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

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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

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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

Table 2
Participation details for observations.

Stream of act health	Formal observation (h:min)	Informal observation (h: min)	Totals (h:min)
Aged Care and Rehabilitation	17:20	53:40	71:00
Community Health	53:20	7:10	60:30
Cancer Services	16:53	8:00	24:53
Mental Health	17:40	7:30	25:10
Hospital	22:12	5:40	27:52
Total	127:25	82:00	209:25

staff and case conferences. Observations in informal settings captured everyday conversations, activities and care delivered outside of these formal events, such as by accompanying individuals or standing by the nurses' stations in wards. Detailed handwritten notes were taken of participants' dialogue, activities and movement, and physical surroundings. In informal settings, this involved action within the eye and earshot of the observing researcher. During formal events, the observing researcher recorded participant dialogue as meticulously as possible, noting the degree of certainty with which dialogue was apprehended and indicating where dialogue was missed. These activities enabled the original analysis below of the number of turns taken by various participants at talk, and the approximate relative length of time they spent talking, in case conferences, as indicated by turn-length in the typed transcript.

Fieldnotes for both interviews and observations were analyzed by the three first listed authors and interpretations were negotiated with the fourth and fifth-listed authors. Instances of interactions between, and discussions about working with, staff from different occupations, were compared and contrasted iteratively. These enabled us to ground indicators of collaborative power in case conferences, which we document in the findings below. We engaged in cross-member checking to validate patterns in the findings, in order to discern patterns beyond individual differences in perspective and behavior (Gold, 1997).

Findings

Modes of patient management

The exercise of power was associated with patient management, and was different from acute to community settings. Patient management across settings aligns with variations in the use of competitive and collaborative power across the health system. Patient management involves guiding patients through the following phases in their care trajectories: presentation or referral to a service; assessment; diagnosis; admission; treatment; engagement for advice or shared care of clinicians from various occupations and medical or surgical teams; transfer or discharge; and follow-up care. These phases often overlap, and the sequence in which they occur can vary from patient to patient.

Patient management needed to be balanced with the belief by providers from across divisions in the importance of having distinctive roles and input into patient care among different occupations. For instance, a doctor-manager in mental health services lamented the reduction in distinctive roles among allied health clinicians in community mental health settings.

> I'm really concerned that the emphasis on multidisciplinarity has meant that allied health are losing assessment skills within their own profession … It's really important to have professional leadership [to develop distinctive skills].(Doctor-manager, Mental Health, interview)

Patient management was characterized by intraprofessional management by doctors. Doctors provided patient management, which centrally involved liaison with doctors from various departments. Both doctors and other clinicians conveyed that they expected doctors to take on a coordinating role in patient management in health care teams.

> The patient comes in under my authority. They're under my name, so I really decide if they come … I have responsibility for them.(Physician, acute ward, focus group)

Patient management by doctors involved both intraprofessional and interprofessional work. The expectation for this was held by both doctors and other clinicians. Doctors and other clinicians held that doctors had formal responsibility for patient care, indicated by a palliative care manager confirming, "the doctors have formal legal authority". Negotiation happened within, and, at times, to extend such role expectations.

Patient management differed from acute to community-based units. Most community-based units held case conferences of clinicians from different occupations. Case conferences are meetings to discuss the progress and decisions to be made about individual patients. Case conferences, as formal events, away from direct care delivery to patients, can be seen as an example of the ability of clinicians, and doctors in particular, to render the illness experience as timeless and hence controllable (Frankenberg, 1992). A feature of case conferences was a paper list which contained the patient name, age, admitting doctor (in acute settings), diagnosis and case plan. Unlike community-based case conferences, case conferences in acute services usually consisted only of doctors or of doctors and senior nurses. They rarely involved clinicians from other occupations. Medical ward rounds were the sites of key decisions about the patient trajectory in acute wards.

Observations revealed that an omnipresent role for doctors, and what defined their patient management role, in hospital-based services, in particular, was to make key decisions and organize key steps in the pathway of the patient through a health service. Hospital-based observations showed that the tasks of organizing key steps of the patient pathway were discussed and allocated during medical and surgical ward rounds within particular teams.

> *Geriatrician*: See if they can take him. … He's 89 and lives independently … I said I'm happy to get involved but I don't think he should come here (as an aged care admission).(Aged care and rehabilitation services, observation)

Thus the relationships among doctors, from various medical and surgical teams, were central in the function of broadly directing the patient journey through a health service.

Domination

Despite the broadly espoused commitment, including by doctors, to having different roles contributing to patient care, allied health clinicians in acute hospital settings, in general, believed that opportunities for input into patient care were, at best, *ad hoc* rather than systematic. The following comment from a focus group was made in answer to the question: "How do you find working in your organization?"

> *Social worker:* On a medical ward doctors get the first and final say … (Doctors) don't learn from us … People don't just have a medical aspect. They have an [occupational therapist], a dietician, a physio and a social worker aspect – sometimes one more than another.(Allied health clinicians, acute ward, focus group)

During observations, an allied health clinician said to the observing researcher: "If a doctor says (they can't go) they won't be discharged … If I say they can't go (it makes no difference)". Comments by a medical student suggest that doctors are taught, and come to exercise, responsibility for determining whether and how clinicians in other occupations will make decisions about patient care. The researcher asked them what they thought of a week-long placement with students in various health professional courses.

