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1 **Boundary spanners: negotiating connections across primary care and domestic violence**
2 **and abuse services**
3

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13

14 **Abstract**
15

16 Improving access to support for people experiencing domestic violence and abuse
17 requires better connections between healthcare services and specialist domestic
18 violence and abuse (DVA) support agencies. We examined the work involved in
19 restructuring the relationship between primary care and specialist DVA support
20 services. This was part of a broader study of the implementation of a general practice
21 DVA training and support programme (IRIS). We conducted an ethnography in two
22 different UK areas where the IRIS programme was being delivered. We investigated the
23 work done by specialist DVA workers (Advocate Educators) in the dual role of
24 providing training to GPs and advocacy support to patients. Drawing on concepts of
25 boundary actors and boundary objects, we examined how interactions between
26 clinicians and patients changed after the introduction of the IRIS programme. The

27 referral pathway emerged as a boundary object, meeting a shared ambition of general
28 practitioners and patients to distribute responsibility for addressing DVA. However,
29 maintaining this as a boundary object-in-use required significant, and often unseen,
30 work on the part of the Advocate Educator as boundary spanner. Our study contributes
31 to scholarship on boundary work by highlighting the role of marginal boundary actors
32 in maintaining the use of boundary objects among disparate groups.

33

34 **Key words:** UK; boundary object; boundary work; boundary spanners; domestic
35 violence and abuse; gender based violence; primary care; implementation

36

37

38 **1. Introduction**

39

40 There is a growing emphasis on improving patient care by building better pathways
41 between different parts of the health care system in the UK. This includes improving links
42 within healthcare services, between different public services, between National Health
43 Service (NHS) and health research communities, and between public and community
44 services. However, studies of collaboration demonstrate clearly that enabling structural
45 connections between different types of organisations and groups does not in itself
46 guarantee improved quality of interaction (Rycroft-Malone et al., 2015).

47

48 Wenger (1998) proposed that different groups of professionals operate in different
49 communities of practice. What is required to build connections are practices or processes
50 that have symbolic resonance in different worlds and enable interaction between them
51 (Melville-Richards et al, 2019) and people operating in bridging positions at the

52 boundaries between groups (Levina & Vaast, 2005). These are often referred to
53 respectively as boundary objects (Star & Griesemer, 1989) and boundary spanners (Long,
54 Cunningham, & Braithwaite, 2013).

55

56 This paper explores the boundary work involved in improving connections between
57 primary healthcare services in the UK and specialist domestic violence and abuse (DVA)
58 support services. We investigate the work done by boundary spanners in the dual role of
59 providing training to GPs and advocacy support to patients.

60

61

62

63 **Background**

64

65 **The Identification and Referral to Improve Safety (IRIS) programme**

66

67 This paper takes as a case study the implementation of a primary care DVA intervention
68 developed in the UK called Identification and Referral to Improve Safety (IRIS). The
69 intervention aims to improve identification of DVA in primary care settings and increase
70 referral to support services. In the UK, DVA is defined as ‘any incident or pattern of
71 incidents of controlling, coercive, threatening behaviour, violence or abuse between
72 those aged 16 or over who are, or have been, intimate partners or family members
73 regardless of gender or sexuality’ (Home Office, 2016). Abuse can encompass, but is not
74 limited to, psychological, physical, sexual, financial, and emotional abuse.

75

76 The IRIS programme includes: training for the whole team co-delivered by a specialist
77 DVA support worker (Advocate Educator) and a clinician; a direct referral pathway to the
78 Advocate Educator (AE) providing advocacy support for patients; a prompt to ask about
79 abuse in the electronic medical record; and domestic violence resources and materials
80 for practices. The AE represents the two central parts of the intervention, through the
81 provision of education to general practice and advocacy support to patients.

82

83 The IRIS intervention focuses on improving access to DVA advocacy services. Advocacy
84 is a term that incorporates legal, practical and emotional support. Advocates give a voice
85 to survivors of abuse and support them to make changes in their lives. Specialist services
86 in the UK are the product of feminist activism in the 1970s, which aimed to offer support
87 to women experiencing abuse. This started with refuges and rape crisis centres, and later
88 expanded into a wider range of advocacy services. These services are often provided in a
89 community setting and are structured around theoretical models of empowerment,
90 involving tailored assistance relative to the needs of individuals (Reisenhofer & Taft,
91 2013). This is viewed as a form of secondary prevention, in that it can reduce repeat
92 incidences abuse and may improve the psychological wellbeing of survivors (Rivas et al.,
93 2015).

94

95 There is increasing recognition in public policy and academic research of the association
96 between experiences of DVA and a number of negative health outcomes (Anonymous
97 2014), the high prevalence of DVA among those attending health care settings (Anonymous, 2002), and the important role that can be played by clinicians in
98 identification and referral for specialist support (WHO, 2005). However there remains
99 limited movement of patients between health care settings and specialist support
100

101 services. Clinicians infrequently enquire about DVA, typically citing discomfort in raising
102 the issue and lack of time as a barrier to discussion (Anonymous, 2005). Women are
103 reluctant to disclose without being directly asked (Anonymous, 2006). Women report
104 valuing a validating, non-judgmental response from a trusted health professional and
105 their support facilitating change (Anonymous., 2003).

106

107 DVA interventions in health care settings have historically focused on providing training
108 to clinicians about how to recognise and respond to DVA. These have had a limited effect
109 on identification of patient experiencing DVA and on referral for further support (Minsky-
110 Kelly, Hamberger, Pape, & Wolff, 2005). In the early 2000s, the IRIS intervention was
111 developed to improve the primary care response to DVA in the UK. A central component
112 of this model (see figure 1) was the advocate educator: a specialist DVA support worker
113 with the dual role of delivering training to general practice teams and advocacy to
114 patients experiencing DVA referred by GPs. Referrals to advocacy DVA advocacy can
115 reduce further physical violence and improve quality of life (Anonymous., 2015).

116

117 Insert figure 1 here.

118

119 In a randomised controlled trial in Bristol and London, the IRIS intervention was found
120 to be successful at improving the connection between general practice and specialist
121 support. IRIS increased identification of DVA in patient records (3-fold) and referral
122 (discussion of referral 22-fold, actual referrals 6-fold) of patients (Anonymous, 2011).
123 Following this success IRIS was recommended in a number of national guidance
124 documents (Department of Health, 2017; Home Office, 2016) and has been commissioned
125 locally in over 40 areas of the UK.

