



Family physicians' power and team-based care: Lessons from a 60-year-old primary care clinic

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ABSTRACT

The article focuses on the tension between team-based care approaches that emphasize interprofessional collaboration and existing power imbalances between family physicians and other health care providers. It contributes to the literature on the implementation of team-based care models in primary care clinics by adopting a *governance* perspective, often overlooked in these transitions. While existing research has acknowledged power imbalances between family physicians and other health care providers, it has paid less attention to how governance mechanisms may shape these dynamics. Through an in-depth case study of a 60-year-old Canadian primary care co-operative, we address this gap and explore how these power issues play out in a context of collaborative governance and shared decision-making. The methodology is qualitative, relying mainly on data from 42 interviews, as well as on observations and document analysis. On the one hand, the research reveals that some governance mechanisms play an important role in team-based primary care settings, helping attenuate the tension and facilitating collaboration between providers. On the other hand, it shows that, even in a long-standing team-based care model promoting equality between health care professionals and between providers and patients, power imbalances persist. The research illustrates the cultural anchorage of medical domination, highlighting (i) the importance of looking at one organisation's informal norms and cultural context when implementing team-based approaches to care, as well as (ii) the critical need for interprofessional education to actively engage with and address the underlying power dynamics that exist within health care settings.

1. Introduction

Team-based care is increasingly recognized as a structural feature of successful primary care systems and, as such, is promoted as a solution to Canada's current primary care crisis (Aggarwal et al., 2023). In the 2000s, the Canadian First Ministers promised to transform primary health care by integrating family physicians (FPs) into interdisciplinary care teams (Suter et al., 2017). Over the past two decades, provinces and territories have adopted variations of this approach (Hutchison et al., 2011), yielding early successes such as better patient attachment to regular providers and enhanced experiences for both patients and providers (Levesque et al., 2015).

Despite the potential of team-based care approaches, many initiatives continue to face obstacles such as the lack of clarity regarding professionals' scope of practice, incompatibility with the fee-for-service physician payment method, and the absence of meaningful patient voice (Aggarwal et al., 2023; Levesque et al., 2015; Mitchell et al., 2012). Major barriers also relate to issues of power dynamics and cultural

change (Fiset-Laniel et al., 2020; Suter et al., 2017). Studies have shown that efforts to establish a genuine team-based model often come up short, remaining largely physician-centric (Suter et al., 2017). While shared decision-making is a key attribute of teamwork and team-based care approaches (Xyrichis and Ream, 2008), it is partly compromised by the existing power imbalances between providers (Baker et al., 2011; Khan et al., 2022). This applies in particular to the relationship between FPs and other providers in primary care settings, where FPs generally play a leading role (Nugus et al., 2010).

Although there is a literature that addresses the issues of status differences, hierarchies and unequal power relations between professionals in team-based care settings (Brooks et al., 2020; McDonald et al., 2012; Nugus et al., 2010; Reay et al., 2017; Sheridan et al., 2018; Willis, 2006), such dynamics are often overlooked in the process of *building* team-based care environments (Dickinson and Pierre, 2016). The literature also generally overlooks the role of governance models and mechanisms (Baker et al., 2011) in shaping team-based care, even though governance has been shown to structure status and power

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imbalances in other organisational settings.

With this research, we propose addressing this issue, drawing lessons from a primary care clinic with more than 60 years of experience in operating a multidisciplinary model of care. The Saskatoon Community Clinic (SCC) has a wide range of health care professionals—all salaried employees, including FPs—to provide comprehensive patient care. Set up as a co-operative, the SCC is governed by a board of directors elected by its members. This model differs from the dominant private practice clinic model, where primary care facilities are typically owned and governed by FPs. Thus, the SCC presents a unique opportunity to explore how these power issues play out in a primary care clinic that is grounded in collaborative governance and shared decision-making.

With this case study we sought to understand:

- What are FPs' role, power and experience of working in a team-based care setting like the SCC?
- What governance mechanisms facilitate or inhibit interprofessional collaboration between FPs and other health care providers?

To address our questions, we first examine the literature on the challenges posed by the integration of different health care professionals into a team-based primary care practice, focusing on the tension between FPs' professional autonomy and team-based approaches. We then provide contextual background on the studied clinic and describe our methodology for collecting and analyzing data. We summarize the results by drawing three themes from the thematic analysis of the data: (i) FPs' role and power at the SCC; (ii) FPs' experience of working at the SCC; and (iii) FPs' collaboration practices with other health care providers. We conclude with policy recommendations for effective implementation of team-based care.

1.1. Theoretical framework

Team-based primary care can be defined as “the provision of health services to individuals, families, and/or communities by at least two health care providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated high-quality care” (Mitchell et al., 2012, p. 5). The model is recognized as a feature of successful health care systems (Institute of Medicine et al., 2011) because it supports what has come to be known as the *quadruple aim*: improved patient experience, population health, health care provider work-life balance, and reduced health care costs. In so doing, team-based care holds the promise of helping to solve the current crisis in primary care in Canada (Brown-Shrevens et al., 2023).

