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Power in interprofessional education and collaborative practice: has anything changed?

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Introduction

In our editorial to accompany a 2019 special issue in this journal, on theories of power in interprofessional research, we opened with a vignette about a medical student who was asked to remove his white coat before an interprofessional simulation, and refused. His faculty mentor explained that the coat symbolised leadership, and that students choose medicine because they want to be in charge. Seven years on, it is worth asking whether that student would take the coat off today, and whether the field is any better equipped to explain why he might not (Cohen Konrad et al, 2019).

Power, which often presents itself in the form of hierarchy, is one of the most consistently identified barriers to interprofessional collaboration, yet how it operates remains comparatively under-theorised. For all that has been written about collaboration, communication, and shared decision-making in health and social care, comparatively little explanatory attention has been paid to how power actually operates between professions, why it persists, and whether it can be changed. What literature exists tends to confirm the tenacity of hierarchy through single time-point analyses of small samples, rather than offering evidence of what successful change looks like, or even whether it is achievable. This rolling themed issue of the *Journal of Interprofessional Care* was convened to address that gap. The

eight papers gathered here draw on ethnographic, qualitative and mixed-methods research from rehabilitation, primary care, simulation-based education, and networked and community care settings across several countries. Taken together, they offer a more differentiated account of power in interprofessional practice than is usually available: one in which hierarchy is neither simply an obstacle to be trained away, nor an immovable structural fact, but something continuously produced, negotiated and, occasionally, renegotiated.

The tenacity of hierarchy

Several contributions confirm just how deeply hierarchy is embedded in everyday practice, often without the health professionals concerned articulating it. Olufson et al. (2023) found that hierarchy shaped whether nutrition care and mealtime support were treated as legitimate interprofessional business in rehabilitation units. In that study, nutrition was widely regarded as less important than physical therapies, and long-standing routines about who was permitted on the ward at mealtimes quietly excluded some staff from participating. Rather than concluding that these hierarchies should simply be flattened, the authors suggest that in some circumstances they might instead be acknowledged and worked with.

A similar picture of hierarchy operating below the surface emerged from Macdonald et al.'s (2023) study of interprofessional care networks. No physician in their sample spontaneously identified negotiation as something they engaged in with other health professionals; their position at the top of the hierarchy was instead experienced as an entitlement to accept or reject others' input, interwoven with a chronic scarcity of time. Other health professionals, by contrast, described their acceptance of others' perspectives as something largely decided for them by the workplace hierarchy. Notably, none of the study's participants characterised these dynamics as interpersonal conflict; they were understood, instead, as organisational or systemic.

Robertson et al. (2022) found a related pattern in the context of interprofessional simulation debriefing. Power discrepancies were rarely addressed openly in interprofessional sessions, even though the same participants discussed power freely when debriefing within their own profession. Traditional patterns of interaction, centred on physicians, were reproduced rather than examined.

Together, these papers suggest that hierarchy in health and social care is not primarily sustained by individual attitudes that might be corrected through better communication training. It is reproduced structurally: through the division of labour, professional history,

organisational routines, and an education system that, as Paradis and Whitehead (2018) have argued, tends to gloss over the influence of workplace systems and structures altogether.

Agency with constraint

A second cluster of papers examines what individual health professionals do in the face of these structures, and at what cost. Farrell et al. (2021) drew on classic typologies of social power to show that health professionals can embrace or relinquish power moment to moment, particularly when deciding whether to speak up about patient safety concerns. Physician trainees and less experienced nurses were more likely to relinquish their power and stay silent, weighing the risk of appearing incompetent or provoking conflict against the imperative to raise a concern; some described lasting moral distress as a result. The authors recommended not only teaching speaking-up skills, but teaching health professionals to recognise the different sources of power available to them, while making psychological safety, modelled visibly by those with more power, a precondition for such training to work.

Rakvaag et al. (2023) offer a complementary account through the lens of positioning theory. GPs and community pharmacists in Norway continually co-construct storylines that position GPs at the top of a hierarchy rooted in professional prestige, remuneration and educational pathways, producing patterns of medical dominance that are well documented elsewhere. Yet the same data show that these positions are not entirely fixed: younger GPs were positioned, and positioned themselves, as more open to collaboration than an "old school" generation, and both professions constructed storylines in which GPs were simultaneously highly autonomous and dependent on pharmacists for quality control. Positions, in other words, remain open to negotiation, even where the underlying hierarchy does not disappear.

