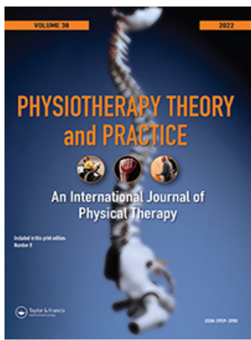

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Boundary work in task-shifting practices – a qualitative study of reablement teams

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ABSTRACT

Background: Health services worldwide have provided incentives for establishing teams to accommodate complex health care tasks, enhance patient outcomes and organizational efficiency, and compensate for shortages of health care professionals. Parallel to and partly due to the increased focus on teamwork, task shifting has become a health policy. Task shifting involves new tasks and responsibilities, which may result in social negotiations about occupational boundaries

Objective: The aim of this study was to explore how the division of tasks, responsibilities, and roles in reablement practices can appear as boundary work between physiotherapists (PTs) and home trainers (HTs)

Methods: The study drew on data from fieldwork with seven Norwegian reablement teams, including observations and individual interviews with PTs and HTs. We conducted thematic analysis informed by a theoretical framework on professional boundaries

Results: We identified two different practices, which we labeled as: i) "The engine and the assistant" and ii) "The symbiotic team." We drew on these practices and theory of boundary making and boundary blurring to interpret the results

Conclusion: The findings indicate that boundary-making processes may generate asymmetric power relations that may constrain autonomous work and job satisfaction in teams, whereas boundary-blurring processes may promote collaborative practices that enhance holistic approaches and mutual learning on reablement teams.

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Boundary work; occupational boundaries; teamwork; health care services; task shifting

Introduction

From a global perspective, health policy makers emphasize interoccupational collaborations and teamwork in a range of complex health care services (World Health Organization, 2010, 2013). Health services worldwide have provided incentives for establishing teams to enhance patient outcomes and organizational efficiency (Liberati, Gorli, and Scaratti, 2016) and compensate for shortages of health care professionals (Nugus et al., 2010). Parallel to and partly due to the increased focus on teamwork, task shifting has become a health policy (World Health Organization, 2005, 2010).

Task shifting is described as the delegation of tasks to existing or new candidates with narrowly tailored training (Fulton et al., 2011; Kakuma et al., 2011; Nancarrow and Borthwick, 2005; van Schalkwyk et al., 2020). In a recent systematic review, Sarigiovannis et al. (2021) studied task delegation by allied health professionals to allied health assistants. They found that ambiguity regarding the scope and role of allied health assistants, in addition to efforts to protect the professionals' job roles, was assumed to be a barrier to task shifting and the utilization of assistants. However, the lack of research creates questions about task shifting in health care practices (Sarigiovannis et al, 2021).

Reablement is a relatively new home rehabilitation service involving intensive, time-limited, person-centered approaches that aims to enable people with or at risk of functional decline to cope with everyday life (Aspinal et al., 2016; Cochrane et al., 2016; Legg, Gladman, Drummond, and Davidson, 2016; Metzelthin, Rostgaard, Parsons, and Burton, 2020). In a Delphi study by Metzelthin et al (2020, p.8), the service model is described to be holistic, which they elaborate as 'taking into account various needs of the client,' based on multiple professional views. Teamwork is a central characteristic of reablement services, which utilize task shifting, and interventions are often delivered by allied health assistants, who are referred to as home trainers (HTs). Auxiliary nurses (who have completed a two-year formal education program) or care assistants without formal education often tend to hold these positions

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(Hjelle, Skutle, Alvsvåg, and Førland, 2018; Meldgaard Hansen and Kamp, 2018). Physiotherapists (PTs), in addition to other allied health professionals, have more of a consultant role, assessing users and guiding HTs (Birkeland et al., 2017; Eliassen, Henriksen, and Moe, 2018a, 2018b; Hjelle, Skutle, Alvsvåg, and Førland, 2018; Tessier, Beaulieu, McGinn, and Latulippe, 2016).

Reablement practices involve rehabilitation and training initiatives traditionally conducted by PTs, and these domains are still highlighted as central parts of PTs' professional identity (World Physiotherapy, 2021). Task-shifting practices involve a delegation of these traditional tasks to HTs, which may challenge traditional professional and occupational boundaries (further referred to as occupational boundaries). There is a need to explore how task shifting in the new service organization of reablement affects the occupational boundaries of PTs and HTs.

Occupational groups have their own individual culture, including values, beliefs, and attitudes, that reflects historical factors, social class, and gender issues and involves the construction of occupational boundaries. Such boundaries act as institutionalized social differences, and they regulate who ought "to be included and who excluded" (Apesoa-Varano, 2013; Lamont and Molnár, 2002; Liberati, Gorli, and Scaratti, 2016). Sociological theory of the evolution of health and care professions illuminates how professionalism represents a set of arrangements to secure the monopoly of tasks and exclusive areas of knowledge, thereby regulating the boundaries of the occupation and maintaining professional autonomy (Abbott, 2014; Baker, Egan-Lee, Martimianakis, and Reeves, 2011; Freidson, 1983, 2001). Baker, Egan-Lee, Martimianakis, and Reeves (2011) described the concept of "professional elbowing" as a boundary-setting practice to carve out a profession's own niche, defining the uniqueness of the profession. Occupational identity and jurisdictions are maintained not only through education and training but also through internal socialization processes in terms of social negotiations in daily practices (Allen, 2001; Apesoa-Varano, 2013; Freidson, 1976; Hall, 2005). Social processes where boundaries are constructed and negotiated are referred to as "boundary work" (Abbot, 1995; Liu, 2015). Task-shifting practices, whereby new occupational groups undertake certain tasks, may challenge and reinforce occupational boundaries (Abbott, 1995; Pedersen, 2020; van Schalkwyk et al., 2020).

