Charting the way for collective competence research

Dialogue with Dr. Lorelei Lingard

How can we translate the individual competence of each team member into collective competence as one team? Here, Dr Khoo Hwee Sing from HOMER speaks to Dr Lorelei Lingard (Founding Director and Senior Scientist, Centre for Education Research & Innovation at Schulich School of Medicine & Dentistry) about her research on collective competence, to find out its implications on inter-professional collaborative practice and inter-professional education in healthcare settings.

I am trained as a rhetorician. The study of rhetoric is the study of communication practices, both written and oral. So I have always been interested in how people communicate. Particularly, how people communicate through talking with one another.

I decided to study healthcare communication, because there is such a huge impact of communication in this setting. When I made this decision, I was doing my doctoral research. I had been having more regular interaction with the healthcare community, and began to see, first hand, how important communication was.

One of the reasons I broadened out from the operating room theatre about 10 years into my research career was that I realized that even though the work I was doing was very powerful and useful, it wasn't transferable necessarily to teams that were not trapped together in the same four walls. So I began to choose research settings where teams were more distributed, more organic, where they interacted only briefly, or never interacted physically at all.

I think that we still lack a really deep scientific understanding of team communication practices. It's still very early in that research domain, so we tend to want to try simple fixes … I also see how much further we have to go, to really understand team communication practices and really achieve meaningful improvement and change.

We published a paper recently on the tension between leadership and collaboration on clinical teams because there is both a strong value for collaboration and also a strong expectation that somebody, usually the physician, is going to lead. (Yet) leadership can be collective, so a team can mutually decide in particular moments, because of particular needs, that particular people will lead but that they won't be the "leader" of the team.

I think we should have an awareness of how collective competence isn't anti-individual. It actually wants you to see individuals in relation to each other. So if we said understanding how the personalities in a team intersect, conflict, relate; that is definitely relevant to collective competence.

Dr Lorelei Lingard presented her work on collective competence.

Part of collective competence would be to understand the power and hierarchy dynamics in which the team functions ... A group of individually competent people can form an incompetent team. If they don't understand the relationship of power among them, that can produce collective incompetence … That's not true only in the operating room; it's true in every healthcare team setting.

In our current study … We altered our definition of team that we'd always used in the past to include the patient, their family care-givers, any community care givers and any healthcare providers. We actually started with the patient, and said, 'Tell us who is on your healthcare team?'. And anybody the patient recommended, we recruited and if they agreed, we interviewed them.

There are so many differences; some of them are exciting, and some of them are just methodologically challenging … If you start with the patient and you ask them who is on your team, and you interview those people … is the team you interviewed the real team? What if the patient doesn't mention their respirologist, but their cardiologist mentions their respirologist? If the patient doesn't view them as being important to their healthcare, should you include them?

That's how many different stories you get, so it's much more complicated. Whose story is the right story? How do you weave them together in a way that gives us insight and not just a sense of overwhelming chaos? It's a very difficult dataset to analyze … They all have some 'truth' in them, but how (can) you pull them all together and say something meaningful and helpful about team communication?

I have been talking about collective competence for a handful of years now, and every time I talk about it and write about it, I learn something new in how difficult it is for people to actually understand it and how difficult it is for them, even if they understand it conceptually, to know what it would mean translated into their practice.

I think we have a generation of work to do to translate the idea of collective competence into things like competency frameworks, regulatory frameworks for the various health professions, assessment strategies, and accreditation strategies.

One of the ways that medical education can begin to do something with that is to continue to work on inter-professional collaborative practice and inter-professional education. That is one, very obvious way, that we shift our focus from training a physician to training the group that will have to practice together.

It's not perfect. In some ways, the work around IPC (inter-professional collaboration) and IPE (inter-professional education), you know, it has a lot of flaws; but I think it's resonant with the idea of collective competence and so it's going in the right direction.