



## AT THE INTERSECTIONS: MAKING SENSE OF COMPASSIONATE, COLLABORATIVE PERSON-CENTRED PRACTICE(S)

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## Disclosure Statement

- I have no conflict of interest
- I am employed by the Northern Ontario School of Medicine
- This research is currently funded by the AMS Phoenix Caring Project



## Learning intentions ...

- Explore the complexity of compassionate, collaborative, person-centred practice
- Place compassionate, collaborative person-centred care at the intersection of three interdependent domains of practice
- Explore what this might mean for health professional education



## Brief discussion in pairs...

"And what", said the professor, "is your theory of practice? How would you explain "practice" to an alien?"



A starting point might be ... "Practice, to me, is ... What I think we are doing is ..."

(A "theory" is a set of ideas or principles on which the practice of an activity is based ...)

2 minutes! Just focus on whatever comes to mind!



## Key Concepts in the Socio-scientific Theory of Compassionate, Collaborative Person-centred Practice

- "Practices" have both scientific and social domains
- These domains **operate and evolve together through the everyday interactions** between the members of a particular community/unit/team
- Therefore, particular **practices evolve in ways that are unique in each practice community**
- **Knowledge-generating dialogues/conversations and a commitment to relational ethics uniquely characterize collaboration** and distinguish collaboration from communication, coordination, cooperation, co-location ...
- Assuming the patient/family is a key member of the HC team, **relevant, compassionate, collaborative, person-centred practice** are found in the **intersections of the scientific and social aspects of practice**



When "science" or "evidence-based practice" is the sole/predominant driver of our thinking ...  
(Hint: The neglected or less valued conversations are not in this domain!)



- Improving practice is about improving both the evidence and the accuracy of its translation
- There is "a right way", so whether we succeed or fail is about individuals making decisions based on the evidence (this can lead to blame and fault finding)
- This thinking led to the EBM movement and the development especially in health services of "implementation science" the purpose of which is to discover how to ensure the proper translation of science into practice – the "translation" metaphor continues to dominate
- All this has a profound effect on what we allow ourselves to think about, consider important, valid, worthy of study ... there is a near exclusion of the social aspects of practices ... we know it's there, we just don't find it important to talk about!

Bruner, 1990; Sandberg and Tsoukas, 2011: 340-341; Rorty, 1979; Stacey, 2007, 2010





## Something to think about ...

Recently, I asked a chiropractor whether he still experienced professional "tensions" between chiropractors and physicians. His reply was ...

"There are two kinds of chiropractors... philosophical chiropractors and those who are evidence-based. I'm in the latter category. So, no ... there are no tensions with the evidence-based group. **The evidence speaks for itself and that levels the playing field.**"



Yet, healthcare is a profoundly human and moral enterprise ... so can science be the whole story?



"... Professional practices are **interpretive practices**, centrally concerned with **how [and in what context] practitioners ... make judgments ... [and perform actions]** ..."

In EVERY clinical encounter, we are called to know more than we were taught.

Clinicians believe evidence ONLY to the extent that the evidence matches their experience and (to a lesser degree) on whether they know and respect the person providing the evidence.

Kinsella, EA. (2012). Practitioner reflection and judgement as praxis. In Kinsella, EA & Pitman, A (Eds). *Praxis as professional knowledge: Practical wisdom in the professions*. Rotterdam: Sense Publishers; Gabbay, J., & Le May, A. (2011). *Practice-based evidence for healthcare: Clinical mindlines*. New York: Routledge.



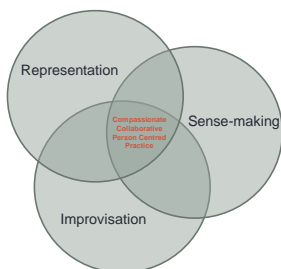
Hmmm ... how do we account for the fact that we can do anything at all!!!!

Of course, science isn't the whole story, even though it is an important part of the story ...



To make sense of compassionate, collaborative, person-centred care we need to develop a "thick" understanding of practice ...

Three interdependent processes each of which is very complex, partial, critical ...