Sociological literature has traditionally defined professions by traits and characteristics that distinguish them from other occupations, e.g., advanced training and education, service orientation, and codes of ethics (Abbott, 1995). Based on a functionalist perspective and delimiting characteristics for professions, only a few occupations, such as doctors, psychiatrists, lawyers, and priests, achieved status as professions in the early rise of professional theory. In the early 1900s, an expansion of occupational groups, such as nurses, social workers, and PTs, claimed their status as professions. This was heavily debated by those who argued that such "semiprofessions" (cf. Etzioni, 1969) lacked an exclusively hegemonic ownership of their work tasks (Abbott, 1995). Despite debates in the fields of sociology, these occupational groups managed to achieve professional status due to the development of a theoretical knowledge base and education systems during the mid-1900s (Freidson, 2001). Today, physiotherapy is considered a profession in Western countries. Although some of their work tasks require esoteric and specialized knowledge, PTs also engage in tasks that are based on general and exoteric knowledge, such as health promotion and enhancement of general physical function.

The earlier debates about professional status were often limited to the question of demarcations of professions, and boundary work was merely understood as conflicts while claiming occupational jurisdiction (cf. Abbott, 1995). According to Liu (2018), a more nuanced conceptualization of boundary work processes is needed. As he states, a boundary "is a site of conflict and cooperation between two or more professional or nonprofessional actors seeking to establish jurisdiction over similar work" (Liu, 2018: 46). Liu (2018) developed the concepts "boundary making" and "boundary blurring" to understand the nuances of boundary work, which is both dynamic and complex. Whereas boundary making refers to the process of demarcation, distinguishing professions from each other, boundary blurring refers to a more ambiguous and cooperative process of hybridization. We find these concepts appropriate to understand boundary work processes in task-shifting practices between professionals and nonprofessionals in reablement teams, as boundary work has been described to involve both conflicts (Apesoa-Varano, 2013; Comeau-Vallée and Langley, 2020; Liberati, Gorli, and Scaratti, 2016) and collaborations (Akkerman and Bakker, 2011; Quick and Feldman, 2014).

There is a considerable research corpus on boundary work in hospital settings, which often targets the relationship between physicians and nurses (Allen, 2000; Allen, 2001; Apesoa-Varano, 2013; Hall, 2005; Liberati, Gorli, and Scaratti, 2016). However, the literature on professional boundaries has paid little attention to the boundary work between professionals and nonprofessional assistants, such as between PTs and the new

occupational group of HTs on reablement teams. Reablement research has described the composition of interprofessional teams (Birkeland et al., 2017), reablement employees' roles (Hjelle, Skutle, Alvsvåg, and Førland, 2018), and barriers and facilitators of teamwork in reablement (Moe, Gårseth-Nesbakk, and Brinchmann, 2019). Nevertheless, the literature lacks descriptions of how these shifts of tasks and responsibilities contribute to a (re)construction of occupational boundaries between PTs and HTs, which is an essential aspect to achieve an understanding of team interactions.

Purpose

The aim of this study was to explore how the division of tasks, responsibilities, and roles in reablement practices can appear as boundary work between PTs and HTs.

With the goal of tracking reablement as a new set of occupational tasks and roles, we drew on the theoretical concept of boundary making and boundary blurring by Liu (2015, 2018) to interpret the results in this study.

Materials and methods

The study is framed within a social constructivist paradigm due to our interpretation of the construction of professional boundaries as a continuous ongoing social negotiation process. As occupational boundaries are constantly renegotiated through internalized and largely unspoken social processes in situated contexts (Apesoa-Varano, 2013; Hall, 2005), we needed to obtain access to microactions in everyday life practices as well as first-hand experiences to achieve valid insight.

Study design

Direct observation of everyday practices contributes to identifying elements of collaborative practices and interactions that are not always obvious to individuals (Morgan, Pullon, and McKinlay, 2015). Additionally, we were interested in the first-hand reflections of team members. Therefore, we considered a study design that combines field observations and interviews as appropriate for the purpose of this study. We collected data by observing employees on reablement teams in their work environments (work environment observations), including videotaped observations of PTs and HTs in user encounters (user encounter observations). In addition to the observations, we conducted individual interviews with both PTs and HTs after the sessions.

Study setting

The study was conducted with seven reablement teams within seven different Norwegian municipalities. The municipalities were strategically chosen to study populations of various sizes (from fewer than 15 000 inhabitants to more than 100 000 inhabitants).

Norwegian health and social care services are publicly funded and should be offered to all citizens, regardless of their financial situation, social status, gender or age (Norwegian Ministry of Health and Care Services, 2015). Reablement is part of the services provided without fees. There are two main reablement models in the Norwegian context: 1) a specialist model and 2) an integrated model. The first model consists of a multidisciplinary team that is organized independent of traditional home care services and works exclusively with reablement users. The second model is incorporated into traditional home care service. Care personnel from the home care service are expected to conduct reablement training initiatives under the supervision of therapists in addition to their regular home care services (Fürst and Høverstad, 2014). Six of the included reablement teams were organized as specialist teams independent of home care services. One team was organized as an integrated team, drawing upon the existing home care services in the municipalities. In this reablement team, HTs were employed in the home care domiciliary service in the municipality.

Recruitment and participants

We contacted general managers of reablement teams to inform them about the study. General managers who consented to participate distributed the study information to team members. In addition to all team members' approval of the "work environment observations," one PT and one HT from each team also agreed to participate in the "user encounter observations." The inclusion criterion for the PTs and HTs was at least 6 months of experience with reablement. Six of the seven PTs were females, whereas all seven HTs were females. None of the HTs had higher health care education (university degree), but all seven had a two-year formal education as auxiliary nurses (high school degree). The PTs' professional experience ranged from one to 20 years. The PTs' and HTs' experience working on reablement teams ranged from one to three years. Table 1 presents more information about the participants' occupational experience.

