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Power dynamics and interprofessional collaboration: How do community pharmacists position general practitioners, and how do general practitioners position themselves?

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ABSTRACT

Power differentials and medical dominance can negatively affect collaboration between physicians and pharmacists. Norway is recognized as having a relatively egalitarian work sector, which could affect power differentials. In this qualitative study, we used positioning theory as a framework to explore the aspect of power dynamics between Norwegian general practitioners (GPs) and community pharmacists. We used the concepts of reflexive and interactive positioning to identify how GPs positioned themselves and how they were positioned by pharmacists in six focus groups. Data were analyzed using systematic text condensation. We found positioning theory to be a useful lens through which to study power dynamics in relation to collaboration between community pharmacists and GPs. Our findings imply that the presence of medical dominance poses challenges even in an egalitarian Norwegian setting. However, although both GPs and pharmacists draw on a 'medical dominance' storyline, we have also identified how both pharmacists and GPs draw on alternative and promising storylines of collaboration between the two professions.

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Interprofessional collaboration; pharmacists; physicians; positioning theory; power dynamics; medical dominance

Introduction

In a paper by Konrad et al. (2019), the authors called for more research on power dynamics in relation to interprofessional collaboration. Power, which can be defined as being in possession of control, authority, or influence over others (Merriam-Webster, n.d.), is highly relevant to the collaboration between general practitioners (GPs) and community pharmacists. These two groups of professionals interact with each other related to the pharmacists' task of dispensing GPs' prescriptions. A traditional power differential between physicians and pharmacists, with physicians ranking higher in the hierarchy, has been well documented (Cooper et al., 2009; Luetsch & Scuderi, 2020; Thomas et al., 2021; Weiss & Sutton, 2009). In most countries, the dominance of the medical profession controls and limits the professional role of pharmacists (Traulsen & Bissel, 2010), and several studies have described how the presence of medical dominance negatively affects a collaboration between physicians and pharmacists (Luetsch & Scuderi, 2020; Rakvaag, Søreide & Kjome, 2020; Rieck, 2014).

Norway is recognized as a country with a relatively egalitarian work sector (Skarpenes & Sakslind, 2010). This could affect such power dynamics, and potentially be a driver for interprofessional collaboration. In this paper, we aim to respond to Konrad et al.'s (2019) call for more research in this field. We explore the aspect of power dynamics between GPs and community pharmacists in a Norwegian setting, by identifying how GPs position themselves and how they are positioned by community pharmacists in profession-specific focus groups. We will further discuss the potential implications of the identified positions on the collaboration between the two professions, seen in the light of previous research on interprofessional collaboration.

Background

The scope of this paper

Multiple factors have been cited as influencing the collaboration between pharmacists and physicians. Previous researchers have categorized these factors into three main categories: contextual characteristics, participant characteristics, and exchange characteristics (McDonough & Doucette, 2001). The focus in this paper is on exchange characteristics, which encompass the social exchanges between pharmacists and physicians. The characteristics within this category have been described as especially influential drivers of pharmacist-physician collaboration (Bardet et al., 2015; Doucette et al., 2005; Zillich et al., 2004).

The Norwegian context

Norway has a national regular GP scheme, which entails that all residents with a Norwegian social security number have the right to be registered with a regular GP. Most GPs are self-employed on a fee-for-service basis, paid partly by the National Insurance Scheme, and partly by the patient. In addition, GPs

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enter into a contract with a municipality, and they are paid according to the number of patients on their list. GPs have responsibility for treatment and follow-up of the patients on their list. They also have responsibility to refer patients to other services within primary health care or to secondary care, if necessary (Sandvik, 2006).

Community pharmacies in Norway are privately owned, primarily by three large pharmacy chains. Most community pharmacists are employees in these chains, and only a few pharmacists own their own pharmacies. About 3,700 pharmacists work in Norwegian community pharmacies (in 2016; Larsen, 2018). These include both MPharm and BPharm. Community pharmacists (with a few exceptions) do not have the right to prescribe. Their main work tasks include dispensing medications from prescriptions, providing patient counseling, and giving medication advice. In addition, pharmacies offer a wide range of extended pharmacy services, such as checking inhaler technique, multi-dose packing, stop-smoking guidance, measurements of blood sugar and cholesterol, mole scanning, and vaccination. In 2001, there was a liberalization of the Norwegian pharmacy market. Since then, there has been a rapid growth in the number of pharmacies, particularly in cities (Larsen, 2018; Vogler et al., 2014).

