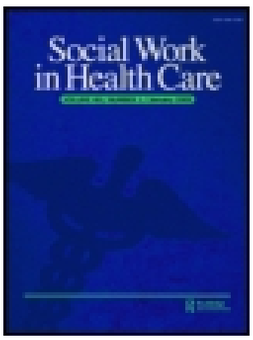

Social Work in Health Care

ISSN: 0098-1389 (Print) 1541-034X (Online) Journal homepage: http://www.tandfonline.com/loi/wshc20

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To cite this article: Anne-Claire Museux MSW, Serge Dumont PhD, FRSC, Emmanuelle Careau PhD & Élise Milot PhD (2016): Improving interprofessional collaboration: The effect of training in nonviolent communication, Social Work in Health Care, DOI: 10.1080/00981389.2016.1164270

To link to this article: http://dx.doi.org/10.1080/00981389.2016.1164270

Published online: 26 Apr 2016.

SOCIAL WORK IN HEALTH CARE
http://dx.doi.org/10.1080/00981389.2016.1164270

Routledge
Taylor & Francis Group

Improving interprofessional collaboration: The effect of training in nonviolent communication

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ABSTRACT

This article examines the effects of nonviolent communication (NVC) training on the interprofessional collaboration (IPC) of two health and social services sector care teams. The study was conducted in 2013 with two interprofessional teams ($N = 9$) using a mixed method research design to measure the effects of the training. Individual IPC competency was measured using the Team Observed Structured Clinical Encounter tool, and group competency using the Observed Interprofessional Collaboration tool. A focus group was held to collect participant perceptions of what they learned in the training. Results revealed improvements in individual competency in client/family-centered collaboration and role clarification. Improvements in group competency were also found with respect to teams' ability to develop a shared plan of action. Data suggests that participants accepted and adopted training content. After the training, they appeared better able to identify the effects of spontaneous communication, more understanding of the mechanisms of empathy, and in a better position to foster collective leadership.

ARTICLE HISTORY
Received 15 December 2015
Accepted 7 March 2016

KEYWORDS
Communication; empathy; interprofessional collaboration; nonviolent communication; training

Introduction

Even if implementing and optimizing interprofessional collaboration (IPC) have been a priority in recent years, the anticipated benefits have yet to materialize in health care organizations (Kirby, 2002; Lindeke & Sieckert, 2005; Romanow, 2002). Implementation of effective strategies calls for a collaborative culture that is difficult to establish in organizations where performance and individualism remain the normative values. Even if many key elements contribute to improve IPC, effective, genuine, and empathetic communication marked by trust and openness is considered as the cornerstone of collaborative practice (McCaffrey et al., 2012; San Martin Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005). The purpose of this article is to describe the effects of communication training on the collaboration skills of two teams in the youth, and family section of a health and social services center.

Collaboration depends on a process that is described as interactional (D'Amour & Oandasan, 2005). According to the Canadian Interprofessional Health Collaborative (CIHC, 2010), practitioners need to develop several competencies to collaborate. Establishing these competencies involves developing a relational dynamic in which practitioners come to influence and support each other in the analysis of situations and in drawing up a shared plan of action. Moreover, one of the main competency domains in the CHIC framework is communication. Communication is the foundation of the relationships on which collaborative practice is built (McCaffrey et al., 2012) and the basis of all forms of cooperation (D'Amour, Sicote, & Lévy 1999). It is also the means of expressing other important dimensions such as mutual respect (Henneman, Lee, & Cohen, 1995). Conversely, communication difficulties between professionals can generate conflicts, stress, or exhaustion and are considered to be the principal cause of medical error and delays (Joint Commission, 2009).

Given the central role of communication and its challenges, there have been various studies proposing ways to optimize communication in professional development settings. Among them are Situation, Background, Assessment, and Recommendation (SBAR; Haig, Sutton, & Whittington, 2006) and Structuring Communication Relationships for Interprofessional Teamwork protocols (SCRIPT; Reeves et al., 2003). Both are designed to facilitate clinical information sharing through the use of communication scenarios, but seem somewhat limited in scope (Haig et al., 2006). Although the protocols are designed to enhance communication, they focus mainly on the way clinical information is shared and do little to address the relational dimension and to creating the kind of authentic communication imbued with mutual trust known to contribute to optimal IPC. McCaffrey et al. (2012) found that communication was improved by active listening, empathy, and a process of self-disclosure based on an awareness of self and the other.