Table 1. Participants' occupational experience

PTs	Experience	HTs	Experience
1	<5 years as a PT, 6 months in reablement	1	5-10 years as health care assistant, 5 years in reablement
2	>10 years as a PT, 2 years in reablement	2	5-10 years as health care assistant, 2 years in reablement
3	>10 years as a PT, 2 years in reablement	3	>10 years as health care assistant, 1 year in reablement
4	<5 years as a PT, 1 year in reablement	4	>10 years as health care assistant, 2 years in reablement
5	>10 years as a PT, 2 year in reablement	5	>10 years as health care assistant, 2 years in reablement
6	5-10 years as a PT, 3 years in reablement	6	5-10 years as health care assistant, 2 years in reablement
7	>10 years as a PT, one year in reablement	7	<5 years as health care assistant, one year in reablement

Ethics

This study was approved by the Norwegian Center for research Data (Ref number: 44747) and was conducted according to the Helsinki Declaration (World Medical Association, 2018). All participants received written information about the study and provided written consent before the data were collected. The data were managed confidentially and with respect to the participants' privacy.

Data development

The fieldwork was conducted between January and June 2016. We conducted two one-day observations in the seven reablement teams (within a 2–3-week interval between the two observations). These **work environment observations** were mainly conducted in open offices, meeting rooms and lunchrooms. Additionally, we conducted video-recorded observations of reablement interventions when both the PT and the HT were present in the user's home (user encounter observations). Immediately after the **user encounter observations**, we conducted semistructured **individual interviews** with the PTs and HTs (N = 14) at their workplaces. During the interviews, the PTs and HTs were encouraged to reflect on actions during the preceding observation and to talk more generally about their experiences of tasks, occupational competence and interactions on the reablement team. The interviews were audiotaped.

Reflexivity

The social constructionist perspective used in the study involved coproduction of the data in the interactional context of the research encounter. Researchers' backgrounds and positions affect what is chosen to be investigated and how results are interpreted (Creswell and Poth, 2017). The first author of this article, who also conducted the observations and interviews (NN), is a PT, and the second author (NN) is a nurse. We both have master's degrees in interprofessional health care, PhDs, and experience in health care service research. Based on our experience, we assert that occupational boundaries are fluid and highly dependent on the context in which practice is conducted. Our preassumptions were that occupational boundaries were differently constructed across different reablement teams, which was the rationale behind the development of this current study.

Analysis

We performed reflexive thematic analyses inspired by Braun and Clarke (2019). This analytical strategy is a rigorous, systematic, and fluid approach to coding and theme development and draws on a *six-phase* model (Braun and Clarke, 2006). First, we read the data multiple times and became familiar with them. Second, we identified meaningful citations and excerpts from the observations that we considered to be relevant for the research question. Based on discussions between the two authors, we decided to search for data that contained descriptions of occupational roles, collaboration and division of tasks and responsibilities between the occupational groups. We also searched the data from the observations for interactions and nuances in the communication between the PTs and the HTs, that could provide information about their collaboration and relational position. All the citations that we perceived as relevant, were coded with inductive, data-based codes (n = 18). Third, we arranged several joint discussions between the two authors where we discussed patterns of shared meaning and contradictions of the codes. Based on these discussions, codes were categorized into code groups (n = 7). Further, we sought for support in theory of professional boundary and boundary work, which provided us with a theoretical interpretation of the content in the code groups, which were developed into subthemes (n = 7). The seven subthemes were eventually condensed into two main themes (n = 2). Fourth, we reviewed and refined the themes and subthemes, which included

several iterative discussions between the two authors and involved, moving back and forth between the different themes and initial empirical data. In the fifth step, we worked on identifying the specifics of each theme as a process of generating labels and headings. Table 2 presents an excerpt of the analysis process and show how codes, code groups, subthemes and main themes were generated. Table 3 provides and overview of all the code groups, subthemes, and main themes. Last, we drafted and wrote up the analysis. Throughout the analysis, we worked iteratively between theory and the data, gradually moving toward the theoretical concept of boundary work. These six steps of analysis, are in line with descriptions of Braun and Clarke (2006, 2019)

Results

Based on the analysis of the observations and interviews, we identified two different practices where the division of tasks, responsibilities, and roles between PTs and HTs could be interpreted as different processes of boundary work. Four of the teams were characterized by a hierarchical team structure, where PTs (in addition to occupational therapists and nurses) were designated as "the engine" and were assisted by HTs. A clear division of responsibilities and tasks was established through team interactions in the daily practices. In the three additional teams, the division of labor was less hierarchically structured. The participants emphasized that all team members were equal partners, each of them with significant competence and contributions. We drew on these two different practices to structure the results according to the following themes: i) "The engine and the assistant" – boundary making and ii) "The symbiotic team" – boundary blurring.

"The engine and the assistant" – boundary making

The metaphor of the engine and the assistant represents the hierarchy and the clear demarcation of roles in four of the studied reablement teams. During the observations, we noticed that the teams divided the responsibility in such a way that the HTs carried out the daily training initiatives, whereas the therapists were responsible for assessments, planning, and supervision. One PT said, "*We are referred to as the engine in the system*." This designation seemed to be an internalized term, as both HTs and PTs referred to the therapists as "the engine" of the team on several occasions.

Hierarchical division of roles

The PTs' competence was described as crucial for reablement practices and was the rationale for defining them as "the engine" of the team. One PT used the metaphor of "a gear in the machinery":

"I cannot imagine that we [the PTs] should not participate [in the reablement teams]. It may sound egocentric, but I think our competence regarding body functions and how we observe and assess such functions is crucial to the [team's] success. Almost every one of the care recipients has some physical or functional problems, for example, impaired walking or reduced balance (. . .). We [the PTs] are specialists in such impairments, and, thus, we are perhaps the experts in the system. (. . .) In my opinion, the PTs are a substantial gear in the machinery" (PT).