> Working together – like on (multi-disciplinary student week) – is really important because we get to know where each other is at … That's important because as a doctor I need to know what the allied health guys can provide my patient and have confidence in them.(Medical student, Aged Care and Rehabilitation Services, observation)

Although still a student, the participant indicated that he would determine whether and how allied health clinicians would provide care for the patient. This suggests a socialized role expectation that doctors evaluate and determine the extent to which they will accept the input into patient care delivered by those with different professional backgrounds.

Case conferences reflected models of power. Case conferences were observed to be managed in one of two ways: authoritatively or by collegial facilitation. Authoritative case conferences were either chaired authoritatively by a doctor or dominated by doctors. Collegially facilitated conferences were led by a doctor, a nurse or an allied health staff member who encouraged the participation of members in different roles, and in which input was self-directed, rather than defined and invited by a doctor or chairperson. In general, community-based conferences were collaborative, featuring a greater variety of input from clinicians in different roles. Most case conferences in acute wards comprised mainly doctors, with one or a small number of nurses, and were generally facilitated respectfully but authoritatively. Such case conferences rarely featured a combination of doctors, nurses and clinicians in other roles. If they did, doctors and nurses spoke more frequently than clinicians in other roles, and clinicians in other roles generally spoke at their behest.

In case conferences that were chaired authoritatively by doctors, the chairperson strove to hold others accountable for their work. This is not to suggest that doctors who authoritatively chaired meetings did not respect the knowledge and unique expertise of other clinicians. The actions of doctors in these contexts demonstrated their interpretation of the medico-legal responsibility they have for patient care as encompassing another professional's opinion and actions. This is exemplified by the following tense dialogue from such a meeting.

> *Doctor*: "Katrina" (allied health clinician 1—AH 1), can you do a RUDAS (Rowland Universal Dementia Assessment Scale) test?
> *AH 1*: Why? …
> *Doctor*: I want to see how far you can push.
> *AH 1:* You could say that without it … It's the time and place. It depends. You've got to have a specific purpose. It's a question of time.
> *Doctor*: … So you're not happy to do it?
> *AH 1*: … [No, it's not that] … [The test is] not all it's cracked up to be.
> *Doctor:* I thought it was your job. It's **my** patient and I would like you to do it.
> *AH 2*: There are other tests …
> *Doctor*: They've used it in geriatrics. It adds weight to the description. Thank you!
> *AH 1*: … I'll do it tomorrow …(Sub-acute ward, observation)

This excerpt bears witness to resistance of the domination of the doctor. Yet, the doctor dominated the discussion and drove the actions of the other clinician regardless of their efforts to define their practice. This reflects competitive power, a zero-sum distribution of power in which one party dominates another. That this exchange happened in a sub-acute rehabilitation setting, in which allied health roles were prominent in frontline care delivery, underscores a pattern of domination by doctors over clinicians from other occupations. By contrast, very few references by participants to clinicians in occupations other than medicine related to the exercise of power by clinicians in one occupation over those in another. This is telling evidence of an order in which doctors interpreted and exercised legal, professional and organizationally-sanctioned power to hold clinicians from other occupations to account.

Competitive power, in the form of domination, was not unidirectional or static. Feelings of being dominated to some degree were evident in most interviews and focus groups. Some nurses in community-based settings felt subjugated by allied health clinicians, and some allied health clinicians perceived that they were being subjugated by nurses. Hospital-based doctors never identified other clinical occupations as dominating them, but, in answering questions about decision-making, leadership, and quality and safety, reported that they felt disempowered by "management" and "administration".

Mutual empathy among clinicians in different roles was evident in the data. On four occasions (in the 68 of 131 interviews and focus groups conducted with community-based services), clinicians lamented and empathized with the busyness and isolation of general practitioners (family doctors). Further, most interactions between doctors and staff in other roles were courteous and cordial, and were not characterized by dominating power. However, doctors were witnessed and reported to exercise role-based dominating power over staff in other occupations. Each of the 12 occasions in which doctors were specifically mentioned in interviews and focus groups, in community-based services, featured concerns by staff in other roles about the perceived domination by doctors of staff in other occupations. This is typified by the following excerpt from a focus group.

> Nursing and allied health's relationship with medicine still has a long way to go. Doctors think they're team players but they want to be the ones to make the decisions. … Doctors don't really respect other professions.(Nurse manager, Community Health, focus group)

This is suggestive of a culturally and organizationally-sanctioned pattern of role-domination by doctors. The above quotes suggest that such domination is being questioned, and hence resisted, though not publicly or systematically. Thus, competitive power is defined by: domination of a clinician from one occupation over others in decision-making; determining the nature and extent of participation in care delivery; determining the nature and extent of talk about care; and evaluating care delivery.

Collaborative power of distributed and valued roles

Participants across all clinical divisions frequently verbalized that they cherished working collaboratively with others. Such affirmation took the form of: valuing working in organized teams, lamenting the lack of teamwork, or, as the following quote exemplifies, endorsing the high quality of teamwork in their particular unit.

> Differences are understood and respected here between professionals. We work together for what is best for the patient.

> All have input; we ask and consult with each other and consulting is across professions … It is a multi-disciplinary team …(Nurse, acute ward, focus group)

No participant in the interviews or focus groups challenged the importance of working collaboratively. This demonstrates strong cultural currency of the need to work together and value the contributions of different roles.

