Role understanding and effective communication as core competencies for collaborative practice

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Abstract
The ability to work with professionals from other disciplines to deliver collaborative, patient-centred care is considered a critical element of professional practice requiring a specific set of competencies. However, a generally accepted framework for collaborative competencies is missing, which makes consistent preparation of students and staff challenging. Some authors have argued that there is a lack of conceptual clarity of the “active ingredients” of collaboration relating to quality of care and patient outcomes, which may be at the root of the competencies issue. As part of a large Health Canada funded study focused on interprofessional education and collaborative practice, our goal was to understand the competencies for collaborative practice that are considered most relevant by health professionals working at the front line. Interview participants comprised 60 health care providers from various disciplines. Understanding and appreciating professional roles and responsibilities and communicating effectively emerged as the two perceived core competencies for patient-centred collaborative practice. For both competencies there is evidence of a link to positive patient and provider outcomes. We suggest that these two competencies should be the primary focus of student and staff education aimed at increasing collaborative practice skills.

Keywords: Interprofessional competencies, collaboration, communication, role clarity

Introduction
The ability to work with professionals from other disciplines to deliver collaborative, patient-centred care is considered a critical element of professional practice requiring a specific set of competencies (Interprofessional Education Consortium [IPEC], 2002). Competencies are defined as broad, general abilities that go beyond knowledge acquisition and include use of clinical, technical, communication and problem solving skills (Norman, 1985). Recent literature on collaborative practice and teamwork suggests a range of competencies that are needed to work effectively within an interprofessional healthcare environment. Competencies most commonly emphasized are communication (Canadian Health Services...
Research Foundation [CHSRF], 2006; IPEC, 2002; San Martin-Rodriguez, Beaulieu, D’Amour, & Ferrada-Videla, 2005; University of Minnesota, 1996; University of Toronto, 2006), understanding other health professionals’ roles (Barr, 1998; CHSRF, 2006; University of Minnesota, 1996; University of Toronto, 2006), effective team working skills including understanding group norms, conflict resolution and the ability to tolerate differences (Barr, 1998; IPEC, 2002; University of Minnesota, 1996), the ability to contribute to shared care plans and goal setting (Barr, 1998; University of Minnesota, 1996), a willingness to collaborate and mutual trust and respect (CHSRF, 2006; San Martin-Rodriguez et al., 2005; University of Minnesota, 1996; University of Toronto, 2006).

The Combined Universities Interprofessional Learning Unit (CUILU) in the UK has moved away from competencies and has a new focus on capabilities as they better reflect the need to respond and adapt to the changing health care environment (Walsh, Gordon, Marshall & Hunt, 2005). Proposed capabilities for collaborative practice include: ethical practice (e.g., respect for other cultures, values and beliefs, patient and user participation, attention to legal and ethical boundaries), knowledge in practice (e.g., knowledge of legal frameworks, team structures and processes), interprofessional working (e.g., integrated assessment plan, collaboration and communication, sharing of professional knowledge and mentoring), and reflection (e.g. feedback, problem solving, lifelong learning, reciprocal supervision). The capabilities approach lends itself to defining core domains of competence for interprofessional practice. A competency framework can help to define pathways of attaining capabilities, and help practitioners delineate their learning needs. We do not consider competencies as terminal points in learning, rather they are tools to help students and practitioners identify specific areas of practice where they could enhance their level of capabilities. In this sense, competencies help to articulate standards of practice in more concrete ways that can direct current and future professional development needs.

While many of the competencies for patient-centred collaborative practice are similar, a generally accepted framework is missing. Research in interprofessional education has focused on how to prepare students with the right competencies to work in an interprofessional healthcare environment. Models have started to emerge for educating Health Sciences students, faculty and practitioners to improve collaboration (Cook, 2005; Oandasan & Reeves, 2005a; Oandasan & Reeves, 2005b). However, without a unified competencies framework for patient-centred collaborative practice, consistent preparation of students and staff is challenging. As professional education programs grapple with how to prepare students, a competency framework provides a basis for directing specific course objectives and infusing curriculum with interprofessional content. Competencies further help to articulate concrete standards of practice that can direct current and future professional development needs.