While the PTs were defined as "the engines," our observations revealed that the HTs fulfilled an assistant role, observing and executing predefined rehabilitation plans developed by the PTs. In addition, observations in the work environment revealed a hierarchical division of roles between PTs and HTs. The therapists tended to take the role of a meeting leader in internal team meetings.

One example that represents a typical team interaction finds a place in an open landscape office:

Table 2. Examples of the analysis process – from raw data to main themes.

Meaningful quote	*"I cannot imagine that we [the PTs] should not participate [in the reablement teams]. It may sound egocentric, but I think our competence regarding body functions and how we observe and assess such functions is crucial to the [team's] success. Almost every one of the care recipients has some physical or functional problems, for example, impaired walking or reduced balance (. . .). We [the PTs] are specialists in such impairments, and, thus, we are perhaps the experts in the system. (. . .) In my opinion, the PTs are a substantial gear in the machinery"*	*"Generally, two of us attend the first visit. We do it like that because it is important to obtain a wide overview. My favorite way of doing it is to visit the care recipient together with an HT. The first encounter with the recipient is important for the HT; the things that I am saying, what I am emphasizing. In addition, I see how the HT relates to the recipient. Thus, on the first visit, I get quite a holistic view. So, working together is the ideal situation"*
Code	"The physiotherapists are the experts"	"We work together to obtain a wide and holistic view"
Code group	Hierarchical team organization	Flat team organization
Subtheme	Hierarchical division of roles	Working together for a holistic approach
Theme	**The engine and the assistant -boundary making**	**The symbiotic team -boundary blurring**

Table 3. Analytical development of the themes

Code groups	Subthemes	Themes
Hierarchical team organization	Hierarchical division of roles	**The engine and the assistant-boundary making**
Asymmetric responsibilities	Claiming the rights of tasks and responsibility	
Unequal recognition	'Reablement physiotherapy' vs traditional physiotherapy	
What is physiotherapy?	Task shifting as a potential conflict	
Conflicts and tension		
Flat team organization	Working together for a holistic approach	**The symbiotic team-boundary blurring**
	Continuous and mutual learning	
Professional learning	Autonomous and empowered team members	

> The team members, two PTs, an occupational therapist, a nurse, and two HTs, have just filled their coffee mugs and are getting ready for the workday. "*Let's get started for the day*". One of the PTs takes the initiative to interrupt the small talk that buzzes in the room: She sits down by her desktop, which has a central place in the office landscape. While she is seated with her back toward the other team members, she opens a software program on her computer, scrolling down for the right access to a list of service recipients. Meanwhile, the other team members settle down by their desks, turning their chairs toward the PT, who clearly takes on a meeting leader role. She reads out a name from the top of the list and turns toward the other PT on the team, who also has a centrally placed desktop in the room. "*This is the lady with the hip luxation. I think it is best if you assess the situation before the HTs are let in there*". The other PT agrees, as she responds: "*Yes, this is her [the care recipient's] third incidence of hip luxation. We have to be a bit careful*". The PTs make this agreement without any consultation with the HTs who sit silently by their desktops, facing toward the PTs without saying anything.

This excerpt from the observation represents a typical interaction in the team that we observed has a clear hierarchical structure. The therapists often took a role as leaders, interacting with other therapists on the team, whereas the HTs typically remained silent, answering direct questions now and then. By stating that a PT should assess the service recipient "before HTs are let in," the PT substantiated that the situation requires some sort of esoteric knowledge that only the PTs possess. She received support from the other PT, who argued on the basis of safety reasons. This solidity and self-confidence were not challenged by the other team members, who merely accepted an inferior position.

Moreover, observations of meetings with care recipients where both a PT and an HT were present revealed that the PT led the conversation while the HTs took the role of an assistant placed in the background. One HT confirmed her role as an observer:

> *"Basically, they [the PTs] take the control in the planning meetings when we visit the care recipient, and I am more of an observer" (HT).*

This exemplifies how the social interactions on the team created and maintained a clear distinction between the two occupations.

Claiming the rights of tasks and responsibility

The clear division of labor and distinct role definitions enabled the therapists to claim monopoly of certain tasks, such as assessments, the development of rehabilitation plans, and the supervision of HTs, which was rationalized based on their formal education and competence. This claim of ownership of tasks was not formally anchored in procedures or professionally justified, which made some of the HTs question the practice:

> *"It was very clear that the PTs should conduct the assessment. But it is not described anywhere that only the therapist should do it. Thus, it is somewhat . . . (long, pensive pause)" (HT).*

The HT found it irrational that HTs could not conduct this particular assessment in which they were trained and had observed the PTs conduct multiple times.

A common perception among the hierarchically organized teams was that the PTs had overarching responsibility. If any adjustments or changes were made, the PTs were always assigned to perform the reasoning and decision making. One PT said that it was irrelevant to discuss HTs' ability to adjust rehabilitation plans because "the engine" holds professional responsibility and, thus, has the authority to evaluate the need for adjustments:

> *"Because the engine is responsible if anything fails [. . .]. We are the professional experts. Thus, in general, it is not okay [for HTs to adjust plans on their own initiative]. In general, they should not make any adjustments on their own. Their responsibility is to give feedback to us" (PT).*

Designating certain tasks to the PTs exclusively contributed to a demarcation between the PTs and the HTs, which we interpret as a boundary making process.

