

Points to Remember to Guide Learning

Point #1: The collective decision-making process

An important component of collaborative practice is the ability to engage in a collective decision-making process.

Collective decision-making process requires:

Identifying Relevant Information as a Team:

Start by:

- Formulating a research question – For more information, refer to [Analytical Questioning](#).
- Searching for information using electronic databases such as AMED, MEDLINE and CINHALL, practice guidelines, Cochrane systematic reviews, and journals that synthesize research articles. Subject guides by disciplines listed in university libraries are useful places to start research on a topic. Each subject guide lists resources (books, article databases, websites, etc.) for the subject area. Along with developing research skills with regard to their own profession's literature, students can learn to access and search literature outside their own professional domain (Villeneuve & Maranda, 2005).
- Sorting through the results to select the most relevant citations and retrieving the citations.
- Critically appraising research by considering the following questions: (Please note that many of the sub-questions are geared to treatment/prevention studies and therefore may not be applicable to other types of studies.)
 1. Are the results of the study valid?
 2. Is the research question clear?
 3. How did the authors carry out the study? Does it make sense?
 4. Where did they do the study? Who funded the study?
 5. Who participated in the study? How were the participants selected to join and how were they assigned to groups?
 6. How long was the study?
 7. Did all the participants complete the study?
 8. What are the results?



9. What are the results reported in the abstract?
10. Did the researchers find that one thing was different from another?
11. How big/significant was this difference? Is this an important difference? How do these research results fit in with what is already known in the team? Are the patients in the study similar to ones in the agency?
12. What are the benefits and drawbacks?

Sharing Points of View:

To improve team dynamics and to make good collective decisions, team members need to understand each other's views, perceptions, feelings and interpretation of the presented literature, its application to the issue, and options for decision or action. Understanding team dynamics, potential sources of conflict, decision-making process and power imbalances helps to ensure an objective assessment of how decisions will be made or opposition is created. There should be open discussion on how the team will make decisions for different issues and how different perspectives will be taken into consideration (Sackett, Richardson, Rosenberg, & Haynes, 1997).

The student can learn by sharing and exchanging theories, models and tools to create a unified approach on specific patient issues (Newhouse, 2008). Also, students can appreciate and accept different ways of knowing, especially when working with complementary/alternative care providers or natural healers who often place emphasis on patient individuality and the resulting therapeutic relationship (Wilson & Mills, 2002).

Diverse Ways of Knowing:

When it comes to understanding interprofessional care and indeed the world around us, there are different methods, approaches or patterns that are commonly used.

- *Empirics*: the scientific approach, or experimental testing. This way of knowing is based on factual descriptions, explanations and predictions based on data. Generating and testing knowledge using this way of knowing is accomplished by the use of experimenting and using the scientific approach to produce empiric theories and statements of fact.



- *Ethics*: philosophy or reasoning. This way of knowing is based on ethical / moral obligations, values and beliefs, and establishing desired ends. Generating and testing knowledge using this way of knowing is accomplished by the use of identification, analysis, clarification and confrontation of beliefs and values as well as dialogue about the justification of beliefs and values to produce standards of practice, ethical codes and philosophies.
- *Personal*: interpersonal, reflective. This way of knowing is based on inner experience, self-awareness, actualizing the authentic self, being present in the moment and using your individual style to develop a therapeutic relationship. Generating and testing knowledge using this way of knowing is accomplished by the use of opening, centering, thinking about how authenticity can be accomplished, listening to responses of others, and reflecting upon the process to produce personal stories and autobiographies.
- *Aesthetics*: the art of care, perception of meaning and significance. This way of knowing is based on creativity, connection to the common human experience and the artful completion of tasks. Generating and testing knowledge using this way of knowing is accomplished by envisioning possibilities and developing appreciation of aesthetic meanings to produce artistry in care provision, poetry, drawing and music.
- *Emancipatory*: social and political activism. This way of knowing is based on critical examination of social, cultural and political context to figure out how it came to be and how to improve it. Generating and testing knowledge using this way of knowing is accomplished by examining inequities in social systems and clarifying cultural values and beliefs to identify what needs to change to create fair and equitable conditions (Chinn & Kramer, 2008).

Each approach has its strengths and limitations and often different approaches are used together (e.g. philosophy and science). Currently in health care, the scientific or evidence-based approach to knowing is highly promoted and advocated. There are, however, calls for a balanced approach in which the different ways of knowing have equal weight and value. As well, multiple ways of knowing are needed to account for all the knowledge of the interprofessional team and to take into account existing knowledge, behaviour and context needed to help guide the acceptance, application and integration of evidence into practice (Fawcett, Watson, Neuman, Walker, & Fitzpatrick, 2001; Tarlier, 2005). Experimental testing is not enough. It would be limiting to restrict oneself to experimental testing since it is only one way of knowing (Fawcett, et al., 2001; Paley, Cheyne, Dalgleish, Duncan & Niven, 2007; Tarlier, 2005).