Developed by Rosenberg (1983, 2003), nonviolent communication (NVC), also known as compassionate communication, is an approach that seeks to foster authenticity and heighten awareness of how our attitudes and actions affect our relationships. A growing body of academic literature has looked at the efficacy and implications of NVC in diverse fields such as education, conflict resolution, and health care (Beck, 2005; Cox & Dannahy, 2005; Dougan, 2011). The approach fosters better relationships; prevents and defuses conflict; promotes awareness of self and personal responsibility (Beck, 2005); and increases empathy and the ability to sustain positive social relationships (Sears, 2013). These effects appear to fit our proposed interprofessional communication indicators and thus justify looking at its effects on IPC.

Methods

Our study had two objectives: investigate changes in interprofessional competencies following NVC training and explore what participants reported learning from their NVC training.

The target population was made up of health care practitioners in the Youth-Family division of a health and social services center in Québec, Canada. Nonprobability judgment sampling was used so that specific criteria would be taken into consideration in constituting the sample (Fortin, 2010). Participants were selected so as to ensure that interprofessionalism played a central role in their practice. Following the center's ethic committee approval, two teams were chosen based on a discussion with managers and in line with institutional needs relating to the project. Members of the teams were those available and interested at the time of recruitment. Data was collected in 2013 from the two teams ($N = 9$) using a mixed method research design aimed at ascertaining the effects of NVC training. We investigated changes in individual competencies as described by the CIHC as well as changes in group performance as measured by the IPC. Figure 1 illustrates the steps involved.

The NVC training session constituted the study's exposure variable. The training comprised a single 7-hour session delivered by a Center for Nonviolent Communication–certified instructor with 15 years of experience. The session used an experiential learning approach inviting participants to draw on their personal and professional experiences to explore and work with the foundations of NVC. The NVC process is founded on four basic skills: observing a situation without evaluation; acknowledging the accompanying feelings; understanding how those feelings are a signal of met or unmet needs; and clearly requesting concrete action to honor all parties' needs, but without making demands. These four skills are based on two essential notions. The notion of *intention*, preliminary to the process, is that of creating a relationship of openness and goodwill. The notion of *attention*, which underpins the entire process, relates to self-awareness, is essential to identify the feelings and needs in play. The effects of our habitual ways of communicating as well as three aspects of communication (self-empathy, empathy, and honest self-expression) were additional topics covered.

Data collection and analysis

Individual and group competency development was measured by means of consecutive structured observations of each team during a simulated interprofessional clinical meeting based on two clinical vignettes. The two vignettes were based on a conversation with a clinical supervisor from the Youth-Family division. It was important for the study that situations be concise and

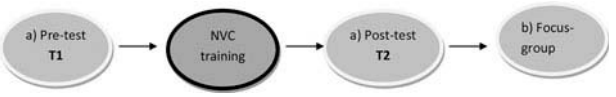

Figure 1. Steps in the study protocol.

understandable for all participants; resonate with their professional experience; require IPC and be of similar complexity for the needs of the pretest and posttest.

Two outside observers were brought in to observe the simulations. The Team Observed Structured Clinical Encounter (TOSCE; Marshall, Hall, Taniguchi, & Boyle, 2008) tool was used to measure changes in individual competency (communication, collaboration, role clarification, client/family-centered practice) and the Observed Interprofessional Collaboration during interdisciplinary team meetings (OIPC; Careau, Vincent, & Swaine, 2014) tool was used to assess the teams' group competency (ability to develop a shared vision and plan of action). The OIPC tool allows for closer observation of the interactional factors at work in team meetings as well as evaluating the group's ability to develop a shared vision and a plan of action. In evaluating communication, these tools apply criteria relating to the ability of participants to communicate assertively, express themselves respectfully, and deploy effective communication strategies. Other criteria relate to the duration of the discussion, kind of information exchanged, level of language used, and participant attitudes. The two measurement instruments, which have good psychometric qualities, were used for the pretest and posttest (T1/T2). A focus group was then led by moderators (or facilitators) who were not part of the research team to collect participant perceptions relating to what they learned in the training session.

