Review Article

Interprofessional Power in Acute Care: Philosophical Reflection using Foucauldian and Critical Perspectives

Poder interprofissional em cuidados intensivos: reflexão filosófica a partir de perspectivas foucaultianas e críticas

Poder interprofesional en cuidados intensivos: reflexión filosófica a partir de perspectivas foucaultianas y críticas

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Abstract

Objective: To discuss the power relations among health care professionals in acute care settings and its interference in the process of knowledge building.

Methods: In this philosophical paper, we explored the influence of power relations on knowledge building using a Foucauldian and critical perspective of Gramsci and Freire related to nursing and health care practices.

Results: There are four sources of organizational power (decision-making, discretion, control of resources, and control of knowledge/network) that act at different levels of healthcare organizations. Intensive care units are an important segment of healthcare setting, and the complexity involved in the daily activities of professionals in this sector can lead to difficult power relations in the process of knowledge building. For instance, when professionals external to the ICU team that hold specific knowledge need to be contacted to help in cases, such as during organ donation and transplantation process. In this situation it is necessary to deconstruct the competitive power in order to build the collaborative power.

Conclusion: Using Freire's and Gramsci's perspectives we argued that lack of knowledge contributes to competitive power which can be overcome if involved individuals engage in the learning process towards a collaborative power approach. Therefore, strategies or action to address interprofessional power imbalances can contribute mutual transformation and change.

Resumo

Objetivo: Discutir as relações de poder entre profissionais de saúde em ambientes de cuidado intensivo e sua interferência no processo de construção do conhecimento.

Métodos: Neste artigo filosófico, exploramos a influência das relações de poder na construção do conhecimento, a partir de uma perspectiva foucaultiana e crítica de Gramsci e Freire em relação às práticas de enfermagem e cuidados de saúde.

Resultados: Há quatro fontes de poder organizacional (tomada de decisão, critério, controle de recursos e controle de conhecimento/rede) que atuam em diferentes níveis das organizações de saúde. As unidades de terapia intensiva são um importante segmento do ambiente de saúde, e a complexidade no cotidiano dos profissionais desse setor pode dificultar as relações de poder no processo de construção do conhecimento. Por exemplo, quando profissionais externos à equipe da UTI, que detêm conhecimentos específicos, precisam ser contatados para auxiliar em casos, como durante o processo de doação e transplante de órgãos. Nesta situação, é necessário desconstruir o poder competitivo para construir o poder colaborativo.

Conclusão: Usando as perspectivas de Freire e Gramsci, argumentamos que a falta de conhecimento contribui para o poder competitivo, que pode ser superado se os indivíduos envolvidos participarem no processo de

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aprendizagem em direção ao poder colaborativo. Portanto, as estratégias ou ações para lidar com os desequilíbrios de poder interprofissional podem contribuir para a transformação e mudança mútua.

Resumen

Objetivo: Discutir las relaciones de poder entre profesionales de salud en ambientes de cuidado intensivo y su interferencia en el proceso de construcción del conocimiento.

Métodos: En este artículo filosófico, exploramos la influencia de las relaciones de poder en la construcción del conocimiento a partir de las perspectivas foucaultianas y la crítica de Gramsci y de Freire en relación con las prácticas de enfermería y los cuidados de salud.

Resultados: Hay cuatro fuentes de poder organizativo (toma de decisión, criterio, control de recursos y control de conocimiento/red) que actúan en distintos niveles de las organizaciones de salud. Las unidades de cuidados intensivos son un importante sector del ambiente de la salud, y la complejidad en la labor cotidiana de los profesionales de ese sector puede dificultar las relaciones de poder en el proceso de construcción del conocimiento. Por ejemplo, cuando profesionales externos al equipo de la UCI, que tienen conocimientos específicos, tienen que ser contactados para auxiliar en algunos casos, como durante el proceso de donación y trasplante de órganos. En esta situación se hace necesario deconstruir el poder competitivo para construir el poder colaborativo.

