RESEARCH

Journal of Critical Dietetics

ISSN 1923-1237
Vol 3, Issue 2

Toronto, ON

Engaging with diversity and complexity using collaborative approaches to decision making

Marissa Samuelson, Franziska Trede and Joy Higgs
Charles Sturt University, Australia

Abstract

A key challenge in contemporary dietetic practice is facilitating collaborative goal setting and decision-making about dietary behaviours with a diverse range of patients. Contemporary decision-making frameworks for clinical dietetic practice support working in a collaborative manner with patients. However, there remains uncertainty as to how and when dietitians should apply this approach in practice.

In this doctoral research project, Marissa used a philosophical hermeneutic approach to deepen understanding of a collaborative approach to decision-making in dietetic practice. The research focussed on early career dieticians and the findings presented in this paper refer to that group specifically. The research identified the core capabilities required to successfully enact collaborative decision making among this group.

The decision-making practices of more senior dietitians is beyond the scope of this paper. It is of interest to note that such practitioners might well have developed advanced practices in collaborative decision making and require less conscious attention in using the core capabilities presented in this paper, it could also be argued that the idea of collaboration with patients in clinical decision making is a relatively recent practice and idea in this field. Therefore, it is not useful, without further data collection with such practitioners to speculate on their inclinations or practices in relation to collaborative decision making. This would be the focus of future research.

The experiences and perceptions of patients and dietitians were explored through in-depth interviews and individualized, reflective practice activities.

The findings suggest that collaborative decision-making in early career dietetic practice is situational and, to be effective, requires the following core capabilities: developing a caring and trusting professional relationship, developing self-awareness, establishing open and transparent dialogue, identifying and exploring common ground and making time to think and talk with patients. Underpinning all of these capabilities are effective communication skills that enable the trusted relationship to be established.

The final product of the research, the Interpretive Engagement Model of Collaborative Decision-Making (Samuelson, 2013), can be used as a framework to help practitioners reflect on their decision-making practice.

The authors propose that there value in early exposure in of dietitian students in tertiary education to the practices of clinical decision making and discussions around the value of collaborative decision making with patients, plus the questioning current practices in order to cultivate early career dietitians' capabilities to develop their collaborative decision-making practices.

Introduction

The nutrition care process model developed by the American Dietetic Association in 2008 is described as a decision-making framework for clinical practice, which requires dietitians to work in collaboration with patients (Bueche, Charney, Pavlinac, Skipper, Thompson, & Myers, 2008). Taking a collaborative approach to planning interventions with patients, such as setting goals and strategies for nutrition care, is an entry-level competency for Australian dietitians (Dietitians Association of Australia, 2009). Despite the recognised value of collaboration as a way of working effectively with patients, there remains uncertainty as to what collaboration in decision-making means for the roles of dietitians and patients in dietetic practice.

Collaboration is defined in this paper as a process of actively engaging with patients in two way conversations to identify, explore and interpret pre-understandings, and find common ground to inform meaningful decisions about how to move forward with dietetic care. Trede and Higgs (2003) have contended that taking a collaborative approach to professional decision-making[1] can help practitioners to better appreciate the complexity of the circumstances of patients. In dietetics, appreciating how social, cultural, political, environmental and psychological dimensions impact upon eating habits is essential to ensure the decisions made about food and eating are both meaningful and sustainable (McNaughton, 2012).

Working collaboratively has been considered to be an expert skill (Jensen, Gwyer, Shepard & Hack, 2000) that requires re-thinking the professional role and shifting from expert or knowledge teller to facilitator of collaborative decisions with patients and the development of skills such as reflexivity, raising patient's awareness and fostering patient participation (Trede and Flowers, 2014). Charles, Gafni and Whelan (2008) have extensively researched shared decision making and the use of decision aids to foster patient participation. They supported the practice of encouraging practitioners to recognise the value of shared decision making and reported advancements in practitioners'' use of such strategies.

The aim of this research was to identify core capabilities needed to work collaboratively with patients as well as to develop a deeper understanding of collaborative decision-making (CDM) as applied in dietetic practice (with emphasis on early career dietetics). In this paper we present some of the findings of the research, with a particular emphasis on how such an approach can help dietitians to engage with the significant diversity and complexity of the communities in which they work.

Method

In this research, the researchers defined dietetic practice as a communicative practice where two (or more) conversation partners come together to make decisions about food and eating habits, with the ultimate goal of improving health outcomes. The focus of the research on CDM led us to move beyond visions or definitions of dietetic practice as merely the provision of expert dietary information or advice. Given the complex social and discursive nature of dietetic practice as a communicative practice, and the focus on experiences and perceptions of the research participants, a research approach in the interpretive paradigm was selected.

