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The Complexities of Boundaries, Task Claims, and Professional Identity in Teamwork—from Dentists' Perspective

Abstract: This article concerns how dentists in a Swedish dental care organisation conceptualized work division when teamwork was requested by the senior manager and their boundary work in relation to dental auxiliaries. Data were drawn from semi-structured interviews with the dentists. The dentists' made claims to tasks based on legislation and their wanting to focus on tasks that required their expertise. Dental auxiliaries may be reluctant to take on new tasks and become more involved in patient care, which indicates that they have some influence in the work division. Nevertheless, the dentists retained control as their invitation for dental auxiliaries in patient care was based on certain conditions. The dentists' claim to certain tasks may have strengthened their identity as experts and reinforced boundaries between themselves and dental auxiliaries.

Keywords: Boundary work, dental care, identity work, interprofessional teamwork, resistance, power

WHO emphasizes that interprofessional teams are an effective use of health workers because teamwork requires them to operate within the full scope of their profession. This way of working is recommended to meet population needs and to improve cost-effectiveness, quality and access to health services (WHO, 2016). In Sweden and in other countries, government and organisational policies identify teamwork as an effective use of healthcare resources.

Previous studies have shown various professional reactions to the campaign for teamwork. On the one hand, it cannot be taken for granted that professionals will work together without disagreement. The request for teamwork may entail that professionals perceive that certain professional boundaries are under threat, which will lead to boundary work (Fournier, 2000; Liberati, Gorli & Scaratti, 2016; Powell & Davies, 2012; Sanders & Harrison, 2008) that aims to protect and maintain boundaries around tasks (Fournier, 2000). On the other hand, professionals can promote teamwork and cross boundaries. Consequently, individuals from various professions can work closely together in a relationship that is characterized by the intention to do good work rather than by competition (Allen, 1997; Apesoa-Varano, 2013; Carmel, 2006).

In this paper, I focus on how dentists conceptualized work division in a Swedish public dental service (PDS) where teamwork was requested by the senior manager to increase the efficiency of the service. This required dental hygienists and dental

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nurses to be more involved in patient care and to perform tasks that are usually performed by dentists. The focus is on how the dentists' idea of work division had an influence on the boundaries between them and dental auxiliaries and on their professional identity.

Struggle over tasks and the construction of professional boundaries are considered significant in the understanding of the work division in workplaces (Salhani & Coulter, 2009). Classic professionals, such as physicians and dentists, are generally assumed to have more influence on the work division due to their autonomy in patient care and a stronger scientific position than other, more subordinate professions (Brante, 2013; Freidson, 1994). However, subordinates may have some control over work division as they can resist undertaking tasks that are otherwise performed by those in a higher hierarchical position (Apesoa-Varano, 2013; Nancarrow & Bortwick, 2005).

The construction of boundaries is also related to professionals' identity as the construction of identities concerns the differentiation between oneself and others. Identities are significant in what happens at workplaces as they have implications for individuals' behaviour. In organisations, individuals do identity work to create and to maintain a sense of distinctness and a positively valued view of themselves (Alvesson & Willmott, 2002; Alvesson & Sveningsson, 2010). Professionals' ambition to focus on certain tasks and remove less prestigious tasks is one way to maintain or reinforce a positive professional identity. However, individuals who adopt a specific identity may find it difficult to be flexible, which can hinder work being performed in the best ways (Alvesson, 2013).

Boundary work regarding tasks and identities are thus intertwined and have implications for the work division at workplaces. The aim of this paper is to examine the complexities of dentists' boundaries between themselves and dental auxiliaries. In the following sections, I describe the paper's approach as applied to professions and boundary work and to the dental context. Thereafter, I present how the data was collected and analyzed. In the empirical section, I will show dentists' boundary work concerning tasks and identities. To conclude, these kinds of boundary work and implications of these on the work division and the care of patients in dental care will be discussed.

