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Chapter

TOWARDS A FRAMEWORK OF CLIENT-CENTERED COLLABORATIVE PRACTICE

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ABSTRACT

The chapter opens with a discussion on the growing impact of chronic disease in populations and the health system pressures to meet demands for ongoing care. In response a focus has shifted to delivery of care through teamwork, advocated because of the burgeoning health human resource shortages. The focus then shifts to how a framework for client-centered collaborative practice can be created in which a partnering relationship develops between clients, their families, and health providers within interprofessional teams. Exploration of this framework begins with a discussion about client engagement and client participation with the role of clients in their self-care being presented as a shift in traditional care provision. A discussion is then presented on the partnering relationships between clients and health providers in which they work together to achieve a common goal through non-hierarchical interactions and combining of their shared resources used through mutual respect for each other's skills and competences as well as shared decision-making leading towards set goals. A case study is provided to operationalize the above concepts. Finally, collaborative client-centered care is provided as the outcome of all parties negotiating and adapting individual inputs into options for care to arrive at a shared plan all can support.

Keywords: client engagement, client participation, shared decision-making, client centered

INTRODUCTION

A great deal of rhetoric has been evident around client-centered practice with limited evidence of its enactment within interprofessional teams, yet in health care systems many institutions have included a focus on client-centered care in their mission statements. In addition, continuing education programs rarely integrate the perspective of the client and family

as key facilitators of practice-based learning. Although much has been touted about the importance of client involvement in their care, practice models continue to advocate existing professional and interprofessional foci, rarely including client and family members as part of the model or, indeed, as key partners in care decisions.

Current multi-disciplinary and teamwork models continue to reinforce profession-specific foci leading to unique language, communication patterns, approaches to client encounters, and ethical codes generated within professions. These are often developed in isolation from those who are the focus of practice outcomes, namely the clients and their families or carers. These practices continue to support health professionals as 'experts,' creating power differentials between providers and clients, while mission and vision statements place clients at the center of their care. Up to one-third of the world's population now experience chronic diseases. While no new data have been made easily available, the World Health Organization (WHO) reported in 2014 that "four chronic diseases (cardiovascular, cancer, chronic respiratory, and diabetes) are responsible for 82% of the mortality rates worldwide" (p. xi.) and further that "the number of NCD [non-communicable or chronic disease] deaths has increased worldwide and in every region since 2000" (p. 9). To address a reduction in the loss of productivity and quality of life for those with these diseases, WHO recommends that health systems "identify and address health-system barriers to NCD [non-communicable or chronic disease] care, with a special focus on strengthening patient centered primary health care" (World Health Organization, 2014, p. 127). The growing prevalence of chronic diseases are reflective of improved treatment and pharmacological advances, leading to increased life expectancy and improved function and quality of life for those with a chronic disease or injury. However, our health systems are often focused solely on acute illness while only recently advocating for the adoption of healthy lifestyles, which in many countries and cases may be beyond the reach (e.g., those who are below the poverty level). The concerns about health system costs have caused governments to adopt policy directives that push management of their care to the patient, particularly for those with chronic diseases that necessitated ongoing monitoring. As limited health human resources are available and accessible to patients, the need increases to have models of care that provide a means to support the health requirements of more and more complex patients while helping these same patients to manage their own ongoing care within their capacities within their home communities. Interprofessional patient-centered collaborative practice is such a model. However, enacting this form of practice necessitates a shift in how patients and their families see their roles in managing, monitoring, and maintaining their health states and a shift in the assumptions health professionals hold about the role of clients managing their care, with themselves as facilitators and supporters or coaches for these clients. This is of particular importance when patients or clients are in this role in models such as mid-range theory of self-care management in chronic diseases (Riegel, Jaarsma, & Strömberg, 2012) and when conducting assessments of their ability to care for themselves through such instruments as the Illness Perception Questionnaire (Moss-Morris et al., 2002).

In this chapter we will review the existing literature related to interprofessional teamwork and client engagement or participation in their care. This will be followed by a discussion of the role of evidence-informed practice within an interprofessional collaborative team, and finally how all these elements can be brought together into an integrated practice framework. The framework will then be applied into a case situation to demonstrate how a continuing interprofessional educator might develop the means to begin influencing a broader shift from

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the traditional focus on the individualized health provider to all-party participation in shared care around shared goals with the inclusion of patients and family members.