In practice, a relatively equal display of power was more visible in community-based services than in acute hospital services. Most community-based teams held case conferences with clinicians from various occupations. The relative absence of domination in community-based services was tied to the character of work required of community-based clinicians.

> I feel that here … we're respected for our profession … We're encouraged to think autonomously (and) as part of a team. … We respect each other's expertise. … Community health is all about valuing the team.(Psychologist, Community Health, focus group)

Working interprofessionally in a team required knowledge, skills and strategy, using agency, or collaborative power.

> Our aim is to get a plan of action and to find the right strategy. It could be a single medical intervention or it could be [more complex, like] a case of abuse or neglect. … It's not a formal referral. It's dynamic, client-centred and efficient. We come to a single plan and parts are allocated to different people and they come in and out of focus.(Social worker, Community Health, focus group)

In these ways power is engaged to maximize the potential contribution of both distinctive and overlapping roles, and, hence, the capacity of the unit.

In collegially facilitated conferences, almost exclusively witnessed in community-based settings, the client list was used by the chair to guide the meeting discussion from one client to the next. They were relaxed, and jovial, but task-oriented. Clinicians took explicit responsibility for their own work and nominated specific goals to accomplish towards discharge and follow-up care. To this extent, clinicians volunteered accountability to each other in the meeting. Clinicians freely contributed when they could add to the discussion of a particular client. In terms of frequency of turns, input in such conferences was relatively evenly distributed among the clinicians; most clinicians spoke more than once and they informally interjected to comment on various patients.

From saturated analysis of key features in collaborative case conferences, including those discussed above, we discerned a number of features of collaborative power. Collaborative power, representing agentic power of interprofessional team-working, was characterized by the following features. The first was "appropriate role distinctiveness", in which the talk and actions of clinicians exemplified a recognizable body of distinctive knowledge and work, was evident. For instance, physiotherapists generally discussed mobility and physical stability. Second, there was relative and "appropriate role interchangeability", in which clinicians engaged in talk or work in an area generally associated with the body of distinctive knowledge and work of another occupation.

> [Mostly our roles overlap] … I'd like a student to look at us working and for them to try and guess the profession.(Social worker, Community Health, focus group)

A third feature was "snowballed topics" – that is, connecting various ideas which led to a change of topic. Snowballed topics were exemplified by a doctor asking an occupational therapist about a home visit which started a conversation between the occupational therapist, social worker and doctor about finance, family support and the family meeting plan. This prompted the social worker to say: "Put me down for social work assessment". The speech pathologist then said the patient needed more support for his artistic and academic endeavors. This prompted the senior nurse to ask about whether he needed a vocational assessment and rehabilitation service referral. The speech pathologist then talked about the need for the patient to reintegrate into university and their office space. This prompted the physiotherapist to say that a goal should then be to get him "independent with the quad stick".

The fourth feature was "dynamic sequencing" of cases – that is, returning to discuss patients already discussed if a new, relevant point occurred to one of the participants.

> The speech pathologist said a patient likes taking notes so much that they take them while watching TV and with family and friends. Social worker: "You've created a monster." Occupational Therapist: "His planning for the bus has improved". Social worker: "That reminds me, I'll cancel [another patient's] transportation because he can sort the buses out, too".(Case conference, Aged Care and Rehabilitation Services, observation)

Collegially facilitated conferences exhibited an atmosphere which allowed such varied and dynamic participation into discussion of progress and planning for patients. The fifth feature was "facilitative information-sharing", sharing role-specific information that would be useful for a clinician in another role to perform their care.

> Nurse: He seems to have overcome his anxiety about moving back into the old house. Psychologist: That's good. We can work on his relationship with his brother.(Case conference, Mental Health, observation)

The sixth feature was "facilitative tool-sharing" – sharing abstract care strategies that would be relevant across roles, such as how to most effectively engage with a patient.

> *Speech pathologist:* "He was much brighter and less aggressive. He said the issue was when people (get angry) and don't listen. (The lesson is to be assertive) I was quite firm with him and he responded to that …".(Case conference, Aged Care & Rehabilitation Services, observation)

These strategies characterize the clinicians' display of collaborative power and their competencies to work interprofessionally. Such power was evident in the hospital, but more widespread in community-based settings.

Case study: care setting and interprofessional power relations

One division within the system demonstrated the significance of acuity of care in the way clinicians exercise power. The service contained, among other units: an acute based ward; a sub-acute, rehabilitation ward; and a transitional care unit. "Subacute" denotes a post-acute phase following acute care; its patients require at least weekly medical intervention and residence in the hospital, such units typically being for rehabilitation (Rozzini, Sabatini, & Trabucchi, 2003).

The different functions of each setting were mirrored in different levels of acuity of patient condition and treatment. Space, time and staff interaction supported the particular function of each unit. The acute unit provided intense medical treatment for acutely ill patients. The sub-acute unit provided intensive rehabilitation.

