Western University
Scholarship@Western

Nursing Publications | Nursing School

2015

What is Competence in Client-Centered Collaborative Practice?

Carole A. Orchard
University of Western Ontario, corchard@uwo.ca

Lesley Bainbridge
University of British Columbia

Follow this and additional works at: https://ir.lib.uwo.ca/nursingpub

Part of the Nursing Commons

Citation of this paper:
Orchard, C., & Bainbridge, L. (2015). What is competence in client-centered collaborative practice? In C. Orchard, & L. Bainbridge (Eds.) Interprofessional client-centered collaborative practice: What is it? How can it be done? chapter 2. N.Y.: Nova Scientific Publishers.

Chapter

WHAT IS COMPETENCE IN CLIENT-CENTERED COLLABORATIVE PRACTICE?

Carole Orchard[1] and Lesley Bainbridge[2]
[1]Western University, London, ON, Canada
[2]University of British Columbia, Vancouver, BC, Canada

ABSTRACT

This chapter provides an overview of the topic of competence in general usage and then in professional practice and its application into interprofessional client-centered collaborative practice. Collaboration is then discussed as both an outcome and a process. This follows a discussion related to the four approaches that can be adopted to assess competence. The reader is then presented with an in depth discussion of the CIHC Interprofessional Collaboration Competency Framework and of its competency domains and descriptors. A case study is provided within the chapter to present how each of the competencies may be demonstrated within a primary health care team environment.

Keywords: competence, competencies, capability, core competencies, domain competence, subject competence, personal competence, social competence

INTRODUCTION

Over the past two decades authors have presented arguments and counterarguments on how to define competence. Competence is viewed in a variety of ways as (a) an area of work (Moore, Cheng, & Dainty, 2002); (b) developmental and elaborative (Hackett, 2001); (c) associated with personal traits, tasks people do, or outcomes needed for work (Mansfield, 2004); (d) comprising technical, professional, managerial, human, and conceptual aspects (Derouen & Kleiner, 1994); and (e) as worker oriented, work oriented, or multidimensional (Grzeda, 2005). To be competent requires meeting a standard of practice, which reflects an adequate level of skill to enact a role.

The level to which an individual can demonstrate competence is not the same concept as the competencies that define individual characteristics, characteristics of an organization, or tools to set conditions to assist educators in preparing those for the labor market (Garavan & McGuire, 2001). Competencies are often presented in a variety of classifications, including core competencies associated with an organization's ability to deliver its services, functional competencies that link job roles to their enactment in organizations, or specific competencies identifying what an individual is expected to bring into the workplace to perform effectively (Le Deist & Winterton, 2005). Professions also often use the terms core or essential competencies to describe professional standards of practice. In education settings, most graduates of health professional programs are expected to demonstrate proficiency in specific competencies in order to enter into their professional practice roles. In practice settings, employers provide job descriptions that specify functional competencies for employees to enact within the organization.

Hence, there is a myriad of ways that the terms competence and competencies are used. Le Deist and Winterton (2005) suggest dividing competencies into those associated with functional and those associated with behavioral areas of performance. However, Stoof, Martens, van Merriënboer, and Bastiaens (2002) see this as too simplistic and present a counterargument by suggesting a framework to guide how one views competence and competencies, which they term the "boundary approach" (p. 345). In this framework, Stoof et al., suggest that when you view competence that combines its demonstration in the task provided and a person's own knowledge and understanding associated with the task, then a definition of competence is related to an individual's own competence that he or she brings into practice, which is termed "inside-out" (p. 354). An example of inside-out competence is when an employer considers a person to be hired for a position. In contrast, when the focus is on how well a person performs tasks and evidence of the person's knowledge, skills, attributes, and abilities are part of this, the focus on competence is deemed to be from the "outside-in" (Stoof et al., 2002, p. 358). An example of outside-in competence is when a supervisor assesses a staff member's performance. Cheetham and Chivers (1996) proposed an earlier "holistic model of professional competence" (p. 24) comprising cognitive competence (to know and understand), functional competence (skills to be demonstrated), personal competence (knowing behavioral expectations), ethical competence (applying values), and meta-competence (coping with situations). Le Deist and Winterton (2005) support the above debate and suggest the need to view competence through a meta-competence lens that contains additive components of cognitive, functional, and social competence.

Setting aside the nomenclature arguments about how to classify competence, we return to how professional competence (often in the form of sets of competencies) is commonly described. The most common components are associated with the knowledge, skills, attitudes, and values that an individual brings to his or her practice from both professional standards of practice and from personal social learning. Hence, competencies, as Travis (2002) suggests,

> provide (i) quality standards for professional workplace training and development, (ii) benchmarks for assessing the competence of ... professionals, (iii) a framework for evidence-based practice, (iv) benchmarks for measuring service quality and (v) "real world" learning outcomes and assessment criteria for professional education programs. (p. 269)

Other authors suggest that the use of competencies is too limiting to reflect the complexity and uncertainty in today's practice, which often requires rapid and time-sensitive decisions and actions. These authors suggest the use of capabilities rather than competencies to support practice performance. Capability has been defined "as an integrated application of knowledge where the student or practitioner can adapt to change, develop new behaviours and continue to improve performance" (Walsh, Gordon, Marshall, Wilson, & Hunt, 2005, p. 28) and further as "the extent to which individuals can apply, adapt and synthesize new knowledge in different service contexts" (Fraser & Greenhalgh, 2001, p. 799). Physician practice development currently reflects "entrustable professional activities" (ten Cate & Scheele, 2007, p. 79-80, which seems to also reflect a capability approach. Others have suggested that capabilities of individuals to practice is a more valuable approach, while still others supporting this position suggest the competencies are only associated with less-than-expert level of practice. Garavan and McGuire (2001) as well as Stoof et al., (2002) settle this debate by stating capability is but a component of competence, albeit an important one.

To date, a growing number of core competency frameworks have been developed, approved by various regulators and professions, and applied to performance of members. These frameworks apply to professional standards as well as to context-specific competencies that cross professional boundaries such as patient safety and public health. More recently, the Canadian Interprofessional Health Collaborative (2010) released its *Interprofessional Collaboration Competency Framework,* and the American Interprofessional Education Collaborative (2011) released its *Core Competencies for Interprofessional Collaborative Practice*. These latter two frameworks align with professional entry to practice competencies. Hence, the use of competencies to define performance standards has become a common approach to performance measurement far beyond just education and health care. In this chapter, we will discuss how competencies and competence are perceived by team members within a professional perspective, how trust is developed within teams, and finally we will explore some examples of interprofessional competency or capability frameworks. These discussions will be embedded within a case example.