CLIENT ENGAGEMENT

Client engagement is a popular term used by health system policymakers and administrators to describe a direction for inclusion of the client and family or carer in influencing services and care provided that reflects their needs, preferences, and choices. Engagement has been defined as "actions people take for their health and to benefit from health care" (Carman et al., 2013, p. 223). However, a disconnection remains between the definition, its theoretical foundation, actual practice, and furthermore to the dimensions of what fosters client engagement (Barello, Graffigna, & Vegni, 2012, p. 1). Carman et al., (2013) suggested that client engagement is characterized by four features: (a) shared power and responsibility, (b) clients as active partners in defining agendas (in policy and in program committee work), or making decisions (when at the direct care interface level), (c) provision of bidirectional information flows throughout the process, and (d) sharing in decision-making responsibility. They further provided a framework arguing that client engagement is positioned on a continuum from consultation to involvement and finally to partnership and shared leadership (Carman et al., 2013). Engagement can occur at three different levels within organizations — at the policymaking level, the organizational design and governance level, and the direct-care level (Carman et al., 2013).

It is now becoming more common to find clients and family members on quality improvement committees and for health agencies to authentically implement client and family advisory committees. Clients and family members have also increasingly been invited to participate at the policy level by governments. This participation is an outcome of legislation found in the United Kingdom, Australia, New Zealand, and in the provinces of British Columbia and Ontario in Canada. Hence, the engagement of clients is becoming an expectation within health systems. However, the inclusion of clients and their family members at the direct-care level is, as Haigh (2008) suggested, "patchy" (p. 458) and "superficial" (p. 458). Clancy (2011) further cautioned, "Well-intended initiatives often appear to fall short of collective aspirations that build a system responsible to the needs of patients and families" (p. 390). In order to move to greater authentic inclusion of clients and their chosen caregivers as active participants in their care requires supportive environments created at health institutional governance levels. To do so will require the "embracing of new norms and substantial changes to their culture, processes, and structure" (Carman et al., 2013, p. 228).

Currently, most health institutions tend to be system focused. They may have a stated value of being client-centered; however, the processing of clients through their institutions is rarely designed around comprehensive client-centered care, but rather the client is required to fit into the service structures, processes, and schedules of the institution. A further constraint for many clients with chronic disease is the acute focus of care within many hospitals. This means that clients with chronic diseases are left to acquire an acute complication of their disease before health services and those professionals working in these agencies provide care to these clients. Thus, many clients are left to carry out their own self-care following the resolution of a complication. However, these clients have asked for monitoring programs to guide and to

support them as they manage their own health state to prevent complications. Interestingly, in a time of financial constraints one would expect that health agencies would quickly re-focus their efforts around such support to save costs associated with more expensive treatment for complications. An example is the lack of ongoing support programs to assist clients with diabetes to manage, monitor, and maintain their health. In another example, renal failure as an outcome of diabetes is preventable with good long-term management. When renal failure arises as a complication it requires the most expensive treatment through provision of ongoing dialysis care. Does it not make sense to re-think care approaches to address such outcomes and prevent them? Such an intervention would decrease health care costs and the use of resources while also providing a higher quality of life for those with diabetes. This means that health care teams need to develop ongoing monitoring approaches to assist in partnerships with these clients to maintain their health related to their diet, exercise, medication regime, and so forth. Thus, an interprofessional team is needed to ensure the comprehensive nature of care is addressed in those clients with complex chronic diseases such as diabetes.

A shift is thus required from what is termed traditional care (Sahlsten, Larsson, Sjöström, & Plos, 2009) or also referred to as older paternalistic paradigms (Carman et al., 2013). In such forms of practice the assumption is "that ... [health providers] know best, [and should] make decisions on behalf of clients without involving them" (Coulter, 1999, p. 719). In true client engagement there is a shift to a focus on "inclusion of patients and family members in all aspects of care delivery and design" (Gittell, Godfrey, & Thistlethwaite, 2013, p. 211). Engaging clients in learning that helps assist them in their own self-management is likely to result in more effective use of resources with a concomitant reduction in overall health costs (Barello et al., 2012).