126

127 While there is ongoing evidence that IRIS leads to increases in identification and referral
128 of patients experiencing DVA (Sohal et al, forthcoming), there remains limited theoretical
129 investigation of how it changes interactions. In this study we have sought to understand
130 the practices that underpinned relationship-building between primary care and DVA
131 support services. This study forms part of a wider investigation of the success of the
132 national implementation of the IRIS programme (Anonymous, 2018).

133

134

135 **2.2 Collaborative work**

136

137 In this section our intention is to introduce readers to the ways in which collaborative
138 work between different professional groups has been theorised, with a focus on
139 boundary work. This sets out a context in which to understand the collaborative work
140 between general practice and DVA support services that is undertaken as part of the IRIS
141 programme.

142

143 Star and Griesemer's (1989) early exploration of the collaboration between biologists and
144 amateur naturalists in the establishment of the Museum of Vertebrate Zoology in
145 California developed the idea that loosely structured working arrangements, or
146 'boundary objects', are critical for enabling different groups to work together. They
147 argued that such objects hold different meanings in different social worlds, with a
148 temporary structure that is standardised enough to more than one world to make them
149 recognisable, but loose enough to have a specific local meaning. They used the concept of
150 boundary objects to explore how maps, libraries and collecting and recording techniques

151 coordinated the interactions between trappers, scientists, state officials and naturalists,
152 enabling the successful development of the museum. In doing so, they demonstrated that
153 the creation and management of boundary objects is an important process in developing
154 and maintaining coherence across intersecting communities (Bowker & Star, 1999).

155

156 Further exploration of the concept has had a tendency to seek a typology of boundary
157 objects in order to establish intrinsic or essential properties which can be replicated
158 (Lindberg, Walter, & Raviola, 2017; Fox, 2011). However, a common finding is that, in
159 many cases, objects that have been designated as useful for boundary spanning and that
160 possess desired characteristics remain un- or superficially used (Levina & Vaast, 2005).
161 Success as a boundary object may be an unintended consequence of design. Rather than
162 trying to determine what a boundary object *is*, other approaches have examined what
163 boundary objects *do* (Levina & Vaast, 2005; Melville-Richards et al., 2019). This is
164 consistent with Star's (1989, 2010) original thesis of boundary objects, in which the
165 object is understood to perform in a specific setting relative to characteristics of the
166 relationships within that context. As Griesemer (1992: 54) puts it, '*what makes a tool*
167 *right for a job... is the joint articulation of tools, jobs and claims*'.

168

169 Melville-Richards et al (2019) elaborate on the action-based qualities of boundary objects
170 that make them useable. While many objects may have the potential to facilitate
171 interaction, those that are successful are objects that are considered *authentic* by users.
172 Only those that are meaningful to the multiple groups involved, able to align divergent
173 interests, and resonate with what is at stake for them in collaboration, prove effective at
174 enabling shared work.

175

176 Their insights also help explain a key challenge of keeping boundary objects-in use:
177 ensuring that they remain resonant with the groups using them despite ongoing change.
178 Boundary objects are temporary working arrangements and in flux relative to changes in
179 the collaborative work from which they emerge (Lutters and Ackerman, 2007), meaning
180 that they can fall out of use. For instance, in their study of the initial success and then
181 subsequent failure of the Liverpool Care Pathway as a tool for improving the care of dying
182 patients in hospitals, Seymour & Clark (2018) found that the pathway became a negative
183 boundary object over time. It began to resonate negatively with the groups using it and
184 led to fierce criticism and disagreement. This was as a result of a policy change that saw
185 the pathway move from a loosely structured working arrangement to a rigid set of rules
186 about process and interaction. It lost the flexibility that led to its initial popularity and
187 which had allowed it to be tailored to suit the needs of the different environments in
188 which it was being used.

189
190 A further challenge is that interactions between groups often involve navigating power
191 imbalances. Boundary objects can be used as tools for negotiating professional
192 jurisdictions (Wright et al., 2019; Bechky, 2003) but, as Allen (2009: 327) notes, while
193 boundary objects, *'have a strong cohesive power to appeal to a range of stakeholder groups,*
194 *their breadth of appeal also disguises tensions between different agendas and frames of*
195 *reference'*. This was evident in Owen's (2015) examination of the acceptability of different
196 complementary and alternative therapies within biomedical institutions. She argued that
197 acupuncture practitioners purposefully aligned with western medicine, using
198 acupuncture needles strategically to create a symbolic shared jurisdiction with medical
199 practitioners. This ensured acupuncture remained within the biomedical sphere, but did
200 not resolve ongoing tensions between different approaches to medical practice.

201

202 Given the inherent difficulties in boundary crossing, Mellville-Richards et al (2019) argue
203 that boundary objects are most likely to emerge and remain in use if there are actors who
204 help the process. These actors operate from marginal positions at the boundaries of
205 different groups and encourage participation. These are commonly referred to as
206 boundary spanners or knowledge brokers. Taking up the role of a boundary actor
207 *'requires becoming a legitimate, but possibly peripheral, participant in the practices of both*
208 *fields'* (Lavina and Vaast, 2005). They *'are able to make new connections, enable co-*
209 *ordination and... open up new possibilities for meaning'*(Wenger, 1998: 109).

210

211 People in boundary spanning roles do work to maintain the positive resonance of
212 boundary objects among collaborators. Lavina and Vaast (2005) note that not all those in
213 designated boundary spanner roles are successful at this work. Similar to unintended
214 boundary objects, the work of brokering can instead be done by those in roles which are
215 not necessarily intended for that purpose. Bossen, Jensen, & Udsen (2014) for example,
216 demonstrate how medical secretaries attend to the uptake among hospital staff of an
217 electronic health record as a boundary object, and Winthereik & Langstrup (2008)
218 highlight the role a trial manager in maintaining shared use of an asthma self-
219 management tool between patients and clinicians. When undertaken by those not in
220 official boundary spanning roles, this work can end up *'undocumented as a part of the*
221 *smooth running of a process or procedure'* (Star & Strauss, 1999). If those who undertake
222 it are not recognised and supported it can lead to role overload, burn out and stress (Long,
223 Cunningham and Braithwaite, 2013).