CASE STUDY

Samira Jarvis is a 29-year-old family practice first-year resident who has been placed in the Golden River Family Health Team. Samira is excited to have this opportunity since the team is composed of 2 Family Physicians, 2 Nurse Practitioners, 1 Registered Nurse, 1 Dietitian, 1 Social Worker, the clinical administrator, and a receptionist. While in her medical school undergraduate program, Samira was well oriented to the CanMEDs competencies for physicians. She also participated in some interprofessional workshops, in which she learned about the roles of these other health professionals. However, she has some concerns about how these other team members will accept her into their environment. Samira asked the Family Medicine Post-Graduate Placement Coordinator how to prepare to fit into this group. The Coordinator seemed surprised by her question and suggested she talk to the Clinic Administrator and provided her with contact information. The administrator indicated that Samira would be oriented to the work when she arrived. On the morning of her first day in the clinic she was met by one of the Family Physicians who introduced her to a set of guidelines

that the total team had created. He indicated that the team operates as a collaborative group and reflects on their teamwork using the Canadian Interprofessional Health Collaborative's (CIHC) Interprofessional Competency Framework and asked if Samira was familiar with this. She indicated yes she had learned about the CIHC competencies in a couple of workshops she attended at the university where she did her undergraduate medical education. Samira felt a sense of excitement to be working with a collaborative team and looked forward to this placement as an excellent learning experience for herself.

As a new team member Samira might anticipate that she will need to earn trust from the other team members, and in turn she will need to learn to trust them. Trust will develop in response to how Samira presents her competence to the other team members. Her quest to become a valued member of the team begins with her gaining an understanding of the guidelines that the team has for working with each other.

Golden River Family Health Team Guidelines for Teamwork
As a collaborative team we strive to --

- Provide excellence in patient-centered care.
- Support collaboration and partnerships with ourselves and with our patients and their families.
- Ensure we are consistently respectful to each other and those who come for our care and services.
- Accept shared accountability for the care or services we provide.
- Encourage each other and our patients and their families to find innovative solutions to health and social challenges.
- Work towards care and services that are continuously reviewed to enhance their quality.

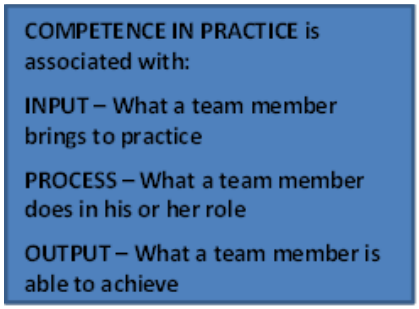
Samira is pleased to see the guidelines that the team uses to inform the way they practice. She also considers how these will apply to the collaborator role in the CanMed's competencies (Frank, Snell, & Sherbino, 2015). The competency states, "Physicians work effectively with other health care professionals to provide safe, high-quality, patient-centred care" (p. 7). To enable competencies,

Physicians are able to:

- Establish and maintain positive relationships with physicians and other colleagues in the health care professions to support relationship-centred collaborative care
- Negotiate overlapping and shared responsibilities with physicians and other colleagues in the health care professions in episodic and ongoing care
- Engage in respectful shared decision-making with physicians and other colleagues in the health care professions. (Frank et al., 2015, p. 8)

Samira realizes that there is consistency between the Golden River Family Health Team (GRFHT) guidelines for teamwork and her own physician competencies, which will assist her when her performance is evaluated by her preceptor and other members of the team. Samara's challenge is to ensure that she is able to demonstrate her competence in her family physician role. Competence is "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, individual and community being served" (Epstein

& Hundert, 2002, p. 226). Samira realizes that she will need to demonstrate two types of competencies within the team — foundational and functional. Her foundational competencies are related to her knowledge, skills, attitudes, and values, while her functional competencies relate to how she will perform in her role. As a new team member she will be assessed on what she brings to her work (input), what she does in her role (process), and what she is able to achieve (output) (Greenhalgh & Macfarlane, 1997).



A person's competence is influenced by time, experience, and the context of practice (Frank et al., 2010). Samira also realizes that she must demonstrate her integrity as a physician in order to earn the trust of team members. Hence her capacity to demonstrate her practice integrity is dependent on her level of expertise, her responsibility for care decision making, and the domain of practice within which she is practicing (Khomeiran, Yekta, Kiger, & Ahmadi, 2006). The ability to demonstrate competence is associated with three components of competence — domain or subject, personal, and social competence.

Domain or Subject Competence

Domain or subject competence is associated with Samara's willingness or ability to carry out tasks and solve problems as a physician (Le Deist & Winterton, 2005). These tasks are also reflected in entrustable professional activities. Researchers ten Cate and Schelle (2007) identified a set of conditions that support the development and enactment of entrustable professional activities, which include the following:

1. Is part of essential professional work in a given context.
2. Must require adequate knowledge, skill, and attitude.
3. Must lead to recognized output of professional labor.
4. Should be confined to qualified personnel.
5. Should be independently executable.
6. Should be executable within a time frame.
7. Should be observable and measurable in its process and outcome ... .
8. Should reflect one or more competencies (p. 545).

Samara realizes that she needs to consider her entrustable professional activities within the context of interprofessional collaborative teamwork. Hence, she will need to learn the skills,

knowledge, and expertise of other team members and determine how she will need to negotiate and adapt to the shared work of the team.

Walsh et al., (2005) extended subject competence to interprofessional teamwork and suggested, "Teamwork includes awareness of others' professional regulations, structures, functions and processes of the team within an environment of anti-discriminatory non-judgmental practice" (p. 235). According to Salas, DiazGranados, Weaver, and King (2008), effective collaboration requires that interprofessional team members be provided with team-building opportunities outside their normal patient care work. These opportunities require team members to practice their interprofessional skills and to receive feedback from each other on the effectiveness of their skill demonstration.