While the team-based model of care looks promising, it requires true interprofessional collaboration between health care professionals from various backgrounds, and interprofessional collaboration does not just happen. Health care professionals must possess a range of ‘soft skills’ (Byrnes et al., 2012) that allow them to overcome numerous obstacles in interprofessional collaboration: it means dealing with different philosophies, cultures, and professional objectives; it necessitates effective strategies of communication and data sharing; and it involves integration of the knowledge and expertise of each professional (D'Amour et al., 2005). Moreover, interprofessional collaboration also requires professionals to “open up their territorial boundaries” (D'Amour et al., 2005, p. 120) and share, to a certain extent, responsibilities. Indeed, according to Xyrichis and Ream (2008), shared decision-making is a key attribute of teamwork and team-based care approaches.

Interprofessional collaboration therefore requires rethinking the power dynamics among health care professionals, where the physician is a figure of authority and holds strong professional, symbolic, and institutional power (McDonald et al., 2012). These power dynamics stem from the medical profession's historically privileged and dominant position within the sector (Willis, 2006). Freidson (2001) discussed this medical dominance as the ability of physicians to make independent

clinical decisions and exercise control over the regulation of their own profession. Beyond their self-regulatory autonomy, doctors also enjoy a form of *authority* over the work of other health care professionals and of *sovereignty* within the sector in that they are considered to be the established experts in all matters relating to health in the wider society (Willis, 2006): they determine professional standards, set ethical guidelines, and make decisions on matters of competence and performance. Moreover, from the general public's point of view, the FPs embody medical knowledge and professional expertise, which grant them symbolic power along with a privileged status in society (Freidson, 2001). Finally, this status is generally reflected at the institutional level, where they usually enjoy a privileged position and greater power compared with other health care professionals. In many health care settings, they occupy leadership roles that give them influence over clinic operations.

The combination of these characteristics tends to set medicine apart from other professional groups and gives physicians a unique position within the health care system. The inherent authority of the medical profession and associated status differences can come into conflict with group dynamics (Brooks et al., 2020; Sheridan et al., 2018) and the collaborative nature of team-based care, which emphasizes shared responsibility, collaboration, and the sharing of decision-making power. Occupying the top of the hierarchy of health care professions, doctors have defended their status and the power that goes with it against challenges from other health care professionals and organisations (McDonald et al., 2012).

Furthermore, their unique status and authority lead FPs to take for granted the roles they assign to themselves and others within the team. These role expectations are embedded in broader, taken-for-granted understandings of professional identities in health care settings (Reay et al., 2017), upheld by commonly accepted views and beliefs about the division of work among providers (Scott, 2014; cited by Reay et al., 2017). These shared understandings reinforce how each provider group views itself and others. Accordingly, other professionals tend to conform to these expectations: “In general, physicians perceived themselves as ‘leaders’ and ‘decision makers’ in healthcare while nursing, therapists and other professions (e.g. pharmacists, dietitians, social workers) saw themselves as ‘team members’ who tend to adopt a holistic approach to care” (Baker et al., 2011, p. 100). These stark differences in role perception reinforce FPs' dominance in the care settings (Nugus et al., 2010), and can hinder a collaborative team dynamic by limiting the participation of non-physician team members in decision-making.

This issue becomes even more critical when considering the question of professional autonomy, which is a key concern for health care professionals (Rafferty et al., 2001). For FPs—who typically enjoy a high degree of autonomy—moving towards team-based care can mean relinquishing some power, as decision-making and responsibilities are expected to be at least partially shared across the team. This shift can challenge traditional professional boundaries, disrupt established hierarchies, and reconfigure relationships among health care providers, potentially leading to power struggles and conflicts over professional turf. On the other hand, relinquishing control and sharing responsibilities enables other professionals—who usually defer to FPs or nurse practitioners—to gain autonomy, which is crucial to the successful deployment of collaborative practices. Indeed, MacNaughton et al. (2013) found that “empowering team members to develop autonomy can enhance collaborative interactions” (p. 9). Successful team-based care models therefore hinge on striking the right balance of autonomy for each professional group without allowing one group to dominate the others.

The issue of power distribution is therefore central in interprofessional collaboration (D'Amour and Oandasan, 2005) and is intimately linked to issues of organisational governance. Governance can be defined as encompassing formal and informal systems, structures, and processes, through which responsibility and accountability are formally or informally distributed among actors within a system or an

organisation (Barbazza and Tello, 2014). Put simply, governance describes who has power to make which decisions, and how. It defines the level of involvement of different stakeholders (e.g., managers, health care providers, and service users) in setting an organisation’s mission and objectives. It also influences the nature of organisational relationships, such as whether they are hierarchical or collaborative, and the degree of trust. These elements of governance influence the way collaborations develop in teams and are recognized as “foundational attributes of interprofessional teamwork within primary care settings” (Khan et al., 2022, p. 52).

