations between physicians and nurses, was associated with medication errors”; drawing also on *experiential* resources they referred to two documented “dramatic examples” of harm caused due to existing obstacles to IPC. In comparison to Nurses, the **Psychologist’s** use of rational resources was *less extensive* and *less diverse*. However, they referred to two reports from health regulatory bodies in

Canada that testified to existing barriers to IPC, and provided rational arguments (such as an “underutilization of health human resources”) for change.

In terms of the junior professions, it is interesting to note that they refer to evidence not so much in the form of statistics and formal evidence, but in the form of more or less generalized experiences or opinions. For example, the **Practical Nurses** repeatedly derived arguments for change from common knowledge – indicated in formulations such as “This is well known”, “it is not unusual” or “common practice” – which was often supplemented by certain concrete examples to give additional credibility. The **Psychological Associates** constructed their response on more local evidence, including a survey among their members concerning experiences with IPC. They attached importance to this experiential evidence by explicitly mentioning the survey in their opening letter and attaching the survey’s results to their response (see Tables 5 and 6).

Self-casting: Authoritative leader vs. Capable but under-recognized participant

The framing of professions’ self-identities was manifested in two ways in the documents: (1) in how they implicitly presented themselves as a more or less significant voice in the discursive space opened up by the IPC initiative and (2) in how they referred explicitly to their identity as a profession within the document. These two ways of self-casting appeared to be broadly consistent with each other for each of the professions, and had similar implications for boundary construction. We identified two main variants that express different claims to knowledge and that position professions differently with regard to each other: self-casting as *authoritative leader* somewhat separate from other parties vs. self-casting as a *capable though under-recognized participant* in a multiparty professional system and discursive space.

In their *self-casting*, the **Physicians** clearly express a role of *authoritative leaders* (see also Table 2). Their framing of their own role in the discursive space around IPC is manifest in the

way they labelled and presented their submission. Specifically, although the Discussion Guide issued by the Advisory Council was framed as an “*Invitation to comment*” on the matter of IPC, in their cover letter, the Physicians demonstrated their autonomy by advancing issues that *they* regarded as crucial, rather than responding to a discussion opened up by the Advisory Council:

Enhancing patient-centred collaboration amongst the health professions **is a priority for the [Physicians]**... In an effort to advance a more patient-centred approach to **collaborative care**, the [Physicians have] produced the attached policy and associated background paper.

Their main document consisted of what they called a “Policy.” In general, policies by the Physicians “describe the Association’s positions on issues relevant to the Canadian healthcare system” and “provide members, Canadian physicians and the general public with well-articulated normative statements” (www.cma.ca). In this vein, their submission delineated 12 “principles” on how the association strived “to ensure the evolution of collaborative care in Canada.”

In terms of explicit references to their identity as a profession, the Physicians express their role as authoritative leaders in three ways. First, they stress their historical “patient advocate” role. Second, referring to medical knowledge, they point to the physician’s “unique appreciation of the full spectrum of health and health care delivery”. Third, they identify themselves within collaborative work environments as the profession that is “best equipped to provide clinical leadership”. In their framing, Physicians leave no doubt that this identity is incontestable – and that there is a distinct exclusionary boundary that cannot be questioned:

The concept of ‘most responsible physician’ **has been and continues to be** used to identify the individual who is ultimately responsible for the care of the patient.

The other four professions cast themselves to different degrees as *capable but under-recognized participants* both in the discursive space of IPC and in the professional system more generally. The **Registered Nurses** (RNs) presented themselves as a strong voice participating in and contributing to the issues at hand: For example, their document was entitled a “Response” to

the ministerial referral, acknowledging other initiators of and parties in the discussion. Also, they took up the general ideas of the Discussion Guide, but expressed their own priorities and arguments by structuring their document according to a set of recommendations rather than following the sequence and content of the Advisory Council’s 43 questions. In terms of their professional identity they presented themselves as capable professionals, but somewhat under-recognized, particularly by physicians. This was insistently expressed by criticizing how the Physicians drew the boundary between themselves and other health care providers. The RNs extracted 13 verbatim quotes from the Physician’s report and contrasted them in a two-column table with the RNs’ view of the roles and responsibilities of professionals in IPC. This alternative vision, according to the RNs, “respects the knowledge, skills, and abilities of **all** members of an interprofessional collaborative team”, thus opening identity boundaries. See the examples below, taken verbatim from the table in the RNs’ report (for additional data, see Table 3):

CMA Vision (<i>Physician Document</i>)	CNA¹ and RNAO Vision (Nurses Document)
“medical care delivered by physicians and health care delivered by others”	Health and health-care services that address full spectrum of population health, health promotion, disease prevention, curative, rehabilitation, and palliative care.
“models of collaborative care must support the patient-physician relationship”	Models must support the integrity of each patient-professional relationship.
“The effective functioning of a collaborative care team depends on the contribution of a physician”	The effective functioning of a collaborative care team depends on the valued contributions of all team members.

While they claimed that RNs “have knowledge, skill, and experience” to perform more inclusive roles, they complained that in current practice these capabilities were often not fully recognized.

Similar to the Registered Nurses, the **Psychologists** acknowledge other parties in the discursive space around IPC, but their discursive position seems more detached and critical. They went further than the RNs in conforming to the “invitation to comment” by explicitly

¹ CNA = Canadian Nurses Association, the national association of nurses in Canada.

structuring their responses according to the 43 questions provided by the Discussion Guide. But in their opening letter, they underlined their importance as an Association in achieving the goals related to IPC, and they also put forward “some concerns relating to underlying assumptions implicit in the questions found in the guide.” Second, in their explicit references to their identity as a profession, the Psychologists presented themselves in terms of what they were capable of doing as well as by what they were hindered from doing under the current arrangements. In their opening letter they stressed that their association was founded “to advance psychology as an independent profession with the highest ethical standards of practice”. But, somewhat contrasting this claim with actual practice, as shown above, they indicated that instead of interprofessional teams referring to a “number of professions working together” – including them – the notion was often “limited... to medicine and nursing alone” (see also Table 4).