The strategy of philosophical hermeneutics informed by the work of Hans-Georg Gadamer (1960/1992) was chosen for the project. A core goal of this approach is to come to a deeper understanding of a phenomenon through dialogue. People come to dialogues with pre-existing perspectives, or *pre-understandings*. During dialogue people share and shape each others' pre-understandings as they work to better understand each others' perspectives and goals. Gadamer argued that pre-understandings are shaped by the social, cultural and historical perspective, or what Gadamer termed the horizon, of the individual. This means that it is important to consider the context within which dialogues occur, as well as the actual content and goals of the dialogue. Davey (2006), expanding on Gadamer's idea of *horizon,* also argued that these pre-understandings often need to be provoked for deeper understanding of circumstances, perspectives and values to be achieved. Conflicting opinions expressed during dialogue should be openly examined and contemplated as alternative ways of thinking that can inform researchers' evolving understanding.

Adopting a hermeneutic (interpretive) approach, coming to an understanding about patients' perspectives on food and eating, as well as the current

1 We define professional decision-making as an umbrella term that includes a range of decision-making approaches undertaken in a professional context, including practitioner-centric, patient-centric, shared and collaborative approaches.

and past context in which they live and work, is the precursor to making meaningful decisions about how to achieve dietary changes. Further, for practitioners to engage in a dialogue with their patients where they genuinely engage with diverse points of view, they need to remain open to having their perspectives challenged and to allowing their pre-understandings to evolve. This openness to challenge of pre-existing ideas and positions is a core element of Gadamarian hermeneutics (see Davey, 2006).

In this research, dialogue was used to gain a deeper understanding of a range of perspectives regarding professional decision-making in general, and CDM in particular. A philosophical hermeneutic study of the literature was undertaken to gain an understanding of the perspectives of CDM (as a practised phenomenon and as a potentially desirable practice) that already existed in the literature and to form a basis for our approach the interviews conducted with participants. Searches of the literature were conducted using key words (decision making, clinical reasoning, shared/ collaborative decision making, dietetics decision making) using health care databases such as Ebscohost Health and Medline and by directly searching a range of key journals in medicine, nursing and allied health disciplines.

The set of literature texts were explored in depth using hermeneutic interpretive strategies. The focus of such strategies is to repeatedly (iteratively) cycle the researcher's thinking between the individual pieces (or parts) of the literature texts (e.g. the findings of a particular study, the differences between diverse study populations) and the emerging understanding (or whole) the researcher is gaining of the research phenomenon. Progressively the whole picture is critiqued against the parts and the parts are incorporated into the whole (emergent) interpretation. This is referred to as use of the hermeneutic circle. Paterson and Higgs et al (2005, p. 345) explained that in the hermeneutic circle the:

> *"parts (of the text) are integrated in the whole and define it. At the same time researchers recognise how the whole contextualises each of the parts, seeking to illuminate the phenomenon within its context".*

Another core Gadamarian strategy used in the text interpretation in this study is the practice of dialogue of questions and answers. This strategy involves reading and re-reading the texts using key inquiry questions such as (What is this text saying about dietitians' attitudes to CDM? What are the challenges faced by dietitians who want to engage their patients in CDM? What capabilities are needed to do CDM well?) Largely, the research is dialoguing with the text (and indirectly with the text authors and research participants) about these questions.

In a second study, the perspectives of dietitian and patient participants were explored through in-depth interviews. Ethics approval for the research was obtained from Charles Sturt University and the two Area Health Services within which the research took place. Dietitian and patient participants were recruited for the research via purposive sampling. Interviews were conducted by Marissa, who obtained signed consent forms from all participants. Dietitians took part in a series of three interviews to facilitate deep engagement and dialogue between the interviewer and interviewee. Dietitian participants were asked to complete reflective practice activities between interviews to deepen their understanding of CDM; results of reflective activities were discussed in subsequent interviews.

Four text sets (or collections of texts from a) the literature, b) the early career dietitians interviewed c) the same dietitians reporting their reflections following the first interview and d) the patients of these early career dietitians). These text sets were then subjected to text interpretation using two key hermeneutic strategies a) the hermeneutic circle and b) the *dialogue of questions and answers* as outline above. Finally the interpretive strategy, *fusion of horizons* or perspectives, was adopted to draw together the various perspectives contained in the texts with those of the key researcher.

Applying these interpretive strategies ensured that all the voices in the dialogues were heard, which informed the emerging understanding of CDM in dietetic practice. Reflexivity was an important component of the method; researcher reflexiveness ensured that the key researcher continued to reflect on her pre-understandings and where they came from, and how they evolved over time during the research itself. From these interpretations a deep understanding of the phenomenon of CDM in dietetics was produced; it is presented in the Interpretive Engagement Model of Collaborative Decision Making (Samuelson, 2013).

Findings

Nine dietitians participated in the research. All were female and had worked in rural and/or regional environments for most of their career. The majority had less than 3 years experience working as dietitians. Six worked as sole practitioners and all reported working with a variety of patients and multidisciplinary team members. Six dietitian participants worked across two or more settings (e.g. long-term care, community care, acute care), and seven reported providing services in multiple geographical locations. There were six patient participants, all of whom were female, middle-aged and living in rural or regional (non-metropolitan) environments and all of whom had been treated by early-career dietitians. In consideration of the focus of this research on diet and eating habits it is relevant to note that four of these participants worked full-time and five were the sole cook for their families. All patient participant had children, but only one had children living at home.