Although the literature addresses the issues of status differences, hierarchies, and unequal power relations between professionals in team settings (Brooks et al., 2020; McDonald et al., 2012; Nugus et al., 2010; Reay et al., 2017; Sheridan et al., 2018; Willis, 2006), governance aspects are rarely addressed, despite their importance (Baker et al., 2011). Numerous policies “ascribe (implicitly or explicitly) team leadership to family physicians” (Suter et al., 2017, p. 4), or simply do not question those aspects or their practical implications.

1.2. Background: a co-operative primary care clinic

The co-operative clinic model is a legacy of the Canadian Medicare reforms in the 1960s. In 1962, Saskatchewan FPs went on a 23-day strike to oppose the expansion of public insurance from hospital services to physician services. During the strike, the government’s negotiating position was strengthened by the mobilization of thousands of Saskatchewan citizens who set up almost a dozen co-operative associations, secured premises, and recruited FPs from the UK and later Asia to provide medical services (McPhee, 1973; Rands, 1994). The SCC was one of those clinics that came into being with the promise of providing medical care to “everyone seeking it” during the crisis. Since its inception in 1962, the SCC’s team-based care model has operated as an alternative to the existing physician-led private practice model that continues to deliver most of the primary care in Saskatchewan and Canada.

Today, the SCC has around 170 employees serving 17,000 patients at two Saskatoon sites. The clinic’s model of care is multidisciplinary, including FPs and nurse practitioners, as well as a variety of other (allied) health professionals such as counsellors, lab and x-ray technicians, occupational therapists, physical therapists, dietitians, registered nurses (community, mental health, and primary care), pharmacists, and visiting specialists. All providers are salaried employees of the clinic, including the FPs.

Unlike FP-led primary care clinics, the SCC is largely funded through capitation funding by the Ministry of Health, with some supplemental funding from the Saskatchewan Health Authority (SHA) for specialized services such as those geared to refugees. The SCC also generates some modest revenue from its pharmacy, a foundation, and (optional) membership fees.

From the beginning, the clinic’s governance model embraced a philosophy of collective ownership and control by its members and consumer participation (Gruending, 1974), seeking to share decision-making and to give more room to the patient voice compared to traditional medicine. To that end, the clinic was set up as a co-operative under Saskatchewan’s Co-operatives Act and is run by a board of directors composed of co-operative members, including patients, interested citizens and occasionally staff. The SCC is characterized by a relatively flat governance structure, consisting of five main layers:

- (i) the **membership**, responsible for electing the board of directors and able to pass resolutions to guide the direction of the clinic;
- (ii) the **board of directors**, composed of co-operative members and responsible for the overall strategic vision of the organisation and for keeping up to date the policies and procedures guiding the organisation running;
- (iii) the **executive director** (ED), hired by the board of directors and responsible for ensuring the operationalization of the strategic

- vision and supervising all staff. At that level we also find the **two medical directors**, responsible for supervising the FPs;
- (iv) the **management team**, composed of the department heads, responsible for monitoring operationalization within their department; and
- (v) the **staff**, responsible for delivering the services to service users.

The clinic thus has a distinctive governance model, different from the dominant private practice model. Its founding philosophy and operating principles—including democratic participation, interdisciplinary group practice, salary payment for providers and consideration of the social determinants of health—represent a break with the prevailing medical model of the time and still today, namely a physician-centered, fee-for-service, and biomedical approach to health care.

2. Methods

To address our research questions, we employed qualitative methodologies and conducted a case study on the SCC. Team dynamics in health care are inherently complex, involving multiple stakeholders and diverse practices and perspectives. The case study approach allowed us to delve into these complexities and understand the interactions and dynamics at play (Flyvbjerg, 2006). In addition, the selected clinic represents an unusual and distinctive case within the Canadian health care system, characterized by its long history of team-based care, its salary payment model for all providers, and its co-operative governance structure that emphasizes collaboration and shared decision-making. The SCC thus constitutes an edge case, contrasting with most health care settings that are physician-centric in their governance model and where physician pay is based on a fee-for-service model. For those reasons, it offers a unique opportunity to observe how power dynamics manifest in governance structures that aim for more collaboration and less physician dominance, and to uncover insights and patterns that might be obscured in more common governance structures.

We conducted semi-structured interviews (N=42) between November 2023 and April 2024 (with the exception of five pilot interviews conducted in February and March 2023) with all major types of stakeholders, including board members, staff¹, and patients/members (see Table 1). Interviewees were recruited using convenience and snowball methods: first, an invitation was sent to the entire target population; second, we allowed willing participants to recommend other interviewees, while ensuring a variety of viewpoints in each interviewee category. The interviews aimed to understand the interviewees’ role at the SCC, their experience in their role/function, their work relation-

Table 1
Number of interviews by category of interviewee.