The **Practical Nurses** position themselves as a voice in a discursive space with multiple parties led by the Advisory Council, for instance by explicitly structuring their responses according to the 43 questions provided by the Discussion Guide. In contrast to the other four texts, though, the submission of the Practical Nurses came neither with an opening letter, nor did they highlight their own issues of importance (e.g., through specific recommendations or a survey). In terms of their professional identity, the PNs expressed concerns about under-recognition and hence only indirectly cast themselves as capable professionals: They mentioned that subgroups within professions – like them – “may be seen as having less power” or complained that “[i]t is not unusual for hospital board members to think that nurses’ practice is only under the direction of physicians” – while in fact other professions including themselves as nurses are independent providers (see also Table 5).

The **Psychological Associates** positioned themselves as a contributing voice to an overall discursive space, but in contrast to the RNs and Psychologists, as one among many others, explicitly “appreciate[ing] the opportunity to have [their] voice heard”. Like the Practical Nurses, they structured their response according to the 43 questions of the Discussion Guide, but also provided four recommendations upfront before they addressed the questions. In comparison to the senior professions, and like the Practical Nurses, the Psychological Associates’ self-casting as a profession was more indirect and focused on hindrances to their possible roles. They stated that their title “is not well understood by members of the public, by Psychologist(s) (,,) ...or by other health professions” which was seen as an “obstacle to optimizing the skills and competencies” of their members. This critique was addressed in particular to members of their senior profession (also see Table 6).

Altercasting: Problematizing (Up) vs. Ignoring (Down)

Altercasting constituted the fourth focus for framing. Because some professions positioned (or not) other professions very explicitly and separately from their own self-identity framing, we treat this category separately. We found that professions either *problematized* or *ignored* other professions, depending on whether other professions were situated further up or further down in the status hierarchy, implying different constructions of boundaries.

In contrast to their very explicit and highly laudatory self-casting, the **Physicians** engaged in a form of *altercasting* that can be characterized as “*ignoring*” – referring to other, lower status professions mostly in an indirect and generic way. By setting themselves apart from “**other** health care professionals,” they clearly closed the boundaries between themselves and various other groups without recognizing them as distinct from one another. Furthermore, by casting

themselves as authoritative and superior (as indicated in the previous section) the Physicians indirectly altercast those “other” groups as less capable (see also Table 2).

In continuity with the oppositional way in which **Registered Nurses** referred to the Physicians’ submission when expressing their own professional role (shown above), they went on to *altercast* physicians very critically, i.e., *problematizing* their role. They characterized “organized medicine,” a label that depersonalizes the profession and foregrounds its institutional character, as having a “preoccupation with shared scopes of practice as inherently competitive” and a “reluctance to engage in professionally appropriate power-sharing with other disciplines.” In sum, the Registered Nurses cast Physicians as defensive of professional boundaries, as anti-IPC, and moreover, as exercising wholesale subordination of other professions to the detriment of patient care and other professions. Interestingly, however, and similar to the Physicians, other professional groups of lower status were not mentioned explicitly in the Registered Nurses’ submission. Thus the RNs altercasted others by *problematizing* up, but *ignoring* down (Table 3).

Similar to the RNs, the **Psychologists** *problematized* the existence of an unjustified dominance of one profession over others. In contrast to the RNs, their critique was less pointed, however, and they often only used notions of “some professions” without specifying that they meant the physicians. When they did refer specifically to physicians, they remained unspecific about other professions, indicating that “**a professional** with particular skill sets should be able to provide [a certain] service with independent authority without the need of a physician to delegate that authority”. In sum, the Psychologists remained more non-specific when referring to other professions, expressing a somewhat more distant position. At the same time, the Psychologists made no specific reference to other, lower status professions, reflective of the pattern of *ignoring down* that we found for the Physicians and the RNs (see Table 4).

The **Practical Nurses**, like the RNs, *problematized up* by explicitly altercasting physicians as dominant but they also included their own senior profession (the RNs) within their critique, for instance when disqualifying liability arguments by RNs and Physicians as a mere “excuse,” as already stated above. Moreover, at various points in the text, medical dominance was related to existing regulations and government bodies that were criticized as “perpetuat[ing] that physicians can determine the practice of other professions” (see Table 5).

The **Psychological Associates**’ altercasting also follows the pattern of *problematizing up* addressed in particular to the Psychologists, that they characterized as lacking an “awareness of the scope of practice of Psychological Associates” and as responsible for related deficiencies in intraprofessional relations:

“A lack of communication to members of the public and other health professionals about scope of practice issues for **members from the College of Psychologists** is a barrier to collaboration. Public education about scope of practice is essential and **is not as well done as it could be.**”

The Psychological Associates addressed more generally other health care providers as not sufficiently familiar with their scope of practice; or as being supported by legislation in their exclusive role over other providers (including themselves). With regard to physicians, they stated that “the need for referrals for some services to be signed by a physician [e.g. admission to a hospital] hinders access for patients” thus impeding IPC (see also Table 6).

Summarizing, we identified four foci for framing through which professions mobilized boundary-relevant themes and put forth their claims to maintain or change jurisdictional demarcations between them – issue framing, justifying, self-casting and alter-casting. We also found distinctive variants within the four foci for each of the professions reflecting different overall framing strategies as illustrated in Tables 2-6 and summarized in Table 7 (see next section). The most striking distinctions in framing strategies are between Physicians and the other professions but there are also some interesting nuances differentiating Registered Nurses

and Psychologists when it comes to justifying and altercasting. In the following section, we discuss more in detail the four foci for framing, their differential use and how the different framing strategies can be understood in relation to the professions' respective field positions.