As part of a large Health Canada funded study focused on interprofessional education and collaborative practice, our goal was to understand the competencies for collaborative practice that are considered most relevant by health professionals working at the front line. These perceptions have implications for how well collaborative practice is currently developed at the sites and show how receptive and committed staff are to working interprofessionally in the future. The data should elucidate the core competencies needed for effective collaboration in an interprofessional health care environment and encourage continued dialogue among researchers, educators, and practitioners about ways to support the development of interprofessional competencies in health professional education.
Methods

Qualitative data were collected between October 2005 and April 2006. To be representative and ensure the collection of rich data, individual and group interviews (Munhall & Oiler, 1986; Patton, 1990) were conducted with health professionals and administrators from seven health care sites across Alberta that differed in regard to size, urban and rural location, services provided and population served. A semi-structured interview guide was used to elicit health professionals’ perceptions of the organizational culture and structure, physical environment, cultural competencies and other factors that would enhance effective collaboration. In-depth responses were acquired through probing. Interview participants comprised 60 health care providers (aged 18–55 years) representing nursing (43%), allied health (48%), physicians (1%) and other professions. Most were female (88%); 88% were front line staff and 12% were administrators.

Ethics approval was obtained from the ethics boards of the University of Calgary, the University of Alberta and David Thompson Health Region. Interview transcripts were analyzed through inductive content analysis with support of QSR N6 (2006) computer software. The analysis was iterative whereas researchers read, interpreted, discussed, and revised interpretation of the data (Cavanagh, 1997; Hsieh & Shannon, 2005). Transcripts were read thoroughly before coding; codes were labelled, described and defined. Data relating to competencies were synthesized and emerging themes were tracked in memos.

Findings

The sites participating in our project operated at different levels of interprofessional practice. While most respondents experienced tensions from the ways they interacted with each other they recognized the value of collaborative practice for both patients and staff. Many recognized the inherent danger in “doing things just one way” [Rehabilitation Assistant] and never making an attempt to change, “it’s easy to get like stuck in a box” [Occupational Therapy Assistant]. They saw participation in the project as an opportunity to introduce change. They also valued the contact with students for bringing “fresh energy to their workplace” [Occupational Therapy Assistant]. Other individuals argued that there was neither much professional nor social interaction between health professionals from different disciplines, and they commented on the disadvantages arising out of this gap for the whole group.

The following sections highlight two core competencies that consistently emerged from the interviews as being important for effective collaborative practice: role understanding and appreciation of other roles, and communication.

(1) Role understanding and appreciation of others roles

As some authors argue (Orchard, Curran & Kabene, 2005; Henneman, Lee & Cohen, 1995), recognition of the value of other professionals for patient care is an important prerequisite for collaboration to occur. Most respondents at the participating sites recognized the fundamental importance of acknowledging and respecting the expertise of all professionals for the benefit of the patient.

Well, it reinforced my positive feelings about working with the groups. I fundamentally believe that everybody has something of worth to bring to the table and it may be different, but it certainly is worthwhile looking at. [Nurse]
The realization that no single discipline can meet all of a patient’s needs drove the desire to collaborate. Further, there was recognition of the importance of expertise that patients bring to the health care process as expressed by this health provider.

We’re not, in our occupational therapy, we’re not the ones fixing and saving the person. And that we all have a role to play, as well as the patient does. Just to appreciate everybody and their input and the patient’s input. [Occupational Therapy Assistant]

While it was largely accepted that collaboration is essential for effective patient care, many of the providers interviewed struggled with the “how to” work interprofessionally. This respondent refers to finding her role in the team:

I think it’s definitely a learning process, to learn to work as a member of the team. Because you have to figure out where you fit into that team. And I think as a newer professional that was—it’s just part of the learning process. [Social Worker]

Many of the concerns underlying the “how to” seemed to emerge from a lack of understanding of professional roles and responsibilities of others. Without this mutual understanding, meaningful communication and relationships, including those with the patients, can be more difficult to develop (Hall, 2005). Some respondents freely admitted that they are not as informed as they should be, which made them realize that their role may be misunderstood by others as well. The following statement is representative of how most of the responding health care providers feel:

I’m the first one to admit that I don’t know what someone else does; it’s always good to find out and to learn, but don’t assume to know what my job is [Nurse]

When other colleagues are perceived to take over one’s roles, respondents become protective of their own scope of practice and may show more resistance to collaboration. This is expressed in the following quote:

I know a lot of interdisciplinary teams where people are doing something that you think is your role. So when people move back and forth and have other people doing what you perceive as your role, it can be upsetting [Administrator, Manager]

In addition to causing tensions between individuals, lack of role understanding is also seen as underutilizing professional expertise as this respondent observes:

Not necessarily understanding what people’s scope of practice should be so that we’re all operating really to our full capability, and deriving job satisfaction from that. [Administrator, Manager]

“Role blurring” has been identified as a serious risk for conflict and burnout among team members that requires good leadership and conflict resolution skills to resolve (Brown, Crawford, & Darongkamas, 2000; Hall, 2005). Some respondents suggest defining clear boundaries and demarcating individual contributions to overcome “role blurring”:
So it was very clear to each person what the other professional’s contribution was. And I think it’s really important to set up collaboration between professionals in a way that the roles are clear and where those roles intersect is clear. [Educational Psychologist]

Other respondents alluded to “striking a balance” between the need for interdependence and the desire for professional autonomy as well as the importance of recognizing each others’ expertise and strength in the delivery of patient care.