Professions and semi-professions

What constitutes a profession is a debated matter (Brante, 2011). For the purpose of this article, I use the definition of professions as science-based occupations, which implies that professionals integrate scientific principles and findings into a practice, and apply the formally organized theoretical knowledge of a field. Further, lengthy, specialized academic education is necessary to practise, and professionals are required to apply for a licence from the state upon graduation. Professions are characterized as occupations that allow a high degree of autonomy in the daily work. This implies that professionals have a mandate to make choices and decisions about what work they will do as well as how it should be performed and evaluated (Brante, 2013; Freidson, 1994). This general description of a profession is comparable with that of the classic professions (Brante, 2013), such as medicine and dentistry (Adams, 2003; Freidson, 1994; Trathen & Gallagher, 2009). Professionals' work is believed to be of significance for the well-being of individuals and of society. Professionals are supposed to be committed to doing good for others and to be ethical, but they can also strive to achieve their own interests, such as having control over certain tasks (Freidson, 1994).

Classic professions originated in the nineteenth century. The development of the welfare state and higher education in the twentieth century led to an expansion of semi-professions, which include for example nurses, dental hygienists, and social workers. When higher education programmes for these occupations were integrated

into universities, their practices became more science-based (Brante, 2013). The prefix *semi* implies that these occupations do not fully encompass the same characteristics of the classic professions. Important differences for this paper are that (1) a semi-profession's knowledge and authority are subordinate to another profession, which means that the profession is not the primary asset point for the highest knowledge in a field; (2) semi-professions have less autonomy in relation to other professions; and (3) they have been less successful in "closing" their field of work (Brante, 2013). In dental care, dental hygienists were established in subordinate roles in relationship to dentists, which involves a narrower range of tasks that they are permitted to perform when caring for patients (Adams, 2003). Dental nurses were established as assistants to dentists and have less formal education than dental hygienists.

Professional boundary work

Boundary work concerns professions' claim of jurisdiction, that is, the right to perform certain tasks and have control over an area of work (Abbott, 1988). Another term is a professions' scope of practice (Macdonald, 1995). Professions' boundary work is described as the construction of demarcations that establish a professions' control over the scope of practice as a basis for authority and exclusivity (Fournier, 2000). It concerns constructions of differentiation between a group and others with the goals of the expansion or monopolization of authority or expertise as well as autonomy over professional work (Gieryn, 1983).

A professions' jurisdictional claims involve three parts: "claims to classify a problem, to reason about it, and to take action to it: in more formal terms, to diagnose, to infer, and to treat" (Abbott, 1988, p. 40). In healthcare this means that practitioners use their knowledge to evaluate a patient's problem, make a diagnosis and perform treatment. The individuals who make the diagnosis are not necessarily those who perform the treatment; physicians can delegate parts of treatment to subordinates. Professions can make claims on who should see patients first, evaluate their problems, make the diagnosis and determine treatment, and perform treatments. Subordinated professions may want to expand their scope of practice with the aim of greater autonomy, independence and social status (Adams, 2004). In interprofessional competition, the degree of abstraction of a profession's knowledge will have an effect on its possibility to sustain its jurisdiction: "abstraction enables survival" (Abbott, 1988, p. 30).

Boundary work can take place at three types of arenas: the legal system, which can grant formal professional control over tasks; the public media, where professions can build images with the aim to put pressure on the legal system; and the workplace, where boundaries can be blurred and distorted (Abbott, 1988). The focus of this paper is on boundary work at workplaces. At this level, formalized work descriptions do not always matter, and consequently, boundaries between professional jurisdictions can be eroded (Abbott, 1988). Instead, work division in workplaces is established through negotiations of who should do what, when, how and why (Abbott, 1988; Allen, 1997; Powell & Davies, 2012; Svensson, 1996). Work division should be seen as a process of social interaction in which individuals are "engaged in attempting to define, establish, maintain, and renew the tasks they perform" (Freidson, 1994, p. 58).

The room for negotiation in healthcare is limited because the work division is regulated by laws and prescripts that establish the kinds of tasks that professions are permitted to undertake. The state can confer on a profession legal control over a work field through a license to practice (Freidson, 1994; Macdonald, 1995), as is the case with physicians and dentists. However, despite the strength of legal regulations, laws or a licence to practice, a profession may not have total control over certain tasks. Some tasks can be performed by more than one occupation, which opens up

for negotiations in healthcare organisations (Allen, 1997; Svensson, 1996). Professionals can try to expand their scope of practice by taking on more specialized and prestigious tasks, but they can also defend the status quo and resist undertaking new tasks (Nancarrow & Borthwick, 2005; Powell & Davies, 2012). Boundary work can also concern the blurring and crossing of professional boundaries, which in healthcare could result in nurses taking on tasks that fall outside their jurisdiction (Allen, 1997).

