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EDITORIAL TITLE

Theories of power in interprofessional research – developing the field

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ABSTRACT

This editorial introduces a special issue on theories of power in interprofessional research. Building on the intentions of the late Professor Scott Reeves, Distinguished Editor, the identification that the notions of power have been visible yet relatively inconsistent in interprofessional research warranted a focused attempt to draw together scholarship from across the globe. Power runs throughout and often dictates interprofessional dynamics yet the visibility of theoretical engagement with the subject has not reflected this. We would therefore like to invite submissions which attempt to address the issue of power in interprofessional contexts, utilising theory to explore empirical phenomena, case studies, conceptual thought or evidence review. The piece below provides a brief, speculative overview of theoretical contributions which focus on power and how they may be used to inform interprofessional research. Including examples of previous application of theory, possible approaches to framing and insight into conflictual, consensual and constitutive modes of thought the aim here is to suggest ways in which potential contributors might frame their submissions. Given that coherent inteprofessional engagement is influenced by power systems and struggles, the need to bring together work which attempts to understand and respond to this has become a pressing contemporary concern.

MANUSCRIPT

> *When asked to take his white coat off before the start of an interprofessional simulation activity, the medical student looked stricken and then simply refused, leaving the other students with an array of responses. "The coat symbolizes that physicians are leaders," his faculty mentor later explained. "Students choose to be doctors because they want to be in charge and that shouldn't be taken away from them." And it's not only the students whose identities are flustered by the potential elimination of the white coat identity. Some long time, practicing clinical professionals similarly find the request unthinkable.*
>
> (Aggregation of accounts taken from Interprofessional Sessions at the University of New England)

Introduction

Power and its manifestations - such as the symbolic authority of the medic's white coat - have always formed part of the various professional projects that make up healthcare practice and education. Yet surprisingly little use has been made of theories of power in interprofessional education, practice, and research. Given the continued drive towards integrated and collaborative healthcare systems, theoretical as well as practical tools are required to explore the dynamics of power and their effects on interprofessional working across disciplines and domains.

It is now imperative that we explore the exigencies of power in healthcare practice and education and how it affects and disrupts the intrinsic goals of interprofessional working across professional domains and further – what implications it holds for successful integration of collaborative healthcare and health-related practice. Although power dynamics play out in all professional venues across the globe, the need to develop existing thought regarding their role in interprofessional education, practice, and research has become apparent (Baker et al, 2011, Baldwin, 2009, Suter et al, 2012).

Our colleague and previous Editor in Chief, Scott Reeves was eager to instigate a conversation about power and hoped to directly address its theoretical neglect by inviting authors to weigh in, offering their perspectives and thus conceptually developing and innovatively consolidating previous literature. This editorial acts as a call to action, asking for power to be approached and discussed via the development of a special issue that will further support this editorial and research within this specific area.

Whilst there has been increasing attention to the adoption and acknowledgment of theory throughout the field (D'Amour et al, 2005, Hean et al, 2009; Hean et al, 2012, Hean and Reeves, 2013), Scott and colleagues noted an absence of explicit conceptualization specifically addressing power and power relationships. This oversight is both curious and concerning, given that relationships between professionals in health practice and educational institutions, are by and large situated within hierarchical structures and are historically unequal in nature.

The relative under development of the role of power in the literature however is perhaps not completely surprising. Responding to this invites courageous conversations that by their very nature invoke disagreement in a field that strives for collaboration and teamwork. Ironically, if the end goal of interprofessionality is shared responsibility and decision-making, then such power disparities most certainly must rise to the surface and be addressed. To do so should advance the interprofessional field by collectively tackling a commonly cited challenge to its full integration. Ignoring this perpetuates a stalemate to progress. To paraphrase Foucault, forms of oppression and domination that remain invisible run the risk of becoming the norm.

Power is a contested topic in both definition and application (Lukes, 1974, 2005, Connolly, 1993) and the social science literature amongst others, offer a vast array of differing concepts, frameworks and perspectives. Although somewhat inconsistent and in places, under developed, there have been some useful theoretical contributions to the interprofessional field. This editorial provides an overview of some of the theories of power that may be applied to interprofessional education and practice, taking on the mantle of provocative exploration. Key theories of power are discussed and interrogated, and a range of key factors are explored in an

attempt to suggest how the literature may inform our understanding of the potent influence of power in interprofessional relations and practices. The following also suggests ways in which readers may frame their submissions, providing tentative examples of the utilization of theory for interprofessional discussions of power.

Previous application

Despite gaps in the literature, important acknowledgement, discussion, and application of seminal power theories across macro, meso, and micro contexts have been brought to light in healthcare practice and education within interprofessional contexts (Foucault, 1977, 1980; Friedson, 1970; Friere, 1968; Strauss, 1978; Witz, 1991). Baker and colleagues (2011), for instance, employed Witz's model of professional closure in their exploration of power structures following the introduction of an interprofessional education initiative. Finding that the perceptions of professionals either reinforced or attempted to redefine existing power structures in a particular interprofessional education context, this work sheds light on the potential for various forms of contestation within interprofessional settings.