How can we transform belief systems to adopt client engagement in their care? Shifts are needed beyond just administrators and policymakers to health providers, clients, and their family members or chosen caregivers. Health professionals who persist in caring for their clients using a non-collaborative approach have the potential to provide care that is professional specific in a time when interprofessional teamwork is required. Hindrances have been identified as to why health providers are reluctant to shift into collaborative models of care with their clients; these include health care providers' perceptions that (a) clients lack sufficient knowledge and understanding to participate (Henderson, 2003); (b) they need to hold on to power and control to support their beliefs that they know best for clients (Henderson, 2003); (c) clients should trust that health providers to know best (Saunders, 1995); (d) such care will increase demands by clients for more care (Saunders, 1995); (e) their role will be undermined (Saunders, 1995); and (f) submissive care to clients can be provided faster and safer (Saunders, 1995). If we analyzed these hindrances, most reside within health providers and their views of what they would be giving up — power, control, expertise — undermining of their professional role. The other hindrances cited related to client knowledge and higher demands for services. The former issue can be addressed by understanding clients' knowledge needs and addressing these, while the latter is a difficult argument to accept. If clients were able to monitor their chronic condition and thus minimize complications it would seem that they would require fewer health system resources rather than more. Thus, it is difficult to accept the identified 'hindrances' beyond that of a resistance to change due to the loss of professional status, power, and control over clients.

In a Cochrane review of patient engagement, Gruman et al., (2010) found, "Most well-developed interventions to increase engagement are directed at modifying patient medical

compliance, chronic disease self-management and transitional behaviors associated with promotion of health and prevention of disease, smoking, diet and exercise" (p. 354). A further finding was "the stifling effect that health professionals appear to have upon the voice of service users [patients] and providers" (Haigh, 2008, p. 458). Further evidence of the often-existing power differential between health providers and clients was found in a qualitative study by Frank, Asp, and Dahlberg (2008) who focused on client participation in emergency care. Frank et al., identified three themes that related to patient participation in their care: caregivers offer conditional participation, patients demand participation, and mutual participation. They concluded that "the conceptualization of patient participation is consequently conditional and on the caregivers' conditions" (Frank et al., 2008, p. 2560). In a further grounded theory study, Sahlsten et al., (2009) identified the core category as being insight through consideration that is dependent on providing an obliging atmosphere and emotional responses that are sensitive, thoughtful, and trustworthy between parties through a dialogic process that supports learning between the parties and results in gaining competence in partnering within a supportive environment. Sahlsten et al., (2009) concluded, "The present findings imply that nurses ought to change their traditional role from being a giver and helper to instead guiding and providing the patients with opportunities to take more control over their own situation" (p. 495). The same message is likely to apply to other health provider groups as well. Shifting to a truly client- and family-centered care approach requires, as one practitioner stated to me, "not a change in how we practice, but a change in how we think about our practice" (Clinical Psychologist, personal communication, March 20th, 2009).

It appears that collaborative practice necessitates health providers to give up aspects of their controlling role while having clients 'stretch' their previous participation in their care. Clancy (2011) suggested that for health providers to shift to more collaborative care clients, must meet a set of expectations, including whether and when to seek care; which plans and providers meet their needs; how to manage their health; and how to cope with sometimes conflicting advice from providers, friends, and family. Coulter (2012) shifted the expectations to what clients want from health providers, and specifically noted the following client desires:

> [The] ability to access timely, reliable, effective, and safe health care when ... [needed]; ... adequate information and support to participate in decisions that affect them; ... [be treated with] empathy, dignity, and respect; ... told about options for treating or managing their condition and that their preferences ... [are then taken] into account; and ... not .. [having] to worry about the financial consequences of being ill. (p. 80)

Some authors have suggested stretching clients' participation to demonstrate this new role in the team. However, there is a paucity of writing on what this team role is for clients. What is provided relates to the role of clients in their own care, excluding the interconnection between their role and that of the interprofessional collaborative team.

What about the client and family? They too have roles that require a shift in their view of the health provider/client/family interactions. What might that role look like? An example of a potential description is provided below.

Who Is a Patient or Client?