Corbaz-Kurth et al. (2025) point to trust as a further lever. In their qualitative study of interprofessional teams and networks, their participants described power as something that could be shared on the basis of knowledge and experience rather than title or function, particularly through inclusive attitudes, humility, and mutual acknowledgement of others' roles. Notably, this was emphasised most by participants with less seniority, while cultural and communication-style differences, rather than cultural distance itself, remained the more likely source of one group dominating another.

Reframing power

Two papers challenge the assumption that hierarchy is straightforwardly something to be dismantled. Drawing on critical management theory, Boulton and Boaz (2023) argued that power in organisational life is complex, multidirectional and productive: it is what makes certain collaborations possible, not simply what constrains them. In their study of peer coaching and implementation support, successful collaboration depended on how well practitioners could navigate, rather than escape, their organisation's power structures.

Karppinen et al. (2025) reach a related conclusion through their study of team talk. Professional identities, they show, are continually talked into being as team members negotiate claims about expertise, roles and responsibilities. What the authors term block narratives, which differentiate professions from one another, can reinforce traditional hierarchy, but they also clarify who is responsible for what, enabling the team to function efficiently. Thread narratives, which emphasise shared and universal experience across roles, can build equality and shared understanding, but risk blurring the distinct expertise that collaboration depends on. Neither narrative type is straightforwardly desirable; the two need to be held in balance.

Read against the first two sections, these papers usefully complicate the special issue's implicit question. The task may not be to determine whether hierarchy can be abolished, but whether the division of labour that hierarchy organises can be reframed so that differentiation between professions does not default into the subordination of some professions to others.

Implications

Taken as a whole, this collection points to three priorities for the field. First, for research, the descriptive literature confirming that hierarchy persists is now substantial; what is needed next is research that examines attempts at change, however partial, and asks why some succeed and others do not. Across the wider literature, cross-sectional, small-sample studies of hierarchy's tenacity, however well executed, may now add only incrementally to what the literature already shows.

Second, for education, several contributors note that interprofessional curricula rarely name power explicitly, even where they teach communication, teamwork, or role clarity. Robertson et al. (2022) suggest that facilitators be prepared to raise power directly during debriefing, drawing on established typologies such as French and Raven's (1959) bases of power, rather than leaving it to be inferred. Macdonald et al. (2023) go further, arguing that education should equip students not only to work flexibly across roles but to understand, and ultimately

organise collectively to challenge, the systems and structures that sustain hierarchy. This requires faculty who are themselves prepared to teach about power, which is a development need in its own right.

Third, for practice and policy, the burden of managing power differentials in these papers falls disproportionately on those with the least power, whether that is the nurse deciding whether to speak up, or the community pharmacist waiting to be contacted. Several authors are explicit that this needs to shift; inclusive behaviour modelled visibly by those in more senior positions, and organisational conditions that make space for negotiation, are consistently identified as more likely to shift dynamics than skills training aimed at those with less power alone.

A final observation is that the three themes above broadly track the conflictual, consensual and constitutive perspectives on power we set out in our 2019 editorial: hierarchy and its structural reproduction, the negotiation of agency within constraint, and power as productive and identity-constituting, respectively. This alignment was not designed into the issue's call; it emerged from the empirical work submitted to it, which is itself worth noting. Social theory more explicitly, however, appears only selectively in this literature. The approach taken in empirical work tends to focus on how power emerges from interactions between people. The structural and critical traditions we highlighted in our 2019 editorial have found relatively little purchase. This means that some gaps remain. Gender is not a substantive theme in the findings, despite its relevance to professional differences, nor are race or class considered in any depth. Patients appear only intermittently, and the evidence base largely reflects practice within healthcare systems in the Global North. It is also surprising that the impact of the Covid-19 pandemic on interprofessional working has not received greater attention.

Conclusion

So, has anything changed? Can historically embedded hierarchies in health and social care ever be genuinely dismantled? This themed issue does not offer a confident answer. What it offers instead is a more precise account of where power resides, how it is enacted, resisted, and occasionally reframed, and what education, research, and organisations might do differently as a result. That, in itself, represents real progress on a topic that has for too long been acknowledged in principle and left unexamined in practice. We offer this collection as a prompt for further research that can move beyond documenting the persistence of power and hierarchy, toward evidence of how, where, and for whom it can be changed.

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