Social Science & Medicine 71 (2010) 898–909

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

How and where clinicians exercise power: Interprofessional relations in health care

Peter Nugus [a,*], David Greenfield [a], Joanne Travaglia [a], Johanna Westbrook [b], Jeffrey Braithwaite [a]

[a] University of New South Wales, Australia
[b] University of Sydney, Australia

ARTICLE INFO

Article history:
Available online 4 June 2010

Keywords:
Collaboration
Patient management
Interprofessional learning
Australia
Power
Negotiated order
Interprofessional practice

ABSTRACT

This study aims to contribute to the limited set of interactional studies of health occupational relations. A "negotiated order" perspective was applied to a multi-site setting to articulate the ways in which clinicians' roles, accountabilities and contributions to patient care are shaped by the care setting and are influenced by the management of patient pathways. The study responds to the polarized debate between a critical perspective that calls for collaboration as the re-distribution of occupational power, and a functionalist view that argues for better coordination of health care teams. The study draws on data from 63 interviews, 68 focus groups and 209 h of observation across acute and non-acute health services within a state/territory in Australia. The paper reveals the exercise of both "competitive power" and "collaborative power" in the negotiated order of health services. Both forms of power are exercised in all settings. Relationships among clinicians in various occupations are mediated by the expectation that doctors assume responsibility for patient management and coordinating roles in health care teams, and the degree of acuity of particular health care settings. The combination of a negotiated order perspective and its unique application across a whole health system shows the continuation of a broad pattern of power by doctors over those in other roles. The paper also reveals novel criteria for evaluating the extent of power-sharing in interprofessional interaction in case conferences, and a unique quantification of such interaction.

Introduction

At least until the 1980s, medicine maintained a relative position of autonomy from external evaluation, while wielding authority over other occupations in the health division of labor (Willis, 2006). In terms of authority and status, in the English-speaking countries, at least, medicine has largely resisted attempted incursions into its scope of practice, and largely retains its power base (e.g., Allsop, 2006; Bourgeault & Mulvale, 2006; Boyce, 2006). In the sphere of localized interaction, where this study lies, communication has been shown to be terse and uni-directional (Reeves et al., 2009), and collaboration by autonomous clinicians has been shown to be selective, happening on a case-by-case basis, largely at the discretion of medicine (e.g., Salhani & Coulter, 2009). The patterns that constitute such power have been framed as "medical dominance" (Freidson, 1988[1970]; Willis, 2006).

To enhance patient outcomes, reduce burgeoning costs of providing health care and to compensate for staff shortages, governments and health services in Australia, the UK and elsewhere, have created incentives for establishing teams, sharing roles, power and responsibility for care, comprised of clinicians from various occupations (e.g., NHS Executive, 1998). The desire for collaboration has been framed as interprofessional learning (IPL) and interprofessional practice (IPP) (e.g., Braithwaite et al., 2007).

The progress of patient pathways through a health service requires coordination, or management (Komet, 2001). This study uniquely deals with the tension between the perceived need for patient management, and calls for patient care to be delivered collaboratively (e.g., Gröne & Garcia-Barbero, 2001). Collaboration is a process of positively communicating among clinicians to address client needs (following Abramson & Mizrahi, 2003). A key component of collaboration is the relative autonomy of clinicians over their scope of practice to deliver patient care. We define patient management as the coordination of patient care. It inevitably involves the use of power. Relatively few studies have focused on the *in situ* interactions among clinicians in different occupations (e.g., Reeves et al., 2009). Therefore, we appeal to a more nuanced

* Corresponding author. Australian Institute of Health Innovation, Faculty of Medicine, AGSM Building, University of New South Wales, Sydney, NSW, 2052, Australia. Tel.: +61(0) 410470 772; fax: +61(0) 2 9663 4926.
E-mail address: p.nugus@unsw.edu.au (P. Nugus).

0277-9536/$ – see front matter © 2010 Elsevier Ltd. All rights reserved.
doi:10.1016/j.socscimed.2010.05.029

interpretation of power than typically afforded by medical dominance, which emphasizes conflict (Lewis, Heard, Robinson, White, & Poulos, 2008). Power can be diverse and distributed, rather than uni-directional and static, and can be negotiated and used tactically and strategically (de Certeau, 1984), as has been demonstrated in health care (Salhani & Coulter, 2009). Power is a competency that can be viewed as positive, productive and cooperative (Hartsock, 1983), in contrast to a zero-sum, competitive interpretation of power, characterized by discussion of the re-distribution of power (e.g., Fitzgerald, Mark, & McKee, 2007). Accordingly, our study elaborates a distinction between "competitive power" and "collaborative power".