Interviewees categories	(n =)
Board members (BM)	9
Management staff (MS) (i.e., ED, medical directors and department directors)	11
Health care staff (HS) (i.e., FPs, nurse practitioners, registered and licensed nurses)	9
Allied Health Professionals (AHP) (e.g., mental health counsellors, physical and occupational therapists, lab technicians)	8
Services users (SU) and members (M)	4
Affiliate/Partner (A/P)	1
Total	42

¹ One interviewee had been retired for a few years. We included them in the interview process because they had spent their entire career at the SCC and thus could offer valuable historical context for our investigation.

ships, and their understanding of team-based care and co-operative governance. Interviews were conducted until methodological saturation was reached.

The interviews were transcribed verbatim using Microsoft Word and then verified by a researcher. Next, the transcripts were returned to the interviewees, giving them the opportunity to check the content, make changes, or add further information if they deemed it necessary. The transcripts were then thematically analyzed using NVivo. The coding categories were generated both inductively—i.e., based on what emerged from the data analysis—and deductively—i.e., framed by the existing literature and relevant theoretical frameworks. Over the course of the analysis, these codes were linked together by taking into account observations. They were then summarized in writing. This process helped identify and select the broader themes used in the empirical section to convey our findings. In the remainder of this article, excerpts from interviews are used to illustrate our point. Real names were replaced by pseudonyms.

In addition to interviews, we employed two other complementary methods: document analysis and nonparticipatory observations. This approach is in line with the case study approach, which calls for multiple types of data sources and an immersion in the observed environment (Flyvbjerg, 2006). First, we conducted an analysis of the documents that describe the clinic’s governance and organisational structures and provide evidence of its evolution and implementation (e.g., reports, organisation chart). That helped us develop an understanding of the clinic’s background and context and to design the interview and observation guides. Second, we carried out nonparticipatory observations (N=13) of different types of meetings (see Table 2) where the clinic’s approach to care and governance model unfolds in practice. The aim of these observations was to understand how stakeholders work together, how information is shared, and how they make decisions. These observations were crucial for providing contextual depth and a nuanced understanding of the interview data, enriching the analysis by highlighting behaviors, interactions, and environmental factors that may not be captured through interviews alone. Overall, the triangulation of data sources enhanced the robustness and validity of the study.

3. Findings

In this section, we outline our major results. We first summarize the stakeholders’ perception of FPs’ role and power in the clinic and then describe the work experience of FPs in a team-based care setting. Finally, we describe the interprofessional work relationship between FPs and other health care providers. The data we use to illustrate these findings comes mainly from interviews, but the interpretations also draw from the results of the document analysis and nonparticipatory observations.

3.1. Family physicians’ role and power in the clinic

With regard to FPs’ role and power within the SCC, empirical results show that while the clinic’s collaborative structure attenuates their power, FPs still retain considerable decision-making authority and remain a highly influential group. First of all, the co-operative structure necessarily introduces a plurality of interests in the decision-making process, positioning the FPs as one group among many when it comes

to making decisions. The following quotation from a FP highlights the point:

“You think as a physician that that’s the best way, but they [the board of directors] have other reasons, like a bottom-line, I guess, and different employees and different people they’re trying to appease. And the government funds us and all these things. I think it gets a bit watered down when you [a FP] are trying to make changes” (HS4).

Nevertheless, FPs benefit from a privileged and powerful position in the organisation, as one former FP from the SCC noted:

“They [FPs] are employees of the clinic; they are not owners of the clinic [...] but they still are a pretty influential group. [...] I think there was like 15 of us, I mean, we certainly had a lot more say than any other 15 people at the clinic” (HS10).

This influence reflects, in part, the traditionally significant role of FPs within the broader health care system. However, it is also facilitated by the position of the FP group in the SCC’s governance structure, which amplifies the voice and impact of FPs in organisational decisions. From the outset, the clinic was sponsored by FPs and patients, and those two groups were responsible for running the organisation: the board of directors and the FP group. This initial arrangement positioned FPs as a separate group within the organisation. Although the governance structure has changed considerably since then, with the board of directors taking on more responsibilities in terms of hiring and management (Gruending, 1974), this power-sharing arrangement remains in force today.