Second Order Analysis: Framing Strategies and Field Positions

The previous section examined the discursive boundary work of five different professions across four distinct foci for framing. We showed (a) how *issue framing* could involve either the narrowing or the stretching of definitions of inter-professional collaboration, associated with closing or opening boundaries, (b) how *justifying* solutions to boundary issues might rely on normative, rational or experiential resources; (c) how *self-casting* might construct professions as either authoritative leaders or capable but under-recognized participants in both the professional field as a whole and in the discussion of IPC, and (d) how *altercasting* involved problematizing or ignoring other professional groups in order to contest or reaffirm boundaries. Table 7 summarizes these findings, showing the patterns observed across the four foci for framing for the different professional groups, along with their classification according to field position. We now draw on the above analysis to show how the framing strategies of the different professions cluster together, theorizing their relationship with field positions. We examine the broader implications of this analysis for other situations in which multiple professions interact at the field level around boundary issues, and relate our findings to the previous literature. We structure our key insights in this section according to the two dimensions of field position (status and centrality), focusing first on status relations between professions of *similar* degrees of centrality, and then examining the nuances visible when centrality is more closely considered.

Insert Table 7 here

High status and generic naturalistic framing

The most striking pattern emerging from our first order analysis and revealed in Table 7 concerns the differences between the framing strategies of physicians (the highest status, most central profession) and all the others. While physicians *narrowed* the definition of IPC, justified their approach mainly on the basis of *normative* resources, referred to themselves as *authoritative leaders* and *ignored* distinctions among other groups, the other professions *stretched* the definition, drew on multiple *rational and/or experiential* resources, identified themselves as *capable but distinctly under-recognized* and *problematized* professions higher in the status ordering. We argue here that the overall pattern of framing observed for the physicians is importantly related to their high status in the field and can be characterized as “naturalistic” and “generic.” Moreover, we argue that this pattern is likely to be reproduced in other situations where high status professions use discursive means to defend existing boundaries.

We label this pattern observed across the four foci for framing as “naturalistic” following the language suggested by Vaara and Tienari (2002) because the strategies adopted for each of the foci for framing in Table 7 affirm directly and indirectly the preferred solution as a more or less “natural” state of affairs, about which there cannot or should not be any argument. For example, the *narrowing* of the issue reformulates the status quo as already reflecting the direction for change (e.g., existing forms of “collaborative care” are equated with IPC), *justifying* this on the basis of assumptions or normative principles construed as a matter of fact rather than through evidence-based argument. This underpins a perspective in which current boundary arrangements cannot be seriously questioned. Similarly, in their self-casting, by labeling their document a “policy” rather than a “response,” they *assume authoritative leadership* indirectly (i.e. as if it were “natural”), bolstering their more direct references to themselves as leaders.

Finally, in their altercasting, the absence of differentiation accorded to “lesser” groups (*ignoring*) again naturalizes the separation between themselves as uniquely important and generic unspecified others. Thus, their framing strategies as well as being naturalistic are also *generic* in that their discourse does not identify other professions as worthy of specific attention.

Theorizing around these empirical observations, it is as if these high status professionals have concluded that if they were to frame their position as in reaction to others’ proposals, if they were to engage in more formal and detailed rational justifications surrounding their position, or if they were to recognize the distinctiveness and diversity of other groups, they might implicitly place more value on these proposals than they deserve and consequently accord them legitimacy. In other words, generic naturalistic framing enables high status professionals to downplay challenges by using the language of authority associated with their status, and presenting their preferences as the natural order of things. We suggest here that similar patterns in discursive strategies may be likely for other high status groups attempting to defend existing boundaries.

This is confirmed in our own data when we consider the altercasting of the registered nurses and the psychologists in relation to their own junior professions, with respect to whom they hold field positions of relatively higher status. Neither the nurses nor the psychologists refer specifically to the members of their junior professions within their submissions to HPRAC, even though an opening up of boundaries could presumably imply a potentially greater role for the lower status group. In other words, their approach to *ignoring* lower status groups fit the pattern of naturalization we noted for the physicians.

The relationships we are suggesting here are also to a degree echoed empirically in other work, although not necessarily theorized or drawn together to explicitly relate field positions to strategies of boundary work. The pattern of naturalistic framing appears to be similar to Suddaby

and Greenwood's (2005) rhetorical strategy of "ontological theorization." The law firms in Suddaby and Greenwood's study clearly represented a profession defending their terrain against intrusion from challengers, although we hesitate to position their status as necessarily higher than that of the accounting firms. Also, Lockett et al. (2014) in a study of social positions in context of change (though not of discursive boundary work) found that the highest status actor displayed least acknowledgement of other professions' impact on their own work.

Lower status and targeted argumentative framing

As shown in Table 7, the four lower status professions (with respect to physicians) collectively mobilized a different set of framing strategies that we characterize as "targeted" and "argumentative." By *stretching* the notion of IPC, these professional groups took up the new discursive opportunity structure (McCammon et al., 2007) offered by the Advisory Council, placing their own distinctive stamp on it, and then drawing on a variety of justificatory resources including *rational* and *experiential* arguments to support their positions.

Perhaps most interesting is the way all the lower status groups promoted redefinitions of boundaries not only through their self-casting as *capable* but *under-recognized*, but also through their explicit *problematization* of *targeted* higher status groups as barriers to IPC and to more open boundaries. While all the groups targeted the physicians, the lowest status practical nurses and psychological associates explicitly targeted their more senior professions. In other words, the *generic naturalistic* framing of higher status professions is explicitly deconstructed in the *targeted argumentative* framing of other professions. While higher status groups "assume" power as legitimate (without using the word), lower status groups "unmask" power often referring to it in highly explicit terms (see extracts in the text and in Tables 2-6), and targeting proximal groups in the status hierarchy equally with those at its apex.