224

225 To summarise, the insights from the existing theoretical literature are that different
226 professional groups can be supported to collaborate through identifying flexible working
227 arrangements, 'boundary objects', which enable them to interact toward a shared goal
228 but also achieve goals that are relevant within each particular group. These boundary
229 objects emerge out of the requirements of a particular set of interactions, and might be
230 practices, processes, materials or concepts. To become boundary objects-in-use, they
231 must resonate and hold meaning for all involved, and be capable of converging multiple
232 interests. This work also crucially involves boundary spanners who operate at the
233 margins of groups and maintain commitment to using boundary objects, acting as
234 interlocuters between the different stakes involved in an interaction.

235

236 The concepts of boundary object and boundary spanner have been widely applied as
237 heuristic tools to examine and design processes that could lead to improved interactions
238 across professional groups in healthcare. This has included looking at how new
239 institutional structures facilitate interaction (Melville-Richards et al, 2019), how clinical
240 guidelines link different professional groups (Akoumianakis et al, 2010), the successes
241 and failures of care pathways as a mechanism for ensuring cooperation between groups
242 (Allen, 2009; Håland, Røstad, & Osmundsen, 2015; Seymour & Clark, 2018), and how
243 different hospital departments interact around patients (Anonymous, 2018).

244

245 In this study we apply these concepts to the study of collaborative work between general
246 practitioners and specialist domestic violence support services. We make a contribution
247 to this literature through a close examination of the boundary spanning role of the
248 Advocate Educator. We explore how they attend to boundary objects-in-use to support

249 connections between primary care, people who have experienced abuse, and specialist
250 support services. In doing so, we highlight otherwise unseen aspects of their work.

251

252

253 **3. Methods**

254

255 We adopted an ethnographic approach to study the practices involved in the
256 collaborative work between primary care services and specialist DVA support services.

257 Two geographic areas delivering IRIS in England were selected as intrinsic cases (Stake,

258 1995). One researcher (GF) led the original trial of IRIS and facilitated collaboration with

259 the national IRIS implementation team. Through a joint approach between the research

260 and implementation teams two case studies were selected out of thirty possible areas,

261 informed by Miles & Huberman's (1994) sampling criteria for cases. These included being

262 relevant to the pragmatist conceptual framework of the study, having the potential to

263 generate rich data, being ethical and being feasible. Four specific criteria were

264 developed: having been running for over two years, similarity to the original model,

265 capacity to participate in the study, and being practical locations for travel and data

266 collection by the research team.

267

268 Links were made with the main provider of DVA services in each case study area, with

269 access negotiated by AD. The case studies were both in large urban areas in England

270 where a local government body and a Clinical Commissioning Group jointly funded a

271 community DVA provider to deliver IRIS. Data from the case studies are treated

272 collectively in this paper as the practices of boundary work were similar in both.

273

274 AD collected data through participant observation and interviewing. Fieldwork was
275 conducted over 20 months between August 2015 and March 2017 (over 100 hours per
276 field site). AEs were the primary informants in each case study and enabled connection
277 to other actors. Participant observation was structured around project management and
278 commissioning of IRIS at an organisational level, the day-to-day delivery of IRIS as a
279 programme of work (training and advocacy), and engagement in IRIS by its intended
280 beneficiaries (clinicians and patients). Field notes formed the basis of the data from
281 participant observation.

282

283 19 semi-structured interviews were conducted in each case study area with clinicians
284 (case study one: 5, case study two: 8), services users (case study one: 8, case study two:
285 5), and actors involved in the commissioning and delivery of IRIS (case study one: 6, case
286 study two: 6). Options for selective sampling among commissioners, managers and
287 members of the IRIS team were limited, in that there were only a small number of
288 professional roles in each case available for interview. Clinicians were purposively
289 sampled according to different levels of engagement with the IRIS service (never referred
290 vs. many referrals). Service users were sampled in order to represent a wide
291 demographic range, in terms of age, gender, ethnicity and experiences of abuse. AEs
292 recommended and approached service users who they considered it would be safe to
293 invite to participate in the study.

294

295 Sample size was guided by Malterud, Siersma, & Guassora (2016) concept of 'information
296 power'. For this study this represented a point where a wide range of different practices
297 became visible and enough data was available to analytically engage with the emerging

298 research problems, with contradictions and deviant cases present but with decreasing
299 frequency.

300

301 Interviews were conducted at locations identified as convenient for participants,
302 including general practice offices, coffee shops, homes, and commissioning headquarters.

303 Meeting in a safe location was a priority for interviews with service users. Interviews
304 were audio recorded and transcribed using a professional transcription service. Field
305 notes were written before and after each interview, describing the recruitment process,
306 preliminary analytical points and the environment in which the interview took place.

307

308 AD read transcripts and fieldnotes in full to become familiar with the data and moved
309 back and forth between working with codes and re-reading items of data, also returning
310 to listen again to recordings. After a close reading of the text, AD developed initial codes
311 using the 'gerund' approach to coding (Charmaz, 2012), which involves using the noun
312 form of verbs in order to '*build action right into the codes*' (ibid: 5). The analytical focus
313 was on identifying the key practices of each group involved in IRIS, with the rationale that
314 this would support the identification and analysis of shared working arrangements.

315 Analysis was done using a paper-based approach. Notes were taken in the margins of
316 transcripts and field notes, collecting ideas together on a cover note. Analytical ideas
317 were collected separately in a Word document as the analysis developed. Following
318 analysis of several items of data AD employed the One Sheet of Paper (OSOP) approach
319 (Pope, Ziebland, & Mays, 2000; Ziebland & McPherson, 2006), collecting together
320 practices identified from different data to display it in a way that would allow conclusions
321 to be drawn. As data was added and practices that didn't fit with the groupings were

322 identified, the arrangement was reconfigured on a new piece of paper. MK and GF
323 contributed to the ongoing development of thematic narratives as the analysis developed,
324 and member feedback sessions were held with members of the IRIS delivery team in each
325 case.

326

327 This study received ethics approval from the Queen Mary Research Ethics Committee
328 (reference: QMERC2015/29a and QMERC2015b), the Barts Health Joint Research
329 Management Office (ReDa number: QMERC2015.29b) and the appropriate local NHS
330 governance bodies.