When a group of health professionals comes together to focus on the care needs of individual patients there is a shared set of competencies required in relation to their interprofessional communications, patient assessment, client care planning, monitoring of care implementation, and advocacy on behalf of the client and each other (Reeves, Fox, & Hodges, 2009). Interprofessional communication seems to emerge consistently as a critical element in effective interprofessional teamwork. However, the question remains, what constitutes effective interprofessional communications? In a study of nurse-physician communications in a hospital setting, Robinson, Gorman, Slimmer, and Yudkowsky (2010) found that clarity and precision in messaging was dependent on how well team members verified and confirmed the messages they receive. It is also dependent on how well the team members collaboratively problem solve in a client situation and on members' abilities to maintain mutual respect and a calm demeanor no matter how stressful the situation may be. It is also critical that all team members understand and value each other's role. Conn et al., (2009) identified both synchronous and asynchronous communications that occur as scheduled and unscheduled interactions between team members. They found that synchronous interprofessional communications were mostly unplanned and led to more in-depth planning around client care (Conn et al., 2009). The scheduled events occurred often through charting or client rounds, while the unscheduled events occurred through impromptu hallway discussions (Conn et al., 2009). Health professionals seem to depend on their organization's formal communication systems to meet their needs. When these are inadequate, they tend to rely on unplanned opportunistic situations to discuss client care that may never transfer into the formal systems. Interprofessional teamwork needs to focus on the communication structures that all interprofessional team members will use to ensure effective communications occur. Thus, part of team building needs to address the timing, the means, the content, and the distribution of communications across a team. This can be accomplished through the use of communication guidelines.

Samira explored with some of the team members how they manage to effectively communicate with each other. One of the nurses explained that initially there was a lot of miscommunication among team members. As a group, they explored how to create a consistent way to communicate. This resulted in the group adopting the situation, background, assessment, and recommendation (SBAR) template. Samira had heard people talk about SBAR before, but was not sure how it helped with communications. The nurse explained that she too was unfamiliar with it until she attended an interprofessional workshop where it was used. She explained that the *S* was about a brief description of the situation, the *B* is a brief overview about the background to the client situation you are seeking help with, the *A* is your own assessment of the situation, and the *R* are your recommendations. She further explained how

this approach has enhanced communication and the comprehensiveness of information that is shared by and with each team member. The nurse then directed Samira to a number of websites related to the SBAR approach to information sharing. Samara decided that she would explore its adoption and start trying to use it herself in the team. However, this serendipitous conversation with her nursing colleague had alerted Samira to the use of the SBAR approach, not a formal orientation to it. Without the conversation she would likely have continued to communicate in the way she had previously learned. This may have put Samira in a difficult position with the team who may have judged her for her lack of knowledge about SBAR, when in fact the problem resides with the team and the orientation provided to new members. If agreed-upon principles and approaches are not shared with and followed by mentoring new members, collaborative teamwork will fail.

Personal Competence

Personal competence reflects the willingness and ability of individuals to understand, analyze, and judge their day-to-day lives and plans. To be personally competent requires that people have a level of comfort in their independence of thinking and are able to critically judge their own behavior and skills. They have a level of self-confidence and demonstrate reliability as well as the ability to be responsible for what they agree to do within their scope of practice.

Social Competence

Social competence reflects a willingness and ability to enter into and shape relationships with others. Social competence requires personal competence as well as subject competence. In interprofessional collaborative teams social competence is enacted through teamwork. McNair (2005) stated that health professional education poorly prepares students for their teamwork roles; however, significant efforts have been made since 2005 to provide understanding about the various roles in health care. Several researchers have carried out studies to identify the key competencies for interprofessional collaborative practice, including communication, strength in one's professional role, knowledge of professional role of others, leadership, team function, and negotiation for conflict resolution (Macdonald et al., 2010), and understanding and appreciating professional roles and responsibilities, and communicating effectively (Suter et al., 2009).

Team Practice Environment and Individual Fit

The ability to develop competence in collaboration is associated with several factors:

- Experience – the more experience one has the greater the competence,
- Opportunities – opportunities that challenge abilities and performance enhance competence,

- Environment – competence is more likely to evolve when mutual respect, partnership, support and trust is shown to each other,
- Personal characteristics – competence is enhanced when current practices are questioned and when mentoring is provided to each other,
- Motivation – competence is enhanced when an individual is motivated to demonstrate the means to improve another's outcomes,
- Theoretical knowledge – competence is enhanced when an individual seeks out new learning associated with practice questions (Khomeiran et al., 2006, pp. 68–69).

Fitting into the team is associated with a match between individuals' values, what is important to them about their practice, their underlying belief systems, and their views related to how practice should be carried out. When team members' perspectives related to the above are shared among the team of health professionals they become the team's norms of practice (Arford & Zone-Smith, 2005).

Cognitive-based trust in teamwork is, according to Lee (2004), a "rational evaluation of an individual's ability to carry out obligations ... [and] reflects beliefs about that individual's reliability, dependability, and competency" (p. 625). Affective-based trust is that which "reflects an emotional attachment that stems from care and concern that exist between individuals" (Lee, 2004, p. 625). Hence, trusting another team member requires a willingness to take risks by cooperating with that individual and a willingness to refrain from controlling and monitoring other team members (Costa, 2003). When strong cognitive trust is present in teams, there is a reduction in errors within the team (Erdem & Ozen, 2003). Development of trust within collaborative teams has been associated with perceptions of members' competence in their professional and interprofessional practice. Cooperative behaviors and perceived trustworthiness have been shown to be strong elements of effective teamwork (Costa, 2003). Erdem and Ozen (2003) found that when team members begin working together or when there is a change in members within the team, team members focus on the new members' competence by assessing their integrity and ability to fit into the team's norms of practice. Once team members' competence is accepted, then affective-based trust is enacted as relationships develop.

Nevertheless, other authors have suggested that focusing on specific types of competence is limiting. Health care providers need to consider approaches that are inclusive of all types of competence resulting in meta-competence.

Approaches to Competency Frameworks

Over time, four different approaches may be used when exploring competency frameworks: skill based, life-skills based, competency based, and integrative. Each of these is explored in the following subsections.

Skill-based competency frameworks group together several specific objectives for practice, then determine the skills required to meet the objectives, and the assessment of outcome focuses on meeting the objectives. Supporters of this approach suggest that the practice allows for a set of common core competencies that are reflective of the individual's scope and requirements for

practice. They further allow for delineation of the various roles and what the performance expectations of individuals holding this role are expected to demonstrate.

Life-skills based frameworks focus on how people develop their capacity to actively exercise their role as a member of a society. For example, this may include how a client is expected to behave within health care teams and how a professional gains personal experiences that further shape how the individual enacts his or her professional role. Thus, within a life-skills perspective knowing is gained through experiential learning that is often guided by societal values and expectations. Hence, professionals bring both their professional skill-based learning and their experiential learning into their practice, and this shapes how they each view a client encounter and contribute to formulating a shared plan of care.

Competency-based frameworks are shaped by the knowledge and skills individuals have gained and how their enactment results in outcomes. Competence using this approach focuses only on outcomes and not on the process that supported the achievement of the outcome. Hence, competency-based frameworks are associated with the 'knowledge to act' achieved as an outcome. Interventions are the drivers that help to achieve the outcomes. One other feature of competency-based frameworks is that they allow for each outcome achieved to be assessed. Therefore, the importance is not the learning in itself, but how the learning helped achievement of the outcome.