Theoretically, the boundary work strategies we identified here make sense in terms of field positions in several ways. First, because of their lower status, these professions need to bring to bear stronger more evidential and argumentative resources to overcome the resources of authority inherent to higher status groups. By engaging in open debates and by backing up their claims for change with evidence, lower status actors (like the four professions in our case) attempt to position themselves as credible actors and strengthen the claims that they make from their relatively weaker field positions. Second, the targeted undermining of high status groups serves two purposes. On the one hand, it is important for those who wish to open boundaries to level the playing field in order to lay claim to the capacity to participate equally in shared practices. Thus, lower status professions emphasize capability but also note how it is unfairly under-recognized by higher status groups. On the other hand, by drawing explicit attention to power structures and hierarchies in the field, lower status professions counter their naturalization. By so doing, they may delegitimize attempts of higher status groups to block boundary redefinition (whether through discursive boundary work or other forms of influence). We suggest that similar patterns in discursive strategies may be likely for other lower status actors attempting to promote change in existing boundaries.

We find some empirical support for this in other studies that explored discursive strategies of field level actors in times of change. For instance, Suddaby and Greenwood (2005) found that Big Five accounting firms – as proponents of change towards multidisciplinary practices – mobilized “pragmatic legitimacy” (Suchman, 1995) to back up their claims. This notion is similar to the use of rational and experiential resources by Registered Nurses, Psychologists, Practical Nurses and Psychological Associates in our study, although the question of status is not addressed by Suddaby and Greenwood. Similarly, Lefsrud and Meyer (2012) found that in

framing climate change, experts engaged in constructing their own “expert identities” in order to support their own credibility and claims while undermining others’ identities and with it their position in the discussion.

Middle status specificities

So far, we have discussed status in relation to two categories: high and low, proposing that discursive boundary work strategies of high status professions are likely to take the form of *generic naturalistic framing*, while lower status professions are likely to engage in *targeted argumentative framing*. But what about the middle status actors who are positioned higher than their junior groups, but lower with respect to the highest status professions? As we indicated in our field position analysis, the RNs and the Psychologists fall into this category. We will consider the position of psychologists later when we focus more particularly on the role of the dimension of centrality. However, the clear hierarchy among the three professions of physicians, nurses and practical nurses offers some insight into how middle status might matter.

A first observation noted above is that the discourses of the middle status groups appear most like that of high status actors when directed towards the lower status junior professions (the RNs and Psychologists are largely silent about their junior professions), but follows the pattern of lower status groups with higher status groups who appear as the only ones worthy of attention. The pattern of *problematizing up* and *ignoring down* (Table 7) appears to be universal, holding firmly across all status groups.

This is interesting in itself, but we also observed some other more subtle empirical distinctions between middle and lower status professions. Specifically, we saw that the RNs contested the boundary vis-à-vis physicians by drawing on a much greater variety of resources (rational and experiential) to back up their claims than other professions. At the same time, the

RNs *altercasted* physicians in a much more aggressive and oppositional way (Schwalbe & Mason-Schrock, 1996, p. 141) than the other three professions. This was characterized, for instance, by their explicit counter-framing of Physician's understanding of IPC and use of disjunctive language (Werner & Cornelissen, 2014) that characterized Physicians explicitly as dominant and as a major obstacle to IPC and delegitimized their identity claims.

Though not necessarily focusing explicitly on discursive boundary work, certain studies have drawn attention to the particular role and actions of actors with middle-status positions (Lockett et al., 2012; Phillips & Zuckerman, 2001). The Registered Nurses' specific employment of discursive strategies could be understood against this background: It has been argued elsewhere that aggressively challenging high status, central actors may provoke them to defend their position in a way that could be counter-productive (Lockett et al., 2012). The lowest status actors, such as the Practical Nurses (and Psychological Associates within their own status hierarchy), might anticipate limited capacity to bring about change and therefore be more timid in their maneuvers especially with regard to the most distant high status groups. Challengers with middle-status, though, like the RNs, may actually perceive events such as the debate over IPC as a welcome opportunity to enhance their position (Kodeih & Greenwood, 2014; McCammon et al., 2007). Because of their relatively strong starting position, we suggest that they may be willing to throw the weight of their resources and their power into the balance to contest the status quo. They may also have access to a greater store of financial and material resources (research capacity, etc.) to do so. We argue that because these groups have both the motivation and the ability to strongly contest existing boundaries, the discursive strategies of middle status professions are likely to be not only targeted and argumentative but also more strongly evidence-based, more multi-dimensional and more oppositional than those of low status groups.

Peripheral actors and framing strategies

The arguments above do not explain however why the Psychologists, also middle status actors, did not mobilize discursive strategies in an equally strong – multidimensional and oppositional – fashion as the nurses. We argue that it is important to take field centrality into account here. The RNs' position as central actors and their related vested interest in the advancement of IPC played an important role. For instance, Lefsrud and Meyer (2012) have shown the role of interest when finding that experts that felt most affected by the discussion on climate change (in their case: the most threatened expert groups) engaged more strongly in framing strategies than other expert groups.

In contrast to nurses, psychologists and psychological associates with their more peripheral position in the field, did not stand in the line of fire between physicians and nurses and seem to have argued from their more distant position within a separate, psychotherapeutic area (Abbott, 1988). This suggests more generally that in considering the role of field position in influencing discursive strategies, it is important to consider different dimensions of field positions at the same time, here the status but also centrality within a field and the related degrees of interest and concern about specific issues. The simple distinction between high and low status actors or the consideration of differences regarding only one dimension may not fully capture the subtleties in positions (see also Lefsrud & Meyer, 2012; Lockett et al., 2014) and the resulting strategies.

We would add that the peripheral nature of the role of the psychotherapeutic professions is reflected explicitly in the discourse of the Psychologists and to a lesser extent that of the Psychological Associates, especially in their *issue framing*, *self-casting* and *altercasting* of other professions. As shown in Table 4, the Psychologists make a particular point of defining “true” IPC as not just about physicians and nurses but as inclusive of multiple professions including

their own, and complain that their role within IPC has not been sufficiently recognized. In other words, not only do they *problematize up* with respect to other higher status professions (physicians), but they also *problematize across* towards the more central medical area of the overall health care field (physicians and nurses) by whom they are reciprocally *ignored*. This pattern of discursive boundary work also seems likely to recur in the case of professional groups occupying the periphery of the field.