Conclusión: Usando las perspectivas de Freire y de Gramsci, argumentamos que la falta de conocimiento contribuye para el poder competitivo, que se puede superar si los individuos involucrados participan en el proceso de aprendizaje en dirección al poder colaborativo. Por lo tanto, las estrategias o las acciones para hacer frente a los desequilibrios de poder interprofesional pueden contribuir con la transformación y el cambio mutuo.

Introduction

Healthcare environments are progressively becoming interprofessional settings as healthcare providers need to work with professionals from different backgrounds to provide care of quality to patients and families.[1] As a result, the complexity and the interdependency of interprofessional relationships are challenging nurses and other members of the healthcare team.[2-4] Interprofessional relationships can be refer to as the interactions developed among professionals within the healthcare setting they work and it can directly impact the decision making process in clinical settings, either positively or negatively, and the power and status of individuals are part of the work in interprofessional teamwork.[5-8] Interprofessional interactions should build on frank discussions that allow the inputs of everyone in the team. In the acute care settings the power relationships can be particularly challenging for interprofessional teams due to the dynamic, demanding, complex and stressful environments.[9] Given the complexity of interprofessional team functioning in acute care settings, it is important to understand the links between power relations and knowledge building to ensure that quality care is provided.

Although previous studies on power relations have discussed the experience of power between patients and health care professionals, [10-12] the power in the interprofessional interactions is often overlooked. Central to this whole process is the patient, but for the purpose of this discussion we focused on the health care professionals' perspective only. In this philosophical paper, we engage in presenting the power relations among health care professionals in acute care settings and the interference in the process of knowledge development by following a Foucauldian perspective. We use the position of the Organ and Tissue Donation Coordinator (OTDC) nurse within the intensive care environment as an exemplar to discuss power relations, and hierarchical systems. Then, using another vantage point—that offered by critical perspectives such as the work of Antonio Gramsci and Paulo Freire's we aim to examine how the development of critical consciousness can create transformative nursing practice and ultimately addressing power differences within the complex context of health care delivery. Our interest is both epistemological and pragmatic as we ask: what is power? How is power seen and used in acute health care settings? How are the concepts of power and knowledge applied to interprofessional relations in acute health care? And finally, how is power and knowledge balanced in the health care team of intensive care units (ICU) and other health care professionals external to the ICU (e.g., OTDCs). Driving these questions is a pragmatic concern that traditional notions of interprofessional practice in acute care may not sufficiently address the types of deep-rooted factors underlying nursing practice in acute care such as hierarchical systems and power relations. For example, certain interpretations and discussions about interprofes-

sional work tend to turn our attention away from the existence of power differential accentuated by organizational constrains (e.g., policies and procedures, budgets and staff privileges) and the fact that each health provider has varying levels of agency or individual power and authority.[13]

We begin our engagement with the topic by first describing the concept of power and the relation of power and hierarchical systems in interprofessional relations in health care settings. Once the problem is described using Foucault's work, we focus on the work of Antônio Gramsci and Paulo Freire's to identify solutions to the problems presented by demonstrating the importance of critical consciousness to healthcare professionals to be able to shift from competitive power to collaborative power.

A Foucauldian Interpretation of Relations of Power and Hierarchical Systems in Health Care Settings

In one of his lectures, Foucault presented the notion of the triangle power, rights and truth. Foucault discussed that in his past work (before 1971) he has tried to relate the power mechanisms with the rules of rights that provide a formal delimitation of power and the effects of truth produced and transmitted by this power that also reproduces the power. He called this dynamic relation as the triangle power, right, truth.[14] He argued that in any society there are relations of power that constitute the social body, which in turn could not exist without the "production, accumulation, circulation and functioning of a discourse.[14] There can be no possible exercise of power without a certain economy discourses of truth which operates through and on the basis of this operation".[14] Therefore, we cannot exercise power unless by truth, relying on the production of truth through power. He presents examples of truth related to legal and ethical perspectives of rights not only related to laws per se but to the whole systems of institutions and regulations responsible for its application.[14]