Unlike other provider groups, the FPs’ representative directly reports to the board of directors and are not formally accountable to the ED. In that way, the FP group benefits from a more direct connection to the board of directors in comparison with other provider groups: “The medical directors have a direct line of sight to the board where other staff, like an RN [registered nurse] or physiotherapy does not have that direct connection with the board” (MS4). In addition to symbolically separating them from other provider groups and placing them at the top of the organisation’s hierarchy, this unique positioning formally reinforces the influence of the FPs within the organisation by giving them more direct access to decision-making. As documented by Gruending (1974), the issue of lines of authority between the lay board of directors, the ED and the physicians has been a source of tension within the organisation since the beginning and remains so today, as a manager noted:

“We have had some conversations in the past and I actually had this frank discussion with the board about a year ago because there was one physician in particular that felt strongly that administration [the ED] didn’t have any oversight over them as a physician. And my feeling is the ED does, because like when I read the ED’s executive limitations and job description, the ED was hired to manage the entire clinic and manage all employees of the clinic, of which physicians are employees” (MS4).

Over time, with the board of directors taking on a more distant, less operational role, the ED has become more susceptible to pressure from the medical group, especially with the current shortage of FPs which reinforces their strong position. Indeed, in the view of some interviewees, this situation has shifted more power and autonomy to FPs: “That was one of the unique things about the clinic, is the doctors did not run the clinic, whereas in that there are circumstances now where it’s like the doctors are running the clinic when that shouldn’t happen.” (AHP4)

3.2. FPs’ working experience

While FPs may retain some formal power, interview data also reveal FPs are acutely aware of their status as employees. As one FP noted: “It

Table 2
Number of observations by type of meeting.

Observations units	(n =)
Membership meetings	2
Board meetings (public part)	2
Leadership team meetings	2
Leadership team huddles	2
Other committees’ meetings	1
Huddle meetings	4
Total (N =)	13

seems like maybe you're being watched a little bit because you're an employee. So, for some people that's a bigger deal than for others" (HS4). As many interviewees highlighted, this loss of autonomy does not affect the way they practice medicine, but rather their working conditions and their ability to make decisions in terms of how work is organized (e.g., schedules or modalities), protocols, human resources management, or resource allocation. The following excerpt is from a FP discussing the complaints of some of their colleagues who have left or are considering leaving the SCC:

"If they [FPs] think that something needs to be done differently, they feel like they don't get heard. Or it like gets taken to the board, which 'none of us have ever met, and we don't know who they are'. This is like, mysterious board members, right? And then they [the board] are like, 'Oh, no, that's not part of our values or our mission or whatever'." (HS4).

This interview extract highlights the tension between the desire for professional autonomy and the constraints imposed by the SCC's co-operative organisational structure. In referring to the board of directors as an obscure and impersonal body, this FP illustrates a feeling of distance from the decision-making centers—although, as mentioned above, the FP group benefits from a more direct connection than other providers to the board of directors.

While acknowledging some loss of autonomy, most interviewees also noted offsetting benefits from working at the SCC. First, FPs identified the security of a fixed income, no longer having to deal with the stress of managing increasing overhead fees, and not having to manage administrative and recruitment tasks on their own as key benefits that increase their job satisfaction. As one FP explained, "I just get paid my salary and do my job. So, I like that. I like not having to worry about running a business or paying overhead. About running, hiring and firing staff" (HS3). Overall, throughout the interviews, some FPs emphasize how their employee status enhance their work-life balance, with the ability to take sick leave, maternity leave, or holidays—and to "truly feel on holiday."

Second, many FPs emphasized the sense of being supported from working in a team: "We cover for each other and we don't have to go begging to a colleague, 'Can you please look at my labs while I'm away?' You know it's just done right" (MS1). Some FPs feel more empowered by working in a multidisciplinary team-based care model that allows them to ensure better patient follow-up and improve the quality of care. By working collaboratively across specialties, they feel more supported in managing patient needs comprehensively, as illustrated by the following quote:

"I would hate to work in a fee-for-service physician-run clinic, just because like there's a big gap in services that are available to people. [...] I can't imagine working somewhere and being like 'you could really use some counseling. Good luck'" (HS3).

In addition, FPs recognized that their payment model enables them to expand their role beyond patient care to include activities such as advocacy, program development, and interdisciplinary collaboration. This too enhances their professional fulfillment, enabling them to contribute to broader health care initiatives: "We can do more patient advocacy and committee work and interdisciplinary work as opposed to, again, just making sure we see enough patients in the day to get through the day" (MS2). Some FPs even reported feeling more autonomous in how they practice medicine as the clinic's model allows them to provide care to populations that would be difficult or unprofitable to serve under a fee-for-service payment model:

"You're able to do some of the specialty care that in other systems, it would be very hard to do. Like, say, refugee health. As a fee-for-service physician it would be nearly impossible to do refugee [care]. Because the structure isn't conducive for it, because it's 15-minute appointments and all of that" (HS7).