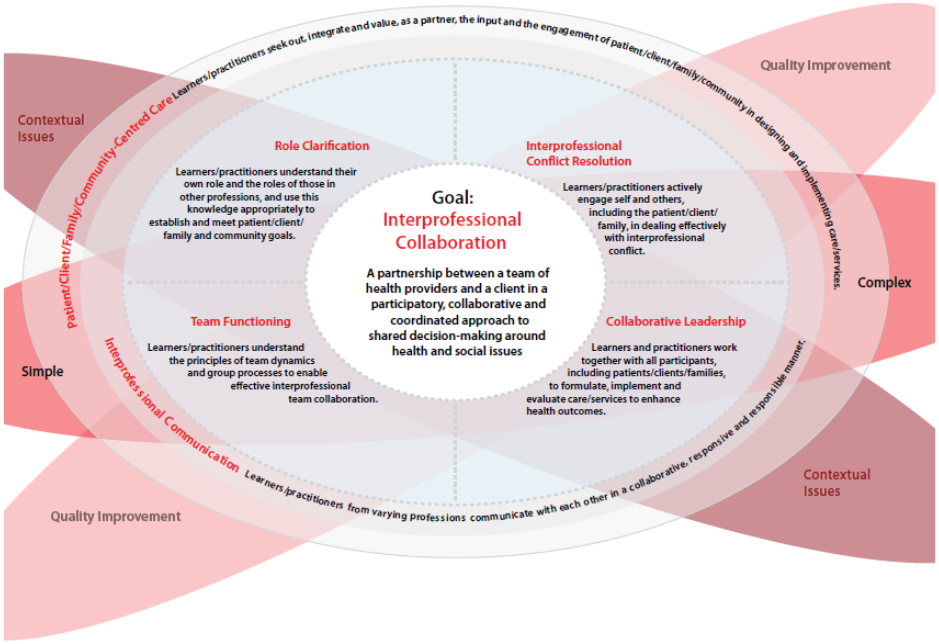
An integrative approach uses a framework that values all of the above three types of competency frameworks. It incorporates skills, life-skills, and competency-based approaches through integrating knowledge, skills, attitudes, and values in order to make judgments about future actions. Roegiers (2007) is one of the proponents of this approach and advocates for learners to focus on situations they encounter in which they are either invited or required to respond using their knowledge and life skills as the resources they need to assess, interpret, and respond to the situation. Thus, the integrative approach recognizes the capacity of individuals to respond in situations of complexity and uncertainly using the knowledge, skills, values, and previous experiences to provide a means to address the situation in a given context.

Application of an Integrative Pedagogical Approach to Interprofessional Collaborative Practice

The CIHC's (2010) Interprofessional Competency Working Group incorporated Roegier's (2007) integrative pedagogy into its national framework. The challenge during the framework development phase was in finding an approach that would allow collaboration within teams to be demonstrated through identified competencies. Since collaboration can be viewed as both an outcome and a process, CIHC decided that other interprofessional competencies already focused on outcomes, but the need to understand the process teams undertake to enact collaborative practice seemed to be of higher importance. The integrative pedagogical approach takes into account team members' shared knowledge, skills, attitudes, and values in order to arrive at the best team judgment related to care for their clients based on their shared contributions. The development of team judgments are also shaped by characteristics of the nature of competence identified by Tardif (1999): it is complex (dynamic organization of competencies); additive (integration of knowledge, skills, attitudes, and values to formulate judgments); integrative (dependent on the shared contributions of the team members);

developmental (moves from novice to expert over time); and evolutionary (applied within a given context leading to ongoing new understandings). Thus, both Roegier's integrative pedagogy along with Tardif's characteristics provide a means to address how a comprehensive framework for assessment of competencies can evolve.

In the CIHC (2010) *Interprofessional Competency Framework*, the competencies evolve from and are foundational to the central goal, which is interprofessional collaborative practice. There are six competencies: (a) client/family/community-centered care, in which "practitioners seek out, integrate and value, as a partner, the input, and the engagement of the patient/client/family, community in designing and implementing care/services" (p. 13); (b) interprofessional communication, in which "practitioners from different professions communicate with each other in a collaborative, responsive, and responsible manner" (p. 16); (c) role clarification, in which "practitioners understand their own role and the roles of those in others professions, and use this knowledge appropriately to establish and achieve patient/client/family and community goals" (p. 12); (d) team functioning, in which "practitioners understand the principles of team work dynamics and group/team processes to enable effective interprofessional collaboration" (p. 14); (e) interprofessional conflict resolution, in which "practitioners actively engage self and others, including the client/patient/family, in positively and constructively addressing disagreements as they arise" (p. 17); and (f) collaborative leadership, in which "practitioners understand and can apply leadership principles that support a collaborative practice model" (p. 15).



Note. From *A National Interprofessional Competency Framework* (p. 11), by the Canadian Interprofessional Health Collaborative, 2010, Vancouver, Canada: Author. Copyright 2010 by the Canadian Interprofessional Health Collaborative. Reprinted with permission.

Figure 1. The Canadian Interprofessional Health Collaborative's (2010) Interprofessional Collaboration Competency Framework.

The CIHC (2010) framework's central goal of *interprofessional collaboration* is further described as "a partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues" (Orchard, Curran, & Kabene, 2005, p. 1) and provides the processes needed for achievement of this goal. The focus of interprofessional collaborative practice is on providing client-centered care, which requires demonstration of interprofessional communication between and across health professionals with clients and families, necessitating an understanding of each other's roles inclusive of each person's knowledge, skills, and expertise that represents shared teamwork, an understanding of how team functioning is achieved through adoption of collaborative (shared) leadership, and team members' abilities to address and resolve interprofessional conflicts (see Figure 1[SN1]). Each of these competencies will be discussed below.

Patient/Client/Family/Community-Centered Care

In patient/client/family-centered care the client initiates care by bringing a health problem to health providers when the client's own resources are not felt to address the issue effectively. Interactions with health providers then integrate the expertise that the client brings with health providers' expertise in order to address the issue and to reduce the impact it is having on the client's functioning and quality of life. In this scenario the client is the driver for his or her health care, and the health providers are the mediators of the resources and expertise available to assist the client to address the health problem. A shared understanding of both parties' perspectives is required in order to reshape potential treatment options into choices that the client and his or her family members or chosen caregivers are able to manage. The combination of the client setting the agenda for his or her health issues and the health provider's need to fit evidence-informed practice into the client's and his or her family's realities is key to client-centered care. The only way in which such shared approaches can be achieved is when the client, his or her family members, or chosen care givers are invited in as integral members of the care team and are not viewed as outside responders to the health provider's suggested interventions. Patient/client/family-centered care is

> a partnership between a team of health providers and a client where the client retains control over his/her care and is provided access to the knowledge and skills of team members to arrive at a realistic team shared plan of care and access to the resources to achieve the plan (Orchard, 2009).