Quantitative data was analyzed with Statistical Analysis System (SAS). The Shapiro-Wilk test was used to verify the assumption of normality and to select two-tailed tests (Student's *t*-test for parametric data and the Wilcoxon test for nonparametric data). A significance level of 0.05 was selected, with a confidence interval of 95%. Means were then compared to observe variations in the individual results for each of the participants. For the purpose of this study, structural adjustments were made to the TOSCE protocol. First, only five levels on the Likert scale were used instead of the initial nine. Then, the indicators for each variable were subdivided. For the purpose of this study, we modified the structure of the tool by adding sub-items to the dimensions which were initially measured by only one item. Because of the small sample size, items were sub-divided in order to provide a more accurate picture of the participant's performance for those dimensions. For example, the initial indicator "communication" was subdivided into three: (1) communicates ideas assertively; (2) expresses ideas respectfully; and (3) uses effective communication strategies with others. All TOSCE indicators were similarly

subdivided. Only four of the original six competencies were retained for this study. The teamwork competency was dropped because it was already covered in the second observation grid on group competency and it seemed unlikely that the conflict-management competency would be observed in the study setting. Considering that this interprofessional meeting was a simulated clinical meeting, it seemed unlikely that a conflict could arise in the short amount of time professionals had to discuss. Furthermore, notwithstanding the complexity of the vignette, it was unlikely that the latter could result in a value conflict between professionals. Given the small sample size (dl = 1), scores awarded by each individual observer for each OIPC questions on the pre- (T1) and posttest (T2) were averaged in order to keep team group competency measurements scalable.

Data collected from the focus group were transcribed in its entirety. An initial pre-analytical step involved a "free-floating reading" to pick out the most important points. The themes most commonly articulated were used to build a classification system. Analytical categories were defined using a mixed method derived from the selected conceptual models and themes that emerged. Data were subjected to a content analysis, which is a useful technique to describe the results of an intervention (Blais & Martineau, 2006).

Results

The two teams were made up of nine members (all women) from three disciplines: social worker, special educator, and psychoeducator, which is a typical professional composition for these teams. Each team also had a coordinator for management and support functions.

Individual competencies: Mixed results

According to the TOSCE, results suggest that NVC training enabled participants to improve mainly in two CIHC-framework competency domains: role clarification and client/community-centered care. Little or no effect was found on interprofessional communication or collaborative leadership, although results in this last domain were close to the significance level, as Table 1 indicates.

Differentiated analysis of the two teams shows differences between the two groups that received the same training. On a scale of 1 to 5, individual variations in participant change, obtained by averaging, suggested that competency improved in role clarification and patient/client-centered practice, which is consistent with earlier data. While progress was observed in only two competency domains for Team 1, all domains showed improvement for Team 2. Surprisingly, communication and collaboration competency actually

Table 1. Changes in four competencies between pretest and posttest (TOSCE) ($N = 9$).

Competencies	*Dl*	*t*-value	T1 average	T2 average	±Standard deviation	*p*
1 Communication	8	1.54	3.205	3.229	± 0.801	0.163†
2 Collaboration	8	0.38	3.305	3.277	± 0.276	0.712†
3 Role clarification	8	2.41	2.914	3.202	± 0.464	0.042†
4 Patient/client-centered approach	8	3.59	2.805	3.483	± 0.65	0.007†

†Test-t
†Nonparametric test (Wilcoxon)

regressed for the majority of participants in Team 1. Seen as a whole, the effect of the training on the individual competencies necessary for IPC was mixed.

Progress in team group performance

Four competencies relating to group performance were assessed, according the IPC tool. Progress was observed in competencies relating to role clarification, client/family-centered care, and collaborative leadership, but surprisingly, communication scores actually declined.

Improvements were observed for the majority of the selected aspects involved in developing a shared plan of action. The greatest improvements were in the two dimensions relating to operationalizing discussions (i.e., the team's ability to make shared decisions and to adopt shared plans of action). The variable relating to the group's ability to adopt a patient/client-centered approach also progressed by a level of one on a scale of one to three.

