COLLABORATIVE DECISION MAKING IN EARLY CAREER DIETETIC PRACTICE

MARISSA JANE OLESEN

BApSci (Nutritional Science)  MSc(Nutrition and Dietetics)

Thesis presented for the degree of

Doctor of Philosophy

Charles Sturt University

March 2013
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF FIGURES</td>
<td>viii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>ix</td>
</tr>
<tr>
<td>CERTIFICATE OF AUTHORSHIP</td>
<td>x</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>xi</td>
</tr>
<tr>
<td>PROFESSIONAL EDITORIAL ASSISTANCE</td>
<td>xii</td>
</tr>
<tr>
<td>PUBLICATIONS ARISING FROM THIS THESIS</td>
<td>xiii</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>xv</td>
</tr>
<tr>
<td>ACRONYMS USED IN THE THESIS</td>
<td>xvii</td>
</tr>
<tr>
<td>GLOSSARY</td>
<td>xviii</td>
</tr>
</tbody>
</table>

## CHAPTER ONE: INTRODUCTION 1

1.1 My professional journey 1
1.2 Rationale for my research 2
1.3 Framing the research topic, aims and questions 5
1.4 Locating the research in a theoretical framework 6
1.5 Overview of research approach 9
1.6 Significance of the research 11
1.7 Structure of the thesis 11

## CHAPTER TWO: LOCATING THE RESEARCH 13

2.1 Framing the dietetic profession 13
2.2 Locating clinical dietetics in the health care landscape 15
2.3 Practice models and roles in clinical dietetics 17
2.3.1 Prescription and advice giving 17
2.3.2 Counselling for behavioural change 18
2.3.3 Counselling for cognitive change 19
2.3.4 Evidence-based dietetic practice 22
2.3.5 Integrative approaches to nutrition care 24
2.4 Australian context for this study 26
2.4.1  Entry-level education and professional development  26
2.4.2  Rural and regional dietetic practice  27
2.5  Conclusion  28

CHAPTER THREE: METHODS  31
3.1  Research phenomenon, aims and questions  31
3.2  Research paradigm and philosophical stance  36
3.3  Research approach  37
3.3.1  Philosophical hermeneutics  38
3.4  Research design  47
3.4.1  Text construction  50
3.4.2  Text Interpretation  63
3.5  Strategies for ensuring quality  64
3.5.1  Rigour  64
3.5.2  Transparency  65
3.5.3  Credibility  66
3.6  Conclusion  67

CHAPTER FOUR: THEORETICAL PERSPECTIVES OF PROFESSIONAL DECISION MAKING  69
4.1  Theoretical framework for professional practice: key dimensions  70
4.1.1  Cultural dimension  71
4.1.2  Relational dimension  72
4.1.3  Discursive dimension  74
4.1.4  Interest dimensions  77
4.2  Professional decision making in health care practice: core dimensions  81
4.2.1  Theoretical underpinnings that provide a basis for professional decision making models  82
4.2.2  Role/s of patients and practitioners  83
4.2.3  Ways of knowing and sharing meaning  87
4.2.4  The nature and complexity of the decision/s to be made  93
4.2.5  Power differentials  96
4.2.6  Nature of decision-making dialogues  100
4.3 Professional decision making in dietetic practice 102
4.4 Implications for professional and collaborative decision making in dietetics 110
4.5 Conclusion 113

CHAPTER FIVE: DIETITIANS’ OBSERVATIONS AND EXPERIENCES OF PROFESSIONAL DECISION MAKING 117
5.1 My interpretive lenses 117
5.2 Relational dimensions of professional decision making 118
5.2.1 Conditions for successful relationships 119
5.2.2 Power relations between dietitians and patients 120
5.3 Discursive dimensions of professional decision making 124
5.3.1 Control of conversations 124
5.3.2 Knowledge exchange in conversations 128
5.4 Self-awareness of influences on professional decision making 131
5.4.1 Educational experiences 132
5.4.2 Perceptions of professional role 135
5.4.3 Professional relationships with other health practitioners 138
5.4.4 Time pressure 143
5.4.5 The practice setting 146
5.4.6 Cultural and contextual background of patients 148
5.5 Conclusion 149

CHAPTER SIX: COMPLEXITIES AND TENSIONS OF COLLABORATIVE DECISION MAKING IN EARLY CAREER DIETETIC PRACTICE 155
6.1 Dietitian participants’ reflections on challenges in professional decision making 156
6.1.1 Professional relationships 156
6.1.2 Dialogues 163
6.1.3 Developing professional identity 173
6.2 Patient participants’ perceptions and observations about professional decision making 179
6.2.1 Patient expectations for nutrition care 180
6.2.2 Patient preferences for participation 183
6.2.3 The nature of conversations 186
6.2.4 Sharing knowledge in decision making
6.2.5 Trust, honesty and shared worldviews
6.2.6 Time for thinking and talking
6.3 Tensions and common ground between dietitians’ and patient participants’ horizons about CDM
6.3.1 Caring and trusting relationships
6.3.2 Transparency and language in dialogue
6.3.3 Professional authority and professional roles
6.3.4 Knowledge and power
6.3.5 Preferences for participation
6.3.6 Creating time for the process of professional decision making
6.4 Conclusion

CHAPTER SEVEN: THE INTERPRETIVE ENGAGEMENT MODEL OF COLLABORATIVE DECISION MAKING AND CONCLUSIONS 205
7.1 Synthesis of findings 206
7.2 The Interpretive Engagement Model of CDM 211
7.2.1 Conceptualising my model 211
7.2.2 The Model – Part 1: The journey of early career dietitians towards CDM capability and ownership 213
7.2.3 The Model – Part 2: The dimensions of CDM as a process of interpretive engagement 219
7.2.4 The Model – Part 3: CDM in action 222
7.3 The researcher’s reflexive journey 227
7.4 Critique of the model 228
7.5 Implications for education and practice 231
7.5.1 University education 231
7.5.2 Professional development for early career dietitians and implications for practice 234
7.6 Implications for further research 238
7.7 Final comments 239

