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Separating, replacing, intersecting: The influence of context on the construction of the medical-nursing boundary

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ABSTRACT

The distribution of work, knowledge, and responsibilities between doctors and nurses is a longstanding object of interest for medical sociologists. Whereas the strategies through which nurses and doctors construct their professional boundary have been thoroughly examined, little is known about why the regulation of the medical-nursing boundary varies across care settings. In the article, I argue that this gap in knowledge can be attributed to insufficient examination of the 'negotiation context', namely the features of the social and organisational environment that directly affect doctor-nurse boundary negotiations. Adopting a negotiated order perspective, and drawing data from a hospital ethnography, the article describes the different ways of constructing the medical-nursing boundary (*separating, replacing,* and *intersecting*) which were observed in three different care settings (a neurology ward, a neurosurgical ward, and an intensive care unit). Constant comparison of the observed interactional patterns led to the identification of three factors that significantly affected the construction of the medical-nursing boundary, specifically: patients' state of awareness, the type of clinical approach adopted by nurses and doctors, and the level of acuity on the ward. The article advances our knowledge of the medical-nursing boundary by shedding light on its flexible and contextual nature and by adding further nuance to the boundary-blurring/boundary-reinforcing dichotomy. New features of the 'negotiation context' are identified that enable more convincing explanations of why the medical-nursing boundary varies across care settings. Finally, the study advances the negotiated order theory by offering a framework for considering the structural differences that shape local negotiations.

1. Introduction

During the last four decades changes in health systems have significantly challenged medical dominance in relation to nursing (Tousijn, 2002; Nancarrow and Borthwick, 2005). The shortage of doctors and the rising of healthcare demand has led to increased 'task shifting' (WHO, 2007). In some high-income countries the role of nurses has been extended to include traditionally medical tasks, such as the prescription of routine medication. Furthermore, substantial reforms in nursing education and policies, together with the rise of new nursing ideologies (Beardshaw and Robinson, 1990), have allocated a more prominent and autonomous role to nurses (Nancarrow and Borthwick, 2005). These changes created potential tensions in the medical-nursing interface, sometimes sparking jurisdictional battles (Abbott, 1988).

Mirroring this increased complexity, social scientists have gradually moved away from the over-deterministic model of the medical dominance (Freidson, 1970) to adopt theoretical perspectives that enable a more nuanced understanding of the interplay between nursing and medicine. Negotiated order is one such perspective (Strauss, 1978; Strauss et al., 1963, 1997). Studies informed by negotiated order have demonstrated that nurses influence patient care in ways that contradict their place in formal organisational hierarchies, and participate in medical work tacitly and flexibly (Hughes, 1988; Allen, 1997; Nugus et al., 2010). Emphasising the "delicate ordering of healthcare work" (Hindmarsh and Pilnick, 2002:141), negotiated order concepts have had tremendous value for the sociology of medical professions, enabling images of nursing and medicine that are more congruent with the reality of clinical work. The current study is grounded in this theoretical legacy. It draws on the notion of 'negotiation context' (Strauss, 1978) to develop a theory of why the construction of the medical-nursing interface varies across care settings and in

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response to which contextual factors – a remarkably under-investigated question in the medical sociology literature.

2. Negotiated order and the medical-nursing boundary

At the centre of the negotiated order approach is the argument that daily work is constructed in ways that only partly derive from regulatory frameworks and formal structures, and are also the product of enduring interactions of all actors involved in the exercise of agency and the concurrent creation of a relatively stable *social order* (Strauss, 1978; Fine, 1984; Nugus et al., 2010). Although structures and rules shape organisational life, these are not inescapably prescriptive nor peremptorily constraining; in many instances rules are cited selectively, stretched, or even ignored by individuals at convenient moments (Hughes, 1984; Strauss, 1978).

This approach leads to a conception of division of labour as a process of social interaction upheld by its participants through their daily work (Strauss et al., 1963, 1997). Jurisdictions are not self-evident and need to be actively negotiated and claimed within a system of work (Abbott, 1988; Allen, 1997). Individuals play an active, though not necessarily decisive, role in the making, negotiating, and maintaining of professional boundaries – what has been defined 'boundary-work' (Abbott, 1988). Accordingly, professional boundaries and identities are tightly intertwined. Since individuals derive their identities and self-esteem from their professional work, they seek to maintain control over the areas of work that affords them symbolic rewards, while discarding 'dirty work' (Hughes, 1984; Kellogg, 2014).

