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The Interplay of Inter- and Intraprofessional Boundary Work in Multidisciplinary Teams

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Abstract

The challenges of managing interprofessional boundaries within multidisciplinary teams are well known. However, the role of intraprofessional relations in influencing the dynamics of interprofessional collaboration remain underexplored. Our qualitative study offers a fine-grained analysis of the interplay between inter- and intraprofessional boundary work among three professional groups in a multidisciplinary team over a period of two years. Our contribution to the literature is threefold. First, we identify various forms of "competitive" and "collaborative" boundary work that may occur simultaneously at both inter- and intraprofessional levels. Second, we reveal the dynamic interplay between inter- and intraprofessional boundary negotiations over time. Third, we theorize relationships between the social position of professional groups, and the uses and consequences of competitive and collaborative boundary work tactics at intra- and interprofessional levels. Specifically, we show how intraprofessional conflict within high-status groups may affect interprofessional dynamics, we reveal how intraprofessional and interprofessional boundaries may be mobilized positively to support collaborative relations, and we show how mobilization within lower-status groups around interprofessional boundary grievances can paradoxically lead to further marginalization.

Keywords

boundary work, case study, interprofessional relations, intraprofessional relations, multidisciplinary team

In many sectors including healthcare (Leathard, 2004), construction (Ahuja, Nikolova, & Clegg, 2017), technology (Dougherty & Dunne, 2012), and creative work (Bechky, 2006), individuals from different disciplines are being called upon to work together in forms of "interprofessional

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collaboration." This is seen as critical to reduce knowledge fragmentation and develop solutions to complex problems. However, interprofessional collaboration also challenges institutionalized ways of working. Professionals who work within an exclusive occupational sphere (Leathard, 2004; Hall, 2005) are being asked to open up and renegotiate the boundaries that define their roles and practices (Abbott, 1988; Hall, 2005); in other words, to engage in "boundary work" (Gieryn, 1983).

Despite the discourse of "teamwork" and its aim to open up boundaries, studies of interprofessional collaboration have tended to highlight continued rivalry (Apesoa-Varano & Varano, 2014; Rodriquez, 2015), with each professional group seeking to protect or pursue their "professional project" (Fournier, 2000; Macdonald, 1995) by maintaining or expanding their jurisdictions (Bucher, Chreim, Langley, & Reay, 2016). Thus, while professionals may blur boundaries temporarily to "get the work done" (Abbott, 1995; Apesoa-Varano & Varano, 2014) or to maintain socio-emotional bonds (Pouthier, 2017), hierarchical status distinctions among professions tend to persist (Finn, 2008; Finn, Currie, & Martin, 2010), inhibiting collaborative relations. Nowhere are these tendencies more obvious than in the healthcare field, where the stratification of professional roles is particularly complex and well-established (Irvine, Kerridge, McPhee, & Freeman, 2002; Nancarrow & Borthwick, 2005). In other words, "social position," defined as an actor's status within a social group (Dorado, 2005; Lockett, Currie, Finn, Martin, & Waring, 2014), largely associated with professional background, tends to be reproduced in interprofessional relations, as does the pre-existing "social order" (i.e., the system of power relations among groups) (Nugus, Greenfield, Travaglia, Westbrook, & Braithwaite, 2010; Strauss, 1978).

Recently, however, several authors have noted that *intraprofessional* relations (between members of the same profession) as well as *interprofessional* relations (between professions) may play a role in enabling or limiting team-based collaboration (Liberati, Gorli, & Scaratti, 2016; Martin, Currie, & Finn, 2009; Nancarrow & Borthwick, 2005; Powell & Davies, 2012). Yet, most studies have focused on intraprofessional subgroups that are themselves hierarchically stratified, such as specialist and generalist doctors or nurses with different training levels (Martin et al., 2009; Powell & Davies, 2012), resulting in similar dynamics to those we see for interprofessional relations, and confirming the importance of "social position" in reproducing boundaries.

Reaching beyond this work, we argue and show in this paper that intraprofessional relations may play a significant role in the evolution of interprofessional collaboration, even when members within each professional group play ostensibly *similar* roles and have *similar* status. This is because collegial or conflictual relations *within* a particular professional group are likely to affect their ability to position themselves strategically with respect to higher- or lower-status colleagues (Miller & Kontos, 2013). Moreover, rivalry between members of the same profession is entirely possible given norms of professional autonomy (Embree & White, 2010; Mintzberg, 1979), with possible ricochet effects on interprofessional collaboration. Yet, few studies have considered how the interplay between intra- and interprofessional boundary work may affect the overall dynamics of collaboration in such settings. Thus, in this paper, we ask: (1) *How and with what effects do groups within a team negotiate intraprofessional and interprofessional boundaries over time? and (2) How does the social position of professional groups influence intraprofessional and interprofessional boundary work tactics and their effects on the social order within a team?*

To address these questions, we examine patterns of intra- and interprofessional boundary work for three professional groups within the same mental healthcare team over a two-year period, focusing on how ongoing boundary negotiations within and between groups reshape the social order in the team. Our study makes three major contributions. First, we identify various forms of "competitive" and "collaborative" boundary work that may occur simultaneously at inter- and intraprofessional levels within this type of team. Second, we reveal the dynamic interplay between

inter- and intraprofessional boundary negotiations over time. Third, we theorize relationships between the social position of professional groups, and the uses and consequences of competitive and collaborative boundary work tactics at intra- and interprofessional levels.

Literature Review and Conceptual Background

Boundaries and boundary work

Boundaries consist of any demarcation that distinguishes one group from another; they "establish categories of people, objects and activities" (Lamont & Molnár, 2002; Zietsma & Lawrence, 2010, p. 191). They are composite (Hernes, 2004), i.e., they may include physical, structural, social, mental or cognitive, and symbolic boundaries, and they can be more or less flexible and permeable (Ashforth, Kreiner, & Fugate, 2000). Quick and Feldman (2014) suggest two conceptions of boundaries: they can act as "barriers" that reinforce separation, or as "junctures" that enable connections. While boundaries are traditionally conceptualized as barriers, Quick and Feldman (2014) show how creating junctures, e.g., by translating across differences, aligning among differences or decentering differences, may empower groups to work together. They labeled these efforts as instances of "collaborative boundary work."

More generally, the notion of "boundary work" refers to any effort aimed at creating, maintaining, blurring or shifting boundaries (Ashforth et al., 2000; Gieryn, 1983; Helfen, 2015; Lamont & Molnár, 2002). This suggests that boundaries do not exist in an essentialist way, but emerge from interactions, supported by the efforts of institutions, organizations, and individuals (Abbott, 1995). The professions are an area where boundary work is particularly salient (Abbott, 1988; Anteby, Chan, & DiBenigno, 2016), both at field level, such as among professional associations (Abbott, 1988; Bucher et al., 2016; Suddaby & Greenwood, 2005), and at the level of everyday work (Allen, 2000; Apesoa-Varano & Varano, 2014; Chreim, Langley, Comeau-Vallée, Huq, & Reay, 2013; Finn, 2008). Boundary work is therefore likely to be particularly prevalent in the context of interprofessional collaboration.