REFERENCES 240
APPENDICES 256
<table>
<thead>
<tr>
<th>Appendix</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1: Literature search strategy</td>
<td>257</td>
</tr>
<tr>
<td>Appendix 2: Ethics approval</td>
<td>258</td>
</tr>
<tr>
<td>Appendix 3.1: Information statement and consent form (dietitians)</td>
<td>263</td>
</tr>
<tr>
<td>Appendix 3.2: Letter, information statement and consent forms (patient participants)</td>
<td>267</td>
</tr>
<tr>
<td>Appendix 4: Dietitian participant questionnaire</td>
<td>273</td>
</tr>
<tr>
<td>Appendix 5: Interview guides</td>
<td>274</td>
</tr>
<tr>
<td>Appendix 6: Decision making models from the health care literature</td>
<td>277</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

Figure 3.1: Overview of research design and reporting.........................................................48

Figure 3.2: Questions that guided construction and interpretation of texts.........................49

Figure 3.3: Selection criteria and recruitment process..........................................................56

Figure 4.1: Key dimensions of a professional practice framework, core dimensions of professional decision making and implications for CDM in dietetics..........................70

Figure 4.2: Key dimensions of a professional practice framework, core dimensions of professional decision making, implications for CDM in dietetics and key capabilities for CDM in dietetics........................................................................115

Figure 5.1: Perceptions and interpretations of dietitian participants regarding PDM.................................................................151

Figure 6.1: Factors supporting and hindering CDM in dietetic practice.................................204

Figure 7.1: Summary of key points from findings chapters..................................................210

Figure 7.2: The Interpretive Engagement Model Part 1: The journey of acquisition of capabilities and understanding about CDM...............................................................214

Figure 7.3: The Interpretive Engagement Model Part 2: The core capabilities and conditions required for CDM.........................................................................................220

Figure 7.4: The Interpretive Engagement Model Part 3: CDM in action.................................223
LIST OF TABLES

Table 3.1: Profile of Dietitian Participants ................................................................. 53

Table 7.1: Sample questions to guide reflection on capabilities of CDM ............... 236
CERTIFICATE OF AUTHORSHIP

I hereby declare that this submission is my own work and to the best of my knowledge and belief, understand that it contains no material previously published or written by another person, nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgement is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

I agree that this thesis be accessible for the purpose of study and research in accordance with normal conditions established by the Executive Director, Library Services, Charles Sturt University or nominee, for the care, loan and reproduction of thesis, subject to confidentiality provisions as approved by the University.

Name            Marissa Olsen

Signature

Date            March 2013
ACKNOWLEDGEMENTS

First, my deepest gratitude goes to my supervisors, Franziska Trede and Joy Higgs, for their tireless support, enthusiasm and encouragement. I could not have dreamt that I would have such amazing supervisors who were so generous in sharing their time, experience and wisdom. You have introduced me to new ways of knowing and thinking, and changed the way I see the world.

I’d like to thank my participants for the privilege of listening to their stories, challenges and aspirations. Their passion for dietetics, resilience in sometimes very challenging practice environments and commitment to becoming the best practitioners they could be to help improve the health of the people they worked with was inspiring.

I am also most grateful to Charles Sturt University for awarding me a Community Health Research scholarship and a Writing Up Grant to support the completion of my PhD.

I am also grateful for the support and critical companionship of my colleagues in the COHORTS group at the Education for Practice Institute (EFPI). I will never find the words to express adequately how lucky I was to be in the presence of such caring, insightful and intelligent people. Thank you all for your encouragement and contributing to an environment where I could break the boundaries of my comfort zone.

Thank you also to my colleagues at the School of Dentistry & Health Sciences, particularly the Nutrition & Dietetics team, who have not only supported me in taking time out to complete my PhD but also provided continued encouragement to work towards this goal.

Thank you to the staff of EFPI and the School of Community Health for their practical and academic support, collegiality and encouragement throughout my candidature. As a member of EFPI I was given the opportunity to meet and engage with a number of nationally internationally renowned scholars and I sincerely appreciate their feedback and encouragement regarding my work.

Finally, a very special thank you to my family and friends for supporting me throughout my PhD journey. I’d particularly like to thank Jason, Karen, Kevin, Matthew, Meredith and Luke for their understanding, patience and for always believing in me, and Sweetie, Baylis and Tompson for sitting alongside me during the long days and nights of writing. My journey would not have been possible nor complete without you, and this thesis is dedicated to you all.
PROFESSIONAL EDITORIAL ASSISTANCE

Joan Rosenthal provided professional editing assistance for this thesis. This assistance was limited to formatting, grammar and style and did not alter or improve the substantive content or conceptual organisation of the thesis.
PUBLICATIONS ARISING FROM THIS THESIS

Abstracts for papers presented at conferences


Abstracts for posters presented at conferences


NB: Marissa Olsen was responsible for the writing of all abstracts listed above, with editing and content advice provided by Franziska Trede and Joy Higgs.
ABSTRACT

Dietetics is a communicative practice where decisions about eating habits come about through conversations between dietitians, patients, members of the health care team and significant others. Collaborative approaches to this decision making has particular relevance in dietetics compared to other practices where education and communication are given less emphasis. Whilst there is significant interest regarding patient-centred approaches to dietetic practice, the nature of collaborative decision making (CDM) has yet to be explored in dietetics, particularly with early career dietitians. The aim of this research was to deepen understanding of the phenomenon of CDM in the practice of early career dietitians.