A report (Oslo Economics, 2020) mapping the collaboration between GPs and pharmacists in Norway found that there is currently limited collaboration between GPs and community pharmacists. The interaction between them could mostly be defined as coordination, most commonly involving non-formalized ad-hoc communication by telephone to clarify issues in connection with dispensing prescriptions. However, the authors found some examples of successful collaboration taking place at small rural sites where the pharmacist and the GP knew each other personally.

Theoretical framework

Positioning theory (Harré & van Langenhove, 1999) focuses on the distribution of rights and duties among people to speak or behave in certain ways, with the aim of highlighting practices that inhibit certain groups of people from performing certain acts or saying certain things by means of a study of *positions* created in *storylines* (Kayı-Aydar, 2019). The act of positioning refers to the assignment of positions or 'fluid roles' to oneself or others through conversation (Tan & Moghaddam, 1999). A position can be specified by reference to a person's role, and the roles individuals have may affect how they position themselves and others. By engaging in positioning, people can claim, deny, and give certain rights, as well as demand or accept certain duties (Kayı-Aydar, 2019).

A storyline can be defined as "the context of acts and positions" (Kayı-Aydar, 2019, p. 6). Participants in a conversation co-construct a storyline in which each participant claims a position for themselves or is given a position by others (Harré & van Langenhove, 1999). These positions can be impacted by existing storylines, as well as by storylines that develop as the conversation unfolds. When people take up new positions, a new storyline develops. As with positions, storylines are not fixed but are open for renegotiation, which means that whenever somebody enacts a certain storyline, other participants in the interaction may choose whether or not they want to be complicit with that storyline and how they are positioned within it. Alternatively, they may generate a competing storyline (Kayı-Aydar, 2019).

Positioning can occur both at an individual level and at a group level, as the personal stories told by people can also include storylines concerning groups of which they are members (Kayı-Aydar, 2019; Tan & Moghaddam, 1999). Intergroup positioning occurs when individual persons or groups of persons position their own or other groups. One example could be the positioning of one's own profession as superior or submissive to another profession (Tan & Moghaddam, 1999). Positioning theory can be useful when studying intergroup relationships. The storylines adopted by different groups may be incompatible or in direct opposition with each other, which can result in conflict. To ease such conflict, it is necessary for the groups to adopt new alternative storylines (Tan & Moghaddam, 1999).

In this study, positioning theory was used as a theoretical framework, both to focus our analysis toward identifying the different positions assigned to the GPs, and in discussing implications of the identified positions in relation to power dynamics and collaboration. We use two concepts – 'reflexive positioning' and 'interactive positioning' – to examine how GPs position themselves and how they are positioned by community pharmacists. 'Reflexive positioning' means the positioning of oneself in response to others, whereas 'interactive positioning' means the positioning of others (Harré & van Langenhove, 1999).

Method

Research design

A focus group design is particularly suited in situations where the goal is to identify the shared experiences, opinions, attitudes, and beliefs of a group rather than those of an individual (Morgan, 1997), and it was therefore considered appropriate to gather opinions from pharmacists and physicians as representatives of their respective professions. This is our second paper to be based on one set of focus group data. In our previous paper (Rakvaag, Søreide, Meland et al., 2020), we identified pharmacists' and GPs' positioning of community pharmacists. We provide here a short summary of participant recruitment, demographics, data collection, and analysis. A more detailed description of the method can be found in our previous paper (Rakvaag, Søreide, Meland et al., 2020).

Participants and data collection

Inclusion criteria for participants were having experience with a community pharmacy or general practice. There were no exclusion criteria. Pharmacists were mainly recruited through a post on a Facebook group that is open to all pharmacists in Norway, with 5,600 members. Physicians were recruited by contacting continuing education networks for GPs. Twelve pharmacists and 10 physicians participated. The participants varied in terms of workplace setting and years of work experience (see participant demographics in Table 1).

Table 1. Participant demographics, retrieved from (Rakvaag, Søreide, Meland et al., 2020).