Interprofessional boundary work

Teamwork discourses that favor the opening up of boundaries have often been encouraged in public policy (Bucher et al., 2016; Currie, Finn, & Martin, 2008). However, the way in which they have been translated at the level of the workplace is fluid and variable (Allen, 2000; Apesoa-Varano, 2013; Finn et al., 2010; Meier, 2015; Sanders & Harrison, 2008). For example, on the one hand, Meier (2015) revealed that different professional groups *are* able to flexibly blur their boundaries in the workplace, creating a collective or "relational" space (Kellogg, 2009) that allows positive exchanges and the achievement of a certain sense of belonging. Meier (2015) suggests that professionals may also sometimes achieve stronger collaboration by recognizing boundaries and working with them. Apesoa-Varano (2013) showed how occupational groups in healthcare settings may "perform each other's non-medical tasks," "transgress diagnostic lines," and "dismiss others' recommendations," sometimes to improve care or preserve relations of reciprocity, but also sometimes to re-establish boundaries if they appear threatened.

These observations contrast with other perspectives, which suggest that teamwork discourses may serve to reproduce boundaries despite accommodation at the margins (Apesoa-Varano & Varano, 2014; Rodriquez, 2015; Vad Baunsgaard & Clegg, 2013). For example, Griffiths (1997) showed how higher-status professionals replicate their influence in multidisciplinary teams, by "re-drawing the boundaries of the category" of client they deal with, to guarantee their own

caseload and undermine others' claims. Professional groups may also re-emphasize demarcations by engaging in "atrocity stories" to cast others in a negative light and their own group more positively (Allen, 2001; Dingwall, 1977). In brief, the literature offers instances of interprofessional boundary work in which team members accommodate, blur, or even mobilize distinctions to collaborate more harmoniously (Meier, 2015), using professional boundaries as "junctures" rather than "barriers" (Quick & Feldman, 2014). Nevertheless, rivalry still seems strongly embedded in these relations. Moreover, multidisciplinary teams may also be subject to intraprofessional forms of boundary work.

Intraprofessional boundary work

Professions not only differ from each other, but they are also internally stratified (Nancarrow & Borthwick, 2005). Indeed, studies dealing with intraprofessional boundaries and their effects on collaboration have most often focused on sub-specialties within groups. For example, Powell and Davies (2012) showed how the effectiveness of an acute pain care service was hampered, not only by difficult interprofessional relations, but also by impermeability between anesthetists and surgeons, and between specialist nurses and ward nurses. Similarly, Martin et al. (2009) showed how efforts to involve general practitioners in genetics care ultimately reproduced hierarchical relations, as specialists worked to confine generalists to an educational role. In other words, the dynamics of intraprofessional boundary work illustrated in these and other studies (e.g., Currie et al., 2008; Liberati et al., 2016) are similar to those associated with interprofessional boundary work: each subgroup works competitively to protect their domain, with higher-status subgroups maintaining their influence over time.

Since intraprofessional boundary relations are far from neutral, we can expect that these may impact interprofessional dynamics. The interplay between inter- and intraprofessional boundary work remains, however, significantly underexplored. For example, one might ask how *intraprofessional* solidarity vs. conflict might influence *interprofessional* relations. The few existing studies that have partly addressed this relationship tend to suggest that strong intraprofessional integration or "esprit-de-corps" (reflecting minimal intraprofessional boundaries) may inhibit interprofessional collaboration (Miller et al., 2008; Pate, Fischbacher, & Mackinnon, 2010). At the same time, such solidarity could constitute an advantage in negotiations with other professionals. For example, Miller and Kontos (2013) observed that nurses from different levels of licensure who demonstrated collegiality tended to mobilize their intraprofessional strength to expand their role vis-a-vis allied professionals, while perpetuating tense interprofessional relationships. On a different note, Liberati et al. (2016) found that different disciplinary groups (in their case, neurology and intensive care) developed quite different approaches to regulating nurse–doctor interprofessional boundaries, resulting in problematic relations across disciplines.

These findings suggest some potentially interesting dynamics relating to the interplay between intra- and interprofessional boundary work. However, more work is needed to understand this more deeply, reaching beyond dyadic relations, and considering the influence of social position, something that is only tangentially addressed in prior research on this interplay.

Social position

We have seen so far that despite intentions to integrate expertise and enhance collective responsibility, status differentials and struggles within and between professions tend to persist. Thus, "social position," referring to an actor's status in a given social structure (Dorado, 2005; Lockett et al., 2014) may critically influence boundary work tactics and their effects. Indeed, boundaries

circumscribe social positions, delimiting the distribution of material and symbolic resources, and motivating actors to protect or enhance their positions (Bourdieu, 1977; Zietsma & Lawrence, 2010). Social position at the individual level may be associated with various characteristics, such as seniority, profession, and social connections (Battilana, 2011; Bourdieu, 1977). However, in the current paper, we focus on social position or status based on profession and thus considered at the collective level.

Specifically, the literature suggests that higher-status professionals are more likely to be content with the status quo (Battilana, 2011; Bucher et al., 2016; Finn et al., 2010; Lockett et al., 2014) and therefore tend to defend their boundaries, while those in lower-status positions seek to change or extend their domains to gain legitimacy. The literature reveals some typical boundary work tactics used in this process. For example, Allen (2000) and Sanders and Harrison (2008) found that higher-status groups tend to discursively construct others as "technicians" in contrast to their own more "holistic" and uncodifiable understandings derived from superior professional experience and training. Bucher et al. (2016) further showed that higher-status professionals used naturalistic language to normalize their priviledged position, while lower-status groups drew on explicit rational and experiential arguments to emphasize their capabilities and urge greater openness (for similar observations in accounting and law, see Suddaby & Greenwood, 2005). Bucher et al. (2016) also unveiled the importance of considering middle-status professionals who appeared more aggressive than lower-status groups in contesting higher-status professions.

Finally, studies have found that exchanges between higher- and lower-status professionals tend to be more unidirectional and imply less negotiation than exchanges among lower-status professionals only (Allen, 1997; Svensson, 1996). In this vein, Nugus et al. (2010) suggested that multidisciplinary settings could be characterized either by "competitive power" (where one professional group dominates) or "collaborative power" (where professionals share influence), a pattern more common in community health settings.

In sum, we see that multidisciplinary teams constitute a complex arena for boundary work that sometimes allows junctures between actors, but often implies struggles. The literature on interprofessional boundary work is well documented, but intraprofessional dynamics have been underexplored. The few existing studies focus mainly on sub-specialties within a profession. Yet, boundary work may also occur among individuals with the same specialization and status. Indeed, as suggested by Irvine et al. (2002) intraprofessional variation can take many forms:

> Within each profession there is a considerable diversity of opinion on its aims and roles, and the methods of interdisciplinary work. The diversity within professions holds out both problems and prospects for collaborative work. (Irvine et al., 2002, p. 206)

We therefore argue for the importance of considering intraprofessional diversity in a broader and more open way than has been done previously. Different kinds of symbolic or cognitive intraprofessional boundaries may be socially constructed around beliefs about the roles and responsibilities of members of the same profession. Moreover, there is a need to better understand the interplay between intra- and interprofessional boundary work where research is still scarce.

Thus, as indicated, our study asks: *(1) How and with what effects do groups within a team negotiate intraprofessional and interprofessional boundaries over time? and (2) How does the social position of professional groups influence intraprofessional and interprofessional boundary work tactics and their effects on the social order within a team?* These research objectives emphasize a processual and negotiated conception of boundaries (Abbott, 1995; Quick & Feldman, 2014). Drawing on the negotiated order perspective, we see boundary dynamics as emerging from and supporting a negotiated social order, i.e., a more or less temporary arrangement of social relations,

Table 1. Professional roles and responsabilities.