Conclusion

In this paper, we asked how professions engage in discursive boundary work in response to initiatives aimed at reshaping professional practice and how these strategies might be influenced by the professions' field positions. We found that responses to the government initiative to strengthen IPC were characterized by the differential use of four foci for framing through which professions defended and contested jurisdictional boundaries in the field. We also examined how these strategies cluster together and theorized their relationship with the actors' field positions regarding status and centrality. Our contribution to the development of scholarship on discursive boundary work is twofold.

First, by examining how macro-actors defend or contest boundaries in the field in their response to a potentially boundary-affecting change, our study draws attention to four foci for framing that may be used to develop discursive boundary work strategies at the field level and identifies distinctive ways in which these foci may be mobilized in discourse, many of which are likely to recur in other situations of boundary contestation. For example, *issue framing* involves either *narrowing* or *stretching* boundary redefinitions enabled by the emergence of a new discursive opportunity structure, a somewhat different set of responses from those suggested by Werner and Cornelissen's (2014). Second, we showed how *justifying* solutions to boundary

issues might rely on normative, rational or experiential resources, categories that echo but also extend previous categorizations (Suddaby & Greenwood, 2005; Vaara & Tienari, 2002). Third, our notion of *self-casting* shows how *authoritativeness* or *under-recognition* may be signaled not only by direct references to professional identity, but also through the way actors implicitly position their own importance in relation to the discursive opportunity structure through the language they use to describe their inputs (e.g., a policy vs. a response vs. an appreciation of the “opportunity to have one’s voice heard”). This dimension of identity positioning or self-casting has not received significant attention in the boundary work literature. Finally, we show how *altercasting* involves *problematizing* or *ignoring* other professional groups in order to contest or reaffirm boundaries, a form of discursive boundary work that functions either by reifying preferred understandings of boundaries (through *ignoring*), or alternatively by undermining the legitimacy of others’ positions (through *problematizing*). Through our analysis, we offer categories and dimensions that may assist other scholars in understanding and further exploring boundary work at the field level in other professionalized settings or to explore whether these forms of boundary work can be found on levels other than the field level.

Second and most importantly, while some studies have shown that professions use different boundary work strategies to put forward different boundary claims, a systematic account of how these strategies may be influenced by actors’ field positions is lacking. Our study moves towards the identification and theorization of these relationships. Specifically, through an examination of the way in which framing strategies across foci for framing cluster together, we argue that while high status groups defending boundaries are likely to engage in more generic and naturalistic patterns of framing that reaffirm the status quo as a normal state of affairs, lower status groups will develop argumentative and targeted forms of framing to persuade audiences of

the need to overturn existing boundaries, while unmasking the taken-for-granted assumptions of normality, power and authority inherent to the framing of higher status groups. We further argue that middle status actors are likely to be more highly motivated and more capable of aggressively challenging higher status actors through their argumentative discursive boundary work than are groups lower in the status hierarchy (cf. Lockett et al., 2012). Finally, we draw attention to the role of centrality as a distinct dimension that can explain certain differences in discursive strategies, moving away from merely dichotomous understandings (e.g., higher or lower status) and following recent calls to consider field positions as multi-dimensional in nature (Battilana, 2011; Lockett et al., 2014). Our study suggests that the field position of actors is important to understanding professions' boundary work and in particular the types of discursive strategies employed, addressing an important gap in the literature.

While our data do not allow us to make direct links to changes that happened in the aftermath of the submissions, an interesting question unaddressed above is what happened in the further course of the IPC initiative. In spite of the varying levels of support for IPC expressed in the professions' responses, the Council's report included two main recommendations to support IPC by regulatory means, the establishment of a "new enabling regulatory framework" and the establishment of a new agency to facilitate interprofessional collaboration" (HPRAC, 2009: 37). Neither of these have been implemented as of 2015. However, a number of legislated changes to nursing practice in Ontario have come into effect. For example, as of 2011, broadly prescribing drugs and ordering laboratory tests appropriate for client care, an act that had been reserved to physicians, became part of the scope of practice of Nurse Practitioners² in Ontario (College of Nurses of Ontario, retrieved May 15, 2012 <http://www.cno.org/en/what-is-cno/regulation-and->

² Nurse Practitioners are RNs with specialized skills and longer training who may perform more controlled practices than regular RNs.

[legislation/legislation-governing-nursing/faq-bill-179/](#)). This change expresses that field positions not only influence macro-actors' boundary work but also that boundary work has the potential to influence a profession's position in the field, in line with the ongoing dynamics of professional stratification discussed elsewhere (Abbott, 1988; Reay, Golden-Biddle, & Germann, 2006).

Overall, our findings indicate that ironically, there is nothing more likely to be controversial or contentious than the issue of collaboration in fields where boundaries are based on long-established hierarchical relationships among different groups. The Advisory Council's call for views on collaboration was an event that set in motion the production of texts that reconstructed long-seated conflicts and contests among the professional groups.

We see a number of potential avenues for further research. First, future studies that add longitudinal data will supplement our findings by shedding light on how the use of boundary work strategies may potentially change over time (Covaleski, Dirsmith, & Rittenberg, 2003; Werner & Cornelissen, 2014). For example, strategies of "naturalization" might turn into more defensive forms of boundary work when for instance ongoing field developments put high status actors increasingly under threat. Second, although our study sheds light on the negotiation and social construction of boundaries through the discursive strategies of macro-actors (Fligstein & McAdam, 2011), it has focused on written and publicly available documents and thus on "front stage" texts. While we contend with others that those texts are "likely to provide traces of private conversations and negotiations behind closed doors" (Maguire & Hardy, 2006), a comparative study on the use of boundary work strategies by actors that strive to maintain their position and those who aim to better it in other, more backstage arenas, would help shed further light on the forms, dynamics and structural configurations of boundary work among professional groups.