Variable	Category	Pharmacists *(n = 12)*	Physicians *(n = 10)*
Gender	Female	9	4
	Male	3	6
Age (years)	Mean	35	45
	Range	25–58	36–66
Work experience (years)	Mean	8	17
	Range	0.6–30	8–38
Level of education	Bachelor's degree	0	NA
	Master's degree	12	
Current workplace	Community pharmacy	10	NA
	Hospital pharmacy	2	
Experience as GP (years)	Mean	NA	11
	Range		1–37
Currently working as a GP	Yes	NA	7
	No		3

NA: not applicable

Six focus groups – three with physicians and three with pharmacists – were held in 2019, using profession-specific semi-structured interview guides with open-ended questions (see interview guides in Tables 2 and 3). We chose to have uniprofessional focus groups, as homogeneous groups are recommended in order to prevent tensions within the groups (Malterud, 2017, p. 138) and enable the participants to express their honest opinions. Although a pharmacist served as the moderator in all focus groups with the pharmacists, researchers with different professional backgrounds (pharmacy, education, medicine) were moderators in the focus groups with physicians. Each session was audio recorded and later transcribed verbatim by the first author. By the end of six focus groups, we considered the chosen sample to hold satisfying information power (Malterud et al., 2016), in that all of the participants had relevant experience with the topic under investigation, which

Table 2. Interview guide for physicians.

Theme	Questions
The GPs	What would you say characterizes a good GP?
	What are the typical features of physicians' professional culture? (Could you characterize 'the typical physician'? Are there any unwritten rules or norms that physicians follow?)
	As a GP, I assume that one often finds oneself in situations where there is not one single correct answer to a clinical problem. How do you feel about having to make decisions in such gray areas?
The pharmacists	What would you say characterizes a good pharmacist?
	Do you think GPs and pharmacists have the same priorities/consider the same things as important?
Collaboration	How would you describe your collaboration with pharmacists?
	Could you please tell us about the last time you had a clinical conversation with a pharmacist, and how the conversation went?
	How would you describe your trust in pharmacists?
	When you are in contact with pharmacists, do you feel that they have trust in you as a GP?
	How do you perceive the division of responsibility between GPs and pharmacists? (For example: who do you see as having responsibility for patient compliance, correct dosage, drug information, practical use of the drug, drug interactions, side effects, etc.?)
	If you set aside practical factors, such as time shortage and lack of communication platforms, which other factors influence your collaboration (or lack of collaboration) with pharmacists?
	How do you perceive the need to improve your collaboration with pharmacists?
	Who should contribute with what in order to improve collaboration?
Findings From Previous Study/Reactions to These	
Shopkeepers/commercial aspect of pharmacy	In a previous study, we found that many GPs perceived community pharmacists more as shopkeepers than as health care personnel and were uncertain about the pharmacists' competence as well as their agenda. The pharmacists did not agree with being shopkeepers.
	What are your thoughts on this finding?
	Why do you think this is the case?
Proactive pharmacists	The GPs are probably the most important collaborators for the pharmacists, outside of their own profession, and the contact with other types of health care personnel is much more infrequent. GPs probably deal a lot more with many different types of health care personnel, as well as with other collaborators. How do you perceive your collaboration with pharmacists compared to with your other collaborators?
	In our previous study, we found that a proactive approach by the pharmacists was important in order to achieve a successful collaboration with GPs. *(A definition of what we mean by proactiveness)*
	Do you have any reflections concerning this finding, based on your personal experiences?
	Can you tell us about an occasion when a pharmacist was proactive toward you? What did she/he do?
	In our study, we also found that knowing each other was important for collaboration. What are your thoughts regarding this finding?
Communication	In our study, we found that some pharmacists were afraid of insulting the GPs whenever they had to contact them regarding prescription errors, and that some GPs felt criticized as they were only contacted whenever there was something wrong with a prescription.
	What are your thoughts about this finding?

Pharmacists: community pharmacists

Table 3. Interview guide for pharmacists.