The mindset of FPs thus plays a crucial role in how they experience working at the SCC and how they perceive the potential loss of autonomy. This mindset, in turn, depends largely on how they perceive their role, the type of care they aspire to provide, the populations they wish to serve, and the types of activities they aim to pursue. For many, the SCC's organisational model aligns with a philosophical vision of medical care. For example, one founding FP described her motivation to join SCC as rooted in the clinic's "philosophical attitude" that viewed patients as active partners in planning their care (Gruending, 1974, p. 4). One interviewee noted the SCC's FPs have historically been more open to embracing structural shifts that challenge the traditional physician-centered hierarchy common in the health care system:

"That's a natural thing in health care, that's where health care is, in Canada, set up. That the doctors are at the top and then it goes down from there. And I think at the [SCC] clinic that the doctors are a lot more receptive to the changes of that, and maybe still don't have the same power that another group of doctors would have" (HS10).

3.3. The work relationship between FPs and other health care providers

Despite the collaborative nature of the organisation, FPs appear to remain largely autonomous in the way they work, deciding how much and in what ways they want to collaborate with other providers. The collaboration practices thus vary highly from one FP to another. One allied health care professional said:

"So, doctor A reads my notes, meets my client, has taken that in, talks with my client in a way that makes him feel like 'God, this guy knows that I have PTSD and he is like behind me', right? [...] Then there's another doctor, I do the same thing with that doctor, doesn't read the notes, doesn't care about the notes" (AHP2).

Physicians often exercise discretion in how they engage with peers and navigate collaborative opportunities (e.g., clinical discussions, care planning). The following quotation reflects this dynamic by describing how some colleagues tend to make less use of the shared space reserved for FPs and nurse practitioners, which can limit spontaneous interactions:

"Some docs spend a lot of time in that central space and some spend no time [...] I feel like they miss out a bit. They're a bit disconnected from the group. [...] It seems it's some of the more senior physicians, so they're in their ways and they have a way of doing it. [...] Some of my physician colleagues, I would maybe see them during the workday, going in and out of the room while I'm going in and then give them a wave but, there wasn't much opportunity for informal case conference unless you sought it out. But here, we're all sitting in the same room and [if] something pops up on our screen that is confusing, it's very easy just to turn around and say, 'Hey, look at this like, what do you think?'" (HS3).

Engagement in collaborative practices thus varies widely from one physician to another, each having their own habits and preferences.

The interviews also generate insights about other features of the SCC's organisational model that facilitate or hinder interprofessional collaborative practices, namely the FPs' payment method and the clinic's governance structure.

3.3.1. The salary payment method serves as a catalyst for interprofessional collaboration

The FPs' payment method plays a key role in facilitating work relationship with other health care providers. To start with, interviewees identified it as a key mechanism for protecting time for collaboration:

"It [the salary payment method] does allow the time for the physician to, on a day-to-day basis, connect with the pharmacist to discuss a prescription or connect up with the physio or the social worker.

Also, it gets an allowance for team meetings, for instance in chronic disease management, if they wanted to talk about how we're going to manage care for an individual or a group of individuals that brings in a diabetes or hypertension and they wanted to work together" (BM1).

Residents are particularly drawn to the salary payment method, as it provides them with more opportunities to collaborate with other physicians and health care providers, allowing them to work in an environment fostering interdisciplinary learning.

The salaried model is also seen as promoting equality among providers, ensuring no single category of provider is seen as responsible for generating the organisation's revenue, while others are just salaried employees. This feature helps to create a more balanced and collaborative working environment, where all team members are valued equally. As one interviewee noted, "There's no 'fee-for-service' versus 'employee' or 'salary' model. Then it's conducive to collaboration. I would say here it's very collaborative, it's very collegial" (HS5).

Finally, salary compensation also avoids competition for resources and reduces the 'protectionist mentality' that impedes a team approach. According to a provider, this helps nurse practitioners assume an important role in the organisation and facilitates collaboration between them and the FPs:

"There's a lot of places [where] the physicians do try to limit what we [nurse practitioners] are allowed to do. [...] I'm just saying in general, there very much has been a protectionist mentality about... well, 'Nurse practitioners are not doctors, they didn't go through Med school, they didn't do this, and now they're trying to take over...' and the big thing is when there is that fee-for-service, then it's taking away the potential for making the living. [...] I do think having a salary as opposed to fee-for-service takes that element away" (HS2).

Paying all providers a salary appears to foster collaboration between FPs and other providers. However, this does not prevent the persistence of a more informal hierarchical structure among providers.

3.3.2. The physician-centric hierarchical structure hinders collaborations

As outlined in the description of the formal governance structure, each professional group is represented within the management team. This means other health care providers such as nurses, social workers, or physiotherapists have managers to whom they report, who can represent their interests and needs. One nurse said: "Our manager is wonderful. [...] she's a good mediator too and she's a very good advocate for the nursing team. And she is a liaison between the doctors and the nurses and the staff" (HS6). As the quotation below illustrates, these managers also play a crucial role in handling potential tensions or conflicts between providers.