The University of Western Ontario, Office of the Interprofessional Health Education & Research (2015) provided the following definition of a patient or client: "An individual who seeks help to manage a health and/or social issue(s) that is (are) interfering with his/her desired capacity to fully participate in his/her family and community" ("Who is a Patient," para. 1).

What Can the Patient or Client do in a Team?

The University of Western Ontario, Office of the Interprofessional Health Education & Research (2015) described the role of the patient or client within the interprofessional care team:

> The patient/client expresses her/his lived experience of illness or injury and conveys what their own values and priorities are. This "story" (as told by the patient) is critical to the team's understanding of the patient/client and to developing appropriate goals and care plan. The patient/client brings into a health and social care team how his/her daily life is impacted by their health and/or social issues (and vice versa) and how suggested treatments and/or actions from the team can be adapted (or not) into their activities of daily living. ("What Can the Patient," para. 1)

How Does the Patient or Client Fit into a Team?

The following excerpt depicts how the patient fits in to the interprofessional care team:

> The patient/client becomes a true member of the interprofessional patient/client centred team in which he/she retains control over his/her care and is provided with the knowledge, skills, and expertise of the health/social care providers so that a plan of care can be negotiated within existing resources. (University of Western Ontario, Office of the Interprofessional Health Education & Research, 2015, "How does the Patient," para. 1)

Education and Preparation

In discussing preparation and education regarding collaborating within a health care team, the University of Western Ontario, Office of the Interprofessional Health Education & Research (2015) stated,

> The patient/client brings his/her understanding of health and social needs and ensures these are recognized within his/her own frame of reference in the interaction with health and social care providers to assist in shaping a plan to address, monitor and reduce/resolve the identified issues. As a patient/client you seek to learn how to prepare yourself to be involved as a team member in your care. ("Education," para. 1)

The Patient or Client Connecting to a Collaborative Practice Model

At the health care team level, the patient or client can request the following:

1. all needed health and social care providers meet with you at the same time to coordinate your care,
2. health and social care providers give you as the patient/client an equal voice in discussions around your care,
3. health and social care providers be willing to negotiate care with you to fit in with what is feasible in your life and to support a reduction/resolution of your health/social issues,
4. the community providers necessary to continue to support your care can be part of the team, and know the needs and plan developed between you and all the health/social care providers to ensure continuance of the plan through a seamless transition from one level of care to another (e.g. hospital to home). (University of Western Ontario, Office of the Interprofessional Health Education & Research, 2015, "Patient/Client Connecting," para. 5–8)

Discussions are now emerging around how this role might be actualized. Coulter (2012) suggested that the goal of client engagement is "to support and strengthen patients' determination of their health care needs and self-care efforts with a view to obtaining maximum value and improved health outcomes" (p. 81). What is proposed in the above discussion is not the norm of a role that patients or clients expect to assume with their health providers in many health settings at the present time. The literature does support positive outcomes from such involvement; clients experience greater care satisfaction, decrease nosocomial infections, decreased falls, and shortened lengths of hospital stays, and health providers experience greater job satisfaction and decreased turnover. There is limited literature to date discussing the role of the patient or client within interprofessional collaborative teams.

Most of the literature has focused on single dyadic interactions between clients and one health provider. However, recent literature and studies are beginning to focus on the elements, conditions, and attitudes needed for this shift to occur within both health providers and clients. Determining what preparation clients require to be able to participate in collaborative teams is scant. A study by Martin (2011) focused on the success of client engagement at a program level in the United Kingdom. He found that success in their team role was dependent on their feelings of being known within the group, and also being given a clearly stated and supported role in the team. Hence, health care institutions likely require orientation programs to be in place that assist clients in assuming their role. When a client is unable to assume such a role due to his or her condition, the role may be transferred to a chosen caregiver who may be a relative or friend. Maintaining the current belief that health providers can assume the client's role in representing client needs is likely to perpetuate a paternalistic approach to care. We will explore what content is required in such an orientation in the next section of this chapter.

CLIENT PARTICIPATION

There is a difference between client engagement and client participation; in the former there is an effort to bring clients and health providers together to work in partnerships, while in the latter client participation relates to the actions taken to realize these partnerships. The

client's level of participation is reported to be dependent on "how much information flows between patient and provider; how active a role the patient has in care decisions; [and] how involved the patient ... becomes [in his or her care]" (Carman et al., 2013, p. 219). However, to date, as Coulter (1999) noted, there is a paucity of research to understand clients' willingness to assume a decision-making responsibility within partnerships. Two aspects associated with this participation have been studied: client health literacy and client activation.