Findings from the dialogue with the literature revealed that professional decision-making has cultural, relational, discursive and interest dimensions (Table 1). The core theoretical and practice dimensions of professional decision-making in health care practice were identified as: theories that underpin decision-making, roles of patients/practitioners, ways of knowing and sharing meaning, decision complexity, power differentials and dialogues.

Table 1: Cultural, relational, discursive and interest dimensions of professional decision-making

Dimension	Description
Cultural	The external work environment, the education and professional culture that dietitians have been educated and socialised within. The practitioner's own cultural/ethnic background.
Relational	The relationships dietitians have with patients and with others they encounter during their practice
Discursive	The conversations dietitians conduct with patients and with others they encounter during their practice
Interest	Interests are the specific concerns, attention and values of practitioners that inform practice. Habermas (1971) identifies technical (empirico-analytical stance), practical (historical-hermeneutic stance) and emancipatory (critical stance) interests

We used this interpretive framework to interpret the experiences and observations of dietitian and patient participants. These relational, cultural, discursive and interest dimensions of professional decision-making of our participants were found to be closely interwoven and interdependent. On bringing together the horizons of dietitian and patient participants, six areas of core concern regarding professional decision-making along with common values held by both dietitians and patient participants. There was considerable diversity in how some of these core concerns were viewed.

Caring and trusting relationships

The findings suggest that the dietitian and patient participants highly valued building relationships with each other that were characterised by trust and caring, and with the common goal of better understanding each other's perspectives to reach agreement on health care goals.

Dietitian participants were aware of the need to build rapport and understand the perspectives of patients to make sustainable and meaningful decisions about their eating habits, particularly given the potential for power imbalances between them and their patients. However, while they valued an open and honest interaction with patients, some dietitian participants were concerned that they would damage their relationship with patients by overtly confronting difficulties in communicating with them.

> *I didn't highlight the inconsistency that she was still getting the symptoms because at the same time I suppose you don't want to make them feel like idiots, that they don't know what they are talking about. But I think I just used it [her knowledge from her experiences] from the point of view that (with) other patients that I have seen, that there's diseases that cause these symptoms - it's not the diet. It's from me seeing other patients and from talking to the specialists and the nurses, that (I know) these diseases can cause these symptoms. So … I was sort of taking it from that point of view with them. [Sabrina[2], dietitian]*

Patient participants wanted dietitians to be honest and open with them, without demonstrating negative judgment.

2 Pseudonyms are used for all participants

I'd also like them to tick me off if I've put on too much weight [laughing]. Not [to call me] the 'piggy in the corner' though, but something like, 'now come on Evelyn …' and she has done that… 'you're putting on weight, what is happening here?' It turned out my husband was making things for me and I wasn't supposed to be eating them. [Evelyn, patient]

Further aspects of the relationship that patient participants valued included the dietitians maintaining confidentiality and privacy, being relaxed and empathic and providing positive support in the long term. Dietitian participants remained relatively silent on these issues, indicating they either had not considered it was important to emphasise these aspects or they were taken for granted as being part of the patient–dietitian relationship.

Transparency and language in dialogue

There was minimal evidence in this research that dietitian participants pursued transparent dialogues about the preferences of patients for participation in making decisions.

A[3]: Did you actually ask him at any point what he wanted from you? I'm here, this is who I am, how would you like me to support you?

M[4]: Not in a direct sort of questioning. I said to him 'I got the referral letter – we need to keep a track on you and things' so yeah, I didn't really directly say 'I'm just here to, [see you] whenever you need'.

A: How do you think that would have gone if you'd done that? How do you think he might have responded to it?

M: He probably would have accepted it but I don't know if he would have called me himself. Like when I've called he has said 'oh and by the way this is a problem [I'm having]'. So yeah he would have been quite happy to have the support there but I don't think he would have made that phone call to get help. [Margot, dietitian]

Margot seemed to be concerned that this patient would disengage completely with her if she took a more direct and transparent approach to seeking collaboration in decision making, and she did not want to risk engaging in this discussion. She chose not to directly say – let's talk about how we can make these decisions together. For most dietitian participants, patients' preferences for professional decision-making approaches, remained unexplored. Instead, dietitian participants chose a decision-making approach based on their dietetic training or professional socialisation, their interpretation of the situation or what they perceived patients' preference might be. That is, they enacted decision-making but didn't talk about the process of decision-making.

While there was little evidence that patient participants influenced the decision-making approach taken by their dietitian, patient participants were happy with the approach their dietitian took with them. Most patient participants described a communication process where dietitians and patients worked together and shared knowledge to come to a decision. In this example the medical model of "practitioner-knows-best" is so inculcated as to go totally unnoticed.