When applied to the study of the medical-nursing boundary the negotiated order approach has demonstrated that the real-life work of nurses cannot be reduced to their formal job descriptions or organisational role (Dingwall and Allen, 2001). Hughes' (1988) study of an accident and emergency unit showed that nursing work in the processes of patient categorisation moved close to the medical task of diagnosis. Similarly, Tjora (2000) determined that in order to manage requests for medical assistance when doctors were unavailable, the nurses of a communication centre drew on their professional experience and assembled knowledge from different clinicians to diagnose patients' conditions over the phone. The medical-nursing boundary can be constructed through either explicit negotiations (namely vis-à-vis disputes concerning professional boundaries) or *de facto* boundary blurring, which refers to nurses informally taking over doctors' work to respond to workplace pressures (Allen, 1997:551). In sum, negotiated order studies show that nurses may participate in medical work tacitly and flexibly, and the boundaries between *curing* and *caring* may be more blurred than is formally acknowledged (Baumann et al., 1998; Chambliss, 1996; Salhani and Coulter, 2009).

Negotiated order studies also challenge the static conception of power implied by the medical dominance model (Freidson, 1970), demonstrating that nurses may exercise power in ways that exceed passive influence attempts. Various scholars suggested that the medicine-nursing power relationship may not be a 'zero-sum' one; forms of *collaborative power* between nurses and doctors may exist (Nugus et al., 2010) and strategies may be developed to increase the influence of both groups in the wider network of healthcare practitioners (Carmel, 2006).

The nuanced description of medical and nursing work offered by this body of literature has remarkable value, demonstrating how close examination of daily workplace interactions is key to grasping the flexible patterns of activities underpinning the medical-nursing boundary. Yet, since the focus of negotiated order studies has traditionally been on how the medical-nursing boundary is regulated in individual care settings, little explanation is offered of whether and how these strategies vary across contexts. As a result, when taking stock of this body of research, some contrasting findings become apparent.

In her study of a medical and a surgical hospital ward, Allen (1997) observed that the fragmented presence of doctors frustrated nurses' attempts to sustain a rigid division of labour, facilitating *de facto* boundary blurring. Thus, the author suggests, nurses were more likely to engage in informal (*de facto*) boundary blurring when doctors were unavailable, while acting within their formal role when doctors were physically present. But Carmel's study of an intensive care unit portrays doctors and nurses purposively blurring their professional boundary when doctors were physically present. Carmel framed this as a strategy to increase the influence of both groups in relation to other specialties and the wider hospital context (Carmel, 2006). Nugus et al. (2010) found that the acuity of the care setting was a mediating variable in balancing collaboration amongst healthcare professionals, with acute care settings characterised by a greater degree of medical dominance than non-acute settings. Yet Hughes's (1988) aforementioned study suggested the opposite pattern.

I argue that these apparently divergent findings can be attributed to insufficient examination and theorisation of the contextual factors which directly impact the regulation of the medical-nursing boundary. The negotiated order approach, and particularly the notion of 'negotiation context' (Strauss, 1978), offers a promising framework for this analysis. Although emphasising the 'primacy of work' in shaping the division of labour that forms around it (i.e. the idea that it is daily work practices themselves that shape division of labour [Strauss et al., 1997]), advocates of the negotiated order approach recognise the constraining role played by the context in which interactions occur. Strauss himself emphasised the existence of *structural properties* which directly influence the course of workplace negotiations, such as the number of negotiators, whom they represent, the sequence and frequency of negotiations, and the issues at stake in the negotiations. The author named these structural properties 'negotiation context' (1978). Busch (1982) added further specification to this argument: he introduced the concept of *sedimentation* to explain the process whereby the outcome of previous interactions becomes part of the structural context and acquires a non-negotiable and taken-for-granted status. Nevertheless, these concepts have rarely been mobilised to explain variations in the medical-nursing boundary. If this continues, studies in this field risk being criticised for being unable to deal with the limiting factors in negotiation settings, a criticism frequently made of negotiated order theory more broadly.

This is where the present study seeks to contribute. Drawing data from a hospital ethnography, it aims to identify the social, contextual, and organisational factors that directly affect the negotiation of medical-nursing boundary (i.e. the properties of the 'negotiation context') and examine how they operate in different care settings. This will be accomplished by comparing the processes through which the medical-nursing boundary is constructed in different hospital wards.

3. Research design

3.1. Context

Data for this study are drawn from a broader ethnographic research conducted in a multidisciplinary public hospital in Italy, between February 2014 and April 2015. The original aim of the research was to understand how inter-professional and inter-disciplinary boundaries in medicine and nursing were negotiated in the context of a policy-driven organisational change (Lega and DePietro, 2005). For the current purposes, I will focus mainly on the data that contribute to a more nuanced understanding of the