Client Health Literacy

A great deal of, perhaps biased, perspectives have long been associated with the thorny issue of who will or will not be active with their care. Coulter (2012) believes that for clients to participate in their care requires them to be able to read literature about their condition, understand what they are reading, and be able to act on the information they have understood. Health literacy is also believed to be a moderator for clients' health outcomes (Lee, Arozullah, & Cho, 2004). Health providers as a rule have achieved at least procedural knowing and many function using constructed knowing. Unless they have gained an understanding of how to adapt their interactions with clients within the client's capacity to understand and process information there is a strong likelihood that helping a client towards more participation in her or his care will be ineffective. Thus, critiques of studies showing education, health literacy, age, and so forth as indicators of participation may be remiss in not attending to how health providers adapt their interactions with clients considering their health literacy. When these are controlled for, will the same results be found? Studies are needed to focus on this important area.

Client–Health Provider Relationships

What is known about client activation? Sahlsten, Larsson, Sjöström, and Plos (2008) carried out a concept analysis of client activation and identified three clusters of their choices for participation: (a) "express their views and opinions or state their preferences without prompting" (p. 5), (b) "express their views and opinions or state their preferences when invited to do [so]" (p. 6), or (c) "accepts the decisions that are made" (p. 5). Features that are reported to be associated with client participation include having an established relationship between patients and health providers; surrendering of some power or control to clients by health providers; clients and health providers sharing of information and knowledge; and active mutual engagement in intellectual or physical activities (or both) between clients and health providers (Sahlsten et al., 2008). However, these attributes do not address the importance of understanding and processing information in allowing these attributes to be realized. Other writers have suggested the use of relationship-centered care, defined as "care in which all participants appreciate the importance of their relationships with one another" (Beach & Inui, 2006, p. S3) as a means to support more patient activation. Relationship-centered care is comprised of four principles for building relationships: (a) a focus on the "personhood of the participants" (Beach & Inui, 2006, p. S3); (b) attention to "affect and emotion [as] important components of these relationships" (p. S3); (c) "relationships occur[ing] in the context of reciprocal influence" (p. S3); and (d) "formation and maintenance of genuine relationships" (p. S3).

However, in all these pronouncements about relationship building the voice of the client and family appear to be absent. While relationship building is associated with trust, gaining trust necessitates all parties valuing each other's competence and abilities. This valuing allows the participants to enter into conditional relationships. If health providers do not perceive clients to be competent in their knowledge and skills to manage their own care, how does this impact on the ability of these relationships being established and supported? Furthermore, if relationships take time to develop, how can short office-based visits (often a reality in primary care environments) result in development of trust between clients and health providers? Coulter (2012) suggests, "If patients are to play a more effective role [in their care] they must be better supported, be better informed, be more discriminating about the effects of medical treatment, and have more opportunities for participation" (p. 81). Furthermore, Carman et al., (2013) suggest that for true partnerships (the outcome of relationship development and coordination across all parties) to be enacted clients and health providers need to work together to achieve a common goal, share mutual respect for each other's skills and competences through non-hierarchical interactions, and share in decision-making and responsibility based on recognition that combining their resources has greater benefits in moving towards goals. Hence, clients need clarity about their 'new' role within collaborative teams and how their health providers will exercise their roles. Clients need to communicate with health providers about their health situation, understand the risks and benefits associated with their care choices, ask questions, and access and help develop and update their health record (Carman et al., 2013). In exchange, health providers in collaborative relationships are expected to give timely, complete, and understandable information while eliciting clients' values, beliefs, and tolerance for risks regarding care choices. Collaborative health providers are also expected to give clients encouragement and support and involve their family members and caregivers based on clients' wishes within their teams (Carman et al., 2013, p. 225). To achieve participatory models for care, health providers must give up their power and influence over clients (Carman et al., 2013) and abandon their traditional directive and paternalistic roles (Longtin et al., 2010), and clients must be ready to assume a decision-making responsibility in their care (Coulter, 1999). Clearly the capacity of clients to take risks in sharing their perceived knowledge and skills in managing their health conditions may not be within all clients' capacities to enter into such partnering relationships. Research is needed to determine what factors influence such capacity development and enactment, and to further determine if such models of care result in improvements in clients' health outcomes.