"We're [nurses] also really good at being able to have that conversation directly with the provider too. But every once in a while, it doesn't happen that way. And so, she [the nurses' manager] is our kind of extended support. [...] She has that authority to say: 'OK, the nurses can't take any more patients today' or something like that. Like 'they already have too much on their plate' because it's a lot harder for us to just say no to seeing a patient or doing something" (HS6).

This representation structure aims to ensure the needs of each group are heard and addressed, which is essential for promoting effective collaboration in a team-based care environment.

In spite of the effective representation of other health care professionals in the formal decision-making structure, our interview data reveal an informal, hierarchical structure between FPs and other health care providers. While staff are not formally accountable to FPs, the latter sometimes act as though it were the case, informally directing the work:

"So even though we say the physicians are employees of the clinic. I mean, as an employee of the clinic, that should kind of level out the playing field a bit. But I think, historically, just the nature of being a physician kind of... there's a different power dynamic there. So even though a Clinical Office Assistant doesn't report to a physician, they're not accountable to the physician, quite often you have a physician saying: 'This is how I want things done.' And they do it. Even though that's not really how things should flow in this organisation, but it does" (MS4).

This example, where non-physician staff defer to FPs' preferences, highlights how traditional hierarchies in the medical field may persist and at times override the intended collaborative structure of a clinical setting. Even in environments designed to encourage a more horizontal approach among providers, ingrained power dynamics and deference to physician authority can subtly shape interactions.

These attitudes are sometimes revealed in the language FPs use to describe their colleagues or the team dynamics. As the following quotation illustrates, one FP describes the work dynamics as collaborative, but also frequently uses the possessive pronoun 'my' when referring to other health care providers:

"For a lot of medical care, the physician often is the sort of team leader so to speak, but we welcome all of that input from our subspecialties, right? So, in some cases I don't feel like I'm in charge, like I'm not the expert in the field, I feel like **my** (boldened by the authors) dietitian is more knowledgeable or **my** physio or **my** pharmacist knows more about this you know. So, when we have a team, it's like everybody has a voice, but sometimes you know, I think the doctor tends to be just kind of the ringleader to gather people together, but that doesn't mean all the doctors make all the decisions." (MS1).

This possessive framing implies a physician-centered perspective, suggesting that other providers function as extensions of a FP practice. Even in collaborative settings where all providers are employees with no formal hierarchical relationship, some physicians—although not all of them—see themselves as the central figure around whom team activities revolve.

This sometimes creates tensions, especially when FPs expect team members to prioritize their specific clinical objectives:

"Other doctors say, 'I want this nurse to book off 3 afternoons a week to work with me for these groups of patients that I'm seeing.' [...] We have a lot of doctors who have special interests and goals and passions, and they would like more resources directed to those areas. And so, there's always a little bit of, 'yeah, we can't do that because the counselor can't be off one day a week just to work with your patients', you know?" (MS9).

These preceding passages also suggest that the responsibility for referring to another provider—or simply involving them in the patient's care pathway—lies exclusively with the FP, underlining an implicit hierarchy in the organisation of care. Language-use and expectations highlight the persistence of a physician-centric mindset among some of the FPs. This can reinforce a physician-centric informal hierarchical structure, shape the way collaborative practices are perceived and enacted, and inhibit organic collaborations in the team.

4. Discussion

The starting point for our questioning was the tension between the team-based care approach that emphasizes interprofessional collaboration, and the power imbalances between FPs and other providers that are ingrained in the health care system (Baker et al., 2011; Khan et al., 2022). With this case study, we explored how these power issues play out in a primary care clinic set up as a co-operative, a setting grounded in collaborative governance and shared decision-making. We described

the perceived role, autonomy and power of FPs in a team-based work setting and their collaborative practice with other health care providers. We explored the extent to which its governance mechanisms facilitate or inhibit power sharing and interprofessional collaboration between FPs and other health care providers.

On the one hand, the findings show that some of the SCC's governance mechanisms—such as the absence of a formal hierarchy between FPs and other providers or the role of other professions in decision-making—help regulate and attenuate that tension and facilitate collaboration. The salaried employee status of FPs also plays a key role in attenuating hierarchy and inducing a more collaborative work environment by aligning incentives and reducing competition. These settings mediate the exercise of medical dominance and facilitate a more collegial approach to decision-making, ensuring that all groups within the clinic have a voice in the organisation.

On the other hand, despite the SCC's peculiar governance model, the case study shows that some voices are heard more than others: power imbalances are still very much present, with FPs retaining a privileged position and power that sometimes jeopardize the team-based care approach. First, FPs still have decision-making privileges within the organisation, with a special position in the hierarchy, more autonomy than other provider groups, and more influence overall. Second, they retain autonomy in deciding whether to engage in a high or low level of collaboration with other health care providers, and some health care professionals still feel informally accountable to physicians. It also showed some FPs still remain in a physician-centered perspective when considering their interactions with other health care providers.