Effects of training according to the participants

Data collected from the focus group enabled us to nuance the quantitative findings regarding three broad categories: their views of the content and teaching strategies; what they learned about communication methods and the emergence of a common language; and development of their self-awareness and empathy skills.

Acceptance of content and teaching strategies

Participants were found to be open to the content of the training session. Two participants noted that training in their careers mainly dealt with questions relating to "[clients'] issues." As one explained: "We're told that we're our own tool for the job, but the training we always get is really cerebral. It's never about who we are, what we feel, or what we go through. This session worked on that very specifically."

The authenticity of the content was appreciated. One participant said she was happy the training was not given with a PowerPoint-style presentation, which "made it more lively." Another explained:

Table 2. Observed differences (Δ) in individual competency: Pretest (TI) and posttest (T2).

Team 1

Competencies	Communication			Collaboration			Role clarification			Patient/client-centered approach		
Participant*	*TI*	*T2*	Δ	*TI*	*T2*	Δ	*TI*	*T2*	Δ	*TI*	*T2*	Δ
1 Marie	2.83	2.5	−0.13	3	2	−1	2.5	2.5	/	2.5	2.25	−0.25
2 Julie	3.66	2.66	−1	4.25	4	— 0.25	3.16	3.5	+0.34	2.75	4	+1.25
3 Anne	3.66	3.66	/	4.25	3.5	— 0.75	3.16	3.66	+0.5	2.5	4	+1.5
4 Alice	3.5	3.83	+0.33	3.5	3.25	— 0.25	3.333	2.833	−0.49	3	3.75	+0.75

Team 2

Participant*	*TI*	*T2*	Δ	*TI*	*T2*	Δ	*TI*	*T2*	Δ	*TI*	*T2*	Δ
5 Sophie	3	3.16	+0.16	3.25	3.25	/	3.25	3.33	+0.08	2.75	3.25	+0.5
6 Emilie	2.33	3.33	+1	2.5	3.5	+1	2.5	3	+0.5	2.75	3.25	+0.5
7 Lea	3.16	4.16	+1	2.75	4.25	+1.25	2.66	3.83	+1.17	3.25	4	+0.75
8 Aude	3.5	2.83	−0.67	3.75	2.5	−1.25	3.166	3.166	/	3.5	3.6	/
9 Chloe	2.33	3.83	+1.53	2.5	3.25	+0.75	2.5	3	+0.5	2.25	3.25	+I

*Participants were assigned pseudonyms to protect their anonymity.

Progress

Regression

Table 3. Observed differences (Δ) in group competency: Pretest (TI) and posttest (T2) ($N = 9$).

Shared vision	TI	T2	Δ
Purpose of the meeting	2	2	0
Affirmation and recognition of expertise	I.75	2.75	+I
Attainment of consensus	2.25	2.5	+0.25
Person-centered approach	2.75	3	+0.25
Communication	2.75	2.665	−0.085
Respectful attitude	2.5	2.5	0
Facilitation/mediation	2	2.25	+0.25
Average	2.343	2.52	+0.177
Plan of action	**TI**	**T2**	**Difference**
Affirmation and recognition of expertise	2	2.5	+0.5
Attainment of consensus	2.5	2.75	+0.25
Person-centered approach	2	3	+I
Communication	2.416	2.75	+0.334
Respectful attitude	2.5	2.75	+0.25
Facilitation/mediation	1.75	2.5	+0.75
Shared decision making	1.5	2.5	+1
Adoption of a shared plan of action		2.25	+1.25
Average	2.074	2.6111	+0.593

Progress

Regression

> I really liked it when the instructor set forth values, like the value of freedom. And he gave us personal examples. I really liked having that background. It seems like nowadays you can't have training without engaging in role play, which drives me crazy. This is basic training that everyone in the healthcare system should have.

The ideas elicited acceptance from participants, who felt that their new learnings were practical and useful.