331

332

333 **4. Findings**

334

335 **4.1 Advocate Educators as boundary spanners**

336

337 There was minimal interaction between general practice and specialist DVA support services
338 in the case study areas prior to the introduction of IRIS in each area. They represented
339 two separate professional environments, or '*planets*' (Hester, 2011). They had different
340 histories, systems of bureaucracy, flows of time, spaces of work, professional skills,
341 identities and jurisdictions. Discussions between patients and GPs about DVA were rare.
342 Specialist services infrequently engaged directly with primary care services and received
343 very few referrals from general practitioners.

344

345 The introduction of the IRIS programme altered this environment. Crucially it introduced
346 new actors, Advocate Educators (AEs). They were recruited from a workforce of

347 experienced DVA support staff within local communities. They had an understanding of
348 the abuse theoretically underpinned by notions of power and control and pragmatically
349 driven by risk reduction. Their desire to be involved in the work was to use general
350 practice as a channel to access and provide support to more women affected by abuse.
351 Despite being formally attached to local specialist services who had been appointed by
352 commissioning bodies to deliver IRIS, they occupied a position at the margins and were
353 able to move between the two groups.

354

355 They would cross the threshold of general practice to deliver training and subsequently
356 use rooms within surgeries to see patients who had been referred. Christine, an AE,
357 reflected that this was different from other services GPs might use:

358

359 *They like to have a face; you can't get that with other services.*

360

361 This personal interaction meant that clinicians perceived them more positively, as Chloe
362 (GP) described:

363

364 *If you meet a secondary care service or a community service that clearly are keen for*
365 *referrals, that does change what you do a bit. You meet others who appear less keen*
366 *or aren't very engaging when you do a referral, you do sometimes think twice.*

367

368 They were also seen as 'different' by patients. Being able to discreetly meet an AE within
369 a GP practice was important to many service users, particularly those who were still in
370 abusive relationships. However, the support provided was different from what they

371 usually received in this setting. Advocacy was tailored to the needs of each particular
372 woman. Anoushka (AE), for example, presented the breadth of the work of advocacy:

373

374 *What we have to do is we have to empower these people by giving them tools, by giving*
375 *them information so they know, should they want to change things, there are ways*
376 *they can do it safely and that they're not alone. It's about slowly breaking down the*
377 *barriers to make them not feel isolated; whether that's they don't speak English, that*
378 *they have no access to benefits, whatever those barriers are, they need to sort it out*
379 *slowly.*

380

381 Women in this study were supported in range of diverse ways, including safely leaving or
382 staying with their partners, seeking asylum, finding new accommodation, negotiating
383 custody of children, making friends, and overcoming anxiety. For many service users this
384 resulted in the relationship with the AE feeling more like a friend than like a professional
385 service. Hannah, a service user, explained this:

386

387 *She's like one of me mates that I can ring when I need her. I just know that she's there. She*
388 *was dead welcoming, and easy to talk to, and she was immediately on my side. And I'd never*
389 *had that happen.*

390

391 AEs exhibited the characteristics of being legitimate but partial members of different
392 groups (Levina & Vaast, 2005). This enabled them to act as a link that would encourage
393 the movement of patients between general practice and specialist support services.
394 However, before this was possible they had to gain access to general practice and

395 introduce a flexible shared working arrangement, or *boundary object*, that would enable
396 the potential for connection between clinicians and patients.

397

398

399 **4.2 Building a pathway to support**

400

401 Before getting access to GPs, and subsequently to patients affected by abuse, AEs had to
402 negotiate with the gatekeepers of general practices. These were practice managers, who
403 controlled access to general practice teams. Training sessions were difficult to arrange
404 within the busy schedule of primary care services despite posing no financial costs to
405 practices.

406

407 AEs employed a range of different tactics in order to access practices. Caroline simply
408 turned up outside the door of a practice manager who had been avoiding her emails and
409 phone calls and '*shamed her into signing up*' with her presence. Rosie took a more
410 dramatic route of influence with reluctant practices, showing them pictures of women
411 who had died as a result of abuse in their area. She jokingly labelled herself as '*the voice*
412 *of doom*'. Having gained access to general practice, they would work flexibly around the
413 timetables of both the practices and the clinicians with whom they co-delivered the
414 training, juggling times and dates.

415

416 Travelling across cities with suitcases full of training materials, AEs tried to cultivate an
417 understanding of DVA as connected to the concerns of general practice among the
418 clinicians attending training. Few GPs asked about DVA before becoming aware of the
419 IRIS programme. It was not a core concept that informed their routine work, and was

420 understood most clearly in relation to legal responsibilities GPs had towards
421 safeguarding children. Some clinicians feared causing offence by raising the topic, and
422 others thought it was not their responsibility. Given that few patients directly raised the
423 issue of DVA, it was often easier to follow other routes through consultations based on
424 presenting symptoms.

425

426 AEs went to great lengths to tailor a local meaning of DVA which would be resonant with
427 general practitioners. They encouraged links between common presentations in primary
428 care, such as headaches, chronic pain and gastrointestinal complaints (Valpied & Hegarty,
429 2015), offering phrases to start conversations about DVA during consultations. They
430 altered the meaning of abuse from being something private within a relationship, to a
431 relatively standardised but broad range of behaviours and characteristics that were
432 contained within a sanitised three-letter acronym. The potential to associate abusive
433 behaviours with symptoms or situations that were common in general practice gave
434 clinicians increased legitimacy to ask about DVA as part of their everyday clinical activity.

435

436 They constructed a referral route that allowed a movement of patients out of general
437 practice and into specialist support, mimicking the processes GPs followed to refer to
438 other services. They would establish broad referral criteria, emphasising their
439 willingness to accept a wide range of patients. Any suspicion of DVA was enough to
440 qualify a patient for the service. They would also practically address technical issues that
441 might impede GPs from contacting them, such as making sure that the referral form was
442 uploaded onto the practice computer system before leaving training. They offered a
443 malleable service, with flexibility in the way in which referral information could be
444 transmitted (by phone call, email, fax) and in when and where they would see patients.

445 This flexibility created an intentionally porous boundary between the IRIS service and a
446 given practice, representing what Star and Griesemer (1989) described as multiple
447 points of translation.