I think it's a matter of sitting down, like she did with me and finding out what I was eating, and then going through it with me and saying "well look if you're having ice cream was it normal ice cream or was it low fat ice cream?" I was having yoghurt, so she told me which yoghurt to eat and which was the best one for me. She also went through that most things these days that are low fat are high in sugar. So I suppose the decision-making was together, I didn't feel that she was dictating to me but I felt that we were doing it together. [Monica, patient]

The type of language used was emphasised by patient participants to be important in facilitating discussions and improving power imbalances:

Well I think you know if they were to say 'you must' instead of saying 'I think that if you do this it will help you' but using that 'must' word that makes people think 'well I must but what if I can't?' If they suggest that 'if you try this' or 'I would suggest' and use those terms you seem to get a better response instead of saying 'you must'… but I think it's mainly talking with them and not at them and that communication is the most important line and give them advice and don't tell them 'they must' and when it's sharing its caring. And that's important that the person feels as though, 'yeah this person cares about me'. I'm not just another number coming through the door. It's a person coming through the door and I think that's important. [Bernadette, patient]

Dietitian participants did not specifically mention the impact of choice of language, again indicating another area for potential reflection for practitioners

3 A – Author 1, researcher

4 M – the dietitian/practitioner

learning about different approaches to professional decision-making.

Professional authority and professional roles

Dietitian and patient participants agreed that overt displays of professional authority were undesirable. However there was evidence among patient participants that once a relationship was established, there were times when such an approach might be acceptable:

> *They can take a bit of control then and it's not left to me or to someone else, the patient, to say 'oh well'. She [the dietitian] said 'I think you're pretty right now, I don't think there's a lot more I can do'. But yet if she had said to me 'I think you should come back in 3 months', I would have made that 3 months appointment and I think that would have made sure that I stayed probably on track a bit better. [Bernadette, patient]*

Dietitian participants saw their role as technical knowledge providers, listeners and managing barriers to change. Patient participants agreed, but reported further roles for dietitians such as providing motivation, encouragement and emotional support. Dietitians saw that the role of patients was to take responsibility for change. Patients agreed but also declared that they could share information about their context, ideas and knowledge derived from experience.

The concept of knowledge sharing in the patient–dietitian relationship was complex. Dietitian participants saw one of their key roles to be to provide technical knowledge and they worried that if they did not share this knowledge that they might not be fulfilling their duty of care.

> *It's that* duty of care *thing as well, it's 'yes you have to do a gluten free diet' and 'yes this is how you do it', but it's not the whole diet, it's not about just avoiding these foods, it's about having the right balance of everything else, make sure that they have enough iron if the iron was low or to avoid becoming low, or making sure they've got enough calcium, and enough fibre and all the other bits and pieces. [Kate, dietitian]*

Dietitian participants had varying views on whether it was appropriate to share knowledge derived from their personal experiences. Some were concerned it could reduce their professional credibility while others perceived that it could humanise relationships and empower patients.

> *When I see someone I like to allocate all that time to them and they should feel important when they're here with me. That we're looking at them, that they've come to see me for a service and now we are looking at how they can improve them. So we don't talk about my personal life beyond stories that are hidden, so it's not "Oh I do this so you should too". It's "have you thought about this?" or "I've got a client who's tried this and that works for them". [Holly, dietitian]*

In contrast, patient participants were more open to dietitians sharing their personal experiences, and welcomed it as a chance to improve their self-efficacy and relationship with their dietitian.

> *A: So what was the good thing about that, about her sharing her experience with you?*
>
> *B: Well I think it motivated me to think "well you know there's someone who's done it. Why can't I do it?" and I think that's yeah, it really helped that way. [Bernadette, patient]*

The difference in opinion between dietitians and patient participants regarding sharing different types of knowledge may have been shaped by different forces. For the dietitians, it may have been that the professional and organisational context they worked within may have reinforced the importance of maintaining professional authority and technical knowledge ownership. For patient participants, living in a rural or regional environment where a wide variety of foods are not readily available, this may have meant they needed to have a greater reliance on adapting technical information through experience (theirs and of others) to achieve their nutrition goals.

Knowledge and power

Patient and dietitian participants on the whole valued sharing technical knowledge that informed professional decision-making in a way that was understandable and useful. However, the dietitians often gave technical knowledge more precedence than other ways of knowing. In contrast, the patients gave equal value to technical and experiential knowledge and understanding of personal context. Further, while the dietitians expressed a commitment to understanding patients' context and influences on eating habits, they appeared uncomfortable at times with the idea of learning from patients' experiences to inform the nutrition care they would provide:

B: I don't know. I don't know whether...

A: What's your uncertainty there?

B: Because I do think they like the reassurance, or they need the reassurance that you know what you're talking about.

A: So you feel like it would, perhaps, take away from that if you...