In negotiations, professionals can use laws and regulations, which are formal and strong power resources, in order to control the work division (Freidson, 1994). They can also use educational resources, such as degrees, authorization and specialist skills that are needed to perform tasks properly, and treatment responsibility (Freidson, 1986). Professionals can further legitimize their work by emphasizing how it contributes to organisational efficiency and the patient-centred nature of their practices (Sanders & Harrison, 2008).

Professionals' influence on work division

Professions have different possibilities to maintain or to expand their boundaries (Fournier, 2000). Traditionally, male-dominated classic professions, such as dentistry, have had more influence on the work division than female-dominated subordinated professions, such as dental hygienists (Adams, 2003). In workplaces, dominant professionals such as physicians and dentists have influence on work division due to their autonomy in patient care and stronger scientific position (Freidson, 1994; Lipsky, 1980; Hunter & Segrott, 2014; Powell & Davies, 2012), and they are said to control the division of labour (Freidson, 1994; Brante, 2013). Healthcare professionals have the autonomy to decide the content of their work and how it should be performed, as each patient should be treated on individual terms and a special kind of expertise is required to do the work adequately (Freidson, 1994).

Professionals in a dominant position depend on subordinates to conduct daily tasks (Abbott, 1988; Lipsky, 1980). However, they may not want to assign every task to subordinates, but only those that they do not want to perform themselves, such as routine work (Abbott, 1988). These kinds of tasks have been labeled “dirty work” (Hughes & Coser, 1994). As a consequence, professionals in a dominant position will retain tasks they find desirable to perform. Furthermore, when tasks are assigned to subordinates, professionals in a more powerful position tend to control their work (Nancarrow & Borthwick, 2005). No evidence supports the notion that physicians have lost important parts of their monopoly on giving orders to others and supervising others' work. Thus, they continue to be in a dominant position (Freidson, 1994).

Nevertheless, physicians and dentists cannot take for granted that subordinates will take on the tasks assigned to them. Subordinates can refuse to do the tasks they are offered (Lipsky, 1980; Nancarrow & Borthwick, 2005). In other words, professionals, like physicians, can exercise degrees of control over patient care. However, nurses and other subordinate groups have some control as well, as they can thwart orders from physicians (Apesoa-Varano, 2013). Nevertheless, the resistance of subordinates has been interpreted as not based on power. A study concerning the request for interprofessional teams in a healthcare setting showed that nurses' resistance to expand their professional boundaries stemmed from professional and individual weakness and fear, as well as a perceived lack of competence to undertake tasks not usually performed by them on patients (Powell & Davies, 2012).

Identity work

Individuals' claim to tasks can also be explained from an identity perspective. The concept of identity concerns the questions “who am I?” and “what do I stand for?”

(Sveningsson & Alvesson, 2003), which involves what is appropriate, desirable and valued at work for an individual (Alvesson & Willmott, 2002). Identities are not fixed and stable, but rather something that must be worked on. Boundary work is a central part of the construction of identities as identity work involves the creation of a sense of a distinct identity by defining oneself as different to someone else (Alvesson & Willmott, 2002). Identity work may be triggered by everyday forms of stress and strain, for example, complex or problematic social situations (Alvesson, Ashcraft & Thomas, 2008). Requests for teamwork that lead to conflicts about tasks and individuals questioning their roles can lead to situations where individuals' professional identity has to be worked on (Hunter & Segrott, 2014). Undergraduate education plays a role in the development of healthcare professionals' identities by the process of socialization into professional values and norms. This implies that they enter a workplace with ideas of how to perform their work (Freidson, 1994). Individuals from different occupations develop different values about their work that will form competitions for tasks. For health professionals, this can concern what constitutes evidence, safe practice, high-quality patient care, correct patient treatment, and who should carry these out (Powell & Davies, 2012).