448

449

450 **Redirecting interactions between general practitioners and patients**

451

452 The stated purpose of the IRIS programme was to change interactions in primary care
453 between clinicians and patients which would lead to more conversations about DVA and
454 more referrals into specialist support.

455

456 For many clinicians, their hesitance in raising the topic of DVA related to being uncertain
457 about what action they could take to support a patient. The key to engagement with
458 clinicians was that, as well as improving their understanding of how DVA fit within
459 healthcare interactions, the IRIS programme enabled them to distribute responsibility for
460 addressing DVA. In this case, the IRIS pathway acted as a resource for putting a boundary
461 on GP's professional responsibility for addressing DVA. Clive articulated this:

462

463 *It's no good me asking all those questions if all I can say to this lady is "Thank you*
464 *for telling me." There's a therapeutic role, but what it's going to generate is she's*
465 *going to come back and talk to me about it again and again and again, and that will*
466 *make her feel better for the five minutes she's here and maybe she'll know that*
467 *somebody is caring that she's shared it with, but we haven't really helped in terms of*
468 *trying to solve her problem. We've helped her to cope with it maybe a little bit, but*
469 *having IRIS means that (a) you can identify it and (b) you've got a referral pathway.*

470

471 Clive argued that being able to both identify and refer were crucially interconnected. DVA
472 was an issue that few GPs wanted to take responsibility for addressing, despite
473 considering it relevant to the holistic work of general practice. As Nancarrow &
474 Borthwick (2005) discuss, boundary negotiation often involves distributing
475 responsibility for work between professional groups. This means unwanted work can be
476 shifted elsewhere.

477

478 GPs are accustomed to referring patients to other services when they encounter
479 problems that believe cannot be addressed in primary care. In the absence of a clear route
480 of referral, many GPs would simply avoid the topic. Where patients did disclose
481 unprompted, GPs might attempt to direct patients towards support for other issues
482 which are also associated with DVA perpetration, such as mental health or substance
483 misuse (Anonymous., 2015). Lily, for example, visited her GP to ask for support in
484 managing the behaviour of her abusive partner.

485

486 *I think maybe the first time I went the doctors, maybe he hadn't been introduced to IRIS.*
487 *From the story I told him, it wasn't so much physical, but very verbal abuse, and he said to*
488 *me, 'Oh you've got to get out of there, you must leave'. And I couldn't. It wasn't actually very*
489 *helpful. So I left there, and he did actually do some things. He did send somebody from the*
490 *mental health team. That I felt at the time was quite helpful, but it didn't actually, it didn't*
491 *lead to anything sort of being done or changing.*

492

493 Lily had visited the GP to seek advice about how to safely remain in a relationship with
494 her partner, for whom she was a full-time carer. In the absence of an understanding of

495 the dynamics of abuse and how to appropriately respond to her disclosure, the GP had
496 advised to leave the relationship and directed her towards mental health support. Lily's
497 request for DVA support remained unmet. Several months later the situation escalated,
498 and she returned to the GP with her granddaughter.

499

500 *So there was two of us saying how things were. And from then, he said to me, there is, I think*
501 *he used the words 'a new service', and 'I could arrange for you to see somebody here from*
502 *the domestic violence team if you'd like to', so I said 'I'd love to, I need someone'.*

503

504 The availability of the IRIS service enabled a different point of connection between Lily's
505 request for help and the GP's desire to direct her out of general practice. It empowered
506 the GP to take appropriate action in relation to DVA. It became a boundary object-in-use,
507 in that it enabled a meaningful and resonant convergence of both needs (Melville-
508 Richards et al., 2019).

509

510

511 As well as connections to other health pathways, DVA has connections with other public
512 services, particularly police and safeguarding teams. Again, in the absence of a clear
513 avenue of DVA support, clinicians might shift responsibility down these routes. Yasmeen,
514 for example, described a challenging initial encounter with her GP when she visited to
515 have a wound dressing changed.

516

517 *I still had stiches in my head, from the head injury, and I went to my GP, and I think he was*
518 *remarkably predictable in his response. I was very vulnerable and I felt it quite acutely, what*
519 *I consider his insensitivity. Because he said 'Well, why the hell didn't you call the police?' And*

520 *I just said, 'Well, it's not that easy'. When a doctor says 'Why didn't you call the police?' you*
521 *feel as though you really have lost your sense of self. But fortunately he was going through*
522 *a training with Lisa [Advocate Educator] at that surgery, so he did call me the next morning,*
523 *and I had to have some blood tests done and a health check, so next time I went he*
524 *introduced me physically to Lisa. I don't know what Lisa said in that training that afternoon,*
525 *but it was enough for him to pick up that phone and call me.*

526

527 The response from the clinician was again to suggest a direction of action that would
528 remedy the situation outside of health care, in this case involving the police. This
529 response did not recognise the patient's presenting needs. Moreover, his response caused
530 Yasmeen to feel further shamed about her experiences. Having received the IRIS training,
531 however, gave him a way to offer a different direction for support.

532

533 The majority of patients experiencing abuse visit their GP without a clear articulation of
534 the support they need in relation to abuse. Instead, they might attend general practice
535 seeking resolution for symptoms that are associated with abuse. The training AEs
536 delivered as part of the IRIS service offered suggestions for how to redirect these
537 conversations. Shazia, for example, went to her GP to talk about depression:

538

539 *It was July, I remember, I was in a bad relationship with my partner, and it ended up with*
540 *violence. I was really depressed, and just felt lost, the only thing that comes to my mind was*
541 *to go to the doctor and ask for help to get some anti-depressant medication. It was hard*
542 *with three children, you sometimes feel depression, because what is happening is very*
543 *horrible. Then when I met her [the GP], she was aware of the violence because she had a*

544 *report from the hospital and the police, and she said 'you have lots of things going on, so it's*
545 *not something that I can help with antidepressant medication'. I was suffering from*
546 *financial problems, living in a violent relationship, so she said 'it might help to refer you for*
547 *something where they can help you with your housing issues, your financial issues and your*
548 *emotional issues' and she referred me to IRIS.*

549

550 In the absence of a conceptual framing of her violent relationship as something that could
551 be directly addressed, the immediate solution available to Shazia was to seek medical
552 help for her emotional suffering. Having the IRIS service available, her GP was able to
553 redirect the conversation away from medication towards advocacy support.