In this research a philosophical hermeneutics approach was adopted utilising question and answer dialogues and fusion of horizons. Texts were constructed and interpreted based on the literature, a series of in-depth interviews with nine dietitian participants and one-off interviews with six dietetic patients. In doing so I sought a fusion of horizons and shared understanding of perceptions and interpretations of professional decision making.

Relational, cultural, discursive and interest dimensions of practice were used as theoretical dimensions to inform the interpretation of my texts. I also identified practice theories, roles of patients and practitioners, ways of knowing and sharing meaning, decision complexity, power differentials and dialogues as core dimensions of professional decision making.

The perceptions and interpretations of dietitian participants regarding professional decision making were complex and dynamic, and different to the perceptions and interpretations of patients. Dietitian and patient participants valued building positive relationships and engaging in dialogic conversation during nutrition care. However patient participants had more diverse preferences, values and expectations regarding professional decision making that extended beyond a preference for being collaborative.

Key tensions for dietitian participants in shaping CDM were reconciling conflicting intra- and inter-personal values, expectations and beliefs about professional decision
making; building relationships and establishing open dialogues with patients; reconciling intrapersonal perceptions of professional identity and managing reactions to participation in making decisions. The way patient participants viewed the core dimensions of decision making was different to dietitian participants and contributed to deeper understanding of the key tensions that dietitians experienced in professional decision making practice.

My research products include the interpretive engagement model for collaborative decision making, core capabilities and required conditions to enable early career dietitians to enact CDM. The core capabilities are:

- 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
- Finding time to think and talk.

My conclusions can be used to guide practice and to inform curriculum development in tertiary education. This research has also resulted in the identification of a range of areas for future research, including the exploration of the nature of CDM in the practice of expert practitioners and strategies to further support early career practitioners to develop their professional decision-making practice.
## ACRONYMS USED IN THE THESIS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>APD</td>
<td>Accredited Practicing Dietitians</td>
</tr>
<tr>
<td>CDM</td>
<td>Collaborative decision making</td>
</tr>
<tr>
<td>DAA</td>
<td>Dietitians Association of Australia</td>
</tr>
<tr>
<td>ICDA</td>
<td>International Confederation of Dietetic Associations</td>
</tr>
<tr>
<td>NCSELD</td>
<td>National Competency Standards for Entry Level Dietitians</td>
</tr>
<tr>
<td>SDM</td>
<td>Shared decision making</td>
</tr>
</tbody>
</table>
GLOSSARY

**Collaborative decision making**
A decision making approach whereby decisions are made based on active engagement of patients and practitioners in identifying, exploring and interpreting each other’s pre-understandings. A process and product of finding common ground between practitioners and patients regarding the phenomenon of interest (in this case the interests, motivations, sociocultural and relational factors that shape eating habits) is sought and informs the final decision made.

**Clinical dietetics**
The application of the science of nutrition for individual dietary therapy in a professional health care setting by an Accredited Practising Dietitian.

**Critical reflection**
Reflection on practice that incorporates consideration of the drivers of practice, with an emphasis on questioning dominant practices and challenging these practices if they are found to warrant transformation.

**Dietitian**
An appropriately qualified professional who undertakes the practice of dietetics in individual, group or population settings.

**Early career practitioner**
A practitioner who has been practising for no more than five years in their chosen profession.

**Patient-centric decision making**
A decision making approach whereby patients make decisions alone informed by technical knowledge of practitioners and patients knowledge from experience.

**Practitioner-centric decision making**
A decision making approach whereby practitioners make decisions alone informed by technical knowledge of practitioners and clinical circumstances of patients.
**Professional decision making**

An umbrella term for decision making undertaken by a practitioner in a professional context. Professional decision making includes practitioner-centric decision making, patient-centric decision making, shared decision making and collaborative decision making.

**Rural and regional environments**

Geographical environments outside major capitals in Inner Regional or Outer Regional Australia as designated by the Australian Standard Geographical Classification Remoteness Areas system (ASGC-RA) developed by the Australian Bureau of Statistics.

**Shared decision making**

A decision making approach whereby practitioners and patients make decisions together however extent of participation of both parties in decisions made is blurred.
CHAPTER ONE

INTRODUCTION

In this chapter I provide an overview of the research undertaken in this thesis. I detail the professional journey that led me to my thesis topic. I provide the rationale for the research and I frame the research topic, aims and questions. Then I locate the research in a theoretical and philosophical framework. I discuss the significance of the research and conclude this introductory chapter with an outline of the structure of the thesis.

1.1 My professional journey

My professional journey leading to my PhD topic was informed by various professional experiences as a clinical dietitian and academic. As a practitioner I worked with a range of patients with acute and chronic illnesses in a range of settings, including hospitals, general practice and community health. At times I felt frustrated that I was not adequately prepared to help people who were living with chronic and complex disease make achievable and sustainable changes to their eating habits. I was not sure why patients did not take up the decisions we made about dietary change.

Through questioning my own practice I learned more about patient-centred care, particularly the importance of asking people for their ideas and input in making decisions about care. I believed that engaging patients in these conversations was important for making decisions about dietary change that was relevant and acceptable to patients. As a consequence, I questioned how I could better understand, explore, acknowledge and incorporate into treatment the range of sociocultural, environmental and psychological determinants of eating behaviours that patients reported. I further questioned how I could better communicate with patients to draw them into making decisions about nutrition.