Not working side-by-side, but working together on something, and realizing our strengths; like, whatever your profession was, people brought certain strengths to the group. [Physical Therapist]

Health professionals also stated that the different philosophical backgrounds and underpinnings each professional brings to patient care adds to the complexity of collaborative practice:

And I think [professional culture] definitely influences the way that we are looking at the healthcare issue or social phenomenon. And it is a process; on the one hand, it enhances everyone’s understanding of the issue. At the same time, it requires the negotiations between these different perspectives, right? So yeah, I would say that [professional culture] is important most of the time. [Nurse]

While some professionals saw diverse professional cultures as enriching the patient experience and leading to a more holistic approach to patient care, others cautioned that professional culture impedes collaborative practice:

[Professional culture] systemically supports professional differentiation and that professional differentiation stands in the way of professionals working together in such a way that they provided the most effective and caring patient care possible. So if we’re talking about culture in that sense, then I think that is a real impediment [Psychologist]

Hall (2005) outlines that defining their own identity, values and sphere of practice was part of the boundary work that disciplines have done to develop and sustain their own authority. As a result, barriers have developed among them that must be broken down before collaboration can develop. Health providers participating in these interviews felt that focusing on the patient’s needs helps to reduce professional boundaries and role conflicts.

Because it’s not about who has got the more important role; it’s about how can we get what this person needs. And recognizing that in doing that, there is a lot of crossover within the disciplines. [Nurse]

I think the most important thing to know is to treat each person as an individual and try to ask them what is important to them. And to say, you know what is the most important to you? How I’ll work with you and probably make them feel really comfortable. [Profession unknown]

This insight on role understanding shifts care from provider-driven to patient-centered and is a step closer to the core intent of collaborative practice. Next, we consider the importance
of communication as the means for fostering effective role understanding in collaborative practice.

(2) Communication

Communication encompasses a wide range of strategies and purposes. Good formal and informal communication among providers as well as between providers and patients with their families is key to collaborative patient-centred care and, specifically, to care coordination (Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 2007; Kripalani et al., 2007).

Interview participants agreed that there were instances where communication needed to be improved. Some professionals are not comfortable speaking up and defining what their roles are which leads to the role confusion previously discussed. There was a perceived need to more clearly articulate how each professional contributes to the team and to more effectively delegate work and direct team members. Others mentioned that in their work areas, there was a lack of communication between providers and that this hampered collaboration.

One goal of communication is to use skilful negotiation to overcome differences in viewpoints arising from different professional cultures or other influences (e.g., personality differences). A manager explains:

And it [collaboration] is a process; on the one hand, it enhances everyone’s understanding of the issue. At the same time, it requires the negotiations between these different perspectives, right? [Nurse]

Reaching consensus was seen as important as evident disagreements between team members may affect patients’ perception of the care process. Specifically, it was felt that the team needs to demonstrate cohesiveness and represent a unified opinion when interacting with patients and their families as expressed in this quote:

So I think we do need to be careful about trying to not present—I don’t know how to say this, because I don’t want it to sound like we’re kind of shielding the client from sort of some of the team processes that might be happening. But at the same time, I do think we have to be careful. Like if there is conflict and just outright disagreement about how to—like what the next step is or where is it that we’re trying to end up, I think that is something the team needs to work out, before the patient necessarily is involved. [Social Worker]

Another important communication skill mentioned was the ability to adjust the language to the target audience. The ability for cross-cultural communication was emphasized in terms of both patient understanding and the capacity to work with members of interprofessional teams:

When you get into the diversity of language and all those things, I just think there are things I don’t know about people, and I think we have to treat them with respect. Try to promote respect and dignity and try to understand people. [Profession unknown]

Health professionals agreed that education has fostered that particular skill:

I definitely think that the schooling that I had helps in how I communicate with clients and different people in our team. Adjusting your communication with different
terminology, you’d use with some one as opposed to another person. Different questions you might ask, even how you would approach the situation. [Rehabilitation Assistant]

Some contexts that foster interprofessional communication are team rounds and charting. Such activities enable professionals to coordinate care and to share patient histories, issues and concerns:

[The rounds are] when you all discuss the patient and then from that point, you can figure out the plan for the day. Again, if you’re not communicating with one another, how are we all figuring out the best plan or the goal for that patient? [Respiratory Therapist]

While role understanding and effective communication clearly emerged as the dominant competencies for effective collaborative practice, participants mentioned a number of qualities that merit brief discussion.