Foucault[14] claimed that power is everywhere and that it can come from everywhere, but it is not an agency or something that can be given, exchanged or recovered. He believed that power is exercised, and that it only exists in action.[14] Therefore, power is a relation of force,[14] it is relative and balanced within the relationships.[15] Power can have different meanings that are dependent on the setting in which power exists,[15, 16] each with its own positive and negative connotations attached to the term. In a positive view it can be the potential for change, the ability to get what one wants or the ability to achieve a common goal.[17] Yet, it can be viewed as something used to oppress, alienate, and depreciate. These descriptions related to the balance of power give us the notion that hierarchy is intrinsic in the human relations. Societies have always had a census of organization that is based on power relations. However, Foucault claims that individuals are not the points of power application, but rather they are vehicles of power.[14] Power is not static, it circulates, so no one can possess power, because it is employed and exercised in a network organization.[14] Thus, individuals are merely articulation elements of power as they simply switch their position of exercising or undergoing power over the time.[14]

There is a hierarchal system established within a hospital's macrostructure and microstructures. The macrostructure refers to the organization as a whole; in other words, the administrative structure, which is made up of the president, chief executive officer (CEO), managers, coordinators, supervisors and so on. That structure can be represented by an organogram, illustrating the positions that each person occupies in a graphical manner. The graphic representation of an organization is static, but the network of people that fills those positions is dynamic.[18] People at different levels of the hierarchical system are in constant inter-relation.[18] In this type of structure, there is a clear power relation that is part of the position that the person occupies. The higher the position a person possess in the organogram, the more power he or she will have.[16] This power is derived from *reputation,*[16] in which people may obey to instructions of an agent due to respect, fear, duty for someone's position, or pay. Therefore, with this macrostructure hierarchy creates a frame for individual power, where a person orders and others are supposed to obey.

The microstructures of healthcare settings are composed by the different services that are necessary to provide direct or indirect care for the patients and the team's interprofessional relations at the endpoint of care. Hospitals typically include many departments, related to indirect care and support (e.g., accounting and administration), indirect care (nutrition, pharmacy and imaging) and direct care (e.g., intensive care, emergency, medicine). Each of those individuals occupy a position in the hospital hierarchy and independently of being in the direct or indirect care they all exercise power in their relationships daily. Power in these institutions is not solely related to the position the health care professional occupies in the health care structure, but is also related to the individual needs of patients in each environment. The interprofessional collaboration in healthcare settings happens when different healthcare providers make a collective effort to work together towards achieving the best quality of care,[19] and this interprofessional collaboration depends on many personal factors that shape individuals' attitudes, behaviors, and social practices.[20] Therefore, the success of interprofessional relations will also depend on the interpersonal relations, the trust, empathy and the identification with one another are crucial to allow the building of collaboration between individuals.[18] It is important to remember that the person providing care in a health care setting is also a human being. Thus, the power in interprofessional relations lays on the ability people have to identify with each other in terms of beliefs, values, legitimizing norms and ideologies.[20]

The power source in organizations can be categorized in four types: (1) decision-making power, (2) discretion, (3) control of resources and (4) control of knowledge and networks.[12] All those categories can be seen in different levels of organizations, and in the healthcare scenario each level can have a combination of the four organizational sources of power, yet some categories stand out from others for each level. For instance, decision making is present in both levels, macro and micro, and the availability of information about the options and possible consequences is important to enable the decision maker to choose wisely.