Theme	Questions
The pharmacists	What do you see as the characteristics of a good pharmacist? Do you have any thoughts about what differentiates pharmacists from other health care personnel? What are the typical features of pharmacists' professional culture? (Could you characterize 'the typical pharmacist'? Are there any unwritten rules or norms that pharmacists follow?) Sometimes when working as a pharmacist at the pharmacy, you find yourself in a situation where there is no single correct answer to a problem. How do you feel about having to make decisions in such gray areas?
The GPs	What do you see as the characteristics of a good GP? Do you see any similarities or differences within the professional cultures of pharmacists and of physicians? Do you think pharmacists and GPs have the same priorities/consider the same things as important?
Collaboration	Could you please tell us about the last time you had a clinical conversation with a GP, and how the conversation went? Do you trust the GPs? When you are in contact with GPs, do you feel that the GPs trust you as a pharmacist? How do you perceive the division of responsibility between pharmacists and GPs? (For example: who do you see as having responsibility for patient compliance, correct dosage, drug information, practical use of the drug, drug interactions, side effects, etc.?) How would you describe your collaboration with GPs? If you set aside practical factors, such as time shortage and lack of communication platforms, which other factors influence your collaboration (or lack of collaboration) with GPs? How do you perceive the need to improve your collaboration with GPs? Who should contribute with what in order to improve collaboration?
Findings From Previous Study/Reactions to These	
Proactive pharmacists	In a previous study, we found that a proactive approach by the pharmacists was important in order to achieve a successful collaboration with GPs. *(A definition of what we mean by proactiveness)* Do you have any reflections concerning this finding, based on your personal experiences? To what extent do you see yourself as being proactive toward GPs? How have proactive approaches from your side been received by the GPs? In our previous study, we also found that knowing each other was important for collaboration. What are your thoughts regarding this finding?
Communication	In our study, we found that some pharmacists were afraid of insulting the GPs whenever they had to contact them regarding prescription errors. What are your thoughts about this finding? Do you express yourself in a particular way when contacting physicians?
Shopkeepers/commercial aspect of pharmacy	In our previous study, we found that many GPs perceived community pharmacists more as shopkeepers than as health care personnel and were uncertain about the pharmacists' competence as well as their agenda. The pharmacists did not agree with being shopkeepers. What are your thoughts on this finding? Why do you think this is so/the case?

enabled them to participate in the conversation. Also, there was a high level of engagement concerning the study topic in all the groups. This resulted in high quality dialogs relevant for the study. We therefore did not consider it necessary to include additional groups.

Ethics

The Norwegian Social Science Data Services (NSD) approved the study. Written informed consent was obtained from all participants. All participants received a gift card with a value of NOK 400 (EUR 37) as a small compensation for travel expenses and time spent.

Analysis

The data from the pharmacists and physicians were analyzed separately, using systematic text condensation (STC). STC is a method for thematic cross-case analysis (Malterud, 2012). The theoretical framework of positioning theory (Harré & van Langenhove, 1999) was used to guide our focus toward the reflexive positions (positions assigned to oneself) described by the physicians, and the interactive positions (positions assigned to others) described by the pharmacists. STC is an inductive and iterative approach, consisting of four steps: (a) getting an overview of the data; (b) organizing the data by coding the text and identifying meaning units; (c) systematic abstraction of meaning units by writing condensates; and (d) recontextualisation by synthesizing the condensates, developing descriptions and concepts. Our findings are presented as concepts that represent the identified positions that pharmacists and GPs in the focus groups assigned to GPs..

Findings

This section is a descriptive presentation of the main positions of the GPs that were identified during the focus groups with GPs and those identified during the focus groups with pharmacists. Although participant quotations are presented in the descriptions of the different positions, these quotations serve as illustrations of the findings and not as descriptions of individual or groups of GPs. Consequently, the following presentation is not a description of *persons*, but of *positions* that are assigned to GPs by themselves or the pharmacists. Therefore, the various positions might conflict with or oppose each other.

Positions identified in the focus groups with GPs – reflexive positioning

GPs are autonomous, responsible, and in charge

GPs are a very autonomous group of professionals; who are most comfortable with being their own bosses, without anyone standing above them in the hierarchy. GPs usually make decisions alone in the many decision-making processes involved in

the diagnosis and treatment of patients. An essential part of being a GP is thus to be able to make independent decisions, trust oneself, and handle uncertainty. As one physician noted, "We make our own decisions and have to trust ourselves" (Group 2, physician 1).

GPs have final responsibility for their patients, and must therefore oversee all decisions concerning the patients' medical treatment. They do not want to be undermined, and can feel indignant and offended if pharmacists give patients advice that deviates from the GP's instructions, or if they discuss clinical issues directly with patients without involving the GP.