Being able to build trusting and respectful relationships and having a desire for continuous learning and reflection were considered essential to moving practice forward. Participants mentioned that they prefer working with people that are committed to shared teaching and learning and are willing to invest time in the process:

I think the willingness to learn and to change as needed. Sometimes in a small site, you get people who have been working here their whole entire lives and used to doing things just one way. And more appropriate ways of doing things are brought about or suggestions for change, but change doesn’t always happen. [Rehabilitation Assistant].

Reflection was seen as a way to recognize which providers need to be involved in the care process. However, one interview participant felt that this could be made more explicit and taken to a different level.

To me, the ideal learning experience would be experiential learning, where there’s involvement and debriefing, and opportunity to reflect on what my involvement [meant], and to hear from others how my involvement affected care, from their perspective, as they would see things that I wouldn’t see. So for me, I feel that involves that experiential, reflection, and then some kind of debriefing. [Chaplain]

Health providers stressed the need for an environment that embraces collaborative practice and allows for collaborative competencies to develop. This includes providing time, resources and encouragement to engage in collaborative practice as well as setting clear expectations.

Well there are lots . . . there is not enough time given to collaborative learning . . . I don’t believe that we’re even that clear about what we mean by collaborative practice. We’ve used words like team work a lot. So to me, those are old words; old meanings. So I think we have to redefine expectations. I think we are relatively inarticulate about what we would like to see. Therefore, we don’t see it. [Health Education Administrator]

These comments highlight the ways in which personal attitudes, ways of working together, and the conditions of the practice environment could foster stronger collaboration.
Discussion

Understanding and appreciating professional roles and responsibilities and communicating effectively emerged as the two perceived core competencies for patient-centred collaborative practice in our interviews with sixty health professionals. Within both competencies a number of specific areas were highlighted that demanded particular attention. For example, the need to set clear boundaries and demarcations or the ability to strike a balance between interdependence and professional autonomy were stressed as important aspects of role understanding. Among other aspects, communication encompassed the ability to negotiate and resolve conflict as well as coordinate care and use language appropriate to the target audience. Competent collaboration further required careful consideration of the impact of professional culture on patient care, finding one’s own place within a team and recognizing each other’s strength. Participants implied that this could only happen in an environment of mutual trust and respect that fosters and encourages collaborative practice.

This picture arising from our data of “what it takes to be a good collaborator” is consistent with previous suggestions from the conceptual literature. However, it is of interest to note though that the perception of a “competent collaborator” as brought forward by our interview participants seems to hinge mainly on two competencies, communication and role understanding. Although communication and role understanding have repeatedly been highlighted as core competencies for collaborative practice in an interprofessional health care environment, a much extended list of competencies has been proposed such as mutual trust and respect, conflict resolution, willingness to collaborate, positive attitude, team skills and reflection (CHSRF, 2006; Canadian Interprofessional Health Collaborative[CHIC], 2007, IPEC, 2002; San Martin-Rodriguez et al., 2005; University of Minnesota, 1996; University of Toronto, 2006). In our data, a positive attitude and willingness to collaborate were seen as antecedent for collaborative practice rather than competencies that needed to be developed. Antecedents describe individual characteristics that help individuals embrace change and ready them for collaborative practice (Henneman et al., 1995). The desire to work together and develop skills was motivated by a patient-centred vision, i.e. the realization that disciplines in isolation are unable to meet all of a patient’s needs. Reflection and ongoing learning were practitioners’ tools that help them embrace new practices.