Health care settings are complex structures with different dimensions of care. The acute care sector is an important part of health care, especially for patients whose life depends on "time-sensitive and, frequently, rapid intervention".[21] The term acute care is broad and includes different health care sectors, such as pre-hospital care, emergency room, and intensive care unities.[21] All of those sectors have a team composed of nurses, physicians, physiotherapists, nutritionists, and others. Everyone in the team is responsible for delivering care based on their expertise to provide holistic treatments for patients. In the microstructure, the ideal environment consists of a collaborative and respectful healthcare setting, in which the opinions and interventions are peacefully discussed until a consensus is achieved within the team about what would be the best option of treatment and presented to the patient or their substitute decision maker for the final say. However, reality may not correspond to this ideal situation, and conflicts may arise from discordance of treatment choices and personal worldviews among the health care team.[22] These disagreements can be the result of interprofessional relations and power degrees that are intrinsically and unconsciously established within the team.

Historically, medicine maintained a relative authority position over other professions concerning the division of labor in the clinical, structural and organizational domains.[23] This dominance was due to the autonomy that the medical professionals maintained from evaluations from other fields.[24] Professional autonomy is intrinsically linked to power, which can lead to monopolistic aspects that frequently result in conflicts between health care professions.[25] Although the dominance and monopolistic treatment of patients by physicians are still present nowadays in the traditional western medicine, the organizational dominance is changing. As a result, different degrees of power are being hold by individuals within a professional group, and the medical domination is being replaced by a more participative environment.

Nowadays, there is a distinction in the type of power exercised by the professionals: *competitive power* and *collaborative power.*[26] On one hand, com-

petitive power refers to a person from a specific profession dominating others with different professions, or also inside the same profession between persons holding different hierarchical positions (i.e. senior vs junior).[26] On the other hand, collaborative power refers to interprofessional non-judgmental participation, and decision-making for patient care.[26]

Intensive care units are a good example of this participative environment related to collaborative power, where the interprofessional team collaboration is linked to better patient outcomes, safety and increased quality of care.[9] Therefore, that network environment usually works in balance and it is fed by information from each professional involved with the treatment of the patient. For example, nurses contribute with direct care information about life signs parameters, behavioral evolution, and physical changes; physiotherapists contribute with respiratory and mobility information; social workers with information about family and social support during the patient's treatment in the hospital and after his discharge; and physicians with information about the clinical findings, diagnosis and treatments to be implemented. In the end, all pieces of information from the knowledge that each profession possesses are balanced and the team decides jointly on the care planning for each patient, who have the final say in their treatment.

However, in some situations the balance can be lost. As an example, professional specialization of health is leading to a growing need for complex interprofessional care, thus, professionals such as OTDC nurses can help the ICU team in difficult cases. OTDCs are experts in organ and tissue donation for transplantation, although this professional is not part of the intensive care team, they work with them to improve organ donation rates. Even though this relation among the intensive care team and the OTDCs seems stable, the team balance can be threatened, and ICU team may avoid contacting OTDCs when needed due to the interprofessional power relations. Among the various roles performed by OTDC is the education of healthcare professionals for early identification of potential donors to increase chances of organ donations in the hospital. However, when patients with brain injury may potentially be evolving to brain death, the ICU team may keep performing intensive care interventions to improve patient's health status instead of proceeding with the evaluation of potential brain death, following patient referral to organ donation organizations with potential donor evaluation by OTDCs. Foucault maintains that power is present whenever someone wants to impose behaviours of another.[27] Therefore, the power flow in this situation will be modified by an external professional bringing new information to the ICU team about necessary interventions for the patient. In the worst-case scenario, the collaboration power is replaced by the competitive power if OTDC's suggestions and knowledge are not well received by the ICU team that can resist changing the care planning.