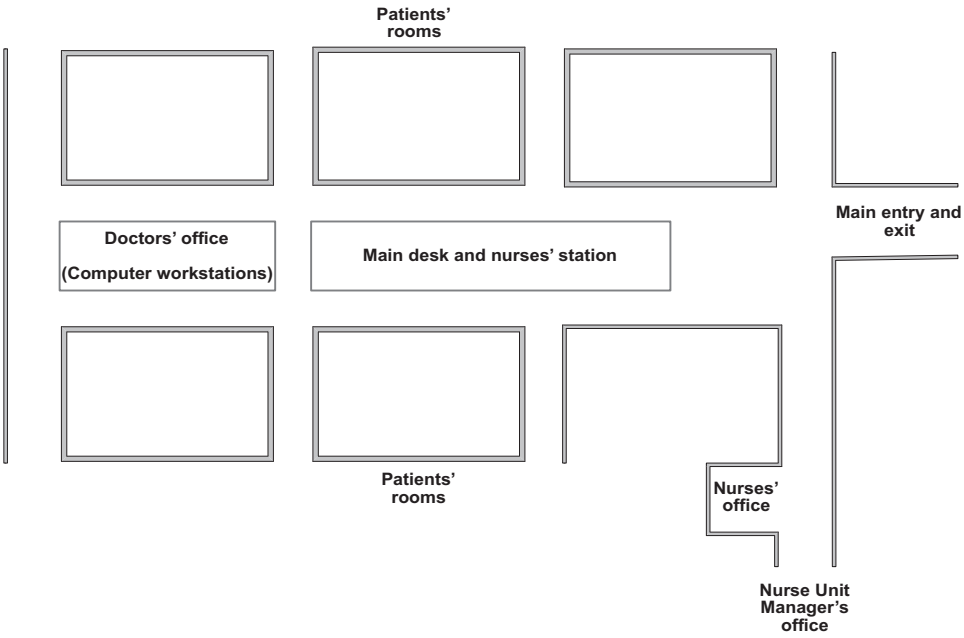

Fig. 1. Space allocation in acute ward.

The transitional unit provided functional opportunities for patients who were not acutely ill, nor required intensive rehabilitation, but who needed functional rehabilitation to support their transition to their home or community care facility.

The design of the spaces and the way time was used by staff and patients reflected the acuity of the care setting. This included the location of health occupations' offices in relation to each other. In the acute ward, most interactions and actions happened in a central location. Doctors and nurses had adjacent offices in the acute ward, but other occupations did not have dedicated offices. The main desk was the focus of activity. Staff and visitors congregated there. The main desk featured computers, as did the adjacent doctors' desks. This is depicted in Fig. 1.

The ward was a hive of busy (though not frantic) activity, being relatively active at all times of the day. Doctors, including physicians, registrars and interns, and the Nurse Unit Manager (NUM), held daily standing "whiteboard" meetings, the purpose of which was to review the care plan and, and so progress patients towards discharge. Biomedical talk dominated, focusing on diagnoses and medications. Patients were discussed in terms of their propensity for discharge, reflecting the pressure on the ward for newly arriving patients, especially those from the emergency department (Nugus & Braithwaite, 2010).

The unit was one of the few acute units that held a case conference comprising clinicians from various occupations. The particular acute case conference observed was attended by four doctors at any one time, one NUM, one Discharge Coordinator (DC), and one of each of the other occupations represented in Fig. 2, below. It was formally co-chaired by the NUM and DC. Doctors, and then nurses, routinely spoke after each patient was named. Allied

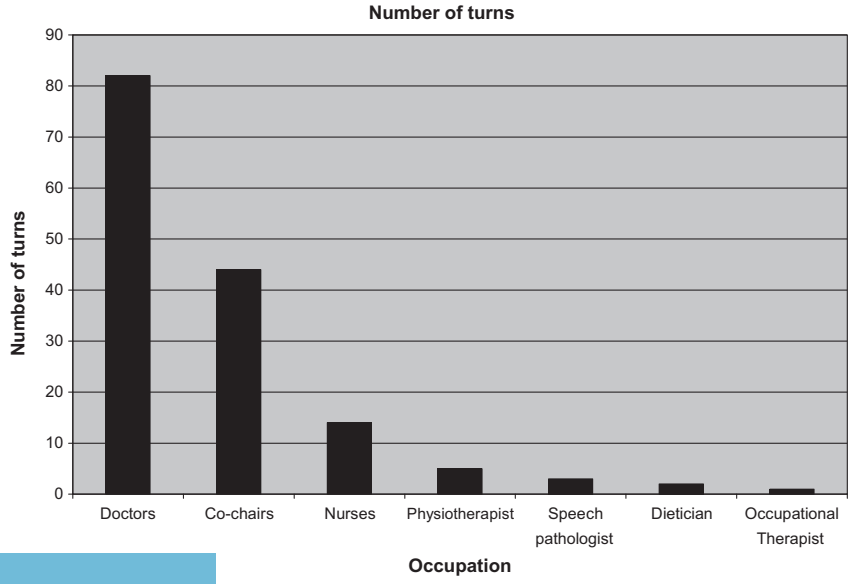

Fig. 2. Distibution of talk in acute case conference.