When I became an academic, I was keen to learn how to better prepare students for the dietetic work they were likely to encounter as early career practitioners. I believed that it was important to pass on the value of patient-centredness to my students because of my belief in involving patients in making decisions about nutrition care and deeply understanding the sociocultural, economic, psychological and geographical as well as
clinical context of patients. My focus turned to questioning how I could best model this approach and teach students alternative approaches to the didactic education and practitioner-centric decision making in dietetics. I realised that although students prefer black and white clear answers I felt it was important to introduce them to the diversity and complexity of clinical practice early. I questioned where and how in the curriculum I could incorporate discussions about decision-making approaches which extended beyond the traditional emphasis on using propositional knowledge in professional decision making to also incorporate patients’ unique needs and concerns. I wondered how I could help students integrate the perspectives of patients into the process of making decisions.

I had experienced the opportunities and challenges that early career practitioners often face working in rural and regional environments where they encounter a wide diversity of patients, team members and tasks/roles they need to perform. I had also experienced the professional isolation that can come with working in a rural environment. Further, during my time as a rural practitioner, I had come to value mentoring as a way to dialogue about practice challenges. As an academic, I was interested to know whether this type of dialogue would be of use to support practitioners to address the challenges they might face in their unique practice settings engaging patients in making decisions about nutrition care.

1.2 Rationale for my research
Collaborative approaches to decision making have been cited as one way to incorporate consideration of the social, cultural and political complexity of patients’ lives in coming to mutually acceptable decisions about treatment (Trede & Higgs, 2003). Eating habits are complex, and decisions about eating can be influenced by environmental, social, behavioural, as well as demographic, psychological, cultural, economic and physiological factors (Abusabha, Peacock, & Achterberg, 1999; Beaudry, Lilley, & Aucoin-Larade, 1991; Jones, Furlanetto, Jackson, & Kinn, 2007; Kayman, 1989;). These factors can impact upon food availability, preferences, access to food, preparation and storage behaviours, as well as eating patterns and traditions (Beaudry et al., 1991; Harris-Davies & Haughton, 2000). Approaches to decision-making in nutrition care that allow exploration of the complexity of these factors are likely to give rise to better understanding of how to support patients to make changes to their eating habits.
In this thesis I conceptualise dietetics as a communicative practice where decisions about eating habits are achieved through conversations between dietitians, patients, members of the health care team and significant others. In dietetics, collaboration is specifically mentioned as a central tenet in the most recent nutrition care process model published by the American Dietetic Association (American Dietetic Association, 2011; Bueche et al., 2008). This model is advocated for use by Australian dietitians by the Dietitians Association of Australia (DAA). The Dietitians of Canada (2000, p. 13) have encouraged dietitians to use a patient-centred approach which incorporates “the use of collaborative and partnership approaches where the client’s own experiences and knowledge are central, and carry authority within the client-professional partnership. In this approach mutual respect, trust and shared objectives are fundamental”. Working collaboratively with patients in determining goals and strategies for nutrition care are elements of individual case management competencies in the National Competency Standards for Entry Level Dietitians as determined by the DAA (DAA, 2009). Despite value being given to collaborative approaches to care in dietetics, there is still a lack of in-depth exploration of the concepts of collaboration, including what the implications are for the professional role of dietitians.

Being collaborative has been cited as an important competency in nutrition counselling. Cant and Aroni (2008a, 2008b, 2009) explored competency dilemmas that dietitians faced in nutrition education of individual patients and found that dietitians had needed greater training following graduation in order to use a nutrition counselling approach that encompassed a two-way discussion. They described four sets of competencies for effective dietitian–patient communication: “interpersonal communication skill, nonverbal communication, professional values and counselling skill” (2008a, p. 502). They argued that these competencies were aligned with themes of partnership and collaboration, including person-centredness, cooperation, promoting empowerment of patients, shared power and decision making. They emphasised the importance of empathy and trust in effective communication in dietetics, and advised that dietitians could consider being more open and using self-disclosure to enhance this trust.

Similarly, Lu and Dollahite (2010) explored self-efficacy of dietitians in nutrition counselling skills and identified characteristics and skills that they deemed essential for patient-centred counselling which included relationship building, educative and communicative roles, working with patients collaboratively to explore and define their aims and goals in counselling, exploring the nature of and contributing factors to eating
behaviours, identifying strategies for change, and providing relevant and appropriate amounts of information.

As Légaré, Ratté, Gravel & Graham (2008) have found, much of the research reported in the literature that considers the experiences (particularly barriers and facilitators) of engaging patients in decision making about care (mostly referred to as shared decision making) is conducted with physicians, indicating a gap in the literature with respect to the experiences of other health practitioners such as dietitians. It is not clear whether the results from studies conducted in the medical discipline are transferable outside the medical context. One group of researchers has explored the salient beliefs regarding and actual use of shared decision making in dietetic practice (Desroches, Gagnon, Tapp, & Légaré, 2008; Desroches, Lapointe, Deschênes, Gagnon, & Légaré, 2011; Vaillancourt, Légaré, Lapointe, Deschênes, & Desroches, 2012). Their findings suggest that relationship and power sharing issues are considerations in encouraging patients to participate in shared decision making. The authors appeared to fall short of exploring the interests that drove dietitians’ practice. The dominant perspectives that inform patient-centred care in dietetics are from a psychological perspective. I wanted to explore professional decision making in dietetic practice from a social and educational perspective. My interests lay in further illuminating the relational and discursive aspects of working in this manner in dietetics, as well as the interests that drive practice and prompt discomfort with a collaborative approach.

In my doctoral research I have built on this existing literature that provides support for collaboration as an important component of nutrition care, by exploring the observations and experiences of dietitians in enacting collaborative approaches to decision making in dietetic practice reality.

There is scope to deepen understanding of the complexities of implementing a collaborative approach to decision making in early career practice. Collaborative decision making (CDM) has been identified as a dimension of expert practice (Jensen, Gwyer, Shepard, & Hack, 2000). Further, there is evidence that emancipatory approaches to health care such as CDM are rarely utilised in practice by professionals at all levels of expertise, and so it is hardly likely that early career practitioners would use this approach (Trede, 2012a). However, early career dietitians can encounter situations where they could be working with a patient who prefers a CDM approach. This makes it
necessary for early career dietitians, while still developing expertise, to be exposed to the idea and practice of CDM.