To achieve a positively valued view of themselves, individuals tend to describe themselves in more positive terms in comparison with others (Alvesson & Willmott, 2002). In an organisational context, this can mean that individuals attribute themselves positive qualities and credit themselves with contributing to positive outcomes and efforts at work but blame others for shortcomings (Alvesson & Sveningsson, 2010). Professionals can also blame those who they perceive as not doing work in accordance with appropriate norms and values (Frank, 2003). Further, professionals may strive to focus on identity-confirming tasks to maintain or reinforce a positive identity. However, the adoption of a specific identity may lead to inhibition regarding the tasks that must be done if they not fall in line with the identity. As a consequence, patient care can be affected in healthcare organisations (Alvesson, 2013).

The dental context

In Swedish dental care, dentists work with dental hygienists and dental nurses. Dentists complete a longer higher education and possess the widest range of qualifications among dental professionals. They are educated to examine, diagnose, prevent, and treat dental and oral diseases in all dental areas. Some tasks in regard to patients are legally restricted to dentists, who have high degree of autonomy with deciding how to treat a patient. Dentists have to complete a 5-year higher education programme to acquire the necessary theoretical knowledge and practical skills. After graduation, they must apply for a licence awarded by the Swedish National Board of Health and Welfare in order to practise. Due to these characteristics of dentistry, it is classified as a classic profession (Adams, 2003; Freidson, 1994; Trathen & Gallagher, 2009). Dental hygienist training involves a 2- or 3-year higher education programme, while dental nurse training is 1.5 to 2 years long and part of the vocational higher education system. After graduation, dental hygienists are also required to apply for a licence.

Dental teamwork implies that dentists work with “other people with lesser training who are able to carry out delegated tasks not requiring the full range of the dentists' skill and experience” (Harris & Haycox, 2001, p. 354). Teamwork is recommended in a Swedish government report to maximize efficiency in dental care and to increase the availability of dental care for patients. It is recommended that dental hygienists promote oral health, perform preventive procedures and examine patients to a higher degree to relieve the pressure on dentists. Although dental nurses usually assist dentists, they should also perform some work on patients, such as certain preventive procedures (National Board of Health and Welfare, 2011).

Previous studies have shown that dentists agree that dental hygienists can do more examinations and treatments on patients which are usually performed by dentists (Abelsen & Olsen, 2008; Kravitz & Treasure, 2007). Dentists see the benefits of letting dental hygienists carry out preventative treatments, as this allows them to focus on more complex treatments (Nilchian, Rodd & Robinson, 2009). However, dentists can also be unwilling to assign tasks to dental hygienists (Abelsen & Olsen, 2008). In a Swedish study, it was shown that dentists demarcated boundaries in relation to dental auxiliaries by emphasizing their treatment responsibility, specialist knowledge, and autonomy in determining what tasks to perform and how to perform them. However, it was also shown that dentists blurred the boundaries by discussing patient treatments with dental auxiliaries (Franzén, 2012). Studies on dental hygienists have shown that, despite expressing a positive attitude towards an extended scope of practice (Abelsen & Olsen, 2008; Reinders, Krijnen, Onclin, van der Schans & Stegenga, 2017), not all of them want to work in a team with a dentist if it is the dentist who solely decides how the work should be carried out (Candell & Engström, 2009). For dental nurses, encouragement from dentists to take an active and shared role in patient care can be seen as rewarding (Gibson, Freeman & Ekins, 1999). Moreover, dental nurses may want more “hands-on” involvement with patients (Macleavy, 2013).

Thus it is not self-evident how tasks can be divided between dentists and dental auxiliaries. This study is a further investigation of the boundaries between dentists and dental auxiliaries in regard to how dentists in a Swedish dental care organisation conceptualized work division and how their ideas were met by dental auxiliaries. Moreover, it also concerns dentists' identity in relation to their claims to tasks.

Methods

The empirical material of this article is based on a study on the development of teamwork in a Swedish public dental service organisation, which I carried out in 2016. In this organisation, the senior manager initiated a course for dentists to develop teamwork and become team leaders. The course started in 2009 and thereafter was held annually until 2016. It lasted for three days: two days initially and one day six months later. At the second meeting, the dentists' experiences of developing teamwork at their workplaces were discussed. As part of the study, dentists who attended the course were interviewed. The issue of professional boundary work in local workplaces emerged as important during the data analysis; therefore, it became the focus of this article.