554

555 Changing the direction of interaction was valuable for clinicians as well. Leanne, for
556 example, described the impact that talking about DVA might have on a consultation:

557

558 *If you've explored it and done everything you can for that physical problem, then you've*
559 *identified there's a problem at home and you can say, "Look, perhaps this is happening*
560 *because of this!" It can help make some of the physical symptoms easier to manage. I*
561 *think on some level people may even realise, because the preoccupation with those*
562 *physical symptoms maybe lessens once you deal with the other things.*

563

564 However, the redirection of the general practice encounter towards the IRIS service was
565 dependent on this converging with the needs of the patient. Diane gave an example of a
566 patient who she perceived was reluctant to address DVA.

567

568 *She denies ongoing violence in the relationship. They're not happy and they both*
569 *acknowledge that, but she won't leave, and she's desperate for a baby which worries me*
570 *because I think she's probably not being honest. There might be violence, but she realises*
571 *that that could impact on me referring her for IVF. So it really is a horrible case and she*
572 *is on medication, which could impact on her fertility, for her mood, and so down we go in*
573 *a vicious cycle.*

574

575 The goal of this patient was to get support from her GP in starting a family. As such, this
576 patient rejected the category of DVA. Instead of holding a positive meaning, in that it could
577 help to address the violence in the relationship, for this patient it resonated negatively in
578 that it closed down options of being referred for fertility services. In this instance, the
579 pathway acted as negative boundary object (Fox, 2011), leaving both clinician and patient
580 in a *vicious cycle* of a repeating and unsatisfactory interaction.

581

582 To summarise, the IRIS pathway emerged in some instances as boundary object-in use
583 due to its success at redirecting interactions in general practice, distributing the
584 jurisdiction of responsibility for addressing DVA to the AE. Patients wanted support for
585 the problems they brought, and clinicians wanted to be able to direct them to alternative
586 services. The potential of an IRIS referral enabled interactions around abuse in primary
587 care to move in different directions. Careful tailoring the concept of DVA to reflect
588 primary care encounters enabled clinicians and patients to mutually achieve different
589 goals.

590

591 **4.4 Maintaining connections**

592

593 Enabling an interaction between a clinician and a patient around DVA did not in itself
594 guarantee that an ongoing connection would be made with the IRIS service. Patients
595 might not take up the service, and GPs might not refer again. As boundary spanners, AEs
596 undertook a range of activities to maintain the referral pathway as a boundary object-in-
597 use.

598

599 For example, upon receiving referral information from a GP, the AE would then attempt
600 to make contact with a patient as soon as possible. Brenda (AE) described the process in
601 her team:

602

603 *We have a policy that says we make at least six attempts over a two-week period from*
604 *when we get the first referral and we'll contact them, contact the same day referral is*
605 *allocated. And if you can't catch them, you have to go back to the GP and get the GP to*
606 *try and call them in. Then they get another seven days so that could be open for three*
607 *weeks without ever having any contact, which is a bit of a pain but the thing is that we*
608 *keep trying.*

609

610 AEs also had to do continued work with clinicians to ensure that they remained
611 committed to making use of the referral pathway. Given that a central meaning attached
612 to the pathway as a boundary object was providing an avenue of support, it was
613 important that they received feedback to affirm this. Nakesh elaborated on this:

614

615 *I think the feedback that you got from the person that was dealing with it from*

616 *IRIS was what made it feel like it was more like a partnership and it was work in progress,*
617 *rather than seeing things as success or failure, or even 'do the referral, problem solved!'*
618 *I think often with these cases, it's not like that because resolution, if it happens at all,*
619 *often might happen quite a bit further down the line. I think just sharing the burden with*
620 *someone, or feeling more that it's a team effort I think is quite helpful, because otherwise*
621 *it can feel like lots of things, but dispiriting is one of the things and frustrating.*

622

623 As well as offering support to patients, AEs continued to offer support to GPs. Christine
624 (AE) described her role as '*building trust with the GP and with the woman*', miming being
625 on the phone to both at the same time. AEs attended to GPs continued use of the referral
626 pathway as a boundary object through offering hope about outcomes for patients. With
627 the jurisdiction of GPs expanding to include addressing DVA, the jurisdiction of the AE
628 similarly expanded to include addressing the concerns of clinicians.

629

630 **5. Discussion**

631

632 Owens (2015) argues that studying boundary work can inform us about health care
633 practices, in this case the complex work of addressing needs associated with DVA that
634 arrive in primary care. The success of the direct referral pathway into support provided
635 by the IRIS programme reflects a need within primary care to delimit the professional
636 jurisdiction for addressing DVA, and share responsibility with other services.

637

638 Returning to Star's (1989) central thesis that boundary objects are formed out of the
639 needs of different communities, we argue that the referral pathway carefully introduced

640 and maintained by the AE redirects interactions about DVA in primary care. It reshapes
641 the jurisdiction of care, allowing it to be redistributed to the IRIS service.

642

643 Boundary objects-in-use are defined as acquiring both a local usefulness and a common
644 identity in practice (Levina & Vaast, 2005). In this study, the direct pathway into specialist
645 DVA support services became a boundary object-in-use. It enabled patients to have their
646 individual needs recognised, and allowed clinicians to put a boundary on their
647 responsibilities. It was able to hold multiple meanings, converge different agendas, and
648 was resonant among different actors (Melville-Richards et al., 2019). It enabled different,
649 more satisfying interactions between general practitioners and patients.

650

651 We paid particular attention to the boundary spanning role played by AEs in building the
652 referral pathway and encouraging others to participate in it. They nurtured points of
653 connection, such as the flexible referral and feedback processes, encouraging the
654 movement of patients into the service. Having an ongoing peripheral presence in general
655 practice enabled them to engage informally in this work. In this case, the essential quality
656 of marginality of the AE as boundary spanner was having a temporary physical presence
657 among the different groups being connected. This was facilitated by their flexibility in
658 being able to move in and out of general practice and in and out of spaces that were safe
659 to meet patients. Like the work done by Melville-Richards et al (2019) into the important
660 qualities of boundary objects, we suggest that in future research it would be beneficial to
661 further explore the qualities of marginality of boundary spanners that allow them to
662 emerge in a given setting.