Professional group	Roles and responsabilities
Psychiatrists	- Diagnosis - Medical treatment (e.g., drug prescription) - Coordination and integration of care
Psychologists	- Psychological evaluation (using psychometric tests) - Psychotherapy
Social workers	- Assessment of the social environment - Family intervention
Psychoeducators	- Support - Environmental adaptation
Nurses	- General health assessment (especially effects of medication)
Speech therapist	- Language assessment and therapy (with specific tests)

which confers a particular role on each professional (Allen, 1997; Strauss, 1978; Svensson, 1996). We assume that professionals' boundary work is motivated not only by the desire to collaborate, but also by the need to carve out a legitimate place in the team that recognizes distinctive skills and practices.

Methods

Research context and data

We carried out a qualitative longitudinal study of a multidisciplinary team labeled Alpha (a pseudonym), attached to a Health and Social Services Centre (HSSC) in Quebec, Canada. We followed this team, specialized in the care of children and adolescents with serious mental health problems, for two and a half years (2010 to 2013). The team was an ideal site for the study as we had access to inter- and intraprofessional interactions and their evolution over time.

The Quebec healthcare system is publicly run. Physicians are not paid by their home institution, but by a separate government body. Other professionals are salaried employees of the HSSC. In 2004, the government published a Mental Health Action Plan that required secondary mental healthcare for children and adolescents to be concentrated in multidisciplinary teams. The Alpha team was created from a merger of two smaller clinics that had two psychiatrists, but by 2010 had grown to 22 professionals (four psychiatrists, six psychologists, six social workers, four nurses, one psycho-educator, and a speech therapist) who at that time met as a unified team to discuss cases. The team is co-managed by the chief psychiatrist and an administrative leader with training in psycho-education. Table 1 summarizes team roles and responsibilities.

Each patient is assigned to one psychiatrist, and other professionals intervene in clinical cases according to their expertise. Cases are discussed in weekly clinical meetings. Given the difficulty of managing such a large group at once, as the research began, the larger team was split into two sub-teams. However, the four psychiatrists still moved across the teams depending on patients, and the two sub-teams met weekly in the same space separated by a mobile dividing wall. The first author attended 14 clinical meetings, 9 intraprofessional meetings (involving members of a single profession to discuss roles, practices, and training), and 11 administrative meetings (bringing together representatives of all professions to discuss organizational issues). Each meeting lasted about two hours. Detailed fieldnotes were written up for each observation, including a diagram

Table 2. Data.

Data collection time 1		Data collection time 2	
Interviews	**Observations**	**Interviews**	**Observations**
2 managers (one manager twice) 4 psychiatrists 6 psychologists 6 social workers 4 nurses 1 psychoeducator 1 speech therapist	5 clinical meetings 7 intraprofessional meetings 9 adminstrative meetings	1 manager 3 psychiatrists 3 psychologists 3 social workers 2 nurses 2 psychoeducators	9 clinical meetings 2 intraprofessional meetings 2 administrative meetings

showing the disposition of members around the table, and a detailed report of verbal interactions and significant non-verbal behaviors.

In addition, the first author conducted 39 interviews (transcribed verbatim) carried out at two time points (T1 and T2), 25 at the beginning and 14 at the end of the research (see Table 2). In the second round, we selected respondents who were most forthcoming in the first round, while ensuring good coverage of each profession.

During the interviews, the first author asked professionals to describe the functioning of the team, their perception of their own profession in comparison to others and their intraprofessional relations. The interviews also clarified incidents previously observed in meetings. Each interview lasted between 60 and 120 minutes. The research was approved by the ethics committee of the authors' home institution, and all team members agreed to participate. Finally, between T1 and T2, the authors made a joint presentation to members of the Alpha team, allowing us and them to reflect on and validate emerging interpretations.

Data analysis

Given the purpose of the study, we focus our analysis on the three largest professions most central to clinical discussions: psychiatrists, psychologists, and social workers. A critical mass of members is necessary to examine intraprofessional relations, which is why we excluded the two psychoeducators and the speech therapist. We also excluded the nurses because of the limited visibility of their contributions to intra- and interprofessional interactions. In Alpha, each nurse is paired with a psychiatrist to constitute a dyadic sub-team, who hold private ad hoc meetings during the week (which we did not attend). The nurses attended the clinical meetings but were usually silent. Furthermore, they did not organize systematic intraprofessional meetings. We therefore collected few instances of interactions between nurses and other professions as well as among the nurses themselves. This arrangement is perhaps intriguing and may merit exploration in further research. However, the variation and complexity generated by the other three groups creates an interesting comparative design, ideal for addressing our research questions.

In fact, our dataset includes three professional groups that show hierarchically stratified social positions. Psychiatrists are the higher-status group, followed by the psychologists in a middle-status position and finally the social workers perceived as lower status. This status hierarchy has institutionalized roots based on the historical emergence and recognition of different kinds of expertise, and the capacity of more established professions to maintain and enhance their resources over time (Abbott, 1988; Freidson, 2001). Thus, doctors occupy the apex of the pyramid (Lockett

et al., 2014) with social workers at the lowest position (Sands, 1990). This also reflects our respondents' perceptions:

> Usually, we see [the hierarchy] as: psychiatrists, psychologists, social workers. (psychologist)

> In my role as doctor – and I think this is the way we are trained, we are at the centre – we direct the treatment. I have the responsibility for an integrated plan of care. And I need to know where my colleagues are, who are applying it on the ground. (psychiatrist)

> Social workers (…) work more with emotions, (…) feelings and relational aspects. (…) We try to objectify as much as possible the feeling we have, but this fuzziness – which is part of our profession, sometimes means that in terms of hierarchy, we are less scientific … we are perhaps seen as a bit less rigorous in the eyes of other professionals. And that can come across as, "Well, almost any well-intentioned person with a bit of empathy could do that." I don't believe that. But, that does mean that we do not get the recognition… (social worker)

We adopted an interpretive grounded theory approach to analyse the data (Charmaz, 2006), using the Atlas.ti software for support. In accordance with our first research question, we began by coding every passage that relates to an activity of boundary work. We were interested in any type of boundaries; this meant that we considered not only social boundaries, but also physical or structural boundaries as well as the subtlest ones, such as symbolic boundaries (Hernes, 2004). For example, an episode of disagreement can represent an instance of boundary work as professionals create symbolic and cognitive divisions.

After coding all segments signaling boundaries, we distinguished between intra- and interprofessional boundary work. We grouped under the theme "intraprofessional boundary work" all activities related to roles, practices, capabilities, relationships, and hierarchy employed by individuals belonging to the same profession, and under the theme "interprofessional boundary work" activities employed by individuals relating to a different profession. Based on this, and sensitized in part by Nugus et al.'s (2010) reference to competitive and collaborative forms of power in interprofessional relations, and by Quick and Feldman's (2014) conceptual ideas concerning boundaries as junctures or barriers, we identified two sets of boundary activities: the first set appeared conjunctive as professionals blurred or managed boundaries to achieve a common purpose, whereas the second set seemed disjunctive as professionals used boundaries to assert rival positions. We coded these "collaborative boundary work" and "competitive boundary work" respectively. We drew on these codes to illustrate evolving patterns of boundary work and analyzed these in relation to respondents' representations of the overall dynamics of the team. This informed us concerning the evolving social order of the team.

Finally, we refined our understanding by identifiying specific tactics of competitive and collaborative boundary work and exploring how professional groups with different social positions used these tactics. We iteratively returned to the literature to theorize the relationships between social position and boundary work tactics.

Trustworthiness

Trustworthiness of the data (Lincoln & Guba, 1985) was assured by focusing on descriptive themes in interviews and by engaging in open discussion with respondents rather than imposing categories. In addition, the first author was more deeply engaged in the site enabling a close understanding of the setting, whereas the second author was an outsider and could serve as devil's advocate.