As I was located in regional New South Wales during the research, my participants were drawn from rural and regional environments in order to facilitate the practical aspects of my method, which required engaging with them on a frequent basis in a face to face setting.

For the purposes of this thesis, regional, rural and remote dietitians are considered to be those working outside major capitals in Inner Regional or Outer Regional Australia as designated by the Australian Standard Geographical Classification Remoteness Areas system (ASGC-RA) developed by the Australian Bureau of Statistics.

In such settings dietitians, particularly in their early career phase of work, may experience additional challenges in collaborating with patients, because often they are working as sole practitioners and thus have limited support from colleagues nearby to provide mentoring and advice in professional decision making and practice actions. As the only dietitian in the health care team, these dietitians need to work without (nearby) role models and with a wide range of patients with an equally wide range of preferences for a decision-making approach, which can include CDM. This challenging environment places professional decision making at the centre of these dietitians’ practice and was thought to have the potential to provide further insight into the impact of the practice setting on professional decision making practices.

1.3 Framing the research topic, aims and questions
My research topic focuses on professional decision-making in dietetic practice, and in particular it focuses on CDM and how it is perceived and interpreted by early career dietitians and their patients. The focus in this thesis is on the perceptions and interpretations of dietitians as they are the decision making partner with professional power. For this reason, the patient voice is provided as a snapshot to contribute to enriched understanding of core capabilities required by early career dietitians to enact CDM in their practice. Further, while dietetic participants were drawn from a rural or
regional environment, and it is acknowledged that this practice setting may impact on professional decision making practices, it was not the primary focus of the research.

Higgs and Titchen (2001a) argued that during the process of becoming a practitioner, individuals learn the rules of the profession; they pointed out that the focus of learning is often on technical knowledge acquisition and skill development. They suggested that exposing students and early career practitioners to theoretical underpinnings of practice beyond those driven by technical interests is important for competence and authenticity in practice. Early exposure to different decision-making approaches can help practitioners to develop the capabilities to effectively utilise CDM in practice. My research provides a deeper understanding of how best to support these practitioners to develop the capabilities needed to implement a CDM approach, as well to recognise when it can be desirable to use the approach in practice.

With an emphasis on early career dietitians, my research aims to answer the following over-arching question:

• What core capabilities are needed for early career dietitians to enact CDM in their dietetic practice?

My research sub-questions were:

• What are key theoretical underpinnings of professional decision making approaches in health care in general and dietetics in particular?
• What is the value and significance of CDM in health care in general and dietetics in particular?
• What are the observations and experiences of early career dietitians regarding professional decision making and CDM in particular?
• What tensions and complexities do early career dietitians face in CDM?
• What can be learned from patients’ perceptions and observations to contribute to shaping CDM?
• What factors support and hinder the development and adoption of CDM approaches by early career dietitians?

1.4 Locating the research in a theoretical framework
The literature of CDM provided an important broad basis for my research. However, although researchers have explored intrapersonal clinical reasoning aspects of early
career practitioners’ decision making (Kosowski & Roberts, 2003; Lamond & Farnell, 1998; O’Neill, Dluhy, & Chin, 2005; Oliver & Butler, 2004; Tabak, Bar-Tal, & Cohen-Mansfield, 1996), there seems to be little research regarding the experiences of early career practitioners of CDM, which makes my research a timely addition to this field of literature. One of those few studies that I want to mention here explored early career medical practitioners’ attitudes to shared decision making (McKeown, Reininger, Martin, & Hoppmann, 2002). The focus on medical practice is of course a different context to dietetic practice, particularly in relation to the greater power differential between doctor and patient than occurs in dietetics. Further, McKeown et al. explored shared decision making, which has a different nuance to decision making that is collaborative. Their shared decision making approach entailed patients and practitioners making decisions together based on information sharing regarding treatment options. In contrast, I view collaborative decision making in my thesis through a philosophical hermeneutic lens, where the collaborative approach has an emphasis on self-awareness of the pre-understandings that are brought to professional decision making. Decision making partners share and explore these interests to find common ground through dialogue. Dialogue goes beyond sharing of evidence to a deep exploration of the social, cultural and relational dimensions of what impacts on eating habits.

Although not specifically exploring CDM, Tapsell (1997) conducted a conversational analysis study to further examine the “talk” enacted between students and patients in a nutrition teaching clinic. She found that agreement about dietary changes was more likely to be reached in decision making when the student dietitians continued to engage patients in dialogue in situations when hesitation or barriers to change were expressed. The author noted that a particular constraint on the conversations included in the study was that students were being assessed regarding their use of patient-centred communication strategies and could have shut down dialogue prematurely to finish the interview in a timely manner. She recognised that time constraints exist in practice and can impact on the success of patient-centred dialogues. While Tapsell’s research provides some identification of potential challenges that might be inherent in CDM in dietetics, my thesis differs from this research in that (a) it aims to explore the dialogue dimensions of CDM, and (b) it focuses on early career dietitians rather than students.

Seright (2011) explored the decision-making approaches of novice nurses working in rural U.S.A. and found that the nurses relied heavily on collaborating with others in the
multidisciplinary health care team to inform their clinical decision making. Patients were not identified by participants as important partners in decision making. This finding may have been due to the focus of Seright’s research being on decisions in acute care hospital settings where it can (at times) be inappropriate or difficult for patients to be involved in making decisions (for instance if the patient is unconscious, intubated or in severe pain). While acknowledging that team relationships can influence early career practitioners’ decision-making approaches, my research builds on this literature by exploring collaboration with patients as active decision-making partners.