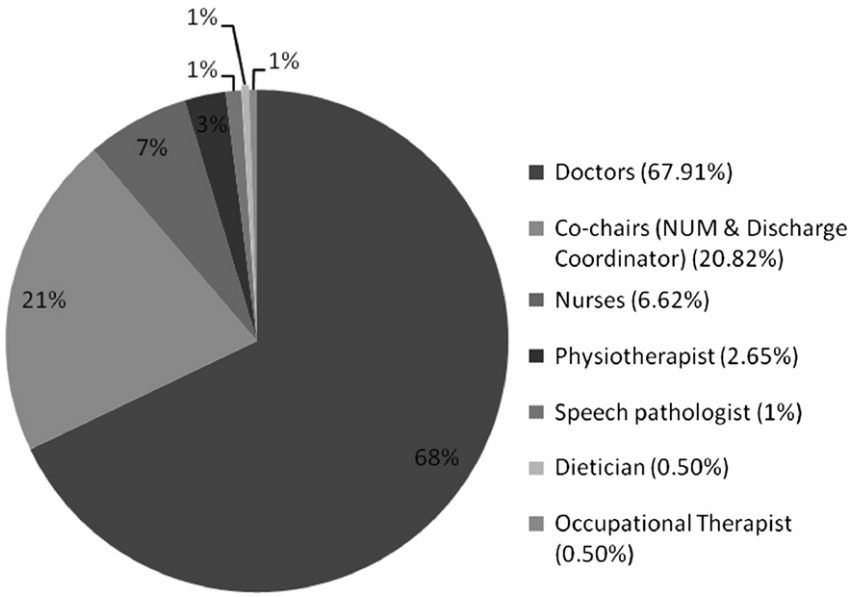

Fig. 3. Relative distribution of time talking in acute case conference.

health clinicians occasionally spoke afterwards and mostly in response to a particular question by a doctor or the chairperson. Doctors spoke most frequently. The relative distribution of talk is shown in Fig. 2.

The graph, and those to follow, displays the relative frequency of turns by role, rather than individual person, because the case conference is a structured role-based event, rather than an unstructured gathering of individuals. This means that participants represented their occupational role, and the number of individuals who shared the talk for each role did not affect the relative turns or time of talking for each role. Commonly, the chair said "medical" or "nursing", for example, to introduce the perspective of each occupation. Fig. 3 shows the relative approximate time clinicians representing each occupation spent talking. Fig. 3, and Figs. 6 and 9 to follow, is based on an analysis of the relative length of turns in the typed transcripts.

Fig. 2 shows that doctors took the most turns at talk. Fig. 3 shows that the lengths of their turns were also longer than those of other clinicians.

Informal interactions in the sub-acute ward were more dispersed across physical spaces than in the acute ward. The ward contained a large gymnasium. Space allocation in the sub-acute ward is depicted in Fig. 4.

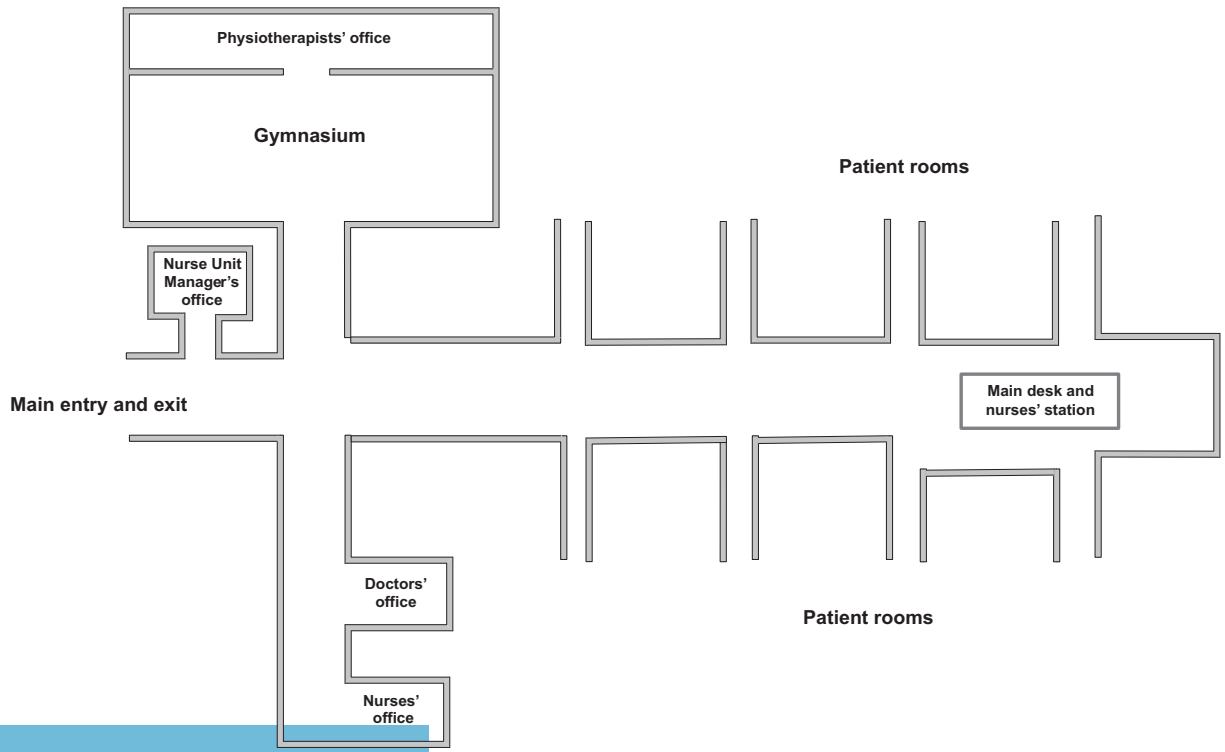

Fig. 4. Space allocation in sub-acute ward.