There is some emerging evidence that when clients, especially those with chronic health diseases, are provided with active participation in their care, they report high levels of satisfaction and feelings of empowerment (Adams, Orchard, Houghton, & Ogrin, 2014) and embrace higher levels of self-care management of their health (Hibbard, Mahoney, Stock, & Tusler, 2007).

Samara remembered how important it is in collaborative practice to authentically include the client as part of the team. She notes a new client, Philip Jordan, is scheduled for a one-hour intake appointment. Samara asks the receptionist, Jane, about what she has learned so far about Philip. Jane comments that he is a diabetic who is currently having trouble with his glycemic

control. He recently moved to Golden River and needs to find a new physician. Samara realizes that Philip could benefit from a team meeting with her, as well as with Shawn who previously worked as a nurse diabetes educator and Philomena the clinic dietitian who could be very helpful in creating a plan for working with Philip. Samara sends a quick text message to Shawn and Philomena to see if they would be available to meet with her and Philip when he comes for his appointment later in the day. They quickly respond back that they can move things to be available. Samara is very pleased, as she believes that this approach will provide a higher quality of care plan to assist Philip. Samara wonders how often such team meetings occur in the clinic. She enters a note on her tablet to check this out later.

Achievement of the above competency by health providers can be a challenge to their existing approaches to client involvement in their health care. It also is a challenge to the role of the client. Samara reminds herself that she will need to ask Philip if he will be comfortable with both Shawn and Philomena attending his care discussions. Overall, Samara realizes how important using effective communication between health team members and their clients and families is to interprofessional client-centered collaborative practice.

Interprofessional Communication

Team communications are composed of shared information among health providers as well as among clients, their family, or chosen caregivers and health care providers. Communications comprise two components: content and relationships. Content relates to what is discussed, while relationships focus on how the senders and receivers feel about each other. These relationships are associated with four factors: (a) *affinity* — connection to one another; (b) *immediacy* — interest or attention to what is being said; (c) *respect* — degree of respect shared between the parties; and (d) *control* — amount of control one party exerts over another during interactions. The patterns for communicating within teams by health providers arise from their professional socialization (i.e., language, sharing information, and approaches to care) and are both unique to each profession and may be shared across other professions (Adler & Proctor, 2010). When communication patterns are not understood by another provider it can lead to patient safety issues (Baker et al., 2004; Institute of Medicine [IOM], 2001) and errors in care decision making (Robinson et al., 2010).

Interprofessional communication is only as effective as the quality of the information being shared and the shared understandings that exist between and among the team members involved in the interactions. Robinson et al., (2010) found that effective communication is reported when (a) clarity and precision is provided and when the parties verify the intent of the information; (b) collaborative problem solving between the parties occurs; (c) delivery of the information is carried out calmly and supportively between the parties particularly in stressful situations; and (d) when mutual respect exists between the parties from an authentic understanding of each other's role.

Samara considered the GRFHT's use of SBAR for their communications and realized how valuable having this consistent approach was to ensuring all the members could understand what was being shared. She realized also that just receiving an SBAR message was insufficient to ensure clarity of the information contained. She learned the importance of contacting the sender and exploring each of the components to ensure she had a shared understanding of the messaging. Samara also wondered how she could extend the use of SBAR into her team

approach to inclusion of the patient and family in shaping care. She realized she needed to explore this more at the next team meeting.

Competence in interprofessional communication is essential for effective interactions with health providers and for ensuring that quality care is provided within a context of safety and their patient abilities. Hence, each member of the team will exercise a role within the team to assist in ensuring care is provided within a context of safe practices and at the highest quality possible within existing resources.

Role Clarification

Role understanding within interprofessional teams is key to supporting the development of trusting relationships. The focus to date has been on health providers' roles, but there is emerging attention to the role of the client and his or her family members or chosen caregivers within the team. The role of the client within the team is to "expresses her/his lived experience of illness or injury ... and its impact on his/her daily life and how suggested treatments and/or actions can be adapted (or not) into their activities of daily living" (University of Western Ontario, Office of the Interprofessional Health Education & Research, 2014, "What Can the Patient," para. 1). The family member or caregiver plays a complementary role to the client and "brings his/her understanding of [the patient's/client's] health and social needs and ensures these are recognized within ... [the patient's/client's] own frame of reference in the interaction [when necessary] with health and social care providers to assist in shaping a plan to address, monitor and reduce/resolve the identified issues" (University of Western Ontario, Office of the Interprofessional Health Education & Research, 2014, "Education," para. 1).

Team members need to gain a clear understanding of the knowledge, skills, and expertise that other health providers in the team can bring to their shared work. Such sharing often results in the ability for team members to use each other's shared areas of knowledge, skills, and expertise to assist in balancing workloads when required. In collaborative interprofessional teamwork, role clarification is an ongoing process (Adams et al., 2014). Roles gained by virtue of regulated practice are but one aspect; while these roles are considered a health provider's unique role predicated on specific training and competence, there are clearly areas of shared practice. The team must effectively match roles and needs and negotiate shared roles to best meet the needs of the client and team. The unique role is termed a focal role, and it is how a health provider takes professional knowledge, skills, and values and adapts them to the needs of the client being cared for within a team perspective (Orchard & Rykhoff, 2015).

The need for team members to share their knowledge and skills from each of their perspectives and then arrive at an agreed, shared approach is an example of how role clarification results in an actual client care situation. Enactment of role clarification in which all members value, respect, and support each other's agreed-upon responsibilities in a care situation is essential in order for trust to develop in teams. Role clarification provides a critical means for team members to function as a collaborative group.

Team Functioning

Interprofessional collaborative teams can be found in any health care setting and are composed of any number of members from small to large. Members' duration in the team and relationships with colleagues in the team enhance the capacity for collaborative teamwork. Components associated with team functioning include team context and structure (i.e., working environment and team coordinating mechanisms), team processes (i.e., the means that team members adopt to support collaborative work), and team outcomes or how well set goals were achieved (Deneckere et al., 2011). The effectiveness of collaborative teams is associated with members' participation and commitment to the team, team objectives, team's clarity and orientation to their tasks, and team members' support for innovation (West & Field, 1995.) Team effectiveness necessitates its members learning to work interdependently in support of shared goals through collaborative discussions and decision making about both their teamwork and their shared treatment approaches with their clients.