It has been recognised in dietetics that practitioners use various approaches to nutrition care depending on their skills (Young, 1965) as well as on the emotional, clinical and cultural and circumstances of patients (Bell, 1986; Laws & Fitzgerald, 1997). Anderson (1998, pp. 139-140) argued that “the dilemma, [is] to find the balance between when to put forward knowledge and expertise and when to hold back”. Gingras (2004) also suggests that self-awareness and an understanding of the context in which counselling takes place is imperative to building relationships of trust between nutrition counsellors and patients. It is further recognised that a patient-centred approach is not always the most appropriate decision-making approach to use in each occasion of health care for each patient (Hancock, Bonner, Hollingdale, & Madden, 2012). Charles, Gafni and Whelan (2000) argued that, due to the complexity and dynamic nature of decision making, it is essential to explore and appreciate the context of health care to ensure that the appropriate approach is utilised. Although some characteristics can make people more likely to want to participate in decision making, patients have a range of capabilities and preferences for involvement in decision making (Hamann et al., 2007; Hancock et al., 2012; van den Brink-Muinen, Spreeuwenberg, & Rijken, 2011).

Building on this literature, an important skill of practitioners is the ability to choose an appropriate decision-making approach to use in each occasion of nutrition care to ensure that each patient’s needs and preferences are met. My research aims to explore how early career dietitians might incorporate collaborative approaches into their work.

My thesis is based on the perspective that the nature of practice is complex, often messy, unique, value-driven and uncertain (Fish & Coles, 1998; Higgs & Titchen, 2001a; Schön, 1983). My literature focus is on theory relating to CDM. Professional decision making is part of professional practice and linked to professional knowledge, skills and traditions.
My theoretical framework draws on the work of a range of scholars, including Higgs and colleagues, Kinsella and Kemmis, with particular reference to their theorising that relates to CDM. Higgs and colleagues (Higgs, Jones, Loftus, & Christensen, 2008; Higgs & Titchen, 2001c) have discussed the importance of considering tradition, relationships and dialogue in practice. Kinsella (2012 p.2) conceptualised reflection as incorporating critical reflexivity and reflecting on the practice phenomenon, where internal dialogues can be conducted regarding a variety of aspects of “being, thinking, doing, deconstructing and becoming” in practice. Kemmis (2010) conceptualised practice as having a rich architecture which is constructed through social, cultural and discursive aspects of practice. Drawing on their theoretical concepts provided a good starting point for placing CDM within a social, cultural and relational perspective. I conceptualise CDM as being based on sharing, exploring and questioning the understandings that patients and dietitians bring to professional decision making.

1.5 Overview of research approach
Liquori (2001) argued that empirico-analytical knowledge dominates food and agricultural science, the food industry and nutrition and health-related sciences, whereas experiential knowledge dominates food and nutrition practice. Because of the greater power of the empirico-analytical paradigm in the natural sciences, she argued that changes in the food supply (including agriculture and food industry) and health care systems are more likely to “profoundly influence how the [nutrition] profession defines its practice and who participates in the decision making about this” (p. 239). Further, it is noteworthy that the empirico-analytical paradigm remains the dominant paradigm in the published dietetic literature. There seems to be a paucity of research using the interpretive and critical paradigms to explore the practice of dietetics.

Calls to diversify the research that informs dietetic practice into paradigms other than the empirico-analytical paradigm are evident in the literature. Buchanan (2004) argued that the scientific model cannot advance our understanding of the complexity of human behaviour. He further argued that because of the emphasis of scientific models on predicting behaviour, using that model to inform practice means there is an increased risk of emphasis on paternalism and attempts to control people’s behaviour. He argued instead for a humanistic model, which is “better suited to achieving the goal of helping people make food choices more consistent with the kind of person that they want to be”
(p. 146) and helps to “reach reasoned mutual agreement” (p. 152) through dialogue about people’s values and ideas about preferred ways of living.

As my research aimed to deepen understanding of the observations and experiences of patients and early career dietitians regarding professional decision making, it was desirable to locate my research approach within the interpretive paradigm. I chose philosophical hermeneutics, emphasising the dialogue of question and answer strategy in this research approach because it provides a good match with my conceptualisation of CDM as shared meaning making and finding common ground through dialogue. Philosophical hermeneutics enabled me to explore the relational and discursive aspects of nutrition care through interpretation of both literature and interview/experiential texts. In my research, the focus is on the nature of the interpersonal decision making that takes place between dietitians and patients.

Philosophical hermeneutics, a hermeneutic perspective arising from the work of Hans-Georg Gadamer (1960/1992) and further elaborated by Nicholas Davey (2006), was specifically chosen because of its emphasis on the dialogue of questions and answers as identified above and the idea of fusion of horizons, which is a key to successful collaboration. Philosophical hermeneutics is based on the proposition that people bring their unique perspectives to conversations, and that these perspectives have been shaped over time by immersion in particular social and cultural traditions. Bringing together (or fusing) these perspectives and coming to a new understanding can allow decisions to be made collaboratively. Further, the fusion of horizons notion had utility in my research in helping to uncover the interests and assumptions that drive practice. My research design included various cycles of dialoguing with the literature, dietitian participants and patient participants. This enabled me to come to a deeper understanding of the participants’ values and beliefs about practice, and how these values and beliefs shaped decision-making approaches and practice challenges. Through ongoing question and answer dialogue, these perspectives can come together and lead to a new perspective or understanding. Philosophical hermeneutics has particular relevance in the provision of nutrition care because it is important not only for practitioners to understand patients’ perspectives but for patients to understand the perspectives of practitioners.
1.6 Significance of the research

My research makes a significant new contribution to the literature regarding CDM for early career dietitians. Collaborative approaches to decision making have particular relevance in dietetics compared to other practices where education and communication are given less emphasis. While a collaborative approach to decision making in dietetics is not always the best choice, there are many instances where it can be. In my thesis, CDM is viewed as having a philosophical hermeneutic underpinning, with emphasis on reaching a deeper understanding of patients through question and answer dialogue. The use of philosophical hermeneutics as a research approach offers a new approach for the dietetics profession to view and understand the discursive, relational and cultural aspects of decision-making in dietetic practice.