B: Yeah, a little bit. A little bit. But definitely, I would definitely – and she knows, when we were talking about it, she said 'oh I suppose you get lots and lots of these', I said 'well, actually, no.' I said 'I don't see a lot of them so I said 'anything that you feel like I'm missing, or you're missing out on,' I said, 'you need to tell me, and we can definitely cover it', but – and although having said that, I have been honest at times where I've had questions and I've said 'look, I really don't know'. I've said, 'I'll find out and we'll talk about it next time'. [Belinda, dietitian]

While patient participants did not identify that is was their role to teach the dietitians, they did feel that the knowledge and experience they brought to decision-making had many benefits. Inviting patients to share their knowledge in this way may be an important area for future consideration for practitioners to offset some of the power imbalances that may be experienced in patient–dietitian relationships.

Preferences for participation

Preferences and expectations for participation in professional decision making were variable among dietitians and patient participants, which is to be expected. Some dietitian participants considered that patients should participate in making decisions at all times, while others described valuing a range of approaches including taking control of making decisions. The preferences for decision-making approaches described by patient participants were varied. Some saw dietitians as companions in the decision-making process where the patient made the decision, and others wanted a dialogue between dietitians and patients to form the basis of making decisions together.

As early career practitioners, the dietitians were still learning about different decision making approaches, but there was evidence that they wanted to experiment as well. Joanna was trying to overtly invite her patients to identify their health care goals during consultations.

I don't know whether I was explaining it wrong, but I wasn't getting the response that I thought I might have gotten. They just weren't over-enthusiastic and wanted me to write it all down and they didn't seem as responsive as what I thought [they would be]. [Joanna, dietitian]

Techniques for engaging and empowering patients such as health coaching and motivational interviewing were of interest for these dietitian participants, indicating these may be areas for incorporation into either dietetic student training or continuing professional development.

Creating time for the process of collaborative decision-making

Dietitian participants were in agreement that dietary change should happen when patients are ready and that they should have sufficient time to make this change. The complexity of change in dietary practices is often complex and involves multiple life dimensions and change processes (e.g. loss, doubt, discomfort, discovery, understanding, and integration see Salerno and Brock, 2008). The participants acknowledged that biomedical, psychological and emotional outcomes resulting from dietary changes are of value. At the same time, most dietitian participants reported pressure that it was most valuable for patients to achieve biomedical outcomes and to achieve them quickly.

That's what dietitians should do. We should make people lose weight. Yes. So I suppose if I had a patient from a GP and I've been seeing the patient for a while and you had to write your final letter after five visits and they hadn't lost any weight, it would be the same sort of thing. But then, you can write all that in your letter, that is, write that they've changed their psychology a lot and I do tell the team that. She's thinking more positively. [Natasha, dietitian]

However dietitian participants weren't always sure about what support they could provide to patients in the long term particularly when change was not taking place or patients weren't ready to make change.

You are thinking like, 'oh you are a dietitian, so you are supposed to be going in there [and giving advice]'… but for someone like that at the very first stage [of change], you're not even really doing dietetic stuff, like when they are in the pre-contemplation stage, you're not even … you're probably… you're just being like a… I don't know, you wouldn't call it a companion, but I suppose you are just being a

sounding board or something like that for someone, like you are not really being a dietitian, so yeah I suppose that's why I find it difficult for those people. [Sabrina, dietitian]

In contrast, the patients gave equal value to biomedical, psychological and emotional outcomes. They wanted time to make decisions and long-term support was more likely to be characterised by provision of support and motivation to make change:

Well, it was the breakfast part I could think about straight away. Because I like fruit it wasn't a problem. But thinking about the fact that I didn't really need as much red meat as I normally have, that was a problem because I love my red meat. So there were a few things like that that it was a bit hard to say [straight away] 'well I'm not going to have those.' Most of it I could make a decision straight away, but the red meat [laugh] … that was a difficult one and being able to say no to chocolate and a few things like that they were harder decisions. They weren't ones that I could make there and then. [Bernadette, patient]

A significant pressure that these dietitian participants reported was from external sources such as other health practitioners who wanted the dietitians to help patients to achieve biomedical outcomes as a means of demonstrating their value in the health care team. This meant that dietitian participants tended to emphasise the outcome of decision-making, while patient participants emphasised both the outcome and the process of decision making.

Discussion

This research provides new perspectives on the experiences and perceptions of patients and dietitians when making decisions together about dietary change. The diversity of views about clinical decision-making was greater for patient participants than dietitian participants and the patients often spoke about aspects of decision-making that the dietitians did not mention. For example, patients spoke about the impact that the language the dietitians used had on their relationships with their dietitians and decision-making processes. Across the range of experiences reported by the dietitian and the patient participants some of their experiences in professional decision making about dietary behaviour were more traditional, practitioner-directed and some were more collaborative.