"Reablement physiotherapy" vs. traditional physiotherapy

The PTs' rationale for claiming ownership of the more formalized tasks and positioning themselves in the center of the team as an "engine" was based on their professional training and education. However, some of the PTs expressed ambiguity, as their new role deviated from their perception of what physiotherapy was "*truly about*." These new tasks were perceived as deviating from traditional physiotherapy, being more general, not very specific, and easier to delegate to HTs. Observations of encounters revealed that the PTs mostly engaged in "talking" and conducted a minimum of traditional therapeutic activities, such as training instructions or manual techniques. One PT, who was employed 50% on the reablement team and 50% in traditional PT services, described how she perceived her role as a PT differently in the two contexts:

"It is more specific physiotherapy when I work in the (traditional) physio services, while the work in reablement is more health promotion, sort of. Health promotion or training that is easier to perform and that does not require expert knowledge to perform. Yes, it is more general exercises, not the specific focus of a hip or an ankle or anything (. . .)" (PT).

The perception of "reablement physiotherapy" as something different from traditional physiotherapy limited the PTs' practices and prevented them from executing certain measures:

"As a PT, I sometimes feel that I want to do it [the training] myself. It is tingling in my physiotherapy fingers. But it is about assigning the responsibility to her [the HT] and trusting that she has the required competence. And I told the care recipient that it is not specific physiotherapy that she receives" (PT).

Another PT described how she perceived that the occupational tasks of "reablement-physiotherapy" was limited compared to tasks of traditional physiotherapy, restricting her from executing certain techniques:

"(. . .) Particularly related to manual techniques and so on . . . . Sometimes, I feel that I should have touched and mobilized a little. I have worked a lot with neurological patients, so I often reflect about that" (PT).

Task shifting as a potential conflict

This shift in roles not only involved new tasks for the PTs but was also perceived as a potential threat to the profession:

"They [the HTs] take over our work . . . at least the training. And that is what really defines physiotherapy. Even if we are supervising them, they take over a critical part of our work. That is a drawback for us PTs because our work is being taken over by unskilled workers" (PT).

The HTs' perception of their exclusion from certain tasks and decision processes also resulted in potential tensions in the team:

"We [HTs] particularly react to . . . Why should we not perform that [the assessment]? We would learn a lot, and the team would be strengthened (. . .). We have had some disagreements in the team, of course. (. . .) There were various views regarding the roles and things like that" (HT).

One PT described how HTs had fewer opportunities to participate in certain activities, such as seminars and courses, which were reserved for PTs:

"[The PTs] engage in activities that the HTs cannot participate in. I would say so. Well, we would like them to join, but they are the ones who are responsible for the daily practices; they are the ones who conduct the training. If they were to be gone for one day, it would be a disaster. Therefore, it is easier for us [the PTs], who are responsible for the administrative work, to take on more sporadic tasks" (PT).

The clear division between the PTs and the HTs was not solely limited to tasks; the participants also recognized this division in the interpersonal relationships on the teams. One PT expressed how this division could be perceived as problematic:

"Related to the lunch break, right? The HTs were seated on one side of the table, and the therapists were on the other side. (. . .) It is about whom we are connecting to, whom we can speak to, have most things in common with. We experienced a kind of division, and I guess the HTs in particular experienced that. They expressed it to our manager. That the therapists were mostly in their office and performed pleasurable tasks, for example, making plans, while the HTs were supposed to do 'the hard work'" (PT).

This socialization process can be interpreted as a process of demarcation, and boundary making, which contribute to distinguish one occupational group from the other.

"The symbiotic team" – boundary blurring

On three of the studied reablement teams, the division of labor was less hierarchical. All the team members were assigned responsibility for assessments and the planning of reablement initiatives, and the PTs were also involved

in the daily training measures. The rationale for such a flat team structure was to prevent unequal power relations on the team:

"We are all trainers, but we should also represent our professions (...). Teambuilding is very important. Nobody should think they are better than others, and everyone contributes equally. Thus, everyone is equally important on this team" (PT).

An excerpt from an observation of a user encounter where both a PT and an HT were present describes an episode where an HT takes responsibility for engaging in clinical reasoning and decision making and the PT steps back. This situation allows the HT to take the lead:

> A PT and an HT visit an older woman who is struggling with dizziness and impaired balance. The PT initiates some exercises that she instructs the care recipient to carry out. The recipient seems insecure and anxious about the activities, whereas the HT steps forward and says, "*Let's try to do the exercises beside the kitchen table and place a chair behind you so you don't fall over.*" She starts arranging the room to accommodate the needs for a secure environment. As she takes the lead in this process, she gradually becomes involved in instructing the training activities in collaboration with the PT.

Unlike the hierarchical arranged teams, where the HTs primarily executed instructed tasks, practices in the symbiotic teams were characterized by collaboration and equal involvement by the team members, and the HTs had autonomy to make their own assessments. This mutual responsibility blurred the distinct demarcation between the two occupations.

Working together for a holistic approach

Both the PTs and the HTs preferred working in pairs and argued that this way of working enabled continuous learning processes, which again resulted in competence that enabled all team members to participate in assessments, planning, and training interventions. One PT described how mutual learning was perceived as a benefit of working in pairs:

"Generally, two of us attend the first visit. We do it like that because it is important to obtain a wide overview. My favorite way of doing it is to visit the care recipient together with an HT. The first encounter with the recipient is important for the HT; the things that I am saying, what I am emphasizing. In addition, I see how the HT relates to the recipient. Thus, in the first visit, I get quite a holistic view. So, working together is the ideal situation" (PT).