The authors worked separately on data analysis and met regularly to discuss coding and emerging themes. Triangulation through multiple researchers, multiple respondents, and multiple sources of data enabled various perspectives to be brought to bear on the phenomenon (Lincoln & Guba, 1985). In addition, the feedback session served as an intermediary member check.

In the following section, we present our first-order findings, showing the collaborative and competitive boundary work that occurred at both the intra- and interprofessional levels, and their combined influence on the social order within the team. The passages in italics in the text below hint at some collaborative and competitive boundary work tactics, which we more systematically analyze according to the social position of each professional group in our second-order findings. Further supporting data for our categories is provided in the Supplementary Online Appendix.

First-Order Findings: Competitive and collaborative boundary work at two levels

We structure the first-order findings to draw out the competitive and collaborative boundary dynamics occurring over time in our research site both *within* and *across* professions, illustrating how patterns of intra- and interprofessional boundary relations for each time period together constitute a particular social order. We also see how forms of boundary work chain themselves together over time, as the three professional groups react to each other's interprofessional boundary work while coping with their own intraprofessional differences as well.

Competitive boundary work (T1)

Intraprofessional level. During the first time period, competitive boundary relations were evident at the intraprofessional level within the group of psychiatrists. At this time, the team held weekly clinical meetings in two simultaneous sub-teams. The sub-teams were each composed of ten or so professionals (three psychologists, three social workers, two psychiatrists, and two nurses, with the psychoeducator and the speech therapist moving between teams). While the involvement of two psychiatrists was seen as desirable by other professionals (*"It is better to encourage sharing and a diversity of viewpoints"*), it became difficult for the psychiatrists themselves who were obliged to discuss cases in the presence of others who might second-guess their judgment –especially because of their different ways of working, and in particular their different philosophies concerning *interprofessional* boundaries:

> Each doctor has their own way of working, and each doctor judges the other doctor according to their way of working. So there were conflicts. (psychologist)

> Dr. Guylaine tends to mobilize our interventions and practices during the meetings (…) we're the ones who bring things to her. But with Dr. Denise, it's she who brings in and orients our work. (psychologist)

As suggested, Dr. Guylaine was less medically interventionist and included the psychosocial professionals in discussions, whereas Dr. Denise tended to impose the medical approach. Thus, competitive boundary work appeared as psychiatrists *confronted each other* during meetings:

> Dr. Guylaine is speaking forcefully in an administrative meeting: "Sometimes, I wonder what impact we are having on problems. As a psychiatrist, I could be out of here, and it wouldn't make much difference. Is it us that is making people sick?"A little shocked, Dr. Denise asks, "Who will look after them, who's going to care for them?" Dr. Louise and Dr. Guylaine respond in unison, "It's not the doctor's job!" Dr. Guylaine

> continues, "If we stopped giving [drug] tomorrow morning, it wouldn't change anything." (…) She concludes, "I'm not saying that we are worth nothing, we still have a role to play, but the doctor should not be the first to intervene. (…) I know, it's a natural reflex, but we have to let our teams take charge socially." Dr. Denise seems upset and has her arms folded. (fieldnotes, administrative meeting)

Dr. Guylaine clearly tried to maintain her viewpoint in the hope of influencing Dr. Denise. However, during an interview, she explained how difficult it is to convince her colleague, noting the demarcation between older and younger psychiatrists in the team:

> I was 25 years old once. At 25, it's important to feel (…) that you are useful for something. And often, it is through action (…) through playing the doctor (…) through sticking on diagnoses and prescribing drugs. (…) For me, diagnoses are not so important, it's rather to invest in the child with a somewhat different perspective… (psychiatrist)

In other words, Dr. Guylaine, a senior psychiatrist, believed that the place of the psychiatrist should be secondary to that of psychosocial professionals in the pedopsychiatric team, where many clients had developmental rather than obviously medical problems. This clashed with the younger psychiatrist, who preferred to intervene more aggressively. This was one of the main sources of conflict between psychiatrists at Alpha, but as other professionals reported, there was also competition among them in part because of their expectations of individual autonomy and leadership as physicians:

> It's harder for the physicians to manage their collegiality amongst themselves than it is for us other professionals. That's because doctors are prima donnas, and it's: "I decide" and "I want". When you put prima donnas together, you are certain to generate quarrels. (psychologist)

Their superior hierarchical position combined with their number within each sub-team created problematic intraprofessional relations. Indeed, their close interaction within the same sub-team implied that they had to share power and this seemed barely negotiable.

Interprofessional level. At the interprofessional level, it was mainly between the social workers and the two other professional groups (i.e., psychiatrists and psychologists) that lines of competitive tension appeared. One area that some social workers found particularly problematic concerned the "placement" of children in institutional care. Although officially such placements required the evaluation of a social worker, psychiatrists or psychologists had on a number of occasions announced to parents that placement would be offered without involving a social worker, creating expectations that were highly problematic in terms of boundary relations. One of our interviewees explained this concern as follows:

> Of course when we have a doctor who declares ex cathedra a placement for a child when there isn't even a social worker involved in the case, this makes us extremely upset because it should be the social evaluation that determines whether there will be a placement or not. (social worker)

A second area of friction was the practice of family intervention. While social workers argued that this practice fell under their jurisdiction, some psychologists also claimed to have the requisite skills.

> There are some psychologists who are a bit too interested in family interventions (…). On the one hand, the social workers say, "What do they think they are doing talking about families and getting mixed up in family interventions?" On the other hand, the psychologists say, "Well, we have also been trained and we

> know how to do family interventions." (…) So there's competition. (…) That translates well the insecurities of the social worker. What is our area, in the end? If you take the families, what is left for us? (social worker)

The ambiguity regarding who is allowed to perform these practices created competition between social workers and the other two professions. Competitive boundary work manifested itself in the way that social workers *tried to elevate an impermeable boundary* around these practices. More often than not, the social workers were dominated by the other professions, who simply continued to *infringe on this perceived boundary*, as the following quotations illustrate:

> I defend our territory, in a way, by saying, "Stop doing placements in our place." (social worker)

> There has always been this culture that psychologists look after the children and the social workers look after the parents. But I would say that the psychologists have never really (…) "respected that," in the sense that if I need to see the parents, I'll see the parents. (psychologist)

We see next how this type of competitive boundary work at the interprofessional level triggered collaborative boundary relations at the intraprofessional level.

Collaborative boundary work (T1)

Intraprofessional level. Among the social workers, the interprofessional discomfort experienced with psychiatrists and psychologists reported above impelled them *to come together. They collectively mobilized to engage in boundary work that aimed to change the shape and form of professional practices.* In so doing, they attempted to overcome their own *intraprofessional* differences concerning social worker roles in order to engage in more forceful competitive relations with their colleagues. These efforts were observed during an intraprofessional meeting, that we report in three segments. The meeting includes five social workers (Nelly, Maude, Celine, Ginette, and Sophie):

> Nelly presents several clinical cases to her social worker colleagues. One of these is a case in which a psychiatrist has requested a placement. Nelly comments, *"I'm wondering how we should respond to this placement request."*
> Maude responds: *"We have to evaluate it… we have to take it on."*
> Nelly adds: *"Perhaps you'll find me a bit idealistic, but I'd really appreciate it if these kinds of referrals stopped!"*
> Celine continues: *"Ah, for that to happen, we'd have to be with the psychiatrists to evaluate the clients [in their offices]. If [the psychiatrist] had a social worker with her, she wouldn't have done that. She wants things to move quickly, she's an operator. What bothers me is the interdisciplinarity question here (...) The mistake is that they talk about placement with clients, without even consulting us."*
> Nelly goes on: *"I hear what you are saying, Celine, but I don't agree with you. We should decide how we want to handle these things between ourselves. We are not in sync on placements. Our position isn't clear."*
> (fieldnote, social workers' intraprofessional meeting)

This extract reveals directly the concern about a perceived violation of interprofessional boundaries by psychiatrists. At the same time, the extract suggests that there are some ambiguities around

the social workers' collective position on placement, and indeed, other data confirm that not all were interested in taking on this task. There is, thus, also an implicit intraprofessional division around this issue, which is, however, passed over as the meeting continues.