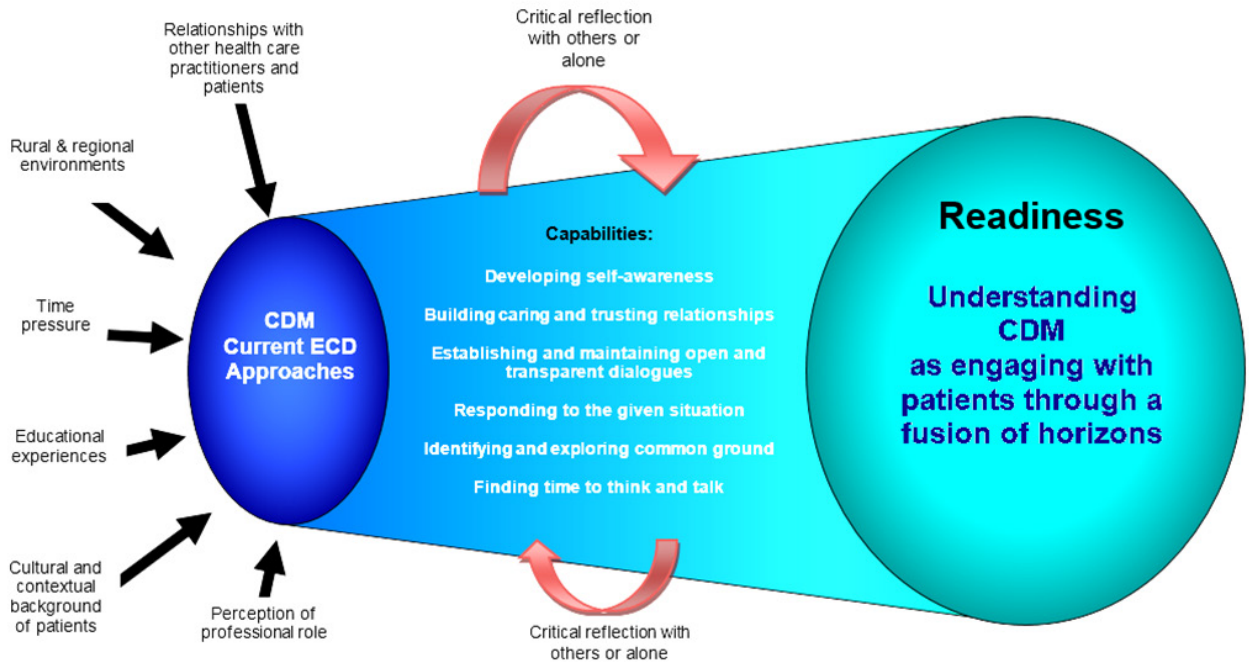
The patients also commented on a wider range of factors that influenced how they perceived the professional interaction. This could be linked to the commonality of the dietitians' professional socialisation during which they would have been exposed to similar professional cultures and norms (as identified in discussions of their past education and work during the interviews). This was, in comparison to the patients who were from a more diverse range of backgrounds. While there were a number of common views expressed by dietitian and patient participants, there were consistent differences in how various aspects of professional decision-making were perceived and what was given value. For example, the dietitian and patients agreed that relational aspects of decision-making were important; however, they had different views on whether being authoritative was always negative. There were also different perceptions about knowledge sharing and teaching each other.

The preferences and views of the range of patients that dietitians work with are very diverse and difficult to categorise. This research demonstrates that dialogues which focus on uncovering and exploring these preferences and views are important for dietitians seeking to engage with this diversity. Based on these findings, we used the interpretive strategies of philosophical hermeneutics to provide a new framework for a collaborative approach to professional decision-making in dietetic practice.

We defined collaboration above as a process of actively engaging with patients in two way conversations to identify, explore and interpret pre-understandings, and find common ground to inform meaningful decisions about how to move forward with dietetic care. At its core, such collaborative conversations and decision making can be understood through the fusion of horizons (or perspectives and interests) of these patients and dietitians through engaging in these conversations, mirroring the work of Gadamer and Davey. The unique interests, needs, preferences, circumstances, experiences, values, beliefs and knowledge of dietitians and patients are brought together in dialogues, where the key goal is to better understand each other's perspectives and come to sustainable and mutually acceptable decisions about what changes patients might make to their diet, and also about how nutrition care is to be implemented.

There are six capabilities needed by practitioners to facilitate dialogue and fusion of horizons (see Figure 1). The left side of Figure 1 depicts the complex range of factors that influence the decision-making approach used by practitioners, including relationships with other health care practitioners and patients, working in a rural or regional environment, time pressures, educational experiences, cultural and contextual background of patients and perception of professional role. We contend that ongoing critical reflection on these factors, either with others or alone, is needed to help practitioners on their journey towards a point of understanding about CDM and readiness to use the approach in practice.