Six dentists were interviewed; four women and two men. These dentists were self-selecting, as they had previously answered a web questionnaire that was sent from the organisational strategist in spring 2016 as part of an evaluation of the course. The questionnaire was sent to 26 of the approximately 100 dentists who attended the course and still worked in the organisation. A total of 19 dentists answered the questionnaire, of whom eight were willing to be interviewed. They were contacted by email in September 2016. One of the dentists did not respond, while another one no longer worked in the organisation.

The interviews were carried out by me in October 2016 by telephone. Each lasted for approximately 30 minutes and was recorded digitally and transcribed verbatim. The interviews were semi-structured with open-ended questions concerning the dentists' perception of the course, ideas about work division, and possibilities to realize their ideas at their workplaces. Although the interviews lasted only about 30 minutes, the dentists were able to give much information as the questions concerned well-defined themes. Additionally, telephone interviews tend to be shorter than those conducted face-to-face, but less quantity of data may not imply less quality of data (Irvine, 2011).

For the analysis, I read the transcripts several times. In the reading, it became

clear that some of the dentists' statements about the work division between themselves and the dental auxiliaries were relevant for the issue of boundary work and categories around this issue emerged. In addition, statements that belonged in the categories were identified. The identification of the categories was based on both the empirical data and my knowledge of boundary work. As the issue of boundary work became the focus of the analysis, I returned to the literature on boundary work for inspiration in the subsequent analysis. The result of this reading was that I came across boundary work as a part of identity work, which resulted in the modification of the first framework of categories. This process means that I used an abductive approach, which involves movement back and forth between the data and the reading of literature on relevant theories in the analysis (Graneheim, Lindgren & Lundman, 2017).

Six dentists were interviewed; this may be seen as a small number, which implies that this article has an explorative character. The interviews contained interesting accounts of the dentists' idea of work division and allowed for an illustration of boundary work performed by professionals in relation to subordinates. The results are presented in the following section.

Results

Four themes emerged showing the dentists' perspective of work division and how these perspectives influenced the boundaries between themselves and dental auxiliaries and their professional identity.

Dentists as gatekeepers and trail blazers

All the dentists emphasized they were willing to involve dental auxiliaries in the care of patients. However, dentists focused primarily on the role of dental nurses as their role would likely be more affected than that of dental hygienists'. Dental hygienists work on their own with patients within their scope of practice. Dental nurses can be employed to primarily assist dentists, sterilize instruments, and work in the reception. The dentists pointed out that they were willing to let dental nurses take part in the examination of patients, realised through asking patients about their medical history, diet, and use of fluoride. One dentist explained how tasks could be divided in the examination of a patient:

When it is an examination, they [dental nurses] take in the patient [to the treating room] and start asking questions about the patient's diet and oral hygiene and whether they use fluoride and such things. Then I come in, take a look in the mouth and evaluate which X-rays needed to be taken and then I go out and they take the X-rays. Thereafter, I come back, look at the X-rays, examine the patient, and explain the oral health status; and then finally, the dental nurse polishes the patient's teeth. So, there is some division of work. (Dentist D)

Dental nurses may also be involved in the treatment of a patient. Dentists remarked that dental nurses could, for example, take impressions, provide permanent and temporary fillings, provide local anesthesia, and perform preventive procedures. However, the tasks that dental nurses and dental hygienists are allowed to perform are restricted by national regulations. The dentists seemed to be aware of these restrictions and did not blur the professional boundaries by assigning tasks to nurses that they are not allowed to perform. Nevertheless, one dentist pointed out:

If you look at how dental nurses are constrained by the National Board of Health and Welfare, it is not really very much. They can do a lot. (Dentist B)

Another dentist emphasized that dental hygienists should only perform tasks that are within their scope of practice and not those that are restricted to dentists:

The dental hygienist wanted to drill, and I did not think that the dental hygienist should do that. (Dentist A)

Dentists explained that the assignment of tasks to dental nurses means that dentists can rid themselves of routine tasks and focus on more complicated patient treatments. One dentist described the opportunity to focus on tasks that were regarded as being at the core of dentists' competences as an important reason to involve dental nurses in patient care:

It is hard to do everything myself, and it is nice when the dental nurses can be helpful in the treatments so I can focus on the diagnostic. I should certainly delegate injections more; that is something I feel would be good to get rid of.