The maturing of a collaborative team evolves through what Howarth, Warner, and Haigh (2012) call member reciprocal *respect* and *trust*. Respect and trust among the members allows for the evolution of a *collective efficacy* to their work; this in turn supports client-centered goal sharing among the team members, which results in a *conditional partnership* within the team membership. Conditional partnerships, according to Howarth et al., lead to a *perceived team credibility* by each member. Continuance of team credibility is predicated on members feeling that their input is valued, sought out, and used within the team, resulting in each member continuing to contribute to the team efforts. If their perceived value decreases, their conditional partnership may end and team members may distance themselves from the team (Howarth et al., 2012).

Creating team structures, processes, and outcomes necessitates team members taking time out of their client care practice to develop teamwork skills through group training (Adams et al., 2014; Salas et al., 2008). Ongoing work to maintain their agreed-upon team functioning is essential for members to maintain and strengthen team credibility. Furthermore, attention to orientation of new members into the team is critical to the ongoing effectiveness of collaborative teamwork. Achieving effective team functioning necessitates members addressing how to develop shared leadership and support from their formal manager (Orchard & Rykhoff, 2015).

Samara realized when her colleagues agreed to work with her on Philip's care that her colleagues welcome interprofessional team functioning. She decides to approach those structures, processes, and outcomes that the team had agreed to in a forthcoming team meeting to gain better insight into the team's functioning to ensure she fits into their practice.

Collaborative and Shared Leadership

The capacity of a collaborative team to share in team leadership is an outcome of effective teamwork. Carson, Tesluk, and Marrone (2007) suggested that collaborative leadership is enacted within two forms: focused and distributed. "Focused leadership occurs when leadership resides within a single individual, whereas distributed leadership occurs when two or more individuals share the roles, responsibilities, and functions of leadership" (Carson et al., 2007, p. 1218). Collaborative or shared leadership is usually supported through a formal organizational leader referred to by Pearce and Sims (2002) as the vertical leader. The collaborative team then interacts with the vertical leader to ensure the teamwork 'fits' within

the overall organization. Orchard and Rykhoff (2015) proposed a complementary leadership framework that combines Pearce and Sims's concepts of vertical and shared leadership, which are integrated through a reciprocal building of relationships between the vertical leader's transformative, transactional, and empowering leadership (Pearce & Barkus, 2004), and the team members' shared leadership connected by shared relational coordination, as proposed by Gittell, Godfrey, and Thistlethwaite (2013). Both the vertical leader and the team in their shared leadership adopt the transformative leadership elements, advocated by Kouzes and Posner (2012), to (a) "model the way" (p. 16) or clarify each other's values and validate and connect actions to the team's shared values; (b) "inspire a shared vision" (p. 17) or help the team to see a desired future; (c) "enable others to act" (p. 21) or seek opportunities for both the manager and the team to innovate and take risks; (d) "challenge the process" (p. 19) or seek innovative ways to change, grow, and inspire; and (e) "encourage the heart" (p. 23) or recognize contributions of each other and the team together. When the shared leadership elements are operationalized in practice, there is a greater likelihood that the competency of collaborative or shared leadership will be demonstrated.

Samara reflected on how she was sharing in the leadership within the small team when she organized a meeting with their new patient Philip. She realized that she had taken control of the situation and seemed to be operating more in an independent than a shared approach. She also thought about how she had approached Philip and felt she needed to work on how to make her clients feel that they were the 'controllers' of their care. She wrote a note to herself that on Philip's next visit to their team she needed to have him determine more about what he really wanted to work on to help support his management of his diabetes. Samara also remembered that at one point in the team meeting with Philip that the dietitian disagreed with Samara's suggestion about how Philip needed to adjust his diet. She realized that she ignored this comment and really needed to be more open to learning how to work through such disagreements. Philomena really has much more knowledge about diet than she does, and Samara needs to let her know she values her input. Samara realized that Philip's treatment team needs to have a process to work through any disagreements.

Interprofessional Conflict Resolution

How people react to disagreements or conflict situations is dependent on their "relationship within the team (power dynamics); the situation the team is addressing; how other people in the team respond; and whether members are seeking to achieve their own personal or the team's goal" (Adler & Proctor, 2010, p. 347). Key interprofessional team working skill development should focus on each member's capacity to negotiate and work toward collaborative decision making. While conflicts are often perceived as 'troublesome' by other health providers, they are actually healthy and allow for a variety of perspectives to be shared, and, when handled well, can result in high quality comprehensive and collaborative patient care planning. The goal in interprofessional conflict resolution is finding a win-win solution to any team disagreement. Sexton (2014) conducted a survey of health educators and practitioners and found only 30% of the respondents (n = 160) reported having received any training in conflict resolution. Zweibel, Goldstein, Manwaring, and Marks (2008) reported on conflict resolution training provided to medical residents and academic health care faculty at two universities in Canada. The workshop was 2 days in length and focused on an integrated framework from scholars in the area. The

framework is comprised of four components: (a) "identifying sources of conflict and conflict management roles" (Zweibel et al., 2008, p. 323); (b) "uncovering the needs and concerns, referred to as interests, that motivate the demands or positions taken by people in conflict" (p. 323); (c) "recognizing the impact of culture on how people define and handle conflict" (p. 323); and (d) applying communication skills" (p. 323). The framework is enacted through small group work, including role playing and facilitated discussions. In a post-workshop follow-up session authors reported "the pedagogical approach of using a conflict resolution framework as a guide for self-reflection, inquiry, preparation, and analysis worked well to prepare professionals for managing conflict in diverse workplace situations" (Zweibel et al., 2008, p. 345). However, this program was carried out with only one profession involved in the learning. Transferring this framework into a wider application has merit. However, the cost of releasing health providers for a full 2 days may not be always feasible. Another approach can be in guiding teams to use a process for resolution of their conflicts. A potential process, which has been used with positive evaluations in collaborative team-building 1-day workshops, is provided below:

- Create an openness to hear others views.
- Consider all views within your own perspective.
- Consider biases that might exist in your viewpoint.
- Consider justification for your biases and how you can come to terms with others views.
- Weight the alteration in your view, based on others views in the contest of the client's safety.
- Share your thinking with the other team members.
- Hear each other's viewpoints.
- Come to a shared agreement. (Orchard, 2014, pp. 48–49)

Samara remembered attending a student workshop on interprofessional conflict resolution and recalled that in any disagreement it is important to assume that different viewpoints from one's own always have some substantive value to the discussion. Therefore, by carefully listening to all the viewpoints expressed in the team and considering these against your own viewpoint provides a more robust perspective on how to address care that as an individual you may not have considered. Hence, using such a process is more likely to result in better care decisions than when health care practitioners make decisions by themselves.