663

664 Where the AE was publicly recognised as a designated boundary worker, with regard to
665 their dual role in training and advocacy, the ongoing work to maintain the referral
666 pathway as a boundary object-in-use was not always seen. This is what Star and Strauss
667 (1999) term '*dis-embedded background work*', where the individual role is visible but the
668 work done remains unseen. Winthereik & Langstrup (2008), for example, found that the
669 undocumented role of the trial manager in attending to the continued connection of
670 patients and GPs in the use of an asthma self-management tool led to it being absent when
671 the tool was rolled out more widely. This was an important contributing factor to its
672 failure in implementation. In the case of IRIS, noticing and supporting the boundary
673 maintenance work done by AEs is central to ensuring the ongoing success of programme
674 implementation. Similarly, in a hospital context, the boundary worker role of specialist
675 cardiac nurses was inconsistently realised in patients admitted with heart attacks
676 (Anonymous., 2018)

677

678 Moreover, neither the boundary spanning undertaken by AEs or the potential for
679 connection offered by the referral pathway as a boundary object was able to overcome
680 the negative resonance associated with DVA in all cases. Raising DVA as an issue in
681 primary care also enabled the opportunity for negative associations to come to the fore,
682 on the part of both patients and clinicians. This builds on Fox's (2011) examination of
683 positive and negative boundary objects. Interactions around boundary objects can
684 emphasise and reinforce differences as well as build connection. In practical terms, in
685 opening pathways towards DVA support some other pathways, such as those to fertility
686 services, might be closed. This also highlights an important limitation of this study.
687 Participants were those who had benefited from connections with the IRIS service, and
688 as such were engaged in its potential benefits as a positive boundary object-in-use.

689 Clinicians and patients who were more engaged in the negative resonances of DVA were
690 unlikely to participate in the research.

691

692 In their original conception As Lutters & Ackerman (2007) highlight, boundary objects
693 remain in use relative to the context in which they are operating. It is highly likely that
694 the practices that might be required to enable interaction between clinicians and patients
695 will change as primary care, the DVA support sector and public commissioning processes
696 change. Furthermore, the cases described here are highly situated examples of the work
697 of implementing IRIS in UK urban settings with a history of delivering DVA support. There
698 may be different points of connection in settings that diverge from the ones encountered
699 in this research. While the boundary objects described may not persist as practices that
700 form connections, we believe that the attention this analysis draws to the tensions in
701 interactions between the groups will remain valuable.

702

703 **6. Conclusion**

704

705 This paper draws on the concept of boundary objects-in-use to show how boundary
706 spanners attend to meaning making at the boundaries of interactions. We have provided
707 a thorough investigation of why particular types of boundary objects arise from the needs
708 and restraints of different groups involved. We have also examined the dynamics of
709 multiple interpretation, making visible the work of negotiating meaning. In this case, we
710 have highlighted the crucial position of the AE in moving between multiple worlds of
711 meaning. With regard to improvements in the general practice response to DVA, this
712 work highlights that it is not simply the receipt of training or improved knowledge of DVA

713 that leads to change, but the careful maintenance of a porous boundary by DVA
714 specialists.

715

716 **References**

717

718 Akoumianakis, D., Milolidakis, G., Akrivos, A., Panteris, Z., & Ktistakis, G. (2010). Clinical
719 Practice Guideline Management Information Systems: Cancer Guidelines as
720 Boundary Spanning Transformable Objects of Practice. In *2010 International
721 Conference on Intelligent Networking and Collaborative Systems* (pp. 230–237).
722 IEEE. <https://doi.org/10.1109/INCOS.2010.27>

723 Allen, D. (2009). From boundary concept to boundary object: The practice and politics
724 of care pathway development. *Social Science & Medicine*, *69*(3), 354–361.
725 <https://doi.org/10.1016/j.socscimed.2009.05.002>

726 Bechky, B. A. (2003). Object Lessons: Workplace Artifacts as Representations of
727 Occupational Jurisdiction. *American Journal of Sociology*, *109*(3), 720–752.
728 <https://doi.org/10.1086/379527>

729 Bossen, C., Jensen, L. G., & Udsen, F. W. (2014). Boundary-Object Trimming: On the
730 Invisibility of Medical Secretaries' Care of Records in Healthcare Infrastructures.
731 *Computer Supported Cooperative Work (CSCW)*, *23*(1), 75–110.
732 <https://doi.org/10.1007/s10606-013-9195-5>

733 Bowker, G. C., & Star, S. L. (1999). *Sorting things out : classification and its consequences*.
734 MIT Press.

735 Anonymous (2018). Details omitted for double blind reviewing

736 Department of Health. (2017). *The Government's mandate to NHS England for 2016-17*.
737 London. Accessed online 11 April 2019:

738 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/600604/NHSE_Mandate_2016-17.pdf

739

740 Anonymous (2009). Details omitted for double blind reviewing

741 Anonymous (2011). Details omitted for double blind reviewing

742 Anonymous (2006). Details omitted for double blind reviewing

743 Anonymous (2014). Details omitted for double blind reviewing

744 Griesemer, J. (1992). The role of instruments in the generative analysis of science.

745 Clarke, A. E., & Fujimura, J. H. (eds) *The Right tools for the job : at work in twentieth-*

746 *century life sciences*. Princeton University Press.

747 Håland, E., Røstad, T., & Osmundsen, T. C. (2015). Care pathways as boundary objects

748 between primary and secondary care: Experiences from Norwegian home care

749 services. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness*

750 *and Medicine*, 19(6), 635–651. <https://doi.org/10.1177/1363459314567789>

751 Anonymous (2008). Details omitted for double blind reviewing

752 Hester, M. (2011). The three planet model: Towards an understanding of contradictions

753 in approaches to women and childrens safety in contexts of domestic violence.