1.7 Structure of the thesis

My thesis contains seven chapters. Chapter 1 is an introduction and overview to the thesis. In Chapter 2 I provide an overview of dietetic practice with a particular emphasis on clinical dietetics in the Australian context. In Chapter 3 I present my methodology, including my research questions, and argue for my choice of philosophical hermeneutics as the philosophical framework to guide my research. In Chapters 4, 5 and 6 I present the findings of each philosophical hermeneutic study I conducted within my research. In Chapter 4 I provide my constructed theoretical framework that is used to guide my interpretation of texts and findings from my philosophical hermeneutic study of the literature. In Chapter 5 I present findings regarding the observations and experiences of dietitian participants regarding professional decision making in dietetic practice. In Chapter 6 I present findings regarding the challenges and complexities that dietitian participants faced in implementing CDM in practice, and factors that can hinder and support CDM in dietetic practice. In Chapter 7 I bring these findings together and present my model for CDM in early career practice.
CHAPTER TWO

LOCATING THE RESEARCH

In this background chapter I provide the historical, global, national and local context within which the phenomenon under study is located. I particularly discuss background issues that provide context for early career dietitians in Australia and for working in regional and rural Australia, as this is where my participants were located.

2.1 Framing the dietetic profession

The importance of nutrition to promote optimal health and treat disease has been recognised since ancient times, but it was not until 1917 that the first dietetic association was established in the U.S.A. (Hwalla & Koleilat, 2004). Other associations were introduced soon after: Dietitians of Canada in 1935 (Dietitians of Canada, 2004) and the British Dietetic Association in 1936 (Hwalla & Koleilat, 2004). The national association for the profession of dietetics in Australia was originally established as the Australian Association of Dietitians in 1976, becoming the Dietitians Association of Australia (DAA) in 1983 (Nash, 1989).

In 2004, 34 dietetic association members of the International Confederation of Dietetic Associations (ICDA) accepted the following definition of a dietitian:

> A dietitian is a person with a legally recognised qualification (in nutrition and dietetics) who applies the science of nutrition to the feeding and education of groups of people and individuals in health and disease.
> (International Confederation of Dietetic Associations, 2004, p. 3)

The ICDA further delineated dietetic practice roles to include administrative, clinical and general dietetics. Dietitians working in administration have “responsibility for feeding of groups of people in health and disease in an institution or a community” (International Confederation of Dietetic Associations, 2004, p. 4). Clinical dietitians have a “responsibility for disease prevention and treatment of individuals in an institution or a community” and general dietitians have “responsibilities for both aspects (clinical and food service) in an institution or a community” (International Confederation of Dietetic Associations, 2004, p. 4). These definitions were set by the
ICDA not to rigidly define the roles of all dietitians, as the roles of dietitians can vary significantly depending on the location and nature of practice, but rather to provide a working context to examine the nature of the overall international dietetic workforce.

In Australia, the titles of “dietitian” and “nutritionist” are sometimes taken to have the same meaning. However, according to the DAA, “dietitians apply the art and science of human nutrition to help people understand the relationship between food and health and make dietary choices to attain and maintain health, and to prevent and treat illness and disease” (Dietitians Association of Australia, n.d., a, first para). Dietetics is a self-regulated profession in Australia and the DAA auspices the Accredited Practising Dietitian (APD) program, which requires dietitians to demonstrate evidence of continuing professional development on an annual basis (Dietitians Association of Australia, n.d., b). Early career dietitians are mentored formally by a senior dietitian for a period of twelve months in this program. The DAA also provides a separate credential of Accredited Nutritionist (AN), which can be utilised for those who have qualifications in nutrition but do not provide therapeutic dietary counselling services to individuals or groups (Dietitians Association of Australia, n.d., c). The Nutrition Society of Australia has established a voluntary Register of Nutritionists, which is a list, compiled by the society, of professionals who have a Bachelor level or equivalent university qualification with a major focus on human nutrition and another related major study stream such as physiology or public health. Practice experience in human nutrition in combination with a science university education is also considered acceptable for inclusion on the register. Members of the register call themselves “registered nutritionists”, and similarly do not provide clinical nutrition services (Nutrition Society of Australia, 2007).

Dietitians within Australia provide a broad range of nutrition and dietetic services. The DAA lists “patient care in hospitals and nursing homes, community nutrition and public health, consultancy and private practice, food service management, food and medical nutrition industries, public relations, marketing and communications, government, research and teaching” as fields in which dietitians work within Australia (Dietitians Association of Australia, n.d., b, 6th para). In their 1997 paper, Hughes and Somerset defined different domains of nutrition service delivery in the Australian context, including clinical and community dietetics, community nutrition and public health nutrition. Hughes and Somerset defined clinical dietetics as “the application of dietetics
in hospital or health care institutional settings” and community dietetics as “the application of dietetics in community settings, including continuity of care for discharged patient populations” (1997, p. 41). Clinical and community dietetics differ from community and public health nutrition in that the latter service types focus on primary prevention strategies such as influencing nutrition-related public policy, food supply, awareness, attitudes and beliefs of communities and populations (Hughes & Somerset, 1997). Although this work was written over 10 years ago, it remains relevant today.