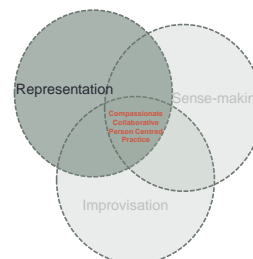


## Representation What we "ought" to do ...

Intellectual tradition: **Episteme**  
Science lives comfortably here ...

- Best practice guidelines
- Algorithms and practice guidelines
- Policies
- Professional regulation
- Translation metaphors
- Strategic Planning
- Assessments, lab values, imaging
- Principle-based ethical paradigms

These helpfully influence activity and thinking, but insufficient alone ...



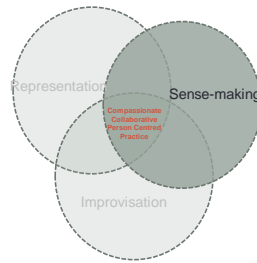


## Sense-making (Signification)

What it is "fitting" to do ...

Intellectual tradition: **Phronesis**  
(practical wisdom)  
How patients and contexts are unique  
lives here ...

- Reflective/reflexive sense-making
- Shared goals and values
- Power dynamics and identity formation
- Knowledge generating dialogues
- Collaborative decision-making
- Discerning what is salient
- Use multiple ways of thinking (e.g. epistemic, technical, practical wisdom (phronesis), critical deconstruction, imaginative, speculative, innovative, "thick" contextual, cultural ...)
- Develop clinical and moral imagination
- Relational ethics paradigms



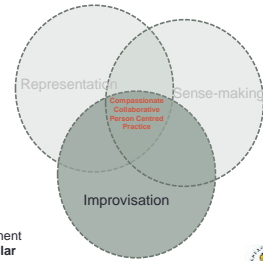
## Improvisation:

What we "can" do ...

(In every clinical encounter, we are called to know more than we were taught.)

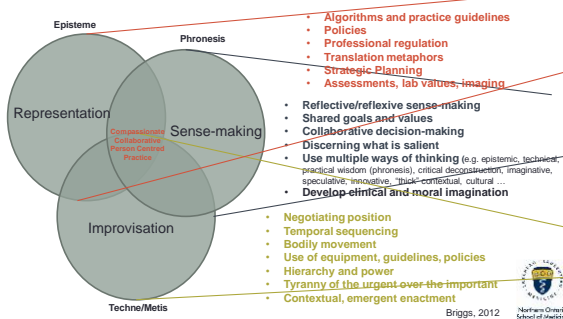
Intellectual tradition: **Techné/Metis**;  
Praxis lives here – action, informed by  
theory and experience, aimed toward  
achieving a particular goal ...

- Technical skill, technique
- Use of equipment, guidelines, policies ...
- Bodily movement
- Negotiating position
- Building and using social capital
- Relational ethics
- Temporal sequencing
- Hierarchy and power
- Contextual, emergent negotiated enactment
- **The continuous emergence of particular practices in particular communities**



## The practice/theory paradox ...

How does understanding the practices of communities in this way contribute to  
or challenge your thinking about interprofessional collaboration?



## What are the implications for health professional education?

- Interprofessionalism is at the core of the social aspects of practice and is grounded in the paradox of our necessary human freedom and interdependence
- Our necessary human freedom and interdependence, coupled with the profoundly moral nature of the healthcare enterprise, supports relational ethics (inclusive of principle-based ethics) as a foundational ethical paradigm for healthcare
- A commitment to relational ethics requires a deep engagement with the "Other" – the "Other" comes in many forms ... patients, colleagues, bosses, subordinates ...
- Fundamentally, the processes and practices of interprofessionalism can be framed in terms of relational ethics ...
- **How is all this modelled and taught in current academic and clinical curricular paradigms?**



## THANK YOU!

- You are welcome to stay in this space to continue conversation about the two presentations in this section
- Or
- Join the Q & A in Notre Dame for the other concurrent session
- Or
- Join PEARLS session in the Palladium Centre "Student success solutions through interprofessional collaboration"
- Or
- Join NICHE Unplugged in Palladium South
- Or, just knotwork over coffee! Refreshments are available now!