Interviewer: What benefits can you see from that?

It will save me time. I can plan the treatment and spend time on things that I should do – medical records, and go through them and, well, do therapy plans and prepare a little for the treatment. (Dentist E)

Thus, dentists maintain a boundary between themselves and dental hygienists based on differences in their competency and in the regulations that stipulate how tasks should be divided in dental care. They did not let dental auxiliaries cross boundaries and work contrary to legal regulations.

Dentists as supervisors

It was evident that dentists had reservations about assigning certain tasks to dental auxiliaries before being certain of their competency. The differences in the dentists' knowledge skills compared to those of the dental auxiliaries could lead to the former not allowing dental nurses and dental hygienists to work without supervision unless they were satisfied with the level of competency. Some of the dentists related the importance of being sure that dental nurses and dental hygienists are qualified to perform the tasks assigned to them and of having control over the treatments that were performed by the others. One dentist spoke of a conflict with dental hygienists who wanted to perform a task that the dentists did not think they should:

There was a dispute about the matrix band [around the tooth that should be restored]. They [dental hygienists] wanted to try first themselves, but I thought they were not really ready for that. They had tried, but the contact with the adjacent teeth had been poor. So, then I wanted to be in control for a little longer. (Dentist A)

Another dentist explained that as long as you have control over dental nurses' work there are no problems assigning tasks to them:

I have control over everything that happens – what happens in the room. My dental nurses do not do anything that I do not check afterward. So, it does not feel like I can miss anything. (Dentist C)

Dentists further explained that controlling dental nurses' work was important to determine quality work, and to ensure they work in accordance with the dentist's view of how it should be performed. This criterion should be met before giving dental nurses some degree of autonomy.

It is about trust. Even if I know that they are capable, I do not know if they do

things my way. I cannot sign notes in a medical record and stand behind a job when I do not know if it was performed in a proper way. First, I want to see how they work. If I have seen that they can, then I let it go. Then I have no problems. (Dentist F)

Another point of emphasis was the importance of working with the same dental nurses to ascertain their competence and thus have confidence in their abilities.

It is very important. I always work with the same two dental nurses. I know what they can [do]. I have taught them, and we trust in each other, so it is the best way. (Dentist C)

In other words, dentists constructed boundaries based on the view that they need to control the work of dental auxiliaries to be sure that they did good work. They also emphasized that they were in a position that gives them the right to evaluate the quality of the tasks performed by the others.

Dentists met with resistance

All of the dentists remarked that they wanted to assign tasks to dental nurses as it was an efficient way of working. They explained that it reduced patient queues, which increased the availability of dental care and prevented aggregated oral health for the patients. For example, two dentists explained:

We have long queues, and we work much quicker when we work in teams in examinations. So it is very efficient. (Dentist E)

It is to be efficient. We have too many patients in relation to the staffing level at the clinic. We have long queues, so the benefit for patients is that they can get an appointment earlier, and at the same time the finances [at the clinic] will be better. (Dentist D)

Another reason to assign tasks to dental auxiliaries was to eliminate unwanted tasks. In return, as one dentist said, dentists could focus on tasks they saw as more fun to take on. This dentist had experienced at another dental clinic how the work division led to time for more treatments that were in line with the dentists' interest, which was appreciated:

It was me, one dental hygienist and two dental nurses, so I could work more in teams. When it came to fillings and examinations, we did that in teams. This meant I gained time for root fillings and prosthodontics, which I found more fun to do. (Dentist A)

Another motivating factor for dentists to assign unwanted tasks was to gain competence development by focusing on complicated tasks:

The biggest opportunity is that I will get more time for complicated patients, and then I will get competence development. You always think of yourself first. I am afraid it is so. I think that if I will be successful, I will be motivated to do it. (Dentist B)