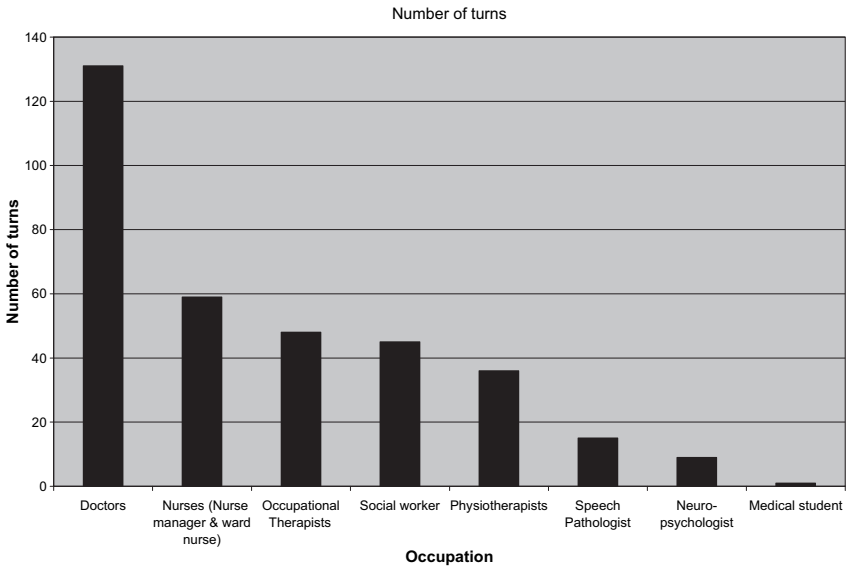

Fig. 5. Distibution of talk in sub-acute case conference.

Space and routine reflected both working together and working distinctively. Doctors and nurses had adjacent offices in the sub-acute ward. The physiotherapists also had their own office. The large gymnasium was the domain of physiotherapists and signaled the centrality of their work to the relationships and routines of the ward. Use of the gymnasium dominated the routines and time-based relationships among clinicians in various roles. Doctors had the most privileged position, in that other activity a particular patient was engaged in stopped while that patient was the focus during the medical ward rounds. The time of physiotherapists was the next most highly prioritized. Allied health staff organized activities and consultation with other staff and patients around the time physiotherapists spent with patients in the gymnasium. A large table near the nurses' station served a collegial function, facilitating information flow and casual conversation among administrative staff, nurses, allied health clinicians and doctors, while they wrote in or read patient notes. In terms of busyness and temporal routines, compared with the acute ward, the sub-acute ward was fairly quiet in the morning. The afternoon featured numerous clinicians writing notes around this table.

As in the acute ward, case conferences were relatively formal. Topics discussed focused less on bio-medical issues and more on rehabilitative issues. They included: mood; degree of independent mobility; attitudinal commitment to improving; degree of impulsiveness (potentially leading to falls); and ensuring that potentially incoming patients were able to improve – that is, that they had "rehab goals". This means that the case conference featured more allied health input than did the acute case conference. The sub-acute case conference was structured so that each allied health clinician spoke about the care they were delivering to each patient. The case conference was attended by two doctors at any one time (physician and registrar, known as a resident in the US and house officer in the UK), one NUM, one ward nurse at a time, two physiotherapists, one social worker, one neuro-psychologist, two occupational therapists, one medical student and one occupational therapy student. The proportion of time doctors spent talking,

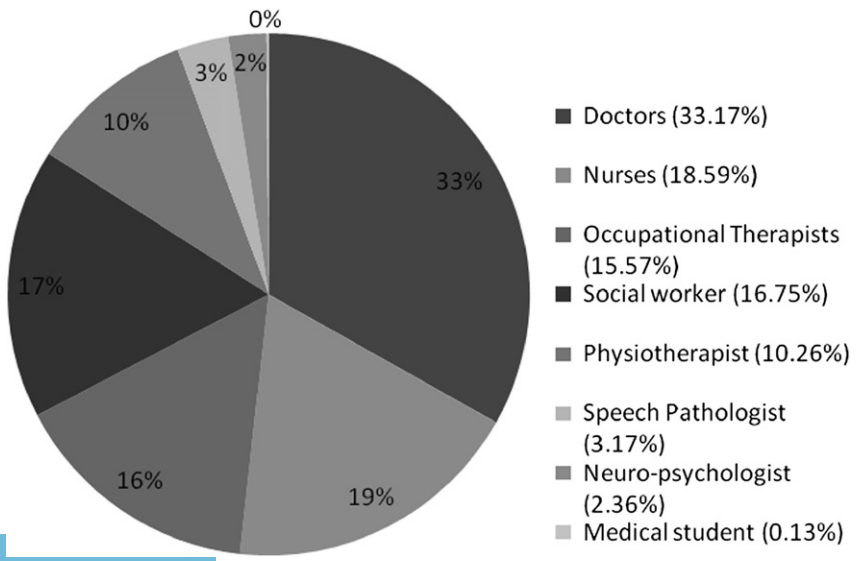

Fig. 6. Relative distribution of time talking in sub-acute case conference.

Fig. 7. Space allocation in transitional care unit.

while the largest among the participants, was less than their relative number of turns because doctors' turns at talk about patient progress were shorter than those of other clinicians, as depicted in Fig. 5.

Fig. 6 shows the relative approximate time clinicians in various roles spoke in the case conference. The first part of the case conference was chaired by a doctor and characterized by collegial facilitation. The second part was chaired by another doctor and was chaired authoritatively, meaning they made evaluating comments on the work of other clinicians after each had spoken.