Understanding Various Types of Teamwork

Multidisciplinary team members work in parallel or sequentially and independently from their disciplinary orientation.

Interdisciplinary team members work collaboratively but still from their discipline-specific orientations. The solution to a common problem is generally not addressed within a common framework of how teams work jointly to meet objectives.

Transdisciplinary team members transcend their separate professional orientations to surpass the disciplinary boundaries seen in multi- and interdisciplinary teamwork. There is an integrated approach to the work; common problems can be addressed in a comprehensive way. The expectation is that through working in a transdisciplinary way, new ways of knowing and understanding can emerge, and new solutions to tackle health problems can be found (Corner, 2003; Hermsen & Henk, 2005; Opie, 1997; Rosenfield, 1992).

Defining the task:

At this stage of the process, team members need to define their roles and responsibilities based on the understanding of the issues. There needs to be a balance between autonomy and independence within one's practice as services are planned. It is important that everyone function to their full scope of practice and that the shared areas of practice are clearly outlined as to "who does what" and "at what time" during the course of a patient's health care experience. During these negotiations, there should be careful consideration on:

1. Agreeing to the level of evidence to direct interventions.

Level of Evidence

Below is a ranking system used to assess the strength of findings for a particular research activity. Clinical practice guidelines are ranked the strongest since they involve the synthesis of evidence from a number of studies as well as a consensus from leading practitioners and policy makers. Opinion articles rank the weakest since they are often based on the perceptions and experience of the author(s) without the support of empirical data.

Level	Description
I	Clinical Practice Guideline - includes evidence from a systematic review and expert opinion
II	Systematic Review - synthesis of all available research articles on one topic
III	Review article - synthesis of selected research articles on one topic
IV	Single Article- Randomized Controlled Trial
V	Single Article – Non-randomized
VI	Opinion or Editorial (Ciliska, 2005; Sackett et al., 1997)



2. Applying the evidence to the clinical state, patient preferences, clinical expertise and available resources (Ciliska, 2005; Sackett et al., 1997).

Behaviours that Promote Building Knowledge as a Team

Individual Level

- Identifies clinical questions and obtains the best evidence to answer them;
- Critically appraises professional and interprofessional research for awareness of the strengths and limitations of the evidence and how it applies to the clinical situation;
- Keeps informed of recent developments in health care practice by reading clinically relevant literature;
- Identifies appropriate interventions that take into consideration best evidence, expertise and patient preferences;
- Works within the availability of resources;
- Evaluates one's own performance; and
- Embraces lifelong and self-directed learning (Ciliska, 2005; Sackett et al., 1997).

Collaborative Level

- Participates in joint decision-making which requires interpreting and incorporating discipline specific evidence for a comprehensive plan of care;
- Agrees on the level of evidence necessary for interventions with other team members;
- Understands one's own role in terms of skills and knowledge and how these apply to a collaborative practice with other providers;
- Discusses research evidence with the preceptor, other team members and patients (Corner, 2003; Hermsen & Henk, 2005; Opie, 1997; Rosenfield, 1992).

One key challenge to interprofessional evidence-based practice is the need to learn how to apply discipline-specific knowledge within the context of collective decision-making. Most work in evidence-based practice is profession specific. Each profession has its unique underpinnings in specific knowledge, values and belief systems, with resulting variations in its current state of research and valuation for specific types of evidence (Ferlie, Fitzgerald, Wood, & Hawkins, 2005; Newhouse, 2008). Also, when working in an interprofessional context, a common language is very helpful. To support evidence-based practice, ensure you are working with a common definition of terms (Belfield, Thomas, Bullock, Eyonon, & Wall, 2001).

Achieving the task:

In order to achieve the task, the team needs to:

- Identify options and research solutions used by others in similar situations and/or the best interprofessional evidence;



- Develop evaluation criteria for options based on the needs of the patient, the organizational culture, policies and procedures, regulatory boundaries, technology capabilities and the expertise of the team;
- Evaluate options against this criteria;
- Examine the concerns and interests that underlie opposing viewpoints;
- Work towards resolution of differences;
- Negotiate consensus on the final details of an action plan for implementation, and;
- Anticipate obstacles to implementation and plan to overcome them.

Evaluating the Process:

Groups can help improve their functioning as a team by evaluating their interactions and decision-making. Ongoing evaluation can help to offset problems, identify inefficiencies as well as capitalize on strengths (Ghais, 2005).