Rowland and Kitto (2014) employed Foucault's theories in their critical discourse analysis of patient safety documentation, and found that the disparate and culturally charged meaning behind patient safety had significant implications for the notions of power which characterised professional relationships. In addition, DeMatteo and Reeves (2013) utilised Foucault's work in their study of professional identity in the 'enterprise culture'. Reeves et al (2009) further drew upon Strauss's (1978) negotiated order theory, in an attempt to explore the nature of interactions between various members of a healthcare team. Their work revealed a notable

imbalance in the 'quality' of interactions which appeared to be dependent on role, or moreover, status.

Potential application

Although power dynamics play out in all professional settings, very little has been written about their role in interprofessional education and within developing health care contexts, where interprofessional education is essential, for example, health workers within primary care teams in low resource settings. Ideally, health education seeks to dismantle the professional practice hierarchy before it forms. However, power inequities are maintained by power identities as noted in the 'white coat' story. Perceived positions of power are enacted in academia, for example, in setting preferences for scheduling, shared learning activities, and curricular content based on the needs and priorities of privileged departments (Jones & Phillips, 2016). In healthcare settings, workers within primary care teams bump up against entrenched power identity structures, for example, when managing decision-making and taking on team leadership roles. Power distinctions may be less apparent in low resource settings where systems face workforce shortages and differing professions are called upon to function at the highest levels of their practice. However, global transformation in health care culture towards collaborative practice is only possible when opportunities for shared decision-making, cross-professional communication, and conflict resolution are institutionally supported and reviewed (WHO, 2010). To achieve this end vision, the influence of power must be named, addressed, and integrated into interprofessional and collaborative training models.

Political power should not be overlooked in the discussion of national and global healthcare dynamics. The exploitation of health and social care by political entities across the world will continue to influence provision. Green's (2013) mapping of the politicized development of interprofessional collaboration situates the field as being rooted in and dependent upon the resident power struggles in the shifting political landscapes which have been evident in UK (and global) contexts. The success with which the interprofessional field has marketed itself whilst remaining concerned with and responsible for improved patient outcomes implies that there is a need in contemporary contexts to engage with a narrative which positions representation for political means against more meaningful practical application. The subsequent significance of interrogating coercive systems becomes clear, going beyond academic interest alone.

Critical and empowerment theories rooted in Marxist sociological and critical social work theories are concerned with misuse of power, marginalization, and oppression based on class/position; bureaucracy, race, and gender across systems. Empowerment theory recognizes patterns of dehumanization and social exclusion attributed to people who historically lack privilege and to systems that maintain impenetrable hierarchical stratification.

Accounts of interprofessional education and collaboration moreover rest on functionalist assumptions. For example, conflict and dissent are construed as obstacles to be overcome in pursuit of a unifying trope such as patient-centredness or treatment outcomes. Yet the context of health and social care is highly complex, presenting agencies with wicked problems that span boundaries and are ill-suited to a plan-and-prepare approach. Studies of activity systems in such contexts (e.g. Engestrom, 1999; Checkland, 1990) point to the

importance of pluralism, creativity and dialogue, rather than prescriptive models of management and practice. A potential reference point here is Habermas' (1987) model of human interests corresponding to three areas of knowledge, the technical, practical and emancipatory, which arguably exist in any interprofessional setting.

One can speculate how these, and other critical theories may help untangle tacit impediments to interprofessional practices now being promoted in education, healthcare, and research. In combination, they offer alternative perspectives through which one can critically analyze popular concepts in contemporary healthcare such as teamwork, patient-centeredness, and shared decision-making that imply mutuality but are perhaps deceptive or misleading. In his seminal doctrine *Pedagogy of the Oppressed*, Paolo Friere (1972) cautioned against the notion that anyone can confer power to another; equity he believed came about through systemic action, collectivity, and social change.

Power dynamics, along with internal and external power structures currently play a massive role in a range of countries where health systems are considered flawed or weak. The WHO (World Health Organisation) is calling for all countries to focus on their health workforce strengthening, including those that are financially stable such as the United States to those in areas of conflict and poor economic growth. In many of these contexts you will see that the power dynamics and structures vary from culture to culture, country to country, particularly in healthcare. Gender also clearly plays a role in the healthcare setting and this ultimately does affect the power dynamic in all geographical contexts, more so in some than others (Dhatt, 2017). The absence of collaboration and interprofessional education and research is clear in these geographies. This is still the case, even though interprofessional education is indicated as

part of the WHO's National Health Workforce accounts (WHO, 2017). Why is this and what are the dynamics and power structures affecting this? How can novel innovation and technology address this?

Framing

Paulo Freire's philosophical work on oppression and what he deemed the 'culture of silence' (1972), in which response to social systems which have created both practical and ethereal cycles of oppression is counteracted by negative self-image, and then affirmed by the development of critical consciousness, is particularly useful. Successful interprofessional engagement is often obstructed by the unspoken power structures which place various professionals in an accepted hierarchy, although an acknowledgement of this will often challenge the assumed roles into which various professionals position themselves without question.