Figs. 5 and 6 show that the two doctors, combined, had the most turns and time talking.

The third site we consider is a post-acute transitional care unit which the service also featured. The unit was intended for patients

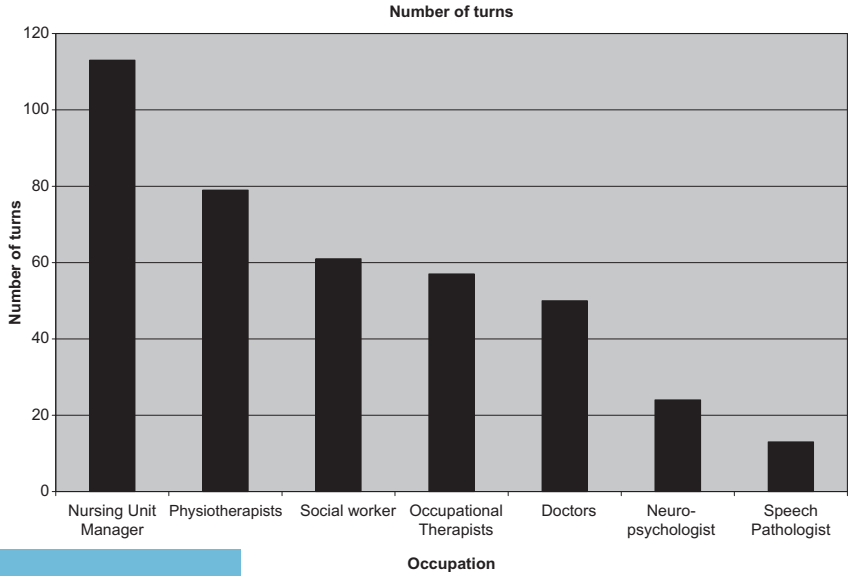

Fig. 8. Distibution of talk in transitional care case conference.

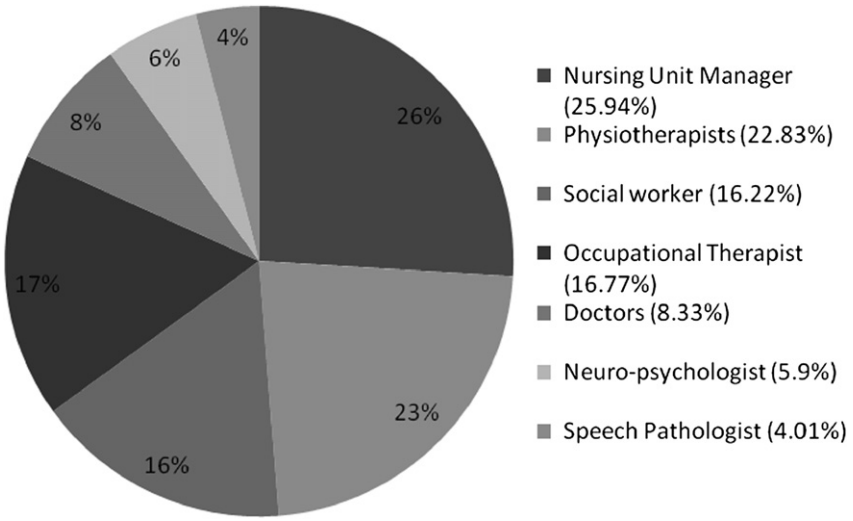

Fig. 9. Relative distribution of time talking in transitional care case conference.

who were no longer acutely (or subacutely) ill, indicated, for example, by the absence of intravenous antibiotics. The transitional care unit appeared more homely and "less hospital-y", as described by a physiotherapist. Nursing and occupational therapy had their own offices. The doctors, social worker, dietician and speech pathologist did not have an allocated office in the transitional care unit. The physiotherapists did not have their own office but used the offices of the nurses and the occupational therapists. The adjacent NUM's office and the nurses' office were discretely located and not visibly the focal point of the space. The unit had a large kitchen, dining/common room, lounge room and gymnasium, as depicted in Fig. 7.

The kitchen, dining/common room and lounge room were amenable to regular, informal consultation with patients. The gymnasium signaled intensive treatment by physiotherapists but it was not as large as the gymnasium in the sub-acute unit. The physical design of the unit was functional for the occupational therapists and speech pathologist, in particular. The occupational therapists had their own large office space, reflecting their high profile and role in the unit. The occupational therapists and speech pathologist often worked together with patients in the kitchen. Doctors and nurses interacted with patients in the kitchen and dining areas. Activity in the public spaces ebbed and flowed. In the mornings, the central dining area of the unit was a hive of activity, with lots of traffic, including visitors, clinicians, patients and other staff. In contrast to both the acute and sub-acute units, afternoons were relatively quiet.

Case conferences were collegially facilitated. Topics discussed were more psycho-social than in the acute and sub-acute wards, including: activities of daily living (e.g., eating, sleeping and showering); family visits; and mood. Participants in the observed case conference were two doctors (physician and registrar) and one of each occupation represented in Fig. 8. Fig. 8 depicts the relative distribution of talk in the transitional care case conference.

Fig. 9 shows the relative approximate length of time clinicians in each occupation spoke.