GPs are health care quality gatekeepers

GPs have the authority and knowledge to define what constitutes good and bad quality health care. They are concerned by a lack of competence or the quality of work performed by other actors within the health care field (included pharmacists), and express a need to assess the quality of the work of others in order to avoid the extra burden of having to 'clean up' afterward. This is illustrated by a quotation from a physician speaking about extended pharmacy services, such as cholesterol measurements and vaccination in pharmacies:

> It would be more acceptable if we knew their internal procedures. It would be okay if I knew that the pharmacists were specially trained, or had taken a 'safety course,' and that they could be held responsible for what they are doing. It has to be addressed clearly – we must be reassured that what they are doing at the pharmacy is quality assured. Then it would be okay by me. (Group 1, physician 1)

As clinicians who see the big picture, GPs are the only ones who can ensure follow-up and continuity in the treatment of patients. If patients use other health care actors instead of their GP, their treatment could become fragmented, and it could also nurture health anxiety and insecurity.

GPs are threatened

Pharmacists who perform extended pharmacy services step into the GPs' sphere and threaten their livelihood. By offering such services, pharmacies 'steal' the GPs' 'easy' patients and their 'easily-earned' income. This leaves the GPs with the more complicated, expensive, and less pleasurable work tasks. GPs and pharmacies are, in other words, in competition for customers. One physician explained, "For us GPs that have private practices, it always gets sort of tense when it comes to finances – it breeds misunderstanding and creates a bad atmosphere when the pharmacies steal my 'flu vaccination patients" (Group 2, physician 1).

GPs' time is precious

GPs are very busy, and they cannot afford to waste any time. GPs are too busy to prioritize any activities to help foster collaboration with pharmacists just for the sake of achieving a collaboration. Potential collaboration with pharmacists can only be achieved if the pharmacists initiate contact, not vice versa. GPs would also need to get some kind of personal gain, such as study credits, to engage in collaborative activities with pharmacists. This is illustrated by the following quotation from a physician:

> GPs work under time pressure, so if we are to have any dialogue with pharmacists in a setting other than the everyday setting, it has to be one that is productive and that gives us something in return, so that we do not waste our time, because that is something we cannot afford. (Group 1, physician 1)

GPs are not infallible

GPs are vulnerable; their mistakes have the potential to be fatal and irreparable. In certain areas regarding medication, GPs have limited competence, and they therefore appreciate pharmacists' help in these areas. The double-checking and quality control performed by pharmacists is reassuring, both for GPs and for patients. In the words of one physician:

> I really appreciate that they [pharmacists] call, of course I do! (. . .) It is important and useful that someone checks, because sometimes it all goes a bit quickly, and then it is easy to make mistakes, even if you aren't supposed to. (Group 3, physician 3)

Positions identified in the focus groups with pharmacists – interactive positioning

GPs are skilled, but busy

GPs are to be trusted, as they are highly skilled and competent within their field of expertise. GPs' time is valuable, but it is limited. Time constraints sometimes hinder GPs from keeping themselves updated on new medications and recommendations, and are sometimes also the cause of mistakes in prescriptions. As making mistakes is human and happens to everyone, the competence of GPs should not be distrusted. A pharmacist explained it this way:

> A GP can be great at treating patients even if he is not updated. This does not make me think that he is a poor physician, I just assume that he might have missed that there is a new treatment recommendation. Then I just notify him. (Group 1, pharmacist 3)

GPs are on top of the hierarchy

GPs are the ones in charge. They always have the final say, and their decisions cannot be overruled by a pharmacist. Consequently, being a GP is more prestigious than being a pharmacist, and their place in the hierarchy is already established at the university level, with medical programmes being longer and having higher grade admission requirements than programmes for other health professions. Patients trust physicians and pay more attention to advice given by physicians than by pharmacists. However, this position also comes with burdens, such as having to bear full responsibility for making a diagnosis and the choice of treatment. As one pharmacist noted, "I think that the GPs have an extra burden of responsibility compared to us, because they must make a diagnosis and choose the correct treatment from among many possible medications" (Group 3, pharmacist 1).

GPs are cooperative and open to input

GPs are very cooperative, helpful, and easy to talk to. Most GPs wish to have a good collaboration with pharmacists. GPs trust pharmacists, and they understand that when pharmacists contact them it is because of something important. They are very grateful when pharmacists discover and correct errors in

prescriptions. One pharmacist stated, "In my experience, most GPs are very supportive and helpful. They understand that we have an important role, and that when we call it is because something is wrong" (Group 3, pharmacist 1).