The complexity and multi-faceted characteristics of effective interprofessional collaboration speaks to Antonio Gramsci's hegemony theory, in which 'working class' or 'culturally oppressed' members of society must engage, align, compromise and connect intellectually with those who traditionally dominate. Although Gramsci largely situates social movements as a series of struggles, the collaborative engagement required here is keenly felt. We know that a range of inequalities exist between healthcare professionals, yet the need to respond to them in creative, intelligent and innovative ways is perhaps not immediately clear. Applying work of this kind begins, at least, to offer an adaptable perspective.

Michel Foucault's work explores many diverse themes, although power seems to underlie each one of these. The way in which he expertly and uniquely described the productive capacity of power offers those with an interest in interprofessional collaboration a distinct opportunity to engage with alternative perspectives on domination and oppression, and think about the way in which healthcare professionals work together in from a less conventional lens. Very briefly, and of course doing a large disservice to the extent of his work, Foucault suggested that whilst power is oppressive, it also has the capacity to liberate, as it runs throughout the entire social body in modern and late modern contexts. No longer enacted by an individual entity, it is intelligent and multi-faceted. Is this reflected in interprofessional settings? The need for collaboration has perhaps realigned traditional notions of power and dominance in healthcare environments, rewarding interprofessionalism but reinterpreting rather than diminishing conventional forms of power.

Conflictual, Consensual and Constitutive Views

The conflictual view refers to a dualistic framework that understands power to be rooted in domination or power over in an overt, visible sense. Grounded in Marxian ideology, Gramsci's (1971) cultural hegemony theory offers an explanation of the inevitable continuity of Capitalism and nation-states, providing a clear narrative which statically situates both oppressor and oppressed. This view has key implications for interprofessional practice and research, as there are evident disparities in both the practical and symbolic resources which various healthcare professionals possess and exploit.

The conflictual view of power was furthered by C. Wright Mills (1956) and other theorists (notably Durkheim 1984 and Weber 1978), however there is growing momentum to look beyond dualistic narratives for the purposes of interprofessional collaboration and with an eye towards a more complex study of power, especially in a rapidly changing healthcare environment. Dahl's (1957) behaviorist work first offered a response to this by bringing to the fore the notions of agency and resources. Is it possible to utilize the traditional conflict based theories which Gramsci, Mills and others developed to turn our attention to consensual treatments of power and the role and significance of notions of agency?

The consensual view delves into the dispersal of power and systems of dominance evident in interprofessional contexts without remaining tied to a two-dimensional, mutually exclusive conception of oppressor and oppressed. Consensual notions imply a move away from simplistic domination and a recognition of the mobilising and stabilising capacity of power in the context of social structure. Parsons (1967) perceived consensual power as an essentially facilitative phenomenon, a force to achieve goals and get things done. For Parsons, power could not be conceptualised as a 'zero-sum' game of winners and losers, this interpretation being too restrictive and one that overlooks the capacity of power to be a constructive force, which can contribute to the maintenance of social stability.

The consensual view arguably provides a more sophisticated acknowledgment of the treatment of power, however there are fundamental characteristics that remain problematically absent. The idea of conventional power in Giddens' (1990) estimation is challenged by a model which is bolstered by reflexivity and agency, themselves often associated with dissidence and change (Friere, 1972). With these factors in mind power can be addressed

in a way which speaks to the subtle yet potent familiarisation of established social regimes, and our consistent and often passive buy in to social structures and accompanying contributions.

This consensual analysis of power lends itself well to an interprofessional application as it acknowledges the dynamic existence and tensions inherent in individual and collective perceptions of role in healthcare contexts. Professional identity is mediated by and dependent upon the institutional context, and whilst professional hierarchy and structure are evident in institutions of healthcare and health education, an intricate and productive agentic struggle between professionals at all levels is continually in action.

The constitutive view offers a third approach to power which both accommodates and goes beyond the previous two conceptual forms. Haugaard (2016) states that: 'While constitutive theorists largely accept the conflictual power/freedom opposition, they consider the normative desire for an escape from power a subtle ruse of domination.' This provides an appropriate opportunity to refer back to the work of Foucault, whose contribution to the study of power is difficult to overlook. Foucault's work can be considered constitutive as there is, throughout his writing, an underlying but inextricable relationship between power and knowledge.

Concluding Comments

This editorial provides a brief and clearly partial overview of theories from the social science literatures (e. g. sociological, social work, philosophy, and political science) that have been used to examine power in interprofessional contexts. As such, we regard this paper as an initial contribution to a special issue of the Journal of Interprofessional Care. One that we hope

sparks the interest of scholars and encourages submissions of their preferred theories to deconstruct and analyze power's vagaries and challenges in collaborative work in addition to their application to interprofessional healthcare. We also view this as an invitation for a special edition as a way to continue what Scott began and in some small way contribute to his irreplaceable legacy.

To contribute to this special issue, please submit short research paper proposals to Simon Fletcher (simon.fletcher@sgul.kingston.ac.uk) by October 31st 2019. These can be current studies, theoretical pieces or empirical research studies. Submissions for this special edition will be due by 14th April 2020, with publication being completed by 2021.

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