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Table 1. Overview of the analysed texts

Authoring body	Reference used in the analyses	Composition and length of the document
Health Professions Regulatory Advisory Council (HPRAC)	Advisory Council	<p>Parts of the report: Opening letter to the Minister of Health; a summary; the main document asking why IPC is an issue, providing a historical perspective on regulatory changes, information about the consultation process, and intermediary recommendations; Length: 16,300 words</p> <p>Discussion Guide: 43 questions on four topics (defining interprofessional collaboration; eliminating barriers to collaboration among the health colleges; finding ways to encourage health colleges to collaborate; interprofessional care at the clinical level). Length: 14,800 words</p>
Canadian Medical Association (CMA)	Physicians	<p>Parts: Cover letter to the Advisory Council; submission in form of a “Policy”; appendix with background paper. Length: 3030 words</p>
Registered Nurses Association of Ontario (RNAO)	Registered Nurses (RN)	<p>Parts: Opening letter to the Advisory Council; submission text with a set of recommendations; an annex with a list of 30 references. Length of submission text: 6420 words</p>
Ontario Psychological Association (OPA)	Psychologists	<p>Parts: Opening letter to the Advisory Council; submission text with explicit reference to the questions of the Discussion Guide (answering 36 out of the 43 questions). Length of submission text: 1850 words</p>
Registered Practical Nurses Association (RPNAO)	Practical Nurses (RPN)	<p>Parts: No opening letter; submission text with explicit reference to the questions of the Discussion Guide (answering 31 out of the 43 questions). Length of submission text: 2390 words</p>
Ontario Association of Psychological Associates (OAPA)	Psychological Associates	<p>Parts: Opening letter to the Advisory Council; submission text with explicit reference to the questions of the Discussion Guide (answering 37 out of the 43 questions); an annex with responses to an OAPA survey on IPC. Length of submission text: 1365 words</p>

Table 2. Illustrative data on framing strategies for Physicians

Foci for Framing	Specific Framing Strategies with Illustrative Data
<p>Issue Framing Professions (1) amend the definition of IPC as the topic of the discussion, (2) refer to problems with the current understanding and practice of IPC, and (3) propose solution to the problems</p>	<p>Narrowing (Physician led “patient-centered collaborative care” needs to be strengthened)</p> <ul style="list-style-type: none"> - “In an effort to advance a more patient-centred approach to collaborative care, the CMA has produced the attached policy and associated background paper.” - “Where non-physicians have been provided with an opportunity to undertake activities related to patient care typically unique to the practice of medicine (e.g., ordering tests) <u>they must not do so independently but undertake these activities within the context of the team and in a manner acceptable to the clinical leader.</u>” - “Governments must enhance access to medical care by increasing the number of physicians and providers, and not by encouraging or empowering physician substitution”.
<p>Justifying Professions ground their arguments in specific sources of knowledge</p>	<p>Normative, if at all</p> <ul style="list-style-type: none"> - “The CMA considers patient-centred care to be the cornerstone of good medical practice. This is reflected in the first principle of the CMA Code of Ethics, which states that physicians have a fundamental responsibility to “Consider first the well-being of the patient.”
<p>Self-casting Professions characterize (1) their role in the discursive space around IPC as well as (2) themselves – their roles, capabilities, practices, relative position to others – in general, and in respect to IPC</p>	<p>Authoritative leader (signalling leadership role with respect to professions and discursive space around IPC)</p> <ul style="list-style-type: none"> - “...the profession acknowledges and accepts that it has a central role to play in the evolution of a team-based approach to care.” - “The <u>mutual respect and trust</u> derived from the patient-physician relationship is the <u>cornerstone of medical care</u>” - “The physician, by virtue of training, knowledge, background and patient relationship, is best positioned to assume the role of clinical leader in collaborative care teams”
<p>Altercasting Professions characterize other professions – their roles, capabilities, practices – in general and in respect to IPC</p>	<p>Ignore down (“Other providers” indirectly and generically cast as less capable)</p> <ul style="list-style-type: none"> - “effective patient-centred collaborative care depends on an adequate supply of physicians, nurses and other providers” - “Collaborative care relationships between physicians and other health care providers should continue to be encouraged and enhanced through appropriate resource allocation at all levels of the health care system” - The Physicians point out that “(i)t is important to differentiate ‘clinical leadership’ from ‘team coordination’”, while ascribing the former to the physician and the latter to the physician or other providers.

Table 3. Illustrative data on framing strategies for Registered Nurses

Foci for Framing	Specific Framing Strategies with Illustrative Data
<p>Issue Framing Professions (1) amend the definition of IPC as the topic of the discussion, (2) refer to problems with the current understanding and practice of IPC, and (3) propose solution to the problems</p>	<p><i>Stretching (Need for changes to establish “authentic client-centred interprofessional collaboration”)</i></p> <ul style="list-style-type: none"> - The fourth section of their submission is entitled: “(D) FACILITATING AUTHENTIC INTERPROFESSIONAL COLLABORATION ACROSS SETTINGS” - Rather than a “my patient mentality, structures must reflect shared responsibility to meet the goals of the clients” - “While respect and collegiality cannot be legislated, it is possible to put into place legislative and regulatory structures that facilitate client and staff safety and increase access to health services through interprofessional client-centered care.” - “RNAO recommends access to the following additional controlled acts for the profession of nursing...”
<p>Justifying Professions ground their arguments in specific sources of knowledge</p>	<p><i>Rational and experiential resources (reports, documented examples, persuasive arguments)</i></p> <ul style="list-style-type: none"> - “A continuing example of this may be seen in those areas where physician resistance to midwives is still evident... A recent dramatic example involved obstetricians threatening to quit if midwives were allowed to conduct deliveries in Belleville.^{9 10}” - “As a result of discussions involving RNAO, NPAO, the Nursing Secretariat and the Canadian Nurses Protective Society (CNPS), changes were made to CNPS coverage for NPs across Canada in 2004 (for details on the coverage available to RNs and NPs as a benefit of their membership in RNAO, visit www.cnps.ca <http://www.cnps.ca> and click on the brochure).”
<p>Self-casting Professions characterize (1) their role in the discursive space around IPC as well as (2) themselves – their roles, capabilities, practices, relative position to others – in general, and in respect to IPC</p>	<p><i>Capable but under-recognized participant (in multiparty system of providers and in discursive space around IPC)</i></p> <ul style="list-style-type: none"> - Title of submission: “Response to Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals” - “This referral to HPRAC comes at an opportune time. While interprofessional collaboration is not a new concept, it has only been in this decade that government, policy makers and leaders within the health care system have recognized the contributions of highly functional and effective interprofessional teams.” - “RNs with the required knowledge, skills, and experience should be authorized to set and cast.” - “These power differentials are also visible in less dramatic circumstances. An ethnographic study of clinical decision making within an intensive care unit found that “the nursing role, while pivotal to implementing clinical decisions, remained unacknowledged and devalued.”¹⁶
<p>Altercasting Professions characterize other professions – their roles, capabilities, practices – in general and in respect to IPC</p>	<p><i>Problematize up (in an oppositional way), ignore down</i></p> <ul style="list-style-type: none"> - “Inherent within organized medicine’s current definition of interprofessional collaboration is a continuation of both medical dominance and the related historical subordination of other health professions” - “Addressing this cultural barrier to interprofessional collaboration is a critical first step in achieving success, as organized medicine’s view of collaborative practice privileges medicine over the needs of clients and authentic interprofessional, comprehensive, integrated health”