GPs are not very helpful or cooperative

GPs are not very easy to collaborate with, mainly due to their attitudes. They are often unavailable, due to long holidays, short opening hours, frequent breaks, undisclosed telephone numbers, long waiting times for contact by telephone, and gatekeeping secretaries. They also do not reply or give feedback to pharmacists' inquiries. The older generation of physicians in particular perceive themselves as being better and more skilled than pharmacists, and do not trust pharmacists' professional knowledge. GPs are not willing to accept help from other professions regarding patient treatment. As one pharmacist pointed out, "A main difference [between GPs and pharmacists] is that the GPs are not open towards accepting any help regarding patient treatment, whereas we are very open towards this" (Group 2, pharmacist 5). Compared to other professional groups, the GPs find it challenging to admit to any mistakes, and they are afraid of losing face. Finally, GPs and the Norwegian Medical Association are protective of their professional territory and economic interests.

GPs must be looked after and controlled

GPs make many mistakes – sometimes serious ones – and they therefore need to be looked after by pharmacists in order to prevent patients from being exposed to harm. One pharmacist exclaimed: "The GPs make so many mistakes!" (Group 2, pharmacist 1). Due to differences in their education, GPs are less precise than pharmacists. GPs also avoid taking responsibility in situations where patients use medications prescribed by other physicians, as they do not see it as their responsibility, are afraid to step on other physicians' toes, or do not dare to interfere with a specialist's decision. In addition, GPs do not give their patients sufficient information, because they do not have, or do not take, the time needed to inform their patients properly. Also, they often do not have the necessary communication skills, and talk 'over the patients' heads.' This applies particularly to older GPs, whereas the younger generation have better communication skills.

Discussion

The identified positions serve as a starting point for discussing common or conflicting positions and storylines in relation to power dynamics and collaboration between GPs and community pharmacists.

Positions and medical dominance

Despite the egalitarianism of Norwegian society in general, several of the identified positions contain aspects that could be described as medical dominance. The concept of medical dominance, originally developed by Freidson (1988), refers to the medical profession's control over the content, terms, and conditions of its own work (autonomy), control over the work of other health occupations (authority), and control over the broader context of health care (sovereignty; Wranik & Haydt, 2018).

Examples of aspects of medical dominance in our material are when not only the reflexive but also the interactive positioning of the GPs draw on a storyline that situates GPs at the top of the hierarchy of health care professions, that questions the GPs' need for knowledge, input and assistance from other health care professions (pharmacists included), and that allows GPs to protect their territory by setting the standards for good and poor quality health care. Many of these aspects fit into the four categories of medical dominance defined by Luetsch and Scuderi (2020): (a) demarcation against and criticisms of pharmacy services that encroach on medical territory (e.g., vaccinations); (b) denigration or denial of pharmacists' or other health professionals' role, skills or service, (e.g., to other health professionals or patients); (c) evasion of scrutiny (e.g., refusal by doctors to engage with a pharmacist who questions prescriptions or to rectify prescription errors [either therapeutic or regulatory errors]); and (d) dismissal or disparagement of evidence-based or patient-based advice to correct medical decisions that could potentially have caused patient harm.

Medical dominance has been reported as one of the key barriers to interprofessional collaboration and teamwork (McNeil et al., 2013). Most of these aspects of medical dominance identified in the positioning of the GPs could be seen as barriers to collaboration, as they draw on and uphold a storyline that underscores the hierarchy in the relationship between GPs and community pharmacists. As storylines allow actors and groups to position themselves and others (Louis, 2008), the storyline of medical dominance is powerful, not only because it assigns GPs high relative power but also because this storyline is highly significant in the interactive positioning of GPs by the pharmacists participating in the focus groups. If alternative storylines are weak, or non-existent, there will also be fewer possibilities for pharmacists to assign alternative positions to GPs that would change the power balance and cooperation between the professions. As groups with high relative power benefit from the status quo (Louis, 2008), there might be no incentives for GPs to negotiate alternative storylines that would allow alternative positions implying alternative power relationships. In other words, the dominant storyline of medical dominance might uphold the current positions we have identified, as a new position would have to be "viable to the extent it is embedded in a mutually acceptable story line" (Louis, 2008, p. 30). In the next section, however, we identify ambiguities in the identified positions, and consider how this ambiguity might support storylines that underscore the importance of collaboration.