Foucault related the notion of power with a negative view opposed to the truth, as something repressive, dominant, and controlling. Later, he demonstrated that power was related with truth in a symbiotic way, where the higher the level of truth, the higher the power.[28] With the evolution of his writings and thoughts, the negative notion of power was replaced by a positive one: power could be seen as a productive force.[28] He argued that power produces effects at the level of desire and *also* at the level of knowledge.[14] To Foucault, when power is exercised through mechanisms for the formation and accumulation of knowledge (methods of observations, techniques of registration, procedures of investigation and research), power evolves, organizes and circulates a knowledge that is able to control others,[14] with knowledge and power creating and reinforcing each other.

In the example of the OTDC, knowledge about the organ donation process is the materialization of the power in that scenario. The resistance of accepting the OTDC's inputs in the treatment is the result of the tension created by power differentials between individuals. These tensions prevent people from gaining knowledge, instead creating hierarchical systems that did not previously exist. This knowledge hierarchy oppresses the team as a consequence, creates a cycle of rejection of the 'owner' of the knowledge, the OTDC nurse.

How can knowledge building occur in this scenario of oppression? How can OTDCs overcome this knowledge oppression and construct the knowledge within the team? What mechanisms can be used to restore the balance of the power flow among the team? These are important questions to be discussed since the results of these power relations directly interfere with health care outcomes.

The control of knowledge and networks are important sources of power in interprofessional structures, thus, power will depend on the individual's position in the communication networks.[15] For instance, the OTDC possess the knowledge needed to improve the organ donation in the intensive care unit, however, if he/she is not able to create an empathic relationship with the intensive care team and sensitize them to the importance of the correct procedures to improve the organ donation, he/she will not be able to achieve his/her goals. For Foucault, power is the relation of forces and these relations "acquire normative force in proportion to its ability to persuade, incite, influence, direct, repress or control the conduct of the other".[29] In this situation the OTDC should use the power of knowledge in his/her "possession" to influence positively the intensive care team (collaborative power). However, the knowledge outcomes will depend on the way this power is employed in the context of acute care scenarios.

Overcoming the "Knowledge Oppression": Critical Consciousness Raising

How can the competitive power be replaced by the collaborative power? To address this question, we used Antônio Gramsci and Paulo Freire's work to demonstrate the importance of critical consciousness to create solutions to the problems identified through the power relations described in the Foucauldian view. Although Foucault ideas were used to present the problem, his conceptions cannot be applied to present possible solutions. However, ideas from other scholars and philosophers are able to raise possible solutions.

In the process of knowledge development, it is important to be aware that humans are independent beings who are able to objectify and recreate the world with their labor.[30-32] Paulo Freire, a Brazilian educator, states that the traditional education that does not give a voice to the oppressed, helps to perpetuate social injustices. He called that *banking education*, which is based on the mere transmission of content and information without discussions or the participation of learners. For instance, using our example, if the OTDC just gives instructions to the intensive care team without considering their opinions and thoughts, the OTDC becomes an instrument of oppression. Freire's work explains the society from the clash between oppressors and oppressed.[32] In the scenario, the OTDC's knowledge is acting in a form of oppression towards the intensive care team. In building the knowledge with the intensive care team, the OTDC must be aware of their responsibilities as an educator; and the intensive care team (the oppressed) should not be the oppressor of the oppressor (OTDC's knowledge) but the restorer of humanized relations. In other words, the intensive care team should not ignore the knowledge of the OTDC. The process of knowledge building should occur through the idea of a liberating pedagogy, which would free the oppressed from the oppressor's alienation process.[32] Freire argues that no one can free anyone, no one frees himself alone: men (sic) are liberated in communion.[32] No one educates anyone, no one educates himself. Human beings educate each other mediated by the world's experiences. Freire preaches a horizontal relation between people that allow the exchange of knowledge and experiences.