CONCLUSION

In this chapter, the concept of competence and its associated competency and competencies have been explored within the context of interprofessional client-centered collaborative practice. Several approaches to how competence can be viewed were discussed, including skill based, life-skills based, behavior based, and finally an integrated approach. Discussion of the application of capability frameworks was also addressed. Finally, the CIHC (2012) *Interprofessional Competency Framework* was discussed as a means to explore how collaboration as a process can be demonstrated. Throughout this chapter, a case study was used

to illustrate how Samara, a young family practice resident, interacted with the elements to show how these apply to her practice within a primary care family practice unit.

REFERENCES

Adams, T. L., Orchard, C., Houghton, P., & Ogrin, R. (2014). The metamorphosis of a collaborative team: From creation to operation. *Journal of Interprofessional Care*, *28*, 339–344. http://dx.doi.org/10.3109/ 13561820.2014.891571.

Adler, R. B., & Proctor, R. F., II. (2010). *Looking out looking in* (13th ed.). Boston, MA: Wadsworth Cengage Learning.

American Interprofessional Education Collaborative. (2011, May). *Core competencies for interprofessional collaborative practice*. Retrieved from http://www.aacn.nche.edu/education-resources/ipecreport.pdf

Arford, P. H., & Zone-Smith, L. (2005). Organizational commitment to professional practice models. *Journal of Nursing Administration, 35*, 467–472. http://dx.doi.org/10.1097/00005110-200510000-00008.

Baker, G. R., Norton, P. G., Flintoft, V., Blais, R., Brown, A., Cox, J., ... Tamblyn, R. (2004). The Canadian adverse events study: The incidence of adverse events among hospital patients in Canada. *Canadian Medical Association Journal, 170*, 1678–1686. http://dx.doi.org/10.1503/ cmaj.1040498.

Canadian Interprofessional Health Collaborative. (2010, February). *A national interprofessional competency framework*. Retrieved from http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf

Carson, J. B., Tesluk, P. E., & Marrone, J. A. (2007). Shared leadership in teams: An investigation of antecedent conditions and performance. *Academy of Management Journal, 50*, 1217–1234. http://dx.doi.org/10.2307/AMJ.2007.20159921.

Cheetham, G., & Chivers, G. (1996). Towards a holistic model of professional competence. *Journal of European Industrial Training, 20*(5), 20–30. http://dx.doi.org/10.1108/03090599610119692.

Conn, L. G., Lingard, L., Reeves, S., Miller, K. L., Russell, A., & Zwarenstein, M. (2009). Communication channels in general internal medicine: A description of baseline patterns for improved interprofessional collaboration. *Qualitative Health Research, 19*, 943–953. http://dx.doi.org/10.1177/1049732309338282.

Costa, A. C. (2003). Work team trust and effectiveness. *Personnel Review, 32*, 605–622. http://dx.doi.org/10.1108/00483480310488360.

Deneckere, S., Robyns, N., Vanhaecht, K., Euwema, M., Panella, M., Lodewijckx, C., ... Sermeus, W. (2011). Indicators for follow-up of multidisciplinary teamwork in care processes: Results of an international expert panel. *Evaluation & the Health Professions, 34*, 258–277. http://dx.doi.org/10.1177/0163278710393736.

Derouen, C., & Kleiner, B. H. (1994). New developments in employee training. *Work Study, 43*(2), 13–16. http://dx.doi.org/10.1108/ EUM0000000004315.

Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *Journal of American Medical Association, 287*, 226–235. http://dx.doi.org/10.1001/jama.287.2.226.

Erdem, F., & Ozen, J. (2003). Cognitive and affective dimensions of trust in developing team performance. *Team Performance Management, 9*(5/6), 131–135. http://dx.doi.org/10.1108/13527590310493846.

Frank, J. R., Snell, L., & Sherbino, J. (Eds.). (2015, March). *The draft CanMEDS 2015: Physician competency framework*. Retrieved from http://www.royalcollege.ca/portal/page/portal/rc/common/documents/canmeds/framework/canmeds2015_framework_series_IV_e.pdf

Frank, J. R., Snell, L. S., Ten Cate, O., Holmboe, E. S., Carraccio, C., Swing, S. R., ... Harris, K. A. (2010). Competency-based medical education: Theory to practice. *Medical Teacher, 32*, 638–645. http://dx.doi.org/10.3109/0142159x.2010.501190.

Fraser, S. W., & Greenhalgh, T. (2001). Complexity science: Coping with complexity: Educating for capability. *British Medical Journal, 323*, 799–803. http://dx.doi.org/10.1136/bmj.323.7316.799.

Garavan, T. N., & McGuire, D. (2001). Competencies and workplace learning: Some reflections on the rhetoric and the reality. *Journal of Workplace Learning, 13*, 144–164. http://dx.doi.org/10.1108/13665620110391097.

Gittell, J. H., Godfrey, M., & Thistlethwaite, J. (2013). Interprofessional collaborative practice and relational coordination: Improving healthcare through relationships. *Journal of Interprofessional Care, 27*, 210–213. http://dx.doi.org/10.3109/13561820.2012.730564.

Greenhalgh, T., & Macfarlane, F. (1997). Towards a competency grid for evidence-based practice. *Journal of Evaluation in Clinical Practice, 3*, 161–165. http://dx.doi.org/10.1046/j.1365-2753.1997.00082.x.

Grzeda, M. M. (2005). In competence we trust? Addressing conceptual ambiguity. *Journal of Management Development, 24*, 530–545. http://dx.doi.org/10.1108/02621710510600982.

Hackett, S. (2001). Educating for competence and reflective practice: Fostering a conjoint approach in education and training. *Journal of Workplace Learning, 13*, 103–112. http://dx.doi.org/10.1108/ 13665620110388406.

Hibbard, J. H., Mahoney, E. R., Stock, R., & Tusler, M. (2007). Do increases in patient activation result in improved self-management behaviors? *Health Services Research, 42*, 1443–1463. http://dx.doi.org/10.1111/ j.1475-6773.2006.00669.x.

Howarth, M., Warner, H., & Haigh, C. (2012). "Let's stick together" – a grounded theory exploration of interprofessional working used to provide person centred chronic back pain services. *Journal of Interprofessional Care, 26*, 491–496. http://dx.doi.org/10.3109/13561820.2012.711385

Institute of Medicine. (2001, March). *Crossing the quality chasm: A new health system for the 21st century*. Retrieved from https://www.iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf

Khomeiran, R. T., Yekta, Z. P., Kiger, A. M., & Ahmadi, F. (2006). Professional competence: Factors descried by nurses as influencing their development. *International Nursing Review, 53*, 66–72. http://dx.doi.org/10.1111/j.1466-7657.2006.00432.x.