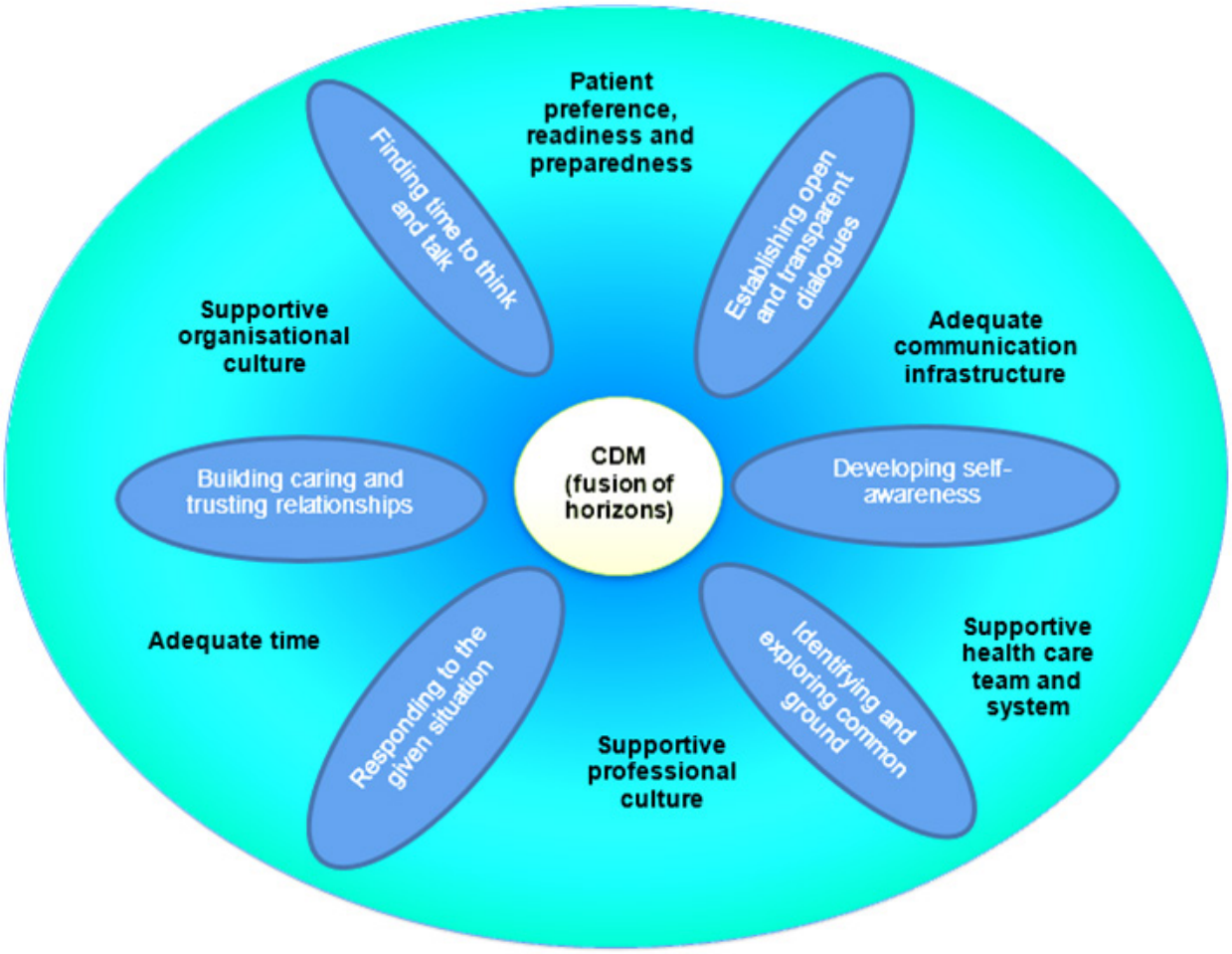
Figure 1[5] The Interpretive Engagement Model Part 1:
The journey of acquisition of capabilities and understanding about CDM



5 Figure 1 depicts the journey of understanding of an early career dietitian (ECD) from their current decision making approaches to readiness to undertake CDM. The multiple factors that may influence this journey are also indicated as well as the importance of critical reflection with others or alone in developing capabilities for CDM.

While developing personal capabilities is important for individual practitioners, it is important to consider the impact of the external social and cultural environment and the views and perspectives of others that practitioners encounter (such as patients, their families and other practitioners). It is important to note that practice takes place in a dynamic and complex environment, with a range of factors that can constrain and facilitate intentions to practise in a particular way. A supportive context must exist to facilitate successful CDM. The Interpretive Engagement Model (Part 2 –seen in Figure 2) depicts the supportive conditions needed for the fusion of horizons that is central to implementation of CDM.

Figure 2[6] The Interpretive Engagement Model Part 2: The core capabilities and conditions required for CDM



6 Figure 2 depicts the range of supportive conditions that are required for the development of the core capabilities for CDM to be enacted in practice.