Impact of communication styles on relationship quality and shared language

Participants noted a new awareness of possible limitations in the way they communicated. One explained that "when issues pile up, it's easy to revert to your habitual communication models, which don't help. … This session showed me that, and gave me some pointers." This participant gave an example and pointed out how failure to distinguish between what was being experienced (feelings) and what was happening (facts) left the person she was talking to unable to solve the problem.

Participants brought up another way in which their normal communication habits caused problems: lack of concision. One remarked:

> I realized that when I'm trying to communicate I spend a lot of time talking about what I'm going through.… You know what I mean? I lose track. What I need is to figure out to say things in a way that has more impact. The idea that you lose people after just 42 words really hit me, and a light bulb went off.

The suggested model of communication was described as "a simple tool that sticks with you." One participant considered it "helpful to have a common language, especially when you're not in the same profession" while for another the recurrence throughout the session of keywords such as *entanglement* and *empathy* provided "clear, shared guideposts." They felt afterwards that they would be able put what they learned into practice:

> The content we were presented with is equally useful for work with clients, communication amongst ourselves to improve our teamwork, and in our personal lives. It's very practical.

> I really found the training tremendously helpful in every aspect of my life…

Self-awareness and empathy

Participants reported learning things specifically relating to their emotional functioning and the impact of empathy on interprofessional relationships.

One participant was struck by the idea that a feeling was "like a reflex," the way it "tells us about an unmet need." She discovered the importance of actively examining the feelings inside her to understand the needs they revealed. This intrapersonal attentiveness or awareness elicited by the training was noted by others as well. One participant declared that the session "was good for getting to know yourself." Awareness was the term that occurred most frequently during the focus group.

Participants felt they were better informed about the function of empathy. One observed how empathy helped "defuse tension" and make relationships more open. Another explained how she made use of this (re) discovery:

> It was during the team meeting. . . . It was all straightened out right away and we even laughed about it. I said "I think my empathy tank is on empty." It was kind of like a good way to look at it so we could get back to the important things. . . . It aroused empathy for me from my colleagues. Giving the thing a name seemed to take the edge off.

The participant's attention to what she was experiencing, expressed in an authentic way, occurred in a supportive climate without wasting any time. Another participant pointed out that a person in need of empathy is in no position to discuss things openly, but she found that not everyone was aware of it:

> I was in a team meeting. I had understood that until you lay your weapons down, you can't really open up. One person got right into the subject, but you could see the other person just wasn't able to listen. I said to myself, "Stop, she can't hear you. There's no point in trying to share this stuff. She needs empathy first."

Participants also saw this (re)learning as affecting relationships with their clients. One explained: "Now I see that whatever families do, it's always an attempt to meet their needs. Knowing that I can support them better, without judging."

Focus group results show that participants really appreciated the training session. Participants reported enhanced awareness of how spontaneous communication methods affect others, a more accurate understanding of the way different approaches to communication work, particularly on an emotional level, and (re)discovery of the contribution of empathy.

Discussion

The study objective was to examine how NVC training would affect the collaborative competencies of two teams. The data indicates that although individual progress was uneven, group competencies improved more, particularly in the areas of decision making and developing a shared plan of action. Although the training session aimed specifically at communication, the data collected seemed to show no significant improvement in communication competency.

Communication: Switching from autopilot to an attentive approach

Participants reported having some doubts about their communication skills after the training session. They noted that despite the importance of communication, interprofessional dynamics can make optimal communication a challenge in several ways. Some authors have criticized practitioner training in communication as insufficient (Doucet, Buchanan, Cole, & McCoy, 2012). Participants named a number of criteria associated with effective

communication, including the importance of being concise for anyone who wants to be understood. They also emphasized the importance of avoiding entanglement; that is, the common tendency to confuse facts with one's experience of them (feelings, needs). This impedes mutual comprehension and harms the relationship between the individuals involved.

The data, however, showed little improvement in communication competency after the training session, with Team 2's performance actually declining. This could be the result of ceiling effects, since initial scores were high, with most participants scoring three or above on a scale of one to five. Participants' high level of individual competency before training might account for the lack of progress. Note that the criteria for evaluating this competency only partially measured what was taught in the training session and was mainly concerned with participants' ability to communicate assertively, express themselves respectfully, and employ effective communication strategies.