However, all the dentists except Dentist F disclosed that they could not assign tasks to the extent that they wanted due to resistance from dental auxiliaries. For example, some dentists said that though dental hygienists were accustomed to working on their own with patients, some of them were not prepared to perform tasks other than usual. Dentist B explained that dental hygienists and dental nurses may prefer to work as

usual and be “more traditional”. For instance, dental hygienists may prefer to perform preventive dental care and dental nurses may primarily want to assist dentists. Similarly, another dentist pointed out that dental nurses may prefer to assist dentists and may not be willing to work on patients. Reasons for this may be not wanting to work alone and not seeing themselves competent enough:

Dental nurses who work in teams must have the competence. They must be able to perform fillings and they must be willing to work on their own, [but] not everyone wants to do that. Maybe [they] just want to assist. There are individuals like that. (Dentist C)

According to one dentist, dental nurses may be afraid of taking on new tasks and may feel forced into doing so:

You notice that there is no interest; they do not dare to examine [a patient]. Many do not dare and do not really want to, but they do not say anything. But if you talk one-to-one with them after you have worked in a team, they are relieved that it is over. (Dentist A)

Similarly, dental auxiliaries' unwillingness to undertake more tasks may be due their self-confidence in taking responsibility. One dentist pointed out:

It is rather mostly the personality. [They may ask themselves.] How secure [do] I feel about myself? How much [do] I like to try something new in my life? (Dentist D)

The lack of interest among some dental nurses in undertaking new tasks was further interpreted as a fear of being given heavier workload:

Many of the dental nurses did not think that teamwork was as fun as we [dentists] thought. They did not want to do more than necessary, so to say. (Dentist E)

The good and the bad

To achieve desired work division, dentists related that they were willing to educate dental nurses to develop their competence, and as a consequence, increase their self-confidence. All the dentists informed that they willingly educated dental nurses by explaining how to perform tasks on patients or by guiding them in their clinical training. One dentist outlined how dental nurses could be educated:

I have initiated an education for dental nurses and educated [them]. We have been through X-rays, temporary crowns, impressions and so on. After every learning component, I sit and evaluate and talk with them about what has been good and how they can try to learn from each other. (Dentist B)

However, some dentists found a number of dental nurses not wanting their advices or wanting to develop their competence, which was described as frustrating:

I made a schedule to train them. I have tried during treatments of patients to perform tasks together [with dental nurses] so they can see that they really can [do it] and that it is not as difficult as they thought. We tried to do it in different ways so it should be fun and that one feels important – that you do something more than before. Sometimes, we succeed and sometimes it feels like [the nurses think] “we don't want to”. (Dentist D)

I want to guide. I want to educate. I want to explain. I want to show. Some dental

nurses want to listen, but others do not. (Dentist F)

I offered to sit and show them [the dental nurses] how to do it, but no, they did not want to work in teams. (Dentist E)

Thus, dentists blamed some dental auxiliaries for being unwilling to develop their skills and, consequently, not being competent or self-confident enough to undertake new tasks. In contrast, dentists credited themselves for being willing to educate dental nurses and contribute towards developing teamwork in the workplaces.

Discussion

The need for interprofessional teams in healthcare worldwide is emphasized on both political and organisational levels. However, it may not be clear how professionals conceptualize teamwork and how their ideas of teamwork influence the boundaries between themselves and the subordinates. Based on the dentists' idea of the best way to divide the work, this paper explored dentists' boundary work in relation to dental auxiliaries in an organisation where teamwork was required by the senior manager to increase efficiency. The focus was on dentists' boundaries that concerned both their claims to tasks and the construction of a professional identity, as these kinds of boundaries are intertwined (Alvesson, 2013).

All the dentists in this study emphasized that they support working in teams as it gives them an opportunity to focus on the tasks that they prefer to do when caring for patients. Further, dentists constructed boundaries around tasks which only dentists are permitted to do and which require their specialized knowledge and skills. The work division was justified by referring to dental work regulations: dentists clearly emphasized that they did not let dental hygienists and dental nurses cross the regulated lines and blur the boundaries. Regulations are formal and strong power resources to be used by professionals in negotiations to support their interests (Freidson, 1986). However, the dentists' claims to tasks can also be seen in the light of the power of professionals' abstract, academic knowledge to exclude subordinates from doing tasks (Abbott, 1988). During undergraduate education, dentists learn abstract knowledge and technical skills that give them the right to perform certain tasks that can be perceived as the core of dentists' practice, which the dentists in this study sought to defend.