In collaborative client-centered practice health providers become facilitators and coaches to clients. At the same time health providers are still responsible for sharing the best evidence they have about the care needs of clients. However, clients have the right to accept or reject suggestions. Some literature advocates this process gives clients choices. However, it is not free choice, as the term choice implies – it is choice within a set of safe parameters such as best-practice guidelines, clinical evidence, and so forth. For collaborative health providers, this shift in their roles may be seen as incompatible with their perception of safe client care. However, is it truly an issue of safe client care or a reluctance to transfer some responsibility to clients to select from a set of presented options? When clients choose an option that is less acceptable to health providers, is this then labeled as 'unsafe' because it is not the ideal choice deemed by the care provider?

Frank et al., (2008) also identified some conditions required for mutual participation in collaborative relationships to occur. These being sufficient time to engage with clients, having

a genuine interest on the part of the caregiver to enter into discussion with clients, and organizations providing opportunity and space to support mutual cooperation (Frank et al., 2008, p. 2559).

Client Activation

Another move to assist in understanding the role of clients in their care and its relationship to their role within collaborative teams relates to work by Hibbard, Mahoney, Stock, and Tusler (2007), who focused on patients' activation to participate in their own self-care management based on decisional theory. Hibbard et al., identified four developmental levels of activation that patients can assume:

1. Passive – clients lack understanding of their role in caring for themselves and expect others to provide their care.
2. Passive – clients either lack basic knowledge and skills needed to provide care for themselves or are unable to connect application of their knowledge and skills to their care.
3. Active – clients have the knowledge to care for themselves and begin to take action, but may lack confidence and skill building to take care of themselves.
4. Active – clients have the knowledge, skills, and confidence to take care of themselves, but may need support if complications or other crises.

These activation levels will influence both the confidence and willingness of clients to participate in their own care with their health provider teams. Knowing a client's level of activation can be assessed by using Hibbard et al.,'s Patient Activation Measure.

Relational building between clients and health providers necessitates the ability to listen and to communicate effectively between all team members (including clients and their family members or caregivers) to ensure a shared understanding of the impact of health challenges to clients and their family members. Due to the potential for varying levels of knowing between parties, it is essential that all health providers verify understanding with their clients and family members or chosen caregivers. No longer should health providers assume directive clinical treatment control over clients and their care in the absence of understanding the impacts of treatments to the norm of living of clients. No longer should health providers only focus on clinical treatments based on best practices and evidence without interpreting these into the context and life skills of clients. No longer should health team members be meeting to develop, plan, and implement care without participation of clients who are the implementer and recipient of this care plan. No longer should clients only be allowed to make decisions related to their care from a health provider driven pre-selected group of options (Tomson, Murtagh, & Khaw, 2005). Hence, moving toward client participation in their care requires a sharing of decision-making power between health providers and clients (Sahlsten et al., 2008, p. 5), providing a willingness to persuade each other to modify varying perspectives on treatment decisions through negotiation and adaptation (Abma & Broerse, 2010). Collaborative client-centered care is the outcome of all parties negotiating and adapting individual inputs into options for care to arrive at a shared plan that all can support.

A case study is now provided to apply what we have been exploring. This study is realistic but represented by a hypothetical situation.

Case Study

Salvador Hernández is a 35-year-old male who immigrated to Canada 2 years ago from Columbia. He came with his wife, Anna, and their 10-year-old son, Juan. They have been living on social assistance and in subsidized housing in Toronto, Ontario, for the past year. Salvador is a very proud man and has been frustrated that he has been unable to gain employment and again be the breadwinner of his family. Salvador has also found gaining competence in English to be a difficult feat. In Columbia he was an engineer with a specialization in electrical engineering, but has been unable to gain recognition as an engineer in Canada. To do so would force him to return to university for up to 2 years. He gets depressed over the reality that he is likely to never realize his dream of returning to his profession, as he lacks the financial resources to undertake these studies.