754 *British Journal of Social Work*, 41, 837–853. <https://doi.org/10.1093/bjsw/bcr095>

755 Home Office. (2016). *Ending Violence against Women and Girls*. London. Accessed online

756 11 April 2019:

757 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FINAL_PUBLICATION_MASTER_vRB.](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FINAL_PUBLICATION_MASTER_vRB.PDF)

758 PDF

759

760 Levina, & Vaast. (2005). The Emergence of Boundary Spanning Competence in Practice:

761 Implications for Implementation and Use of Information Systems. *MIS Quarterly*,

762 29(2), 335. <https://doi.org/10.2307/25148682>

763 Lindberg, K., Walter, L., & Raviola, E. (2017). Performing boundary work: The
764 emergence of a new practice in a hybrid operating room. *Social Science & Medicine*,
765 182, 81–88. <https://doi.org/10.1016/J.SOCSCIMED.2017.04.021>

766 Long, J. C., Cunningham, F. C., & Braithwaite, J. (2013). Bridges, brokers and boundary
767 spanners in collaborative networks: a systematic review. *BMC Health Services*
768 *Research*, 13(1), 158. <https://doi.org/10.1186/1472-6963-13-158>

769 Lutters, W. G., & Ackerman, M. S. (2007). Beyond Boundary Objects: Collaborative Reuse
770 in Aircraft Technical Support. *Computer Supported Cooperative Work (CSCW)*,
771 16(3), 341–372. <https://doi.org/10.1007/s10606-006-9036-x>

772 Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative
773 Interview Studies. *Qualitative Health Research*, 26(13), 1753–1760.
774 <https://doi.org/10.1177/1049732315617444>

775 Melville-Richards, L., Rycroft-Malone, J., Burton, C., & Joyce, W. (2019). Making authentic:
776 exploring boundary objects and bricolage in knowledge mobilisation through
777 National Health Service-university partnerships. *Evidence & Policy: A Journal of*
778 *Research, Debate and Practice*.
779 <https://doi.org/10.1332/174426419X15623134271106>

780 Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis : an expanded*
781 *sourcebook*. Sage Publications.

782 Minsky-Kelly, D., Hamberger, L. K., Pape, D. A., & Wolff, M. (2005). We've Had Training,
783 Now What? *Journal of Interpersonal Violence*, 20(10), 1288–1309.
784 <https://doi.org/10.1177/0886260505278861>

785 Nancarrow, S. A., & Borthwick, A. M. (2005). Dynamic professional boundaries in the
786 healthcare workforce. *Sociology of Health and Illness*, 27(7), 897–919.
787 <https://doi.org/10.1111/j.1467-9566.2005.00463.x>

788 Owens, K. (2015). Boundary objects in complementary and alternative medicine:
789 Acupuncture vs. Christian Science. *Social Science & Medicine*, 128, 18–24.
790 <https://doi.org/10.1016/J.SOCSCIMED.2014.12.020>

791 Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care Analysing
792 qualitative data. *Bmj*, 320(January), 114–116.
793 <https://doi.org/10.1136/bmj.320.7227.114>

794 Anonymous (2009). Details omitted for double blind reviewing

795 Reisenhofer, S., & Taft, A. (2013). Women’s journey to safety - the Transtheoretical
796 model in clinical practice when working with women experiencing Intimate
797 Partner Violence: a scientific review and clinical guidance. *Patient Education and
798 Counseling*, 93(3), 536–548. <https://doi.org/10.1016/j.pec.2013.08.004>

799 Anonymous (2002). Details omitted for double blind reviewing

800 Anonymous (2005). Details omitted for double blind reviewing

801 Ross Winthereik, B., & Langstrup, H. (2008). The Making of Self-Monitoring Asthma
802 Patients: Mending a Split Reality with Comparative Ethnography. *Comparative
803 Sociology*, 7(3), 362–386. <https://doi.org/10.1163/156913308X306663>

804 Rycroft-Malone, J., Burton, C. R., Wilkinson, J., Harvey, G., McCormack, B., Baker, R., ...
805 Williams, L. (2015). Collective action for implementation: a realist evaluation of
806 organisational collaboration in healthcare. *Implementation Science*, 11(1), 17.
807 <https://doi.org/10.1186/s13012-016-0380-z>

808 Seymour, J., & Clark, D. (2018). The Liverpool Care Pathway for the Dying Patient: a
809 critical analysis of its rise, demise and legacy in England. *Wellcome Open Research*,
810 3, 15. <https://doi.org/10.12688/wellcomeopenres.13940.2>

811 Anonymous (2018). Details omitted for double blind reviewing

812 Stake, R. E. (1995). *The art of case study research. The art of case study research*. Sage.

813 <https://doi.org/10.1108/eb024859>

814 Star, S. L., & Griesemer, J. R. (1989). Institutional Ecology, 'Translations' and Boundary
815 Objects: Amateurs and Professionals in Berkeley's Museum of Vertebrate Zoology,
816 1907-39. *Social Studies of Science*, 19(3), 387-420.
817 <https://doi.org/10.1177/030631289019003001>

818 Star, Susan Leigh, & Strauss, A. (1999). Layers of Silence, Arenas of Voice: The Ecology of
819 Visible and Invisible Work. *Computer Supported Cooperative Work (CSCW)*, 8(1-2),
820 9-30. <https://doi.org/10.1023/A:1008651105359>

821 Anonymous (2003). Details omitted for double blind reviewing

822 Valpied, J., & Hegarty, K. (2015). Intimate partner abuse: identifying, caring for and
823 helping women in healthcare settings. *Women's Health (London, England)*, 11(1),
824 51-63. <https://doi.org/10.2217/whe.14.59>

825 Wenger, E. (1998). *Communities of practice : learning, meaning, and identity*. Cambridge
826 University Press.

827 Anonymous (2015). Details omitted for double blind reviewing

828 Wright, S., Porteous, M., Stirling, D., Young, O., Gourley, C., & Hallowell, N. (2019).
829 Negotiating jurisdictional boundaries in response to new genetic possibilities in
830 breast cancer care: The creation of an 'oncogenetic taskscape.' *Social Science &*
831 *Medicine*, 225, 26-33. <https://doi.org/10.1016/J.SOCSCIMED.2019.02.020>

832 Ziebland, S., & McPherson, A. (2006). Making sense of qualitative data analysis: an
833 introduction with illustrations from DIPEX (personal experiences of health and
834 illness). *Medical Education*, 40(5), 405-414. [https://doi.org/10.1111/j.1365-](https://doi.org/10.1111/j.1365-2929.2006.02467.x)
835 [2929.2006.02467.x](https://doi.org/10.1111/j.1365-2929.2006.02467.x)

836

837