The citation above indicates that close collaboration was emphasized as beneficial as it provided a wider perspective of the patient's situation, perceived as a holistic view. With these teams, we observed that both the PTs and the HTs conducted parts of the assessments. The HTs had received either formal or internal training that enabled them to handle the assessment tools. This shared responsibility of tasks limited the hierarchical division among the team members, and a natural part of the practice was to conduct tasks that traditionally have been reserved for other groups, blurring the demarcating boundaries between the two occupations. One of the PTs described how this practice was perceived to enhance the possibility of a holistic approach:

"It is not like that anymore, that we put on blinders and think, 'This is my profession' (...). Thus, I experience that we have a holistic approach. And I experience that everyone thinks this is very exciting and very relevant for our profession" (PT).

This statement indicates that the PT perceived the inter-occupational collaboration as an essential element in order to provide a holistic approach.

Continuous and mutual learning

Learning from each other was one of the main rationales for the flat structure. One of the PTs argued that equal responsibilities and close collaboration were crucial for competence enhancement in the team:

"Yes, you should have an open mind, and you should acknowledge that you are learning ... don't ever think that you have nothing more to learn. You should think that you are learning every day. It is kind of a 'give and take.' In teams and teamwork, you should be inclusive and be able to see everyone, that everyone is important and can be an important contribution" (PT).

This quest to constantly learn something new contributed to obscuring occupational boundaries. The staff participated in tasks traditionally performed by the other occupational group and allowed "the other" to take part in roles and tasks traditionally held by one's own occupation. Quotes from both the HTs and the PTs show how the learning process was mutual, where the HTs learned from the PTs and the PTs learned from the HTs:

"Those [The PTs] are the ones from whom I have learned the most these years. So, it is extremely important that the PTs are included on the team. [...] When we work together with the PTs, we become aware of different things, such as how the user recipient's body posture is. Do they put equal weight on both legs? How do they use their arms? I would say you achieve a whole new perspective on these things, you know?" (HT).

"I have learned a lot from them [the HTs]. A lot of things I hadn't thought about. Believe me, concerning relational and communicative aspects, they quickly take it in. They have worked at nursing homes, at the hospital, and with very ill patients. They have learned interhuman relationships. In addition, they contribute substantially through their health care competence. The learning goes both ways" (PT).

The work environment observations on these themes revealed that both the PTs and the HTs engaged in thorough discussions and reflections concerning the rehabilitation process, creating a joint knowledge foundation.

"After all, we [the PTs] have learned something very specific. They [the HTs] have learned other things. I benefit from their knowledge. They have high competence . . . for example, if a patient has a stoma, they can guide me." (PT).

Members on the symbiotic teams perceived collaboration as mutually beneficial. The teams' construction of common language, joint understanding, and unambiguous goals, can be interpreted as boundary blurring processes.

Autonomous and empowered team members

On the symbiotic teams, the HTs participated in assessments and professional discussions and contributed to the development of the rehabilitation plans. This approach resulted in HTs having increased competence and empowerment to make their own decisions regarding adjustments and modifications in different situations. After observing an HT who made adjustments to a rehabilitation plan, we questioned her about her opportunities to make individual decisions:

"Yes, sometimes I do that [adjust plans], if the care recipient wants it, or if I evaluate that it is time to advance. Perhaps reduce the hands-on support or to try out other things . . . " (HT).

This finding illustrates that the HTs in these teams had autonomy, competence, and, thus, the authority to make their own decisions based on their own reasoning.

Discussion

In this study, we explored how the division of tasks, responsibilities and roles in reablement practices can appear as boundary work between PTs and HTs. We identified two different practices of boundary work. The first practice that we have described, "the engine and the assistant," was characterized by a hierarchical structure with a clear demarcation between the PTs and HTs. This approach was shown to limit occupational expression and create tension and sometimes conflicts on the team. This is in line with the traditional theories of boundary work, as a social strategy of claiming jurisdictional ownership of certain tasks, and what Liu (2018) refers to as "boundary making." The other practice, "the symbiotic team," was characterized close collaboration, mutual learning, and autonomous practices, in line with Liu's (2018) concept of "boundary blurring." In the following, we will draw on these different practices to discuss boundary work in regard to task shifting in reablement teams.

Jurisdiction of tasks and boundary making

In hierarchically structured teams with a clear division of tasks, the PTs argued that they had a superior responsibility for tasks, such as assessments and planning. This finding corresponds with other studies in the field of reablement that described professionals as consultants and HTs as trainers (Hjelle, Skutle, Alvsvåg, and Førland, 2018). Scholars have argued that reablement practices may contribute to reducing the stigma of "dirty work staff" at the bottom of the health care hierarchy, such as care aids and auxiliary nurses. In Western societies, emotional work and "soft skills" are rendered secondary to technical skills, which are considered central to interventions based on a hegemonic discourse of attaining esoteric knowledge (Apesoa-Varano, 2013; Meldgaard Hansen and Kamp, 2018). It has been argued that moving away from traditional care tasks toward rehabilitation reduces stigma, hence increases occupational status among care personnel (Flensborg Jensen, 2017; Meldgaard Hansen and Kamp, 2018). Paradoxically, in this study, the HTs remained at the bottom of the internal team hierarchy, as they followed orders and performed "body work" (Flensborg Jensen, 2017). A systematic review of allied health assistant roles and tasks found that efforts to protect allied health professionals' roles constituted a barrier to utilizing task delegation (Lizarondo, Kumar, Hyde, and Skidmore, 2010).

The professionally educated therapists identified themselves as "the engines" responsible for assessments, planning, and supervision of the "assistants," thus moving away from traditional therapeutic practices, which was described by one of the PTs as "*what physiotherapy truly is about.*" The task shifting involved in reablement moved the HTs toward rehabilitative tasks, the "domain" traditionally held by PTs. This interdisciplinary change across different levels of status is what Nancarrow and Borthwick (2005) defined as "*vertical substitution*." One of the PTs in this study expressed this concept by stating that "*they [HTs] take over our work*," claiming that the training part of labor initially was what defined physiotherapy. The PTs' response to this was to get hold of superior roles in the hierarchies and claim monopoly of certain tasks, such as assessments and

planning, which they argued demanded specialist competence. This finding corresponds with Abbott's (2014) description of professions as constantly striving for jurisdiction and a monopoly of tasks to maintain professional power.