Recently, his wife Anna informed him that she was pregnant. Although overjoyed by this new addition to his family, it also has added to his level of stress. He has also noticed recently that he is very thirsty a lot of the time and is going to the washroom frequently. This is a change in how his body normally behaves, so he is a bit worried as well. He has decided that these changes are just due to his current situation. He is also relieved that his previous insomnia has changed and he is wanting to sleep more and more, even during the day. Again he has decided this change in his sleeping pattern is just a 'catching up' and has dismissed it as a concern. He comes from a culture where men must be tough and not be emotional about such things.

After trying for over a year to find employment, he finally is offered an hourly-paying job in the construction industry as an electrician journeyman. However, his employer insists that he must have a physical examination to ensure his health state before starting work. Salvador thinks this is a waste of time, but he also wants the work, so he makes an appointment at the Primary Health Clinic near his home. This will be his first time seeking any health care in Canada.

Upon arriving at the clinic Salvador is greeted by a Spanish speaking receptionist. He is delighted and begins to feel a sense of comfort. He is then called by a person who introduces herself as Ellen, a nurse working in the clinic. She guides him into a private examination room and takes his blood pressure, temperature, and weight, and then leaves the room and says the doctor will be in soon. Salvador is left alone for about 10 minutes, during this time he begins to worry about whether the nurse found anything wrong with him. Her lack of sharing information about her findings makes him wonder and worry. In his country when people don't share information it usually means bad news. Finally, a male physician comes into his examination room who introduces himself as Dr. Walker. He asks Salvador what he has come for help with. Salvador explains in his broken English about his job and needing to have a checkup. Dr. Walker then asks Salvador about his health. Salvador reassures him that he is very healthy. Dr. Walker asks about whether he has ever had high blood pressure? Salvador becomes quite alarmed as to whether there is something wrong with him, and if this is what the nurse found when she was checking him.

Case Study Analysis

In the above scenario the fictitious case study demonstrates how some aspects of client health provider or staff member encounters can be very *supportive* and reassuring. The receptionist helped Salvador feel comfortable. However, when language is already a barrier and a client masks health issues of importance to only focus on the immediate need, in this case a clearance for work, in meeting with a physician, a more serious potential health issue might not be uncovered unless effective probing from the client occurs. Furthermore, when health providers do not create an environment of *openness* with clients and an in-depth understanding of their current situation, such as Ellen the nurse not sharing her assessment outcome, miscommunication and misunderstandings can occur; in this case, asking if Salvador was feeling anxious and mentioning that his blood pressure is a bit high may have led to the beginning of a meaningful dialogue between Salvador and the nurse. The quality of the nurse and physician interaction sets the atmosphere for discussion. In this case, the nurse could have explored with Salvador his narrative story providing a depth of understanding about his life situation to assist the nurse to explore and to integrate her findings about his blood pressure into their exchange. When only the task of taking the blood pressure occurs without such dialog, issues in his life that might be adding to his stress are lost. Furthermore, it appears to Salvador that (based on previous experiences) the nurse is withholding information from him, which further increased his anxiety and in turn increased his blood pressure. Hence, by the time the physician sees him and mentions his blood pressure, his symptoms are further elevated, which is likely to escalate his anxiety rather than reducing it. Thus demonstrating how a potentially therapeutic interaction may in fact escalate the symptoms.

The first encounter with a client by health providers sets the environment that the client believes they must fit into. An interaction between two parties can range from being a one-way exposition to a "two-way equal exchange of views" (Jarvis, 2012, p. 156). When health providers set the tone that they are the source of expertise to the client, there is a greater likelihood of limiting interactions to one-way exchanges. In Salvador's case, he is provided with the cues first by the nurse who simply takes monitoring parameters of his current condition without exploring with Salvador what life situations are associated with these parameters. Thus, a shared two-way exchange of views is never reached, which according to Jarvis (2012) is a requirement for learning. The one-way exchange of conversation continues when the physician comments on Salvador's blood pressure. As Jarvis suggested, this encounter creates in Salvador a "disjunctional experience" (2012, p. 156), in which Salvador tries to understand the meaning of this information, but may not have the language skills to ask about what this can mean for him, especially when he is starting a new job. The disjunctional experience is processed by Salvador using both internalization and externalization processes to create a meaning for him through the information provided by the physician (Le Cornu, 2009). However, if Salvador feels uncomfortable or unable to share how he is feeling about this information he may remain silent and just take any treatments or prescriptions for medication provided by the doctor. He may then return home and have to make a decision on whether he can or cannot afford any suggested treatments and further whether he believes that his elevated blood pressure is important for him to control.