Table 4. Illustrative data on framing strategies for Psychologists

Foci for Framing	Specific Framing Strategies with Illustrative Data
<p>Issue Framing</p> <p>Professions (1) amend the definition of IPC as the topic of the discussion, (2) refer to problems with the current understanding and practice of IPC, and (3) propose solution to the problems</p>	<p><i>Stretching (Need for changes to establish “true” interprofessional teams)</i></p> <ul style="list-style-type: none"> - “The main difficulty we have with the cultural issues related to our barriers to collaboration would be the strong historical sense of a hierarchy amongst the professions (which is reinforced by legislation discussed above)” - “There would need to be substantive changes in these pieces of legislation to allow for greater equity and, therefore, greater collaboration amongst members of the health care teams.”
<p>Justifying</p> <p>Professions ground their arguments in specific sources of knowledge</p>	<p><i>Rational resources (Persuasive arguments, reports)</i></p> <ul style="list-style-type: none"> - “We would concur with the recent 2007 report from the Conference Board of Canada, “Liability Risks Interdisciplinary Care...”, that although interdisciplinary collaboration might entail some legal risks, there are a few liability issues that should be seen as barriers to interprofessional care.” - “We have questions... about the delegation model. It should be recognized that a professional with particular skill sets to provide a service within an interprofessional health care team should be able to provide that service... without the need of a physician to delegate that authority.”
<p>Self-casting</p> <p>Professions characterize (1) their role in the discursive space around IPC as well as (2) themselves – their roles, capabilities, practices, relative position to others – in general, and in respect to IPC</p>	<p><i>Capable but under-recognized participant (in multiparty system of providers and discursive space around IPC)</i></p> <ul style="list-style-type: none"> - No specific title and no amendments to the structure of the Discussion Guide - “We welcome the opportunity to be able to comment on this important set of questions in the discussion guide. However, ... We are also very concerned about the linkages of guidelines for professional practice and standards....” - “As a result, we believe that the goals related to interprofessional collaboration can best be achieved by the associations, such as the Ontario Psychological Association, because they are better situated to look at the needs of the health care professionals.” - “We also have concerns about the perspectives in some material from the Ministry of Health and other jurisdictions that... have made reference to interprofessional collaboration but, upon further examination, have limited these interprofessional teams to medicine and nursing alone.”
<p>Altercasting</p> <p>Professions characterize other professions – their roles, capabilities, practices – in general and in respect to IPC</p>	<p><i>Problematize up, ignore down</i></p> <ul style="list-style-type: none"> - “The main difficulty we have with the cultural issues related to our barriers to collaboration would be the strong historical sense of a hierarchy amongst the professions (which is reinforced by legislation discussed above)” - “Leadership of a clinical team should not be based on automatic assumptions of leadership due to membership in a particular profession”

Table 5. Illustrative data on framing strategies for Registered Practical Nurses

Foci for Framing	Specific Framing Strategies with Illustrative Data
<p>Issue Framing Professions (1) amend the definition of IPC as the topic of the discussion, (2) refer to problems with the current understanding and practice of IPC, and (3) propose solution to the problems</p>	<p><i>Stretching (Need for establishing inter- and intraprofessional collaboration)</i></p> <ul style="list-style-type: none"> - “RPNAO recommends that all profession acts be amended to include the requirement for not only inter college collaboration, but for interprofessional and intraprofessional collaboration” - “For example, it is not unusual for a Registered Nurse to say that he or she is “responsible” for the care of a Registered Practical Nurse [while in fact, she is not responsible]” - “RPNAO believes that one of the biggest barriers to interprofessional collaboration is the long standing unequal balance of power” - “there are still significant issues within the profession of nursing in that the standards of practice would say that RPNs can perform certain acts, and yet, in reality, they are not allowed to by administrators or employers.” - “would support a law requiring health care providers to work and communicate effectively in or between teams” - “The largest legislative barrier to interprofessional collaboration is the Public Hospitals Act, which entrenches the power of one profession (physicians) in legislation.”
<p>Justifying Professions ground their arguments in specific sources of knowledge</p>	<p><i>Experiential resources (Common knowledge; experience)</i></p> <ul style="list-style-type: none"> - “This is well known in the regulatory colleges’ circles and the profession in general.” - “It is common practice for the Ministry when a College puts forth a request to change regulations, to require that profession to get the “approval” of another profession. For example, nurse practitioners must get approval from medicine in order for a request to be approved.”
<p>Self-casting Professions characterize (1) their role in the discursive space around IPC as well as (2) themselves – their roles, capabilities, practices, relative position to others – in general, and in respect to IPC</p>	<p><i>Somewhat capable but under-recognized participant (in multiparty system of providers and discursive space around IPC)</i></p> <ul style="list-style-type: none"> - No specific title, no amendments to the structure - “RPNAO recommends that...” - “If the Ministry wanted to have a body that looked at consistent professional practice standards etc., there are possibly 2 bodies that they could consider: ...” - “the review process should be designed to find ways to equal the balance of power and ensure that no profession has the power to influence decisions about the scope of practice of another profession and indeed that even within one profession, no single group of professionals can influence decisions about others within their profession that may be seen as having less power.” - “Also, the term “medical care” should be expanded to say “clinical care” It is important that the act governing hospitals, whose boards are largely non-clinical people, does not perpetuate the stereotype that all clinical care is “governed” by physicians.”
<p>Altercasting Professions characterize other professions – their roles, capabilities, practices – in general and in respect to IPC</p>	<p><i>Problematize up</i></p> <ul style="list-style-type: none"> - “The existence of medical committees within the Ministry of Health (e.g. Physician Services Committee) that determine the practice of other professions (i.e. nurse practitioners and midwives) acts to again perpetuate that physicians can determine the practice of other professions.”