The Interpretive Engagement Model of Collaborative Decision Making recognises that decision making is situational, and working in a collaborative manner may not be appropriate for all situations. We argue that the unique circumstances of each patient, each occasion of service and stage of the nutrition care process will influence the choice of decision-making approach. In order to understand and engage in CDM, practitioners need to interpret the unique combination of capabilities, context and conditions of the care occasion to decide whether CDM is an appropriate approach and to what degree engagement in CDM can take place. Then they must actively choose to enact a CDM approach. In The Interpretive Engagement Model, it is the role of practitioners to develop an environment and build relationships of trust, openness and transparency as a precursor to CDM where people feel safe to share their values, beliefs and perspectives. In Figure 3 (The Interpretive Engagement Model Part 3: CDM in action), the green text represents the patient's understanding and engagement in CDM as encircled and facilitated by practitioners (represented by blue text).

The research findings indicated that while these dietitians and patients held many common values, beliefs and perspectives, there were facets of professional decision-making that dietitian participants were unaware of or took for granted. The blue circle in Figure 3 reflects the importance of ongoing reflection on practice, by interpreting the pre-understandings practitioners bring to professional decision-making and how these evolve over time as they continue to dialogue with others.

Figure 3[7] The Interpretive Engagement Model Part 3: CDM in action

7 Figure 3 is a representation of CDM in action, where the process of fusing horizons and engaging in dialogue are central, yet influenced by the capabilities, context and choices practitioners make. It also symbolizes the important facilitatory role of the practitioner, and the importance of embracing the philosophy and intent of CDM in its totality.

Limitations

The small sample size and defined focus of this research are potential limitations of the research. The emphasis of the research was on the experiences and perceptions of early career dietitians. While patient views were incorporated, it is acknowledged that, given the much greater complexity and diversity of values, beliefs and perspectives of patients, further research is required to more deeply engage with their perspectives. Further, while the research was conducted in rural and regional environments, and the nature of this setting did impact on the practice of dietitian participants, the emphasis was on the impact of being in the early stages of the career of dietitians. Exploring more deeply how the geographical setting of practice impacts on professional decision making is another area for future research.

We acknowledge that CDM model as an approach is not necessarily appropriate for all situations and can be difficult to implement in environments where the biomedical model is given greater value. Early career practitioners could find it especially difficult to advocate for such an approach, given that they are still developing professional identities and could lack confidence to challenge the hegemonic standpoint of their workplaces. While there was little discussion from both participant groups about negotiating or discussing preferences for decision-making approach, there was evidence that some dietitian participants were attempting to engage patients in the decision-making process. Dietitian participants were aware of a range of challenges in implementing their chosen professional decision-making approach; further interpretation of these challenges often uncovered some unexplored conflicting values and beliefs.

With these limitations in mind, the model is offered as a framework to guide practitioners towards using a CDM approach. It is not intended as a generalizable theory.

Conclusions

Marissa's key aim in her doctoral research was to deepen her understanding of a collaborative approach to professional decision-making in dietetics, and to determine what capabilities early career dietitians needed to develop to enact this approach in practice. We propose that the fundamental premise of CDM is seeking a fusion of horizons between patients' and dietitians' interests and goals through open and transparent decision-making conversations. The development of a caring and trusting relationship is the precursor to successful CDM.

There are a number of capabilities that dietitians need to develop to become capable and genuine collaborative decision-makers (developing self-awareness, building caring and trusting relationships, establishing and maintaining open and transparent dialogues, responding to the given situation, identifying and exploring common ground, creating time to think and talk). Also, there are many factors or conditions that can facilitate CDM as a process of interpretive engagement. We argue that CDM is situational, and the model presented can help practitioners engage with the significant diversity and complexity that they encounter in day-to-day practice. The model can also be used by practitioners working alone or with a mentor, to more deeply understand the views and beliefs that are driving their practice. We would encourage senior staff to adopt this model to assist junior practitioners to explore CDM in their practice, including reflecting on existing constraints of using CDM and learning how to advocate for CDM, where appropriate, as part of implementing new approaches to nutrition and health care.

An important first step in challenging existing cultural perspectives regarding CDM practices in dietetics is to develop a community of practitioners who engage in dialogues and feel comfortable in questioning the status quo. We propose that this process should commence at the university level when dietitians first start their education. Learning and teaching strategies in classrooms and workplaces should reinforce relational, social, cultural and dialogical aspects of dietetic practice, as well as sensitise students to practice contexts, choices and capabilities. Revision of the curriculum in this manner is more likely to lead to a health care culture where critical dialogues provide practitioners the space to deepen their understanding of practice as well as question and challenge constraining conditions. Such cultures should become the norm, rather than the exception.

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Author Bios

Dr Marissa Samuelson is an Accredited Practising Dietitian and has worked in a variety of settings in rural and regional Australia including community health, private practice, acute care and the Divisions of General Practice. Marissa started teaching into the Bachelor of Health Science (Nutrition & Dietetics) degree at Charles Sturt University in 2003. Her PhD topic combined her interest in the education and practice development of health practitioners, working in rural and regional environments and patient centred communication.

Professor Franziska Trede is Co-Director, International and Partnerships, | The Education For Practice Institute, Charles Sturt University

Professor Joy Higgs is Strategic Research Professor in Professional Practice, Charles Sturt University