Positions and ambiguity

Although the power of the storyline of medical dominance is strong, our analyses also illuminate positions and storylines that highlight other aspects that better promote collaboration. We identified 'windows of possibility' in the material related to collaboration. These possibilities and alternatives are visible in three instances of ambiguity, and they overlap across and within the interactive and reflexive positioning.

There is ambiguity within pharmacists' interactive positioning of GPs concerning their willingness to collaborate. We have identified the two opposing positions of GPs as being both 'cooperative and open for input' and 'not very helpful or cooperative.' At first glance, this may seem to be indecisiveness on the part of the pharmacists. However, our analyses also illuminate that, across the focus groups, this ambiguous positioning draws on a generational storyline, whereby younger GPs are regarded as being more cooperative and more open than the older generation of 'old school' GPs.

An additional ambiguity can be identified from the pharmacists' interactive positioning and GPs' reflexive positioning, whereby both professions position GPs as being highly skilled and autonomous, as having the main responsibility for patients, and simultaneously as being 'not infallible' and being dependent on the pharmacists for quality control. Here, GPs and pharmacists draw on a coinciding storyline concerning GPs' autonomy, dependence, challenges, and need for support in their everyday working lives. This overlap in storylines could benefit collaboration. According to positioning theory, there is less intergroup conflict when different groups have similar, or draw on the same, storylines concerning their intergroup relationships (Tan & Moghaddam, 1999). Agreement regarding professional roles has also been shown to be a core competency that is necessary for interprofessional collaboration (Suter et al., 2009).

Connected to this, and maybe most promising when it comes to collaboration, is the overlap in the GPs' reflexive positioning that 'GPs are not infallible' and the interactive positioning by the pharmacists that 'GPs must be looked after and controlled.' Positioning theory emphasizes that "'group histories' and 'histories of intergroup relations' are not fixed, objective narratives, but are collaboratively produced and ever-changing storylines, seen from particular positions" (Tan & Moghaddam, 1999, p. 187). This implies that both storylines and positions can be negotiated, changed, and adjusted. The overlapping storyline where GPs are positioned as dependent on pharmacists adds to the pharmacists' undoubted dependency on GPs, thereby creating a new storyline that positions the two professions as interdependent partners, with each performing different but important tasks. This narrated relationship of dependency is promising with regard to collaboration – first as such interdependency is found to be a core determinant for physician-community pharmacist collaboration (Bardet et al., 2015), and second because new positions will be viable to the extent they are embedded in mutually acceptable storylines, such as the ones we have identified.

Limitations

Factors other than those discussed here may have influenced our findings. In this study, we limited our scope primarily to 'exchange characteristics.' It is plausible that contextual characteristics, such as different models of employment between GPs and community pharmacists, or different economic incentives for collaboration between the two professions, could have influenced our findings. It is plausible that participant characteristics, such as age, may also have had an influence. In our cohort, the mean age of the participating pharmacists were lower than that of the GPs. This may be due to the slightly different modes of recruitment, and may potentially have influenced our findings.

Conclusion

We introduced the use of positioning theory as a novel theoretical approach in the research field of power dynamics in relation to interprofessional collaboration. As far as we know, positioning theory has not previously been used by others to study the power dynamics between pharmacists and physicians.

Our findings imply that the presence of power disparities and medical dominance poses challenges and barriers to the interprofessional collaboration between GPs and community pharmacists, even in an egalitarian Norwegian setting. However, our findings also suggest that there is potential for collaboration. By using positioning theory, we identified how the participants drew on shared and unshared storylines and positions that illuminated the rights and duties of the different professions. The identified instances of ambiguity and overlap in how both professions positioned the GPs could be regarded as promising with regard to collaboration. Most importantly, the ambiguity indicates that the positions are not entirely fixed, and that there is room for creating new or further developing alternative storylines that are more promising for collaboration.

Although both GPs and pharmacists in our study clearly draw on the 'medical dominance' storyline in their positioning of the GPs, the pharmacists do not restrict themselves to this storyline; they, as well as the GPs, draw on alternative and promising storylines of collaboration between the two professions. Our findings suggest that there are alternatives to the storyline of medical dominance that are relevant for the positioning of GPs and for the collaboration between GPs and pharmacists.

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