An alternative perspective on health systems to the conflictual emphasis of medical dominance, and that aligns with a disbursed and situated notion of power, is the perspective that the health system is a "negotiated order". Strauss, Schatzman, Ehrlich, Bucher, and Sabshin (1963) argued that the way treatment and care are organized only partly derive from "rules" and the unfolding pathology of the patient, but are also the product of continual negotiation, in interaction, by the players involved in the exercise of agency and the simultaneous creation of a relatively stable hospital "order" (Strauss et al., 1963).

Negotiated order reflects the central tenets of the theory of symbolic interactionism, outlined below, and was tailor-made to characterize social life in health services. Social orders include structural influences on relations between professions, such as the broader institutional and policy framework (Martin, Currie, & Finn, 2009). In the relatively structured environment of a workplace, new staff enter communities which have relatively stable orders in terms of roles and identities (Strauss et al., 1963). Actors choose from a repertoire of what are acceptable actions and responses, befitting role expectations, under particular circumstances. These constitute patterns of influence, or power, over them of which they might not be aware. What they choose to say or do may resist or challenge this pattern, expanding the repertoire, but also possibly expanding the conditions of influence over their fellow interactants, and themselves in other times and places. Such influence extends even to those outside of their sphere of interaction but part of interconnected discursive communities (Katovich & Maines, 2003). Because the character and extent of mutual influences interaction is often unknown, negotiated orders of power can exist in spite of the benevolent attitudes or intentions of individual actors (Nugus, 2008).

Previous studies have engaged a negotiative perspective on the ordering of health care. The association between professions and their work – their "jurisdictions" – are actively negotiated to deliver a patterned order of role relations in an interdependent system (Abbott, 1988). The development and even the definition of teams, their internal distributions of power, and boundary demarcation between occupations and teams, are dynamic, contextual and negotiated (e.g., Allen, 1997; Griffiths, 2008). Broader patterns of inequality and domination have been found and reinforced in self-monitoring teams (Barker, 1993), constituted in interactions within teams, and are sourced from and have consequences beyond the immediate interactive environment (Finn, 2008).

In this study we aimed to discern how clinicians exercise power. Previous studies have engaged a negotiated order perspective to examine health occupational relations (e.g., Reeves et al., 2009). A negotiated order perspective is uniquely engaged in this study to account for the possible co-existence of agency and structural influences, evident in competitive and collaborative power. Having been examined in a limited range of settings, the interactive, negotiated orders of health care need to be tested across a variety of health care settings (Reeves et al., 2009). The settings offered by a whole health system are systematically diverse. Therefore, if negotiated order is to account for the way power is exercised, it needs to be tested across multiple settings to show whether or not the exercise of either competitive or collaborative power manifests in a particular pattern across various settings of a health system.

Methods

The data for this study were derived from a multi-method action research project investigating IPL and IPP across a health system, tertiary education providers and professional organizations. The study was conducted within a politically bounded Australian state/territory and was conducted by external researchers (Braithwaite et al., 2007; Greenfield, Nugus, Travaglia, & Braithwaite, 2010). The current study presents data from the benchmark audit of IPL and IPP within the health services, conducted in 2008.

The research covered a range of clinical settings, represented by the following divisions: aged care and rehabilitation, community health, mental health, cancer services, and acute (hospital) services. Each of these divisions covered the entire system, servicing a population of 330,000, spread over a geographical area of 2300 square kilometers, and each consisting of multiple units serving the population. Aged care and rehabilitation services, cancer services, and the division of mental health had both acute and community-based services. Acute care is care delivered in a hospital, where patients require intensive daily medical treatment and intervention, and in which patients typically have "drips, drains, or other attachments" (Haines, Bennell, Osbourne, & Hill, 2004, p.676). Human research ethics committee approval for the research was secured from a university and the state/territory. The data include: 63 semi-structured interviews; 68 focus groups (comprising 401 participants); and 209 h of observation (127 of formal events and 82 of informal interaction), as shown in Tables 1 and 2.

Data collection for interviews and focus groups was guided by themes, developed from a literature review on IPL and IPP, of: staff well-being and tone of particular workplaces; communication; teamwork; case and service management; leadership; decision-making; and quality and safety. Interviews and focus groups took between 45 and 90 minutes each. Each focus group contained between four and 20 staff members. The first three listed authors conducted interviews and focus groups with clinical staff in their workplaces, explicitly asking them how they perceived each of the above aspects of work in their service. Given the size and scale of the project, simultaneous handwritten notes were taken by the first three listed authors, who are experienced qualitative researchers and adept at note-taking. The interviewers subsequently indicated the level of certainty with which the exact words were captured, and could be used as quotes.

Observations were conducted by the first-listed author of both formal events and informal interactions. Formal events included

Table 1
Activity and participant numbers in interviews and focus groups.

Divisions	c	Focus groups number of groups/number of participants	Total number of participants
Aged Care and Rehabilitation	11	16/101	112
Community Health	9	15/118	127
Cancer Services	11	11/39	50
Mental Health	9	15/80	89
Hospital	23	11/63	86
Total	63	68/401	464