> Maude proposes: *"We could present a procedure at an administrative meeting so that our other* [non-social worker] *colleagues can see what we do, so they can see that we don't provide services once a placement decision is made."*
> Ginette tries to understand the proposal and asks, *"So we would create a placement committee? That's what you're thinking?"*
> Maude agrees.
> Celine objects, *"Hmm… I'm not sure. If we say that we are creating a placement committee, if we label it a placement committee, then that implies we will be doing placements."*
> Maude adds, *"Well, it all depends. It's really to see which clinical files require placement and which do not."*
> Celine proposes, *"I would call it more '"ad hoc consultation'."*
> Nelly returns to the topic: *"I'd just like us to put some guidelines on placements… for us, what is a placement and how should we evaluate it? I just don't want to see any more of these requests… after all the horrors of placement calls we've had."*
> Ginette responds: *"I understand. It's infuriating. She* [one of the psychiatrists] *treats us like people who just execute orders."*
> Maude concludes: *"So we request an item on the agenda of the next administrative meeting to propose that placement should be based on a social evaluation."*

This second extract shows the social workers mobilizing to put forward their collective position with other members of the team. They appear to want to reaffirm their distinctive role in placements and reclaim a clear boundary between them and others. However, ambiguity about what this implies again bubbles below the surface: the social workers do not all agree on the idea of offering placements. The exchange continues, illuminating other alleged interprofessional boundary violations.

> Sophie raises an additional point, *"I know that I often bring this up, but I personally think that we have some educational work to do here. We need to explain to the team that when they do this, it doesn't help the client, it may even harm the relationship when they talk about stuff that doesn't concern them. Of course, we can never entirely escape from professionals who want to take over everything …"*"
> Maude adds: *"And especially in our field! I mean the psychiatrists and the psychologists are always into our domain. They are not shy to say things that belong to our domain, but we cannot talk about this or that drug or this or that test. We look like the profession of basic common sense! I'm pretty certain that [the psychiatrist] thinks that if she thought of it [ordering a placement], we think the same thing. The other day, she was even ready to do a training session on family therapy!"*
> Ginette exclaims: *"What? She really did that?!"*
> Maude confirms this: *"Well yes, for her, it's obvious – that's why I say we need to be strategic…"*
> Ginette seems to be in shock, angry about what she has just heard given that family therapy is a practice normally associated with social work. Attempting to turn it into a joke, she says: *"A good thing I have my gum."* She starts chewing furiously and breathing heavily to channel her stress.

This last extract confirms the social workers' conception of themselves as under-recognized. We also notice that social workers had other sources for complaint besides the issue of placement, such as family therapy. Finally, the extract shows how the meeting enabled social workers *to develop a plan to collectively challenge their colleagues in a subsequent administrative meeting*. One of the social workers described their initiative as follows:

> For about a year, the social workers are in process. And we have not succeeded in agreeing completely amongst ourselves (…). We developed a statement together. We agreed that for every placement request that is formulated by anybody on the team, we would need to work together on it. (…) (social worker)

We relate this to collaborative boundary work, *as social workers try to overcome their internal differences to unify their professional voice*, all this in order to strengthen their competitive position in interprofessional boundary relations.

Psychologists also worked their intraprofessional boundaries collaboratively. However, their collaborative boundary work was quite different from that of the social workers. Rather than coalescing around a "common enemy," they worked together by *ensuring that each had a distinctive niche*:

> Between us [the psychologists], I think that there's a lot of respect for our different strengths, letting us develop what we like. We don't all have to do the same thing. There are some who like to develop testing, for example, or doing neuropsychology. There are others who are really therapists. (psychologist)

> Each person has something of value, their distinct identity within our group. (…) Our territories are pretty well defined, without being too rigid. (psychologist)

Thus, in contrast to the social workers who tried to unify their group through common practices, the psychologists collaborated intraprofessionally by *creating new cognitive (expertise-based) boundaries within their professional group*, which perhaps paradoxically facilitated their intraprofessional cohesion. This seemed productive because each became recognized for their specific expertise, while partly sharing it with the group.

Interprofessional level. Finally, psychologists also engaged in collaborative boundary work with psychiatrists. This manifested itself in a similar way to what we have just described; They maintained distinctive professional boundaries, but used them in an *interrelated and complementary way*:

> The doctor deals with medical treatment. For us, our specificity is therapy. In that sense, doctors are like a support… once we have started therapy, the doctor links in. (…) So it's really teamwork, but we do not have the same role (psychologist)

> Some patients will see the psychologist first, and then he will call me, "I need you." Sometimes, the psychologists will do a kind of pre-evaluation, (…) and they start interventions, and then they come to me. So we join together to do the assessment… that is not a practice that the other professionals (nurses, social workers) can do. So in that sense, the psychologist and the psychiatrist talk to each other. (psychiatrist)

These extracts exhibit *mutual recognition of professional domains, resulting in an apparent collegiality* between the two groups during clinical meetings.

Effects of boundary work on the social order at T1: Simmering equilibrium

The patterns of competitive and collaborative boundary work described above infused the social order within the team, creating a rather fragile ("simmering") equilibrium where tensions bubbled

below the surface. First, competitive boundary work between psychiatrists/psychologists and social workers intensified during this period. Social workers tried to improve their position vis-a-vis others by uniting, but their intraprofessional collaborative boundary work seemed arduous, given their own underlying divisions and the domination of psychiatrists and psychologists who worked collaboratively together. Psychologists emphasized their complementarity with psychiatrists rather than attempting to engage in competitive relations. This supported their precedence over social workers, and sustained them in a privileged situation. With relatively secure positions in the team, the psychologists also collaborated intraprofessionally by claiming niches of expertise that were mutually respected.

Second, the social order was weakened by competitive boundary work among psychiatrists. Professionals appreciated the richness of diversity among the psychiatrists, but experienced discomfort when they witnessed sharp intraprofessional conflict. One of the social workers noted: *"I think the doctors could maintain a little more reserve in front of colleagues in the team*." After a specific conflictual episode, one of the psychiatrists also commented:

> That made me reflect on the role of doctors, and the reserve we should have, and that we don't always have in practice. We are people who (…) are very expressive (…) and quite spontaneous sometimes, and we may throw out things that can be upsetting. And that can have an influence on the team. (psychiatrist)

The psychiatrists themselves thus recognized the impact their competitive intraprofessional dynamics had on the social order. We see now how forms of boundary work evolved over time, focusing on the main changes experienced.