In a real situation a full work up would have occurred since this was Salvador's first visit to the clinic and other health issues such as his increasing urination, fatigue, and thirst are likely to have been identified and acted upon. We have chosen to limit this depth for the purposes of

understanding how patients, such as Salvador, might process a health encounter with health providers when faced with cultural and language limitations. These limitations are likely to further impact on his health literacy and ability to understand the meaning of interactive elements in a client–health provider scenario. For example, his cultural background may be attributed to males assuming the role of breadwinner and authority figure in the home. Such a role could influence him to avoid any discussion about what might be a perceived as a weakness in him.

Hence, in this scenario there is a beginning *engagement* with Salvador by the receptionist, the nurse, and the physician. The elements of engagement, according to Carman et al., (2013) include shared power and responsibility, clients acting as active partners in defining their goals and making decisions, bidirectional information flowing throughout the process, and sharing the decision-making responsibility. Florin, Ehrenberg, and Ehnfors (2008) suggest that when true engagement occurs an individualized tailoring of care results that is based on the client's readiness to be involved in his or her care. Readiness for care is associated with a willingness to change from a current state (that resulted in the health issues) to a state that incorporates modifications in the previous norm. Prochaska and Norcross (2001) developed and tested a typology for acceptance of change, including (from the lowest to highest level) (a) *precontemplation*, in which people do not know there is a need to change; (b) *contemplation*, in which people see current state is not healthy and considering making changes; (c) *preparation*, in which people make a plan to change; (d) *action*, in which people enact the plan; and (e) *maintenance*, in which the plan is enacted and continuing. In Salvador's case he is likely at a precontemplation stage, as when he came in for his appointment he did not even know he was experiencing high blood pressure. When a one-way exchange such as in our case scenario occurs, the likelihood of engagement characteristics existing may be absent. Hence, in this scenario, Salvador experienced the traditional health-provider-dominated interaction, which is not likely to lead to shared decision making or goal setting with Salvador by the end of this encounter. Engagement does provide the conditions for client participation in their care. However, often in the literature engagement is associated with clients who are experiencing chronic health challenges taking on their own self-care management and is not consistently attributed to an interactive sharing of ideas, experiences, and feelings about a client situation between health providers and clients. Two identified limitations to this level of engagement are time and resources.

Florin et al., (2008) developed an instrument to assist clients in understanding their preference for their role based on their control and comfort levels. The Control Preference Role Scale assesses the means for clients selecting their role within their health provider encounters as (a) *passive*, deferring to health providers for decisions; (b) *collaborating*, sharing in decision making with health providers; or (c) *active*, making decisions based on best evidence provided by health providers. These roles have some similarities to Hibbard et al.,'s (2007) activation levels, but incorporate the relational aspects between clients and health providers. However, there is a paucity of work associated with what learning clients need to gain to collaborate and to become active partners with health providers in their care.

Health providers have traditionally practiced based on their professional knowledge and research evidence. Currently, pressures to improve health outcomes in populations are shifting health care to a more collaborative model between clients and health providers. Collaborative models require health providers to also shift in their role from sole professional to interprofessional team members that include clients' voices in their care. To refocus the

engagement toward clients' participation in their care necessitates a change within health professionals' perspective on both the role of clients in their health care and health professionals' roles within interprofessional collaborative teams. To explore these shifts in relationships we must first focus on how care is currently provided and how it can become a collaborative practice.

CONCLUSION

In this chapter discussion has focused on the client and to some extent their family members within interprofessional collaborative practice. The reader has been provided with a number of different perspectives related to learning within these individuals and the influence of interactions between clients and health providers that has the potential to enhance their health. Limitations to enactment of this form of practice were discussed as well as a potential framework for this form of practice. Finally, the reader was provided with some insights into how to prepare clients and family members to their role as a member of interprofessional collaborative teams.

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