The need to align our thinking around core competencies for effective collaboration across professions can hardly be disputed. Without consensus on a shared competency framework, education of health sciences students remains haphazard resulting in health professionals with varying collaboration skills. It has been argued that “only with good definitions and true understanding of the types of ‘collaborator’ competencies we expect our health professional trainees to demonstrate we will be able to teach and evaluate this construct more successfully” (Health Canada, 2004, p.106). This would imply a shared understanding of collaboration and its core elements. Many researchers and educators have adopted the definition of Way, Jones and Busing (2000) describing collaboration as “an interprofessional process of communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided” (p. 4). Others have argued that collaboration is a multi-dimensional construct and that the “active ingredients” relating directly to quality of care and patient outcomes are poorly understood (Schmitt, 2001). This author further suggests that in the absence of conceptual clarity about the nature of collaboration as the central element of interprofessional team care delivery, measurements of outcomes remain elusive. Schmitt
(2001) urges us to carefully examine the structures and processes inherent in collaboration as well as intermediate outcomes to understand which components are pivotal in improving patient care. She states that a “theoretical argument should be articulated linking aspects of the structure, process or intermediate outcomes of collaboration with quality of care outcomes. Conceptual clarity should precede the development and selection of measures of collaboration in studies linking collaboration to quality of care” (Schmitt, 2001, p. 51).

Perhaps our inability to agree on a common set of competencies is directly related to the lack of conceptual clarity of what collaboration is and more importantly, which foundational components impact patient and provider outcomes. As a way to gain more clarity on the competencies most essential for collaboration, each of the competencies proposed in the literature should be examined as to whether and how they contribute to desired patient, provider and systems outcomes.

Much of the literature attests to the link between communication and patient outcomes (Stewart et al., 2000) and communication failure has consistently been linked to patient harm. For example, JCAHO (2007) cites communication failure as one of the leading causes in approximately 65% of the sentinel events reported. Poor information transfer and discontinuity of care have been found to lower quality of care at follow-up and increase adverse clinical outcomes (Kripalani et al., 2007). Furthermore, incomplete or delayed information has been shown to adversely affect follow-up management (Kripalani et al., 2007). The Canadian Medical Protective Association (CMPA) came to conclude that “Poorly functioning teams, in particular poorly communicating teams, increase the safety risks for patients” (CMPA, 2006, p. 2). This statement implies that role understanding leads to better patient outcomes as turf wars and duplication of care are avoided and team functioning increases. There is further evidence that well functioning teams enjoy higher job satisfaction, which in turn has been linked to higher recruitment and retention (Griffin, Patterson, & West, 2001).

While the simplicity of focusing on two core competencies is appealing, the complexity of the two competencies discussed is considerable. Both, communication and role understanding have multiple aspects that require clearly defined learning goals and outcomes. Also, future research may reveal that additional competencies are required to excel in interprofessional team care and achieve positive patient and provider outcomes. This would require expansion of the learning goals to include these new competencies.

Health professionals have stressed the importance of role understanding and communication as building the foundation for successful collaboration; at the same time, they have attested to the need to pay attention to processes that affect collaboration, such as reflection and shared learning. Barr et al., argue that interprofessional learning should be “collaborative, egalitarian, group directed, experiential, reflective and applied” (2005, p. 32) with the emphasis on “learning how to interact with one another . . .” (2005, p. 29). In their view, traditional didactic lecture styles are not suited to interprofessional education as they limit opportunities for interaction. The importance of a fertile environment that enhances interprofessional competence has also been highlighted. The environment acts as a conduit for applying collaborative competencies so desired outcomes such as job satisfaction and safe quality care can emerge. Practice organizations rely on hiring people who already have these competencies, expecting that they will change the culture. Learners need to be made aware of the environmental circumstances (alert zones) in which enacting collaborative competencies becomes difficult and extra vigilance is needed, while practice organizations need to support subtle cultural shifts in order for collaborative competencies to develop (Firth-Cozens, 2001; Henneman et al., 1995).
Conclusion

The paper has highlighted the complexity of competency domains for collaborative practice. While the attributes of a competent collaborator are multifaceted, two core competencies for collaborative practice, communication and role understanding were clearly confirmed. Both competencies have been linked with positive patient and provider outcomes. This evidence suggests that significant gains in quality of patient care and provider outcomes can be achieved by focusing education efforts on enhancing health providers’ communication skills and role understanding. As for many of the other competencies proposed in the literature, such as willingness to collaborate, reflection or mutual respect, the relationship to patient and provider outcomes may be more tenuous.

Our findings can help direct the competencies dialogue towards skills that truly make a difference to patient care. Focusing on two core competencies instead of a larger number of attitudes, knowledge and skills would facilitate the integration of learning objectives and training experiences into existing curricula. It would further help ground educational objectives by building stronger connections between education and practice and outcomes.

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References


Role understanding and effective communication 51