Dentists emphasized the importance of supervising tasks carried out by dental nurses after the tasks had been assigned. They pointed out their treatment responsibility, which is another power resource that professionals can utilize (Freidson, 1986). The dentists' accounts indicated that they saw themselves not only as responsible professionals who must ensure safe and high-quality dental care but also as professionals in a position that gives them the right to decide which tasks dental auxiliaries should do. Moreover, it confers upon them the right to assume the role of supervisors. The dentists' accounts fall in line with the assumption that professionals like dentists are in a position to have more influence over work division than subordinates (Brante, 2013; Freidson, 1994). Consequently, this study did not indicate that dentists have lost a dominant professional position. Furthermore, the focus on more specialized tasks, which dentists can do when dental auxiliaries are carrying out other tasks on patients, can be seen as securing a professional position (Van Bochove et al., 2018).

However, in line with previous studies (Apesoa-Varano, 2013; Lipsky, 1980; Nancarrow & Borthwick, 2005), this study showed that it should not be taken for granted that subordinates will accept the tasks that they are assigned. The dentists in this study were met with both willingness and resistance by dental auxiliaries. In particular, they discussed dental nurses who were unwilling to be more involved in patient care. According to the dentists, the resistance from the dental nurses stemmed

from several reasons, such as the fear of not being competent enough to undertake treatment tasks. It is unsurprising that dental nurses may be insecure about new tasks, as mistakes can have severe consequences for patients. Nurses in medical care can be reluctant to assume new tasks due to concerns about potential side-effects for patients, especially with treatments they are not used to performing (Powell & Davies, 2012). Consequently, as shown in previous studies, this study demonstrated that even if professionals have the power to decide about the division of work, subordinates may have some influence. Boundary work not only concerns professionals' and subordinates' aspirations to expand their scope of practice, but also the defence of the status quo or resistance to new tasks (Nancarrow & Borthwick, 2005; Powell & Davies, 2012).

The dentists credited themselves with being in favour of teamwork to increase the availability of dental care for patients and to help dental nurses in their skill development. However, they placed blame on dental auxiliaries who did not want to take on new tasks or develop more skills. In other words, dentists credited themselves for positive efforts at work and blamed others for shortcomings, which is a common way to achieve a positively valued identity (Alvesson & Sveningsson, 2010). Furthermore, the dentists' eagerness to concentrate on certain tasks can be interpreted as a way to focus on identity-confirming tasks in order to maintain or reinforce a positive professional identity, such as experts. However, the desire to maintain an identity may be at the expense of smooth work division (Alvesson, 2013), as the work has to be done by someone. Taking good care of patients did not seem to be a lesser priority than the dentists' personal interests regarding work division. One reason may be that professionals' identity construction begins during their undergraduate education through socialization into professional norms and values that emphasizes the ethical aspects of work to do good for others (Freidson, 1994), such as for patients.

A limitation of this study is that it only concerns the dentists' idea of teamwork and how they experienced dental auxiliaries' responses to the invitation to take part in patient care. The dentists' understanding of the others' position may differ from the others' view on how patients should be treated and by whom. Therefore, further research is needed to gain more knowledge of the views of dental hygienists and dental nurses on dentists' ideas of work division. There is also need for further research on work division and dental professionals' boundary work in practice.

Although this study concerns dental care, it may also be of interest in other contexts. Individuals within a classic profession are supposed to control the work division, but subordinates may assert some influence through resisting undertaking new tasks. However, as this study shows, within healthcare differences still remain in the power dynamic between professionals and subordinates. Dentists still have a high degree of autonomy in patient care and their invitation for dental auxiliaries to become more involved in patient care was based on the dentists' conditions. One must also take into account differences between contexts that may occur when conducting further research into how professionals conceptualize interprofessional teamwork.

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