A degree of improvement was however observed in certain other competencies, most significantly role clarification. Significant progress was found for all participants. It is difficult to imagine achieving this level of mutual understanding without communicating effectively. Progress was also seen in participants' ability to develop a shared plan of action. The training seems to have enhanced teams' ability to see themselves as "us": the quality of their relationships allowing them to act to meet identified needs. Participants' comments revealed a stronger sense of partnership and authenticity after the training session, the importance of which relates to the key role of relational factors (Henneman et al., 1995), mutual trust and openness being necessary to IPC in any form. Data are in fact consistent with the primary NVC aim, that of improving relationships, in which communication is seen as a means to that end.

Empathy in service of the client/family-centered approach

Results showed a significant improvement in competency with respect to the client-centered approach after the training session. Group performance results were consistent with what was observed for individuals. The client-centered approach was not specifically mentioned by the focus group. Their comments do suggest that they see themselves as better equipped to focus on client needs, and their statements seem to subsume an association between the means (i.e., empathy) and this generic IPC competency. Although participants acknowledged the relational and empathetic dimensions of communication, their relationships with those they communicate with might benefit from a more refined understanding of the needs at play. And though they recognized the potential benefits of this experiential lesson on their relationships with clients, the benefits for their interprofessional relationships seem

equally significant. This is of particular interest given that from what we know, few studies directly address the relationship between empathy and IPC, despite our understanding that showing empathy for other team members is an essential aspect of collaboration. Rifkin (2011, p. 78) reminds us that "empathic extension is the only human expression that creates true equality between people." The link between empathy and equality is central because the relationship of equality between professionals is one of the foundations of IPC (Henneman et al., 1995).

Emergence of favorable conditions for collaborative leadership

The ability to recognize and master emotions appears to be one factor favorable to the development of collaborative leadership. Some authors see a high level of self-awareness as a pre-condition for its emergence (Canadian Interprofessional Health Collaborative [CIHC], 2010; Hurley, 2011). For example, a situation in which a team meeting on wait times is cancelled. A team member picks up on her colleagues' nonverbal communications and reflects back these signals out loud to initiate a common search for solutions. This would be an example of how the NVC strategy empowers each individual to help foster collaborative leadership. This competency also relates to teams' ability to make shared decisions, an indicator consistent with the OIPC results showing team progress in developing shared goals and plan of action.

Limitations

Despite the encouraging conclusions that might be drawn, certain limitations must be kept in mind. It was an exploratory study, and the small sample size precludes generalization of the results. The quantitative data collection tools used (TOSCE and OIPC) produce only a partial picture of the possible effects of NVC training on IPC-related competencies. NVC training acts on a deeper level and needs time to take root before its effects can be fully measured. IPC is a complex and influenced by multiple factors. Although the TOSCE has been validated, its indicators still introduce a certain degree of subjectivity. An indicator such as "promotes the integration of information and perspectives from others" is broad, and would benefit from being made more concrete. Moreover, the modification of the initial tools to fit the purpose of this study may have influenced the psychometric qualities of the tools, which represents a limitation of the study. As for the OIPC, the questions are more objective, due to the definitions provided, but may be two blunt to express the kind of changes observers saw in the teams' ability to adopt a more client-centered approach. The presence of observers and the fact that discussions were simulations constitute further limits. It is difficult to determine whether participants changed their behaviour because they knew they were under observation.

Conclusion

Communication is considered the cornerstone of IPC, so the idea that communication training might affect other competencies makes sense. The NVC model has been described as a simple way to help participants develop a common language. It appears to be an innovative interprofessional education strategy capable of fostering openness, empathy, and trust in interprofessional relationships. The teaching methods it offers encourage adoption and acceptance, consistent with the considerations of Hammick and colleagues (2007), for whom learning effectiveness is optimized when approaches focus on customization and authentic content.

Acknowledgments

We thank Charles Baron, co-director, and Robert Bouchard, Marcelle Bélanger, and Jacques Tremblay of Conscienta Group.

Funding

This study was funded by RCPI (Collaborative Network on Interprofessional Practices in Health and Social Services: http://www.rcpi.ulaval.ca/) and Université Laval's Simone Paré scholarship.

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