Table 6: Illustrative data on framing strategies for Psychological Associates

Foci for Framing	Specific Framing Strategies with Illustrative Data
<p>Issue Framing Professions (1) amend the definition of IPC as the topic of the discussion, (2) refer to problems with the current understanding and practice of IPC, and (3) propose solution to the problems</p>	<p><i>Stretching (Need for establishing inter- and intraprofessional collaboration)</i></p> <ul style="list-style-type: none"> - “OAPA also believes that intraprofessional collaboration and interprofessional collaboration are equally important.” - “A general tool kit with a framework, specific collaborative initiatives, samples of common language that would be used between Colleges around principles, purpose, goals and targets and ground rules would be beneficial. The Ministry of Health should be responsible for developing it with collaboration from Colleges.”
<p>Justifying Professions ground their arguments in specific sources of knowledge</p>	<p><i>Experiential resources (Self-generated data from a survey of members)</i></p> <ul style="list-style-type: none"> - Opening letter: “OAPA is also including the results of a survey we conducted with our membership. We asked them to share their experiences in settings in which they work with a variety of regulated health providers, either in a formalized team approach or a less structured system. I trust you will find their comments helpful.”
<p>Self-casting Professions characterize (1) their role in the discursive space around IPC as well as (2) themselves – their roles, capabilities, practices, relative position to others – in general, and in respect to IPC</p>	<p><i>Somewhat capable but under-recognized participant (in psychological system and discursive space around IPC)</i></p> <ul style="list-style-type: none"> - No specific title - Under the headline “<u>OAPA and Interprofessional Collaboration</u>” the association mentions four recommendations upfront that “The members of OAPA find... to be important in facilitating interprofessional collaboration“ - Letter: “OAPA is also including the results of a survey we conducted with our membership“ - Letter: “OAPA would also like to take this opportunity to highlight the experience of their members regarding interprofessional collaboration” “One of the key issues for us has been the lack of knowledge regarding the one scope of practice for psychology in the province of Ontario.” - “There are parameters impacting on our ability to collaborate due to regulations (e.g. some services are only to be provided by certain health care providers).”
<p>Altercasting Professions characterize other professions – their roles, capabilities, practices – in general and in respect to IPC</p>	<p><i>Problematize up</i></p> <ul style="list-style-type: none"> - “OHIP (Ontario Health Insurance Plan; the authors) billing procedures can be a barrier around interprofessional collaboration. In the mental health field, the need for referrals for some services to be signed by a physician hinders access for patients (psychiatrists, admission to hospital).”

Table 7. Profession’s framing strategies across four foci for framing

Actor Field-position	High-status, center (e.g. Physicians)	Middle-status, center (e.g. Registered Nurses)	Middle-status, periphery (e.g. Psychologists)	Low-status, center (e.g. Practical Nurses)	Low-status, periphery (e.g. Psychology Associates)
Foci for Framing					
<i>Issue framing</i>	Narrowing	Stretching	Stretching	Stretching	Stretching
<i>Justifying</i>	Normative	Rational & experiential	Rational	Experiential	Experiential
<i>Self-casting</i>	Authoritative leader	Capable participant, but under-recognized	Capable participant, under-recognized, and distant	Somewhat capable but under-recognized	Somewhat capable but under-recognized
<i>Altercasting</i>	Ignore down	Problematize up, Ignore down	Problematize up and across, Ignore down	Problematize up	Problematize up

Appendix: Documentary Data Sources

Websites

Canadian Medical Association (CMA): www.cmpa-acpm.ca
The Canadian Medical Protective Association (CMPA): www.cma.ca
College of Nurses of Ontario (CNO): www.cno.org
The Canadian Nurses Protective Association (CNPS): www.cnps.ca
The College of Psychologists of Ontario (CPO): www.cpo.on.ca
The College of Physicians and Surgeons of Ontario (CPSO): www.cpsso.on.ca
HealthForceOntario: www.healthforceontario.ca
Health Professions Regulatory Advisory Council (HPRAC): www.hprac.org
Ontario Association of Psychological Associates (OAPA): www.oapa.on.ca
Ontario Medical Association (OMA): www.oma.org
Ontario Nurses Association (ONA): www.ona.org
Ontario Psychological Association (OPA): <http://opajoomla.knowledge4you.ca>
Registered Nurses' Association of Ontario (RNAO): <http://rnao.ca>
Registered Practical Nurses Association of Ontario (RPNAO): www.rpnao.org

Legislative texts

Medicine Act, 1991, S.O. 1991, c. 30
Nursing Act, 1991, S.O. 1991, c. 32
Psychology Act, 1991, S.O. 1991, c. 38
Regulated Health Professions Act, 1991, S.O. 1991, c. 18

Other documents

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