Figs. 8 and 9 show that the number of turns and time talking were more equally distributed than in the acute and sub-acute case conferences, even though the proportion of doctors, nurses and allied health staff were generally proportional across the three settings. The proportion of time doctors spent talking was less than their relative number of turns because the turns at talk of allied health clinicians and the nurse manager were longer than those of the doctors. The regular presence of clinicians from various occupations enabled care delivery to be negotiated informally in corridors, offices and specific treatment areas throughout the unit.

In essence, different settings of patient acuity reflect differences in the uses of space and time. These, in turn, are mirrored in differences in the degree to which particular occupations' roles are prominent and define their own scope of practice. In acute settings, the scope of allied health practice is more likely to be circumscribed by doctors, who exercise competitive power. In less acute settings, allied health and nursing clinicians are more likely to define their own scope of practice, and exercise collaborative power.

Discussion and conclusion

This study contributes a unique exposition of negotiated order across different but comparable sites. Health care staff are part of a negotiated order which is maintained, reinforced, and sometimes challenged, in interaction (Strauss et al., 1963). The significance of combining a multi-setting study across a bounded health service with a negotiated order perspective was to show the co-existence of competitive and collaborative power in health services. While a medical dominance perspective emphasises conflict (Lewis et al., 2008), a negotiated order perspective explains how, in interaction, actors can exercise agency, or resist power structures, and that power structures can simultaneously provide the conditions under which actors make choices (Svensson, 1996). Sampling from a whole health system provided a diversity of settings. The co-existence of competitive and collaborative power, within each site, and the benevolence and mutual empathy of individuals who are caught up in negotiated orders of which they may not be aware, does not diminish the prevailing order of domination by doctors over staff in other roles, and exaggerated in the acute setting.

Empirically, the study provides an analysis of the way power is exercised in relation to patient management. Specifically, the multi-site character of the study, examined through negotiated order, delivered five original insights into interprofessional relations. First, patient management is a key site of negotiation about clinical roles. Second, both dominative "competitive" power and "collaborative" power co-exist in health services. Third, we found that power is exercised along dimensions of: decision-making, input into care delivery, the timing and topics of talk about care, and evaluation of care delivery. Competitive power involves a clinician or clinicians from one occupation dominating others. Collaborative power involves interdependent participation (such as through role distinctiveness and role interchangeability) and decision-making, and staff evaluating their own performance to hold themselves

accountable to team members. Collaborative power involves independent determination of the timing and topic of talking, evident through: snowballed topics, dynamic sequencing, facilitative information-sharing and facilitative tool-sharing. A by-product of the analysis of case conferences was to distinguish "authoritative" from "collegially facilitated" case conferences. Fourth, acuity of care setting impacts strongly on the degree of input of particular roles into patient care. Fifth, we delivered an original model of quantification of interprofessional interaction in case conferences; the mutual endorsement of qualitative findings with number of turns and length of time in talk justified the role-based, rather than individual-based, method for articulating patterns in interprofessional communication in case conferences.

An individual clinician may need to make decisions about a client's pathway, or progress (Komet, 2001). This study illuminated the tension between the perceived need for patient management, and calls for patient care to be delivered collaboratively (e.g., Gröne & Garcia-Barbero, 2001) by showing how patient management functions in different settings. Doctors have cultural and institutional sanction to manage these pathways, although they do it more directly and frequently in acute, hospital-based services than community-based services. Patient management can take an authoritative form, characterized as domination, through the exercise of competitive power. Alternatively, it can take the form of collaboration, through the exercise of collaborative power.

Dominative power could be experienced from clinicians other than doctors, and doctors sometimes facilitated case conferences in a collegial manner. Although most interactions appeared cordial, there is still – at this snapshot in the history of interprofessional relations – a ubiquity in the actualized and potential domination by doctors across various care settings, with cultural and institutional currency. However, such domination is being questioned by staff.

The study showed that acuity of care setting was a mediating variable in balancing collaboration with the need for patient management, or care coordination. The discussion of the multi-unit service exemplified above was not intended to convey one as better than the other. It is a descriptive rather than a normative account to show that clinicians work according to the demands of patient needs, and spatial and temporal circumstances, in particular settings, among other variables of care delivery. But this has normative implications. Any one prescription of the idealized role and degree of input of clinicians from different occupations within a health care team will not fit all circumstances. To be credible, models of the way clinicians ought to work together need to take acuity of care setting into account.

Furthermore, a reason that doctors determine, and, in some circumstances, constrain, the input of clinicians in other roles into patient care is because doctors are socialized, in tertiary education and at work, through legal, organizational and cultural structures, to see themselves as key decision-makers about patient care and the patient pathway through a health service. As the data showed, other clinicians shared this perspective.

Staff in health services must answer the question: How far can health care be collaborative rather than authoritative? The future of interprofessional relations in health care depends on how well environments are shaped to allow staff to publicly navigate the points at which particular roles have maximum impact for patients. This ideal is applicable to care settings of all levels of acuity. It represents systemic respect for the contribution of various roles to patient care, rather than relying on the benevolence of individual doctors. This ideal might serve to promote the integration of care coordination and collaboration. Future research might address the specific ways that the policy context can and does influence interprofessional relations, and vice versa. Given the role of managers in mediating the interface between policy and practice, future research might also attend to the interplay of managers in interprofessional relations, and the challenges and opportunities of integrating care across formal service boundaries, in the negotiated orders of health services.

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