The results therefore indicate that even in a long-standing team-based care model aimed at promoting equality between health care providers, power imbalances persist. This case study shows that aspects of organisational governance play an important role in the distribution of power and that it can be productive to think of team-based care from the perspective of organisational governance, as formal governance mechanisms can attenuate or accentuate power imbalances. As [Dickinson and Pierre \(2016\)](#) note, health care reforms are generally silent on the question of governance and yet, governance plays an important role in the success or failure of team-based care approaches. Given that FPs are increasingly working in team-based models of care—such as the Patient Medical Home model gaining ground in Canada ([CFPC, 2019](#))—it will no longer be possible to sidestep these issues.

In so doing, however, attention also needs to be directed to the organisation's informal norms and cultural context. Indeed, the research also confirms the cultural anchorage of medical domination ([Nugus et al., 2010](#)). Power is not just about formal authority but is also derived from less tangible and more symbolic elements such as the capacity to control ideas and influence others ([Hardy and Phillips, 1998](#); cited by [McDonald et al., 2012](#)). This is particularly evident in health care, where varying professional statuses create significant power differences. In this case study, FPs remain key actors, benefiting not only from formal authority—due to their position in the organisational hierarchy—but also from a form of symbolic, more informal power, which further consolidates their central role within the organisation. Specifically, FPs' perceptions of themselves and their professional roles, as well as their willingness to adopt a mindset that values shared responsibility and partnership with patients, are key influences in fostering team-based care. This open-mindedness can be seen as a fundamental factor in supporting the collaborative approach of the model.

All this underlines the importance of re-examining work relationships and power dynamics when implementing a team-based care model, in both its structural and cultural dimensions. The distribution of power can shift among team members based on task demands, member expertise, and evolving team dynamics ([Aime et al., 2014](#)). Team-based care requires embracing flexible leadership structures and building a culture that values shared responsibility over traditional hierarchical leadership models.

Finally, our findings reassert the need to introduce interprofessional

education and training that critically re-examines and restructures power relationships ([Baker et al., 2011](#); [D'Amour and Oandasan, 2005](#)). The importance of incorporating an interdisciplinary component in health care professionals' education has been recognized in the scientific literature for decades ([Hall and Weaver, 2001](#)). Numerous studies have emphasized the role of interprofessional education in preparing students for the health care workforce, where teamwork is a key competency ([Patel et al., 2025](#)). By bringing together professionals from diverse disciplines to learn with, from, and about each other, interprofessional education could not only better prepare health care providers to engage in team dynamics, but also has the potential to challenge long-standing assumptions about authority and expertise in clinical settings. However, some studies suggest that interprofessional education initiatives, even when designed to promote equality among professions, can inadvertently reinforce existing power structures, particularly those that favour physicians ([Kuper and Whitehead, 2012](#)). This body of research also points to a lack of attention to social processes in the interprofessional education literature ([Reeves, 2011](#); cited by [Kuper and Whitehead, 2012](#)), with discussions of power dynamics often left unaddressed ([Paradis and Whitehead, 2015](#)). We argue that for interprofessional education to be truly effective in promoting team-based care, it must actively engage with and address the underlying power dynamics that exist within health care settings.

5. Conclusion

This case study finds that even in a team-based care setting designed to flatten hierarchy, amplify the patient voice, and embrace interdisciplinarity, tensions persist between the ideals of team-based care and enduring power imbalances between providers. FPs retain significant influence, not only through formal integration into key decision-making processes but also through the informal symbolic and cultural power they derive from historical societal norms. Addressing power imbalances in team-based care involves not just revising governance structures, but also critically rethinking the assumptions and norms that underpin them.

However, this case study also shows how well-designed governance mechanisms can constitute a first step toward fostering an environment that is conducive to team-based care. The SCC exemplifies this: it anchors patient voice in democratic practices, employs an executive director who reports to a member-elected board of directors (rather than to FPs), has a management structure that ensures all categories of health care providers are represented in decision-making, and uses salary-based compensation for all providers. For the most part, our interview data suggest that FPs are comfortable with this dilution of their power and, in fact, are grateful for the benefits they get in return.

This study has some limitations, most notably that it is based on a single, albeit thoroughly researched, case study. Future research could compare our findings with efforts to build team-based care in other contexts, particularly in the Patient Medical Home model. Our findings suggest that these laudable efforts to foster team-based models of care may encounter challenges given that they are anchored in a FP-led, hierarchical structure. However, certain governance mechanisms could be a catalyst for implementing truly collaborative care.

CRedit authorship contribution statement

Coralie Darcis: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Marc-André Pigeon:** Writing – review & editing, Resources, Project administration, Funding acquisition, Conceptualization. **Haizhen Mou:** Writing – review & editing, Supervision, Resources, Project administration, Funding acquisition, Conceptualization.

Declaration of competing interest statement

The authors report there are no competing interests to declare.

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Data availability

The data that has been used is confidential.

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