Competitive boundary work (T2)

Intraprofessional level. During the first period, we saw social workers collaborating to position themselves collectively vs. others, but we also noticed ambiguities around the social workers' collective position. The divide among social workers had grown by the second data collection. The social workers did not all agree on the idea of offering placements and began to communicate this. Our interviews suggest that if placements were going to occur, they wanted to be responsible for them, but ideally, some would rather not practice placements. Thus, a split emerged between members of the group. It seems that the attempt to mobilize solidarity around a particular form of interprofessional boundary clarification left certain members profoundly uncomfortable:

> What I found difficult, was the kind of impression of consensus that everyone is in agreement on everything… that we are all the same because we are all social workers, and so we think the same way. (…) I expressed that at one of our meetings: "I feel that in this group that I'm not allowed to express opinions that are different from yours (…) I feel that when we talk about placements, for example, I have to be faithful to the party line as if this were a dictatorship." (…) When I started to name these things, the group essentially broke up. (social worker)

Established hierarchical relations among professions as well as the ambivalence of some of their own profession diluted the force of their collective initative and tended to maintain the grey zone around placements rather than eliminate it. Some psychiatrists and psychologists continued to call for placements. A similar pattern appeared regarding family interventions. Thus, prior collaborative boundary work ran out of steam and turned into competitive boundary work. This was reflected in the creation of sub-divisions in the intraprofessional group, or the formation of "clans" (a social worker's exact word). One subgroup argued for maintaining clear boundaries with other

professionals, while another subgroup tolerated and even encouraged more fluidity. For instance, one social worker explained how she perceived grey zones as a resource:

> I think that this [the presence of grey zones] allows greater professional autonomy. (…) The way I practice my profession, I'm not sure whether I am exclusively a social worker. [What I do] comes close to a kind of psychotherapy. Sometimes people say to me, "Ah – you're not a real social worker you are a psychologist who doesn't know it." (…). So the fluidity allows that (…) It allows us from time to time to jump over the fence. And that's not a problem, because where actually is the fence anyway? (social worker)

This extract explains that grey areas may not only allow other professions to infringe on the social work domain, but they may also enable social workers to engage in practices associated with other professions. This presents an opportunity to connect with other professions seen as valuable within the team. This strategy was nevertheless not unanimously shared: *"For others, the ambiguity is insupportable. They become aggressive."*

Over time, given the tense climate between clans, the social workers ceased to meet as an intraprofessional group, with members reconstructing their social relations elsewhere in the team or within a smaller fragmented subgroup.

Collaborative boundary work (T2)

Intraprofessional boundary work. Interestingly, the process was quite the opposite for the psychiatrists. Whereas at time 1 psychiatrists mainly worked their intraprofessional boundaries competitively, at time 2 we saw them in a rather better situation, at least from their own perspective. Following the experience of intraprofessional conflict, the psychiatrists got together to restructure the team. Specifically, with the consent of the team manager, they jointly decided to further split the team (creating four sub-teams instead of two) so that each psychiatrist would work separately with their own dedicated team. We see this as collaborative boundary work because they essentially colluded to attenuate their intraprofessional competition through the creation of distinct domains. As one of the psychologists put it, breaking the team into four structurally bounded subteams with a single psychiatrist constituted *"a way for them to stop having to measure themselves against each other."* Another professional added:

> It's easier to manage because it avoids conflicts between the doctors. The doctors are like divas. With the new division, each doctor has their own team and can reign in their little territory without thinking that the others will come and interfere with their work, or contradict them or question them. (psychologist)

And as one psychiatrist put it: *"The professionals are very adaptable and they accept to take on the colour of each psychiatrist,"* a comment that reveals tellingly how other team members tend to fall into line within the professional hierarchy. We understand from this that with their "own sub-team" and higher status, the psychiatrists were able to impose their distinctive conceptions of teamwork. This was especially attractive to them because they could finally recapture their leadership and autonomy within their team.

Effects of boundary work on the social order at T2: Fragmented diversity

The two main changes observed at the intraprofessional level dramatically influenced the social order within the team. First, the split among the social workers undermined their efforts at

redefining their boundaries vis-a-vis other professionals. On the contrary, intraprofessional conflict exacerbated their marginalization:

> We are seen as the dysfunctional profession on the team… that has always been so, but I would say even more, now! (social worker)

Importantly, this intraprofessional boundary conflict had cascading effects on the whole team:

> There are now subgroups, clans, or cliques among the social workers (…) and that contaminates the dynamics of the team. There is clearly a fragmentation within the whole team. (social worker)

Second, the structural reorganization undertaken by psychiatrists, which served them well as it allowed them to minimize intraprofessional competition, had variable effects for the other professionals, depending on which team they were associated with. Indeed, members noted unequal forms of collaboration developing as the different psychiatrists enacted their preferences concerning role boundaries with other members: some inclined towards a more democratic approach and some towards a more directive form of collaboration that left little autonomy to other professionals.

> There are some doctors who will really consider the team (…). But there are other doctors [who don't] (…) Similarly, there are doctors who are ready to make changes to improve the quality of what we are offering, and there are others who will reply, "Well, with me, this is the way we work." (psychoeducator)

Beyond the dynamics of each sub-team, this created unequal relations across the whole team:

> Each team does not have the same degree of cohesion, nor even the same structure, and the same effectiveness, efficiency or ethics. So it contributes certainly to a fragmentation of the team. (social worker)

In addition, as new boundaries were raised through the initiatives of the psychiatrists, spaces for interaction across the whole team tended to disappear as well:

> It is quite rare, now, that all of us get together at the same time. (psychologist)

> I think we are no longer one big team. And it's nobody's fault. But it is a challenge. (psychiatrist)

Only the psychologists continued their intraprofessional meetings, attempting to hold on to their collaborative intraprofessional relations, and sustain their collective identity across sub-team boundaries. Professionals used strong metaphors to communicate their perception of instability and fragmentation in the team. For instance, a psychiatrist commented:

> [To illustrate the interprofessional team] I'd like to draw something with little cracks in it: zones of fragility. It's like all these stick figures… we hold each other's' hands as a source of strength but at the same time a source of fragility, because the link is only hands which at any time (…) the wind blows, and there's a risk that the hands will be dropped. (psychiatrist)

Similarly, another member compared the team to a shipwreck to illustrate the disintegration of the whole team and the deterioration of the overall collective dynamics:

> There's no more convergence, the tissue of the team is torn. (…) So much has been lost. And we can never put it back together as it was before. We need to create something new… it's really like after a shipwreck – there are dispersed bits and pieces. (social worker)

We clearly see that the social order within the team was fragmenting.

In the next section, we step back from the specific story of the team, to draw out the nature of competitive and collaborative boundary work tactics observed at two levels, and to theorize their relationhip with the social positions of different professional groups.

Second-Order Findings: Boundary work tactics and social positions

The first-order findings first reveal different ways of doing collaborative and competitive boundary work, which we summarize in Figure 1 for each professional group and time period. The study suggests that it is possible to collaborate across boundaries in at least three ways: (1) by practically eliminating boundaries to build consensus around practices (which we call *collectivizing*, as in the social workers' attempts to build solidarity), (2) by erecting new frontiers to become complementary, focusing on the strength of differences (called *differentiatin*g, represented by the psychologists' positive use of distinctions within their own group and with the psychiatrists), or (3) by encouraging ambiguity, allowing professionals to navigate practices in the moment (*accommodating*, represented by the mobilization of grey zones as resources). On the other hand, it is also possible to compete across boundaries, (1) by contesting each other's practices directly (labeled *confronting*, as between the psychiatrists at time 1) or (2) by encroaching on the boundaries that others erect (which we call i*nfringing*, evidenced by the psychiatrists' and psychologists' intrusion into the social workers' domain). Drawing on our first-order findings, we now attempt to theorize about how social position may influence the use and effects of different types of boundary work tactics at two levels.