However, the PTs in the studied reablement teams were moving away from traditional interactional and bodily labor toward a consulting role, in line with Rabiee and Glendinning (2011), who reported that professionals on reablement teams perceived their new role as "standing and watching." On the one hand, PTs were designated as the engines, which also is recognizable from Scandinavian literature of reablement (Hartviksen and Sjølie, 2017; Kiellberg, Kjellberg, Navne, and Ibsen, 2013). On the other hand, HTs were the ones who carried out what was referred to as the "real work." One PT even claimed that "if they [the HTs] were to be gone for one day, it would be a disaster," which conflict with the idea of the therapist as the engine. One could therefore question who the team's engine really was. It seems like both occupational groups tried to make themselves out as those who do "the important work" in comparison to the other occupation. This is an example of how the two groups continuously construct demarcations between the occupations, which can be interpreted as boundary making.

Freidson (1983) expressed concern about professional movement away from daily work, which he argued would create a discrepancy from the "real" work, thus limiting the understanding of and moral connection to the labor. The PTs expressed a distinction between what they perceived as "real physiotherapy" and what they called "reablement physiotherapy." They described that this new demarcation limited them from conducting specialized approaches, such as mobilization and facilitation techniques. This finding illustrates how reablement practices may be re-constructing the occupational boundaries of physiotherapy toward a more general consultant approach, omitting specialized professional skills and limiting occupational exercise.

The empirical findings in this study indicate that PTs in hierarchical structured teams withdrew toward a narrower occupational area, as they "gave away" some tasks and responsibility to the new occupational group of HTs. At the same time, they were clearly protecting their superior status on the team by retaining certain tasks (i.e., assessments and planning) and serving in certain roles (as team leader and supervisor). Despite (or because of?) a narrowing professional boundary, the PTs clearly emphasized self-distinction from the other occupational group, which is in line with what Liu (2015) referred to as boundary making.

It may seem like a paradox that the PTs "easily gave up" some of their traditional tasks while claiming monopoly of the more consultant tasks. This may be a consequence of a weak jurisdictional status of some physiotherapy tasks, which in turn weaken their monopoly of tasks. Jurisdiction and monopoly of tasks have been key characteristics of a profession (Abbott, 2014; Freidson, 1983), but do not apply well to the "new subprofessions," such as physiotherapy, regarding the more general tasks that do not require esoteric competence and specific training. As one PT said, *"[. . .] reablement is more health promotion, sort of. Health promotion or training that is easier to perform and that does not require expert knowledge to perform."* It is difficult to justify a single occupational monopoly over such tasks. The PTs argued that certain tasks, e.g., assessments and planning, required a competence held exclusively by PTs. This illustrates what Abbott (2014) referred to as "intellectual jurisdiction," which is when a profession retains control of the cognitive knowledge of an area of work but delegates practical work to others. By maintaining intellectual jurisdiction over these tasks, PTs managed to retain their hierarchical status on the team.

As Moe, Gårseth-Nesbakk, and Brinchmann (2019) found, asymmetrical power relations among team members in reablement do occur, and the maintenance and reinforcement of unequal power relations cause tension and conflicts on teams. Liberati, Gorli, and Scaratti (2016) showed that rigidly constructed occupational boundaries hinder both intraprofessional and interprofessional collaboration.

Collaboration, mutual learning, and boundary blurring

Liu (2015) criticized Abbott's ecological theory of professional boundaries as merely a conflict of jurisdiction by arguing that boundaries also can become rather blurred. The "symbiotic teams" were characterized by close collaboration between the PTs and HTs. The participants in this study described that collaboration and working in pairs provided a broad view of the patient's situation and various needs, which was emphasized to enhance a holistic approach, which is in line with the ideals of reablement services (Aspinal et al., 2016; Metzelthin, Rostgaard, Parsons, and Burton, 2020). The term *holistic* is debated, and not clearly defined in the literature. However, a literature review summarized definitions of the term to include "whole person care" often acknowledging a body–mind–spirit perspective (Frisch and Rabinowitsch, 2019). In reablement literature, the term holistic mostly refer to person-centered approaches targeting the 'various needs of the client'

(Metzelthin, Rostgaard, Parsons, and Burton, 2020). However, descriptions of initiatives in reablement services are often limited to include physical function (Eliassen and Lahelle,2019), and some have criticized the service for the strong focus on the physical aspect, omitting cognitive and social aspects (Metzelthin, Rostgaard, Parsons, and Burton, 2020). One should therefore bear in mind that the term holistic may be used in a limited way in this study, and in reablement theory and practice in general.

The symbiotic approach aligned with positive outcomes of interprofessional teamwork, such as problem solving, improving planning, and avoiding job duplication and fragmentation (Atwal and Caldwell, 2005; Mitchell, Parker, Giles, and White, 2010; Reeves, Lewin, Espin, and Zwarenstein, 2010). Both the PTs and the HTs engaged in tasks traditionally performed by the other occupational groups and incorporated their extended knowledge into their initial competence. This approach allowed both PTs and HTs to integrate the new field of labor and provide a broad perspective on the user's functional ability.

The social processes on these teams, where PTs and HTs engaged in each other's traditional tasks and clinical reasoning, can be understood through the concept of boundary blurring (cf. Liu, 2018). This concept refers to resembling occupational groups whose interactions generate ambiguous and blurred boundaries. According to Pedersen (2020), such blurred boundaries between occupational groups can contribute to link social worlds and open opportunities for collaboration, learning, and development. Liu (2015) has even argued that blurred boundaries may evolve as a symbiotic relationship among occupational groups.