Additionally, the commitment of the educator with the learners is another point of paramount importance in the aforementioned example of the OTDC for the success of the knowledge building, without it there can be no effective learning. This commitment depends on interprofessional collaboration and is facilitated when professional tasks and goals are clearly established, professional roles are effectively delineated, and interprofessional feedback occurs.[33-35] It is essential that the health care team participates in the knowledge building process and are aware of their role as active subjects of this construction. Gramsci, an Italian

philosopher, presents a concern in mitigate hierarchical relations between the educators and those who learn, advocating a dialectical relationship, between them.[30,31] For Gramsci, a good relationship for knowledge building should be active and reciprocal in terms that "every teacher is always a pupil and every pupil a teacher"[31] (p.348) providing a continual process of self-criticism. Gramsci discussed the importance of the relationship between 'knowing', 'understanding' and 'feeling'. For Gramsci, the learners 'feel', but not always 'know' or 'understand', and the educator 'knows' yet not always 'understand' or 'feel'.[31] Therefore, the dialogical relationship between educator and learners should be fostered to develop into an organic cohesion that allows the construction of 'feeling' into 'understanding' and lastly into 'knowledge'.[31]

Gramsci explains that it is of paramount importance for the educator to engage people in the learning process.[31] Health care teams in acute care scenarios are extremely busy and overwhelmed by the responsibilities inherent to the severity of their patients' injuries. Therefore, a banking education is non-sensical for this population and would interfere in the dynamics of the intensive care unit and in the health care outcomes. The transformative education preached by Gramsci and Freire is advantageous because it can take place in a variety of sites and respects each individual as unique with his beliefs, values, and ideologies.[30-32]

Additionally, to trespass barriers in healthcare power relations, it is important to consider the use of the culture cycle proposed by Freire. The culture cycle comes from the assumption that everyone has the same knowledge and seek to gain more knowledge as a group, however, the experience of oppression can negatively affect this concept.[36] The liberation of the oppressed includes the *conscientization* and problematization, but for one to be *conscientized* about the reality it is first needed to problematize about one's reality.[37] Problematization is a political-pedagogical strategy that supports critical analysis and intervention in the reality through dialogue.[37]As per Freire, dialogue includes reflection and action and it is an important part of the humanity history and it allows us to reflect on what do we know and what we do not know in a collective way, giving space for critical appraisals and opportunity for transformation.[38]

Freire and Gramsci give emphasis in the use of dialogue and the dialogical relationship between trainer and trainees, the trainer does not impose the knowledge to the trainee, instead, the trainer is a source per se of knowledge that instigate the trainee critical thinking so the feeling and understanding can be later transformed in knowledge through an organic cohesion.[31,38] However, as in power, dialogue can be used in an oppressive way, using our example, that would happen if the OTDCs nurse implies do the ICU team that their knowledge/practice is wrong. It is important to use dialogue as an exercise of freedom allowing reflection and action inside the culture cycle.[38] Therefore, Gramsci's critical theory and Freire's critical pedagogy concepts demonstrate that through critical consciousness raising it is possible to achieve change and social transformation with the end goal to provide apt care for the patients.

Conclusion

The process of knowledge building in the ICU team, including other professionals such as OTDC, is complex and we discussed in this paper how important concepts of power and knowledge may interfere direct or indirectly in the construction of common knowledge. The concept of power was unfolded and demonstrated to be a dynamic concept that can be correlated with different hierarchical systems, existing at different levels. The interprofessional power relations in health care settings showed a balance between the roles played for each profession and the knowledge construction among them. Once the balance is broken the relations are threatened and this interferes in the outcome of knowledge building. Knowledge represents the source and the outcomes of power through Foucault's

theory effects in the health care team will vary depending on the way it is employed. For the health care professionals, knowledge can be interpreted as a threat or a help depending on the level of participation they had in its construction. Through Freire's and Gramsci's lenses we argued that knowledge as a threat or oppression can be overcome when knowledge is used in relation to one's role in the system/care, and that knowledge should be shared and trusted. Therefore, interprofessional power imbalances can become action through mutual transformation and change.

Collaborations

All authors participated in the conception of the work, revised it critically for important intellectual content, and provided final approval of the version to be published

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