Higher-status professionals

In our study, we see, not surprisingly, that higher-status professionals (in our case the psychiatrists) tend to gain overall in interprofessional relations. First, they have no difficulty in asserting their role and distinctive practices in relation to other professionals (*differentiating*). Moreover, because of their superior position, they allow themselves to encroach on the territory of others when this suits them (*infringing*).

Theoretically, these findings are so far consistent with the literature. Indeed, like others, we notice that despite intentions to reduce silos and hierarchical boundaries, interprofessional collaboration reproduces power dynamics between groups (Finn et al., 2010; Griffiths, 1997; Irvine et al., 2002; Martin et al., 2009), and higher-status professionals enjoy a privileged place. Like Battilana (2011), we also see that the interprofessional boundary work of this group essentially involves maintenance efforts rather than appropriation of new practices. Our study also confirms the work of Bucher et al. (2016) and Lockett et al. (2014) who observed that higher-status actors tend to simply ignore the claims of lower-status groups.

However, this group was not immune to conflict. Our findings unveil a major challenge at the intraprofessional level. Indeed, the presence of several psychiatrists in the same team seemed problematic: they clashed, each seeking to impose their viewpoints (*confronting*). This suggests that when there are several individuals in the same higher social position, competitive rivalry is likely, each seeking to assert dominance. Other studies have noted the possibility of conflict between

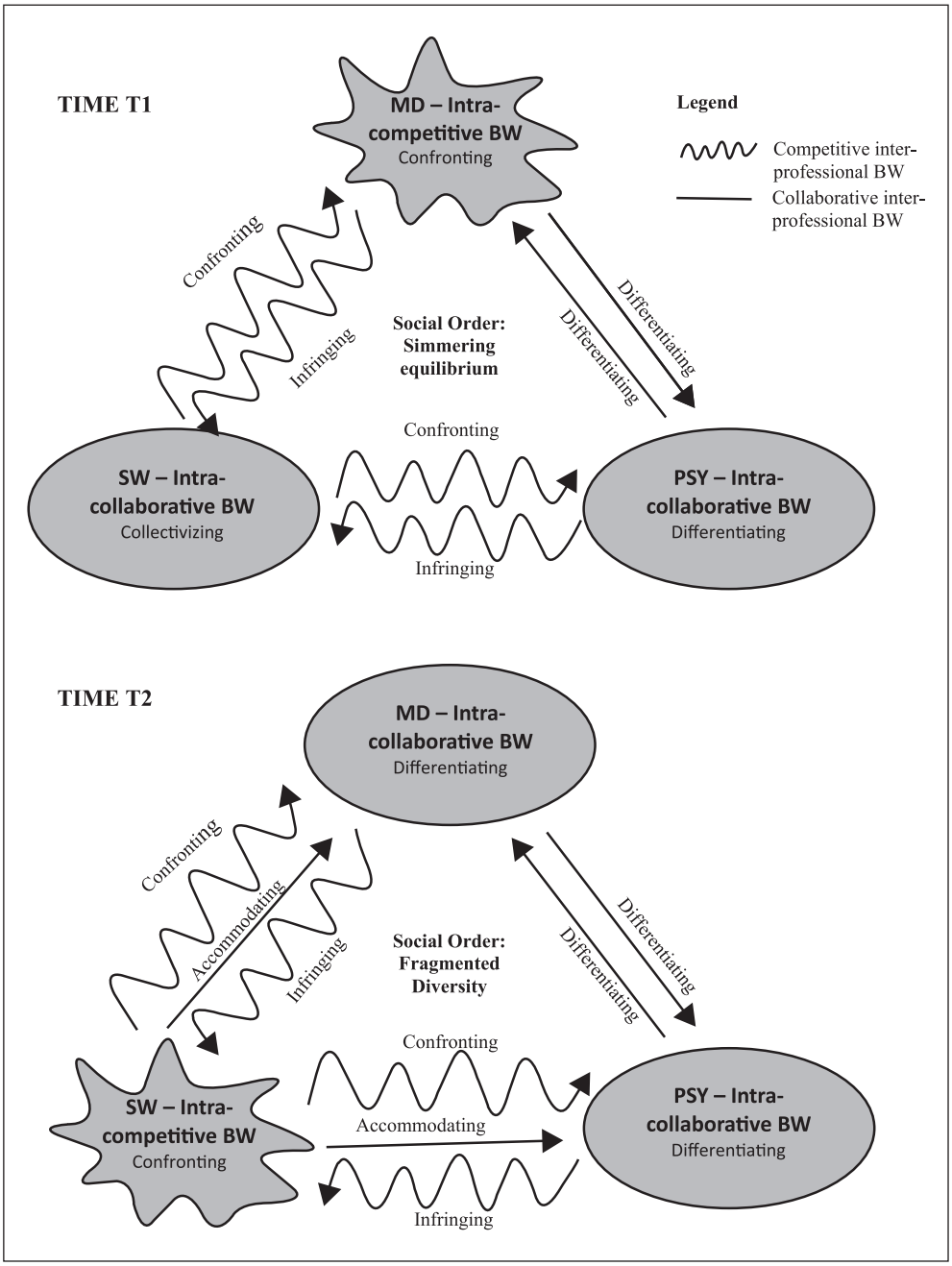

Figure 1. Competitive and collaborative boundary work at T1 and T2.
BW = boundary work, MD = psychologists, PSY = psychiatrists, SW = social workers.

professional subgroups. For example, Powell and Davies (2012) showed boundary struggles among anesthetists and surgeons. However, our research contributes by highlighting the presence of conflict between professionals belonging to the same discipline or specialization; and above all,

by suggesting that a higher social position relative to others carries within itself the seeds of conflict. To quote one respondent, "*When you put prima donnas together, you are certain to generate quarrels.*" To our knowledge, no studies have clearly identified this issue in the context of interprofessional teams. Yet, this is an important finding, because in addition to refining our understanding of the intraprofessional dynamics of the group itself, this can have significant repercussions on other members of the team. As discussed below (see middle-status professionals), this context may actually be beneficial for other professional groups.

The higher-status professionals in our case escaped from this confrontational spiral over time, through intraprofessional differentiation. More specifically, the psychiatrists raised boundaries within their group (*differentiating*) to create space for each to practice as they wished. Although this tactic is used by other professionals too, the intraprofessional differentiation deployed by the psychiatrists is pushed to the extreme as its effects reach beyond the intraprofessional group. Indeed, the elevation of intraprofessional boundaries implied the division of the team itself. This allows each psychiatrist to govern their own sub-team without interference. This tactic appears to be a unique resource, since no other professional group could unilaterally reorganize the entire structure of team interactions. Because of their social position, higher-status professionals have resources to negotiate boundaries that other groups do not (Bucher et al., 2016), allowing them to reinforce their position.

Middle-status professionals

Between the lower- and higher-status professionals are the middle-status professionals, in our case, the psychologists. Recognized for their particular expertise in psychological assessment, they hold exclusivity over the practice of "testing." This "technical" distinction gives them enhanced legitimacy (Sands, 1990). However, their recognition is always fragile and temporary, because it is subject to infringement by higher-status professionals. For example, a psychiatrist in our study stated: *"In principle, with our psychiatric training, we would be equipped to deal with a clinical case from A to Z.*" However, psychiatrists were initially struggling with their own intraprofessional conflict, leaving greater leeway for others. Thus, the psychologists instead took advantage of their differences and connected them collaboratively to those of the psychiatrists rather than addressing them competitively.