Kouzes, J. M., & Posner, B. Z. (2012). The leadership challenge: How to make extraordinary things happen in organizations (5th Ed.). San Francisco, CA: Jossey-Bass.

Le Deist, F. D., & Winterton, J. (2005). What is competence? *Human Resource Development International, 8*(1), 27–46. http://dx.doi.org/ 10.1080/1367886042000338227.

Lee, H.-J. (2004). The role of competence-based trust and organizational identification in continuous improvement. *Journal of Management Psychology, 19,* 623–639. http://dx.doi.org/10.1108/02683940410551525.

Macdonald, M. B., Bally, J. M., Ferguson, L. M., Lee Murray, B., Fowler-Kerry, S. E., & Anonson, J. M. S. (2010). Knowledge of the professional role of others: A key interprofessional competency. *Nurse Education in Practice, 10,* 238–242. http://dx.doi.org/10.1016/j.nepr.2009.11.012.

Mansfield, R. (2004). Competence in transition. *Journal of European Industrial Training, 28,* 296–309. http://dx.doi.org/10.1108/ 030905904105276672.

McNair, R. P. (2005). The case for educating health care students in professionalism as the core content of interprofessional education. *Medical Education, 39,* 456–464. http://dx.doi.org/10.1111/j.1365-2929.2005.02116.x.

Moore, D. R., Cheng, M.-I., & Dainty, A. R. J. (2002). Competence, competency and competencies: Performance assessment in organisations. *Work Study, 51,* 314–319. http://dx.doi.org/10.1108/00438020210441876.

Orchard, C. A. (2009, July 30). Patient centred collaborative care [Video file]. Retrieved from https://www.youtube.com/watch?v=h7jHp5ooNec.

Orchard, C. A. (2014). TEAMc –Toolkit to enhance and assist maximizing team collaboration facilitator workbook. London, Ontario: Western University.

Orchard, C. A., Curran, V., & Kabene, S. (2005). Creating a culture for interdisciplinary collaborative practice. *Medical Education Online, 10*(11), 1–13. Retrieved from http://www.med-ed-online.net/index.php/ meo/article/viewFile/4387/4569.

Orchard, C. A., & Rykhoff, M. (2015). Collaborative leadership within interprofessional practice. In D. Forman, M. Jones, & J. Thistlethwaite (Eds.), *Leadership and collaboration: Further developments for interprofessional education, (pp. 71-94).* Basingstoke, United Kingdom: Palgrave MacMillan.

Pearce, C. L., & Barkus, B. (2004). The future of leadership: Combining vertical and shared leadership to transform knowledge work. *The Academy of Management Executive, 18*(1), 47–57.

Pearce, C. L., & Sims, H. P., Jr. (2002). Vertical versus shared leadership as predictors of the effectiveness of change management teams: An examination of aversive, directive, transactional, transformational, and empowering leader behaviors. *Group Dynamics: Theory, Research, & Practice, 6,* 172–197. http://dx.doi.org/10.1037//1089-2699.6.2.172.

Reeves, S., Fox, A., & Hodges, B. D. (2009). The competency movement in the health professions: Ensuring consistent standards or reproducing conventional domains of practice? *Advanced in Health Science Education, 14,* 451–453. http://dx.doi.org/10.1007/s10459-009-9166-2.

Robinson, F. P., Gorman, G., Slimmer, L. W., & Yudkowsky, R. (2010). Perceptions of effective and ineffective nurse–physician communication in hospitals. *Nursing Forum, 45,* 206–216. http://dx.doi.org/10.1111/j.1744-6198.2010.00182.x.

Roegiers, X. (2007). Curricular reforms guide schools: But, where to? *Prospects, 37,* 155–186. http://dx.doi.org/10.1007/s11125-007-9024-z.

Salas, E., DiazGranados, D., Weaver, S. J., & King, H. (2008). Does team training work?: Principles for health care. *Academic Emergency Medicine, 15*(11), 1002–1009. http://dx.doi.org/10.1111/j.1553-2712.2008.00254.x.

Sexton, M. E. (2014). *Determinants of healthcare professionals' self-efficacy to resolve conflicts that occur among interprofessional collaborative teams* (Doctoral dissertation). Retrieved from http://rave.ohiolink.edu/etdc/view?acc_num=toledo1396104234.

Stoof, A., Martens, R. L., van Merriënboer, J. J. G., & Bastiaens, T. J. (2002). The boundary approach of competence: A constructivist aid for understanding and using the concept of competence. *Human Resource Development Review, 1*, 345–365. http://dx.doi.org/10.1177/ 1534484302013005

Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E., & Deutschlander, S. (2009). Role understanding and effective communication as core competencies for collaborative practice. *Journal of Interprofessional Care, 23*, 41–51. http://dx.doi.org/10.1080/13561820802338579.

Tardif, J. (1999). *Le transfers des apprentissages* [Transfer of learning]. Montréal, Canada: Les Éditions Logiques.

ten Cate, O., & Scheele, F. (2007). Competency-based postgraduate training: Can we bridge the gap between theory and clinical practice? *Academic Medicine, 82*, 542–547. http://dx.doi.org/10.1097/ ACM.0b013e31805559c7

Travis, J. (2002). Cross-disciplinary competency standards for work-related assessments: Communicating the requirements for effective professional practice. *Work, 19*, 269–280.

University of Western Ontario, Office of the Interprofessional Health Education & Research. (2014). *Patient/client.* Retrieved from http://www.ipe.uwo.ca/Professionals/patient.html

Walsh, C. L., Gordon, M. F., Marshall, M., Wilson, F., & Hunt, T. (2005). Interprofessional capability: A developing framework for interprofessional education. *Nurse Education in Practice, 5*, 230–237. http://dx.doi.org/10.1016/j.nepr.2004.12.004.

West, M. A., & Field, R. (1995). Teamwork in primary health care. 1: Perspectives from organizational psychology. *Journal of Interprofessional Care, 9*, 117–122. http://dx.doi.org/10.3109/13561829509047845.

Zweibel, E. B., Goldstein, R., Manwaring, J. A., & Marks, M. B. (2008). What sticks: How medical residents and academic health care faculty transfer conflict resolution training from the workshop to the workplace. *Conflict Resolution Quarterly, 25*, 321–350. http://dx.doi.org/10.1002/crq.211.

SCH