The discussion of "deprofessionalization" and "generalization" due to interprofessional work has evolved around a concern that tasks could become simplified and routinized (Freidson, 1983). In addition, Hjelle, Skutle, Alvsvåg, and Førland (2018:313) emphasized the importance of preserving the particular expertise and knowledge of the profession in intersectional work to prevent a "woolly group of people who only have little knowledge about everything." However, the results from the symbiotic teams indicate that although the participants highlighted their specialist competence, they were not prevented from sharing their knowledge and tasks with others.

Akkerman and Bakker (2011) stated that combining knowledge from different contexts and fields may contribute to achieving professional learning. Instead of simplifying tasks, the PTs and HTs combined their core competences with new knowledge provided through interaction and collaboration in the teams, thus expanding the boundaries of professionalism and providing a person-centered approach, which is in line with the ideology of reablement services (Aspinal et al., 2016; Cochrane et al., 2016; Metzelthin, Rostgaard, Parsons, and Burton, 2020).

In addition to increased collaboration and learning in these teams, both the PTs and HTs described significant autonomous practice. Nugus et al. (2010) argued that the perception of substantial autonomy is essential to the achievement of work satisfaction, motivation, and ongoing learning.

Overall, our analyzes bring some patterns into light, illustration how boundary work is played out in reablement services. In the hierarchical teams, we saw some patterns of exclusion, where both occupational groups tried to highlight themselves as the ones who did the important work, drawing demarcations toward the other occupation. The symbiotic teams, however, were characterized by inclusion of the other occupational group, leading to close collaboration. This study provided an analytical, rather than a normative account to describe the boundary work that occurs in reablement practices, and other studies are needed to conclude about the efficiency of the different ways of organizing reablement. However, the study did yield some findings that indicate that boundary making may generate hierarchical structured teams, asymmetric power relations, and limit autonomous work and job satisfaction in teams. Boundary blurring, on the other hand, seems to support collaborative practices that enhance person-centered approaches and mutual learning on reablement teams.

Strengths and limitations

To our knowledge, the topic of boundary work between PTs and HTs on reablement teams has not been studied before, and this research, therefore, provides a significant contribution to both the reablement literature and the theoretical field of occupational boundaries in general, most specifically, discussions of the boundaries of physiotherapy. However, the empirical and conceptual contribution of this paper extends beyond the field of physiotherapy and may serve as an example for analytical work in the study of occupational boundaries in other fields. The current study design, which allowed the triangulation of different methods, including observations and interviews of both PTs and HTs, provided thorough insights into real-life practices as well as first-hand experiences and reflections of both PTs and HTs, which we consider a strength of the study. The strategic selection of seven different reablement teams from various municipalities generated data from various contexts. A limitation is

that our results stem from a limited number of teams, and other ways of structuring task shifting in reablement teams may exist. However, the two types of boundary work illustrated in this study are relevant to similar reablement teams with regard to analytic generalizations, which is in accordance with Malterud (2001). Although our results indicate some benefits in the symbiotic teams compared with the hierarchical teams, we cannot draw any conclusions about efficiency of the two team structures. Such a clarification would require a different study design and further research is needed.

The data provided from the interviews in this study stems from individual interviews. Group interviews could provide interesting interactional views of boundary work in teams. However, due to a potential power imbalance between professionally educated staff and assistants, we found it reasonable to conduct individual interviews. Interactions between the team members were, however, documented through our observations in the work environment.

Presenting our results through the two identified practices provides a unique understanding of the varied forms of boundary work. However, using a typology to describe variety is never unproblematic, as the nuances between the extremes are not clearly presented. Service recipients were not interviewed in this study, and their perspectives on the roles of team members were not taken into account. The analysis in this study involves boundary work between PTs and HTs. However, other occupational groups are often involved in reablement teams. Including other team members could provide a broader perspective of occupational identities and boundary work on reablement teams. Hence, we recommend further investigation including other health care occupations. The study data were generated in 2016 and, thus, may not be fully generalizable to current reablement practices, as professional boundaries are constantly changing through continuous negotiations.

Concluding remarks and implications

In this study, we identified two different practices, which we have interpreted as two types of boundary work. In the first type, the professionally educated PTs delegated some tasks to the lower-educated HTs, although they clearly guarded some of the formal tasks and took a team leader role to maintain a superior status. Despite ambivalence, HTs more or less accepted a role as an assistant. We have used Liu's (2018) concept of boundary making to highlight how social processes of exclusion and inclusion on the teams contributed to a demarcation between the two occupational groups while maintaining a traditional hierarchical distinction among team members. In the other type, the professional boundaries were more fluid and blurred, and practices were characterized by collaboration and mutual learning.

Unlike the earlier structuralism paradigm of professionalization, Liu's theory of boundary making and boundary blurring conceptualizes occupational development as social processes that continuously re-construct occupational boundaries. According to this perspective, professional associations are results of social processes and are at the same time negotiating their position in the social world, rather than being fixed organizational entities (Liu, 2018). There is no consensus on whether professions should emphasize the maintenance of rigid professional boundaries. Illich (1970) criticized professional boundaries and claimed that the monopolization and "mystification" of knowledge and expertise were merely a way to achieve power and status and, hence, control the market. On the other hand, Freidson (1983) argued that it is essential to maintain certain professional boundaries to avoid deprofessionalization in terms of the "generalization" and "simplification" of professional work.

HTs' and PTs' occupational identities and collaborative relationships are socially interesting regarding the implications for their job satisfaction, not simply because these identities and relationships may influence the quality of services provided to the end recipient of reablement. Future studies on power relations in task-delegating practices as well as job satisfaction within the varied types of boundary work practices are needed.

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