Theoretically, this collaborative interprofessional tactic of *differentiating* is close to the concept of "juncture," suggested by Quick and Feldman (2014), or the idea of *"enabling boundaries through reference to difference"* identified by Meier (2015). Here, professionals recognize and respect differences, and rely on complementarity to build collaborative relations. In contrast to Bucher et al. (2016) who found that middle-status professions in field-level disputes tended to problematize higher-ranking groups and engage in aggressive confrontation, our study suggests that at least in a workplace setting, middle-status groups may benefit from collaborative upward tactics (see also Finn et al., 2010). In our case, the middle-status professionals also joined higher-status professionals in downward competitive boundary work, *infringing* on the boundaries that lower-status groups attempted to establish. This tactic is beneficial as it allows them to expand their practice while affirming their superior position.

We also saw intraprofessional differentiation occurring *within* the group of middle-status professionals. Legitimacy at the interprofessional level seems to give these professionals the opportunity to strengthen boundaries within their own group. Thus, the psychologists created new frontiers, giving each person a unique niche of expertise that allowed them to enhance their value both individually and collectively. Moreover, as in the higher-status group, this tactic prevents intraprofessional conflicts; everyone is distinctive as well as complementary. This result adds a

contribution to the literature on interprofessional collaboration. While multidisciplinary teams are aimed at reducing or blurring boundaries, we see here the emergence of totally new frontiers, but ones that seem to be productive of greater harmony. Our case raises the original, even paradoxical, idea that professionals may gain by maintaining certain distinctions both at the interprofessional level and within their group.

Lower-status professionals

Lower-status professionals are the group with least professional recognition. Groups in this position will seek to enhance their positions (Battilana, 2011). In our case, the social workers, who lacked a distinctive role or exclusive practice (Hugman, 1991), mobilized to change their situation. Through their *collectivizing* efforts, they sought to reach consensus to claim an exclusive professional practice. The idea here is that intraprofessional solidarity (or "esprit-de-corps") (Miller et al., 2008) may enhance power in interprofessional boundary negotiations. The social workers thus collectively opposed other groups and tried to clearly demarcate their territory (*confronting*). Their reception was however tepid and temporary. Middle- and higher-status professionals continued to infringe on the proposed boundary. This in turn contributed over time to the dissolution of the already fragile consensus in the intraprofessional group as it split into "clans." While some persisted in trying to build impermeable boundaries with other groups (*confronting*), others chose to make the best of available grey zones and form alliances with other groups (*accommodating*). Paradoxically, the push for intraprofessional solidarity ended in fragmentation, further weakening the social position of this group.

Theoretically, these results converge in part with the literature on lower-status groups. Battilana (2011) and Bucher et al. (2016) noted how such groups attempt to assert specific expertise. However, by examining the interplay of intra- and interprofessional boundary work, our study suggests some important nuances. Specifically, the absence of an exclusive practice or distinctive expertise in interprofessional relations also makes *intraprofessional* differentiation by niches of expertise more difficult, something that was a source of collaborative intraprofessional strength to higher-status groups (e.g., the psychologists). In other words, intraprofessional diversity seems to be better tolerated when the group's expertise is well established.

These findings contribute to the currently limited literature on the interplay between intra- and interprofessional relations for lower-status professionals. On the one hand, some have advanced that there is an antagonistic relationship between professional identification and interprofessional partnership (Pate et al., 2010; Sands, 1990). On the other hand, Miller and Kontos (2013) noted that intraprofessional collegiality, including the elimination of dissensus, can be an effective tactic for achieving advantage in interprofessional negotiations, though not necessarily conducive to quality. Our study adds to this by suggesting that the elimination of dissensus, or *collectivizing*, is difficult to sustain if the occupational group does not gain recognition. Without some success in interprofessional negotiations, consensus may fade or dissolve, which in turn, further marginalizes the lower-status group.

Discussion and Conclusion

In this paper, we investigated patterns of intra- and interprofessional boundary work engaged in by professionals in a multidisciplinary team. Beyond the dyadic nurse–physician relation traditionally studied in the interprofessional literature (Allen, 1997, 2000), we analyzed three professional groups occupying different social positions within a team over a two-year period, focusing on how boundary negotiations within and between groups reshape the social order.

Our contribution to the boundary work and interprofessional collaboration literatures is threefold. First, we identify forms of competitive and collaborative boundary work, occurring at both inter- and intraprofessional levels. Nugus et al. (2010) described collaborative and competitive forms of power in interprofessional relations. However, they used these concepts to assess degrees of shared involvement within teams as wholes. By analyzing boundary work at inter- and intraprofessional levels, we offer a more fine-grained understanding of social dynamics in multidisciplinary teams by showing how professionals organize their work collectively, i.e., what types of boundaries they maintain, erect, change, or suppress and the tactics mobilized to achieve this. Importantly, we advance the work of Quick and Feldman (2014) who coined the term "collaborative boundary work," to refer to situations where boundaries are seen as "junctures", contrasting this with "competitive boundary work" where boundaries are seen as "barriers." Furthermore, we highlight the possible coexistence of these opposing forms of boundary work *within the same team*. This finding diverges from the tendency to label teams as either collaborative or competitive and to assume static and deterministic modes of interaction in particular settings. By unpacking the dynamics of an interprofessional team over time, we illustrate a more subtle and more dynamic combination of competitive and collaborative relations.

Second, we build on recent calls to consider the dynamics of intraprofessional boundary work (Currie et al., 2008; Martin et al., 2009; Nancarrow & Borthwick, 2005), and more importantly the interplay between inter- and intraprofessional boundary negotiations (Liberati et al., 2016; Miller & Kontos, 2013; Powell & Davies, 2012). We show how boundary work exercised by one group can affect others, both intra- and interprofessionally. We also show how these boundary negotiations contribute to constituting different forms of social order within the team. In particular, our findings suggest that professional groups may gain from maintaining or creating interprofessional *and* intraprofessional distinctions in order to construct a balanced social order. This is rarely noted in the interprofessional literature, which has tended to emphasize the benefits associated with the blurring of boundaries or to decry conflict flowing from boundary maintenance (Finn et al., 2010; Griffiths, 1997). We note however that this boundary work tactic (differentiation) is not equally achievable for all professional groups.

Third, we theorize the relations between social position and boundary work strategies. For example, we argue that high status can be a source of intraprofessional conflict, especially when high-status actors are co-present in interactions with others. Such conflict may be exploited by middle- or lower-status groups, potentially offering them greater scope for autonomous action. This observation reaches beyond the work of Powell and Davies (2012) and Finn et al. (2010), who considered intraprofessional relations among sub-specialties. Furthermore, we suggest that middle-status groups may choose to build relationships with rather than engage in confrontation with higher-status groups (Bucher et al., 2016). The middle-status group in our study is a good example of how intraprofessional differentiation contributes to solidify both intra- and interprofessional relations. Finally, the comparison of social positions shows that the elevation of distinctive intraprofessional boundaries based on expertise is more difficult for lower-status groups. Because of this, their collective struggle against marginalization may shatter their solidarity, instead of reinforcing the group.

These insights confirm the importance of considering the interplay between the intra- and interprofessional levels in multidisciplinary teams, as well as considering multiple forms of competitive and collaborative boundary work. We hope other researchers will build on our ideas. For example, it would be valuable to investigate the implications of intra- and interprofessional boundary relations on client relationships. Moreover, since discourses promoting multidisciplinary collaboration are universal, and since hierarchy is inherent to the system of professions (Abbott, 1988), there is room to explore the emergence of similar dynamics in other sectors, such as accounting (Stringfellow

& Thompson, 2014), construction (Ahuja et al., 2017), and creative projects (Bechky, 2006). Our study contributes to pointing the way.

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Supplementary material

Supplementary material for this article is available online.

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