2.2 Locating clinical dietetics in the health care landscape

While there is evidence of the use of therapeutic diets in hospital-based care as early as the 12th century in London, Hwalla and Koleilat (2004) have claimed that the first clinical dietitian was likely to be Florence Nightingale, a nurse. Nightingale invoked the medicinal and health benefits of food in cooking nutritious foods for both active and wounded soldiers during the Crimean War in the mid-1800s (Hwalla & Koleilat, 2004).

In the U.S.A., dietitians were initially trained in cooking schools before the American Dietetic Association required university training (Chambers, 1978). American and British dietitians then trained the first Australian dietitians in the hospital setting (Winn, 2000). These early hospital dietitians had a variety of backgrounds including nursing, home economics, science and medicine (Hitchcock, 1991; Nash, 1989). By the 1970s, dietitians required university qualifications with biochemistry and/or physiology components in dietetics (Nash, 1989). Based on this history, dietetics as a profession has a mix of origins in science, medicine and nursing, as well as home economics and food science.

Depending on the geographical and organisational setting in which they work, clinical dietitians today can work with a specific group of patients or provide general nutrition care to a wide range of patient groups. They can work with people of all ages and with people from well populations as well as those who have acute, complex and chronic disease. A common casemix can include “diabetes, heart disease, cancers, gastrointestinal diseases, food allergies, food intolerance’s, disordered eating as well as overweight and obesity” (Dietitians Association of Australia, n.d., b, 2nd para). Dietitians often have regular contact with family members, carers and friends of patients.
Because of this complex casemix, dietitians can work with a range of other health care practitioners including those from medical, nursing and allied health backgrounds, as well as food service delivery staff and administration staff. Dietitians can receive referrals to see patients from any of these health care practitioners, and patients can self-refer to see dietitians, particularly those working in private practice or community health settings.

Dietitians’ autonomy for decision-making is conditional; they can make certain decisions independently, but not others. For example, dietitians can independently prescribe oral therapeutic diets to patients, but can be more limited in other aspects of artificial feeding. Decisions regarding the choice of feed, amount and timing of nutrient delivery and how to monitor feeding tolerance are generally the domain of dietitians. Although dietitians can advocate for the route of feeding and when feeds should be ceased, medical staff often make these decisions exclusively. The DAA has argued that the National Competency Standards for Entry Level Dietitians, along with “the DAA or equivalent standards of practice, Code of Ethics or Code of Professional Conduct, position statements, practice papers, dietetic literature, practice guidelines or protocols, institution job descriptions, accrediting organisation standards, federal statutes and regulations” define scope of practice (Practice Advisory Committee, 2006, p.5).

Concerns have been raised in the international literature regarding the failure of recommendations for nutrition care to be put into practice by medical staff, with arguments that dietitians should have greater order-writing privileges in all settings of care, depending on their level of expertise (Silver & Wellman, 2003). Cant and Aroni (2007) found that there was little collaboration between dietitians and general practitioners in setting goals for patients who had been referred for nutrition care within the Strengthening Medicare program (in Australia), as patients presented with health care goals that had already been set by the general practitioner.

The lack of autonomy that tends to exist in certain aspects of the work of dietitians suggests that there is a need for dietitians to collaborate effectively with other members of the health care team to participate in and, where relevant, lead nutrition care decisions for patients. Early career and sole practitioners working in rural and regional environments are especially vulnerable here, when multidisciplinary collaboration can
be difficult due to geographical distance, high workloads and lack of experience in advocating for changes to patient care.

2.3 Practice models and roles in clinical dietetics
In this section, I give the reader an understanding of the evolution of the roles of clinical dietitians. At times, models of the nutrition care process have been called models of the nutrition counselling process, reflecting their underpinnings in psychology. In the current nutrition care process model (NCPM) nutrition counselling is considered a separate intervention within the overall nutrition care process and is separate from assessment, diagnosis, monitoring and evaluation processes (American Dietetic Association, 2011; Bueche et al., 2008). For the purposes of this discussion, the term nutrition care process is used to describe the entirety of the tasks that dietitians carry out (including assessment, diagnosis, intervention, monitoring and evaluation) and nutrition counselling is used to describe one of the interventions that clinical dietitians might use during the nutrition care process.

2.3.1 Prescription and advice giving
The focus of nutrition care during the early years of clinical dietetic practice in Australia was on preventing deficiency and under-nutrition in response to war and economic hardship (Kouris-Blazos, 2002). Consequently, according to retrospective accounts, the roles of dietitians in the 1930s and 1940s included planning, prescribing, preparing, cooking, portioning and delivering diets to patients (Winn, 2000).

International commentary on dietary counselling written in the 1950s and 1960s emphasised the importance of individualising dietary prescription and education to suit the particular circumstances of patients. Further, there was a focus on the educative role of dietitians, primarily in the provision of knowledge and teaching of skills to help patients comply with physician-prescribed diets, as well as lecturing or providing classes to various community members and groups (Bouton & Meredith, 1955; Forbes et al., 1969; Matthews, 1967; Meredith, 1957; Simmonds, 1951; Young, 1965).

The importance of developing a supportive therapeutic relationship was recognised, and a number of authors claimed that rapport building, using effective nonverbal and verbal communication and provision of ongoing support and encouragement, were crucial to the role of dietitians (Forbes et al., 1969; Matthews, 1967; Ohlson, 1973; Young, 1965).
Thereafter, until the late 1970s, the descriptions of roles of dietitians remained focused on instructing patients on how to comply with physician-prescribed diets, albeit taking into account the social, economic and cultural context of patients (Erlander, 1970; Ling, Spragg, Stein, & Myers, 1975; Ohlson, 1973; Zifferblatt & Wilbur, 1977).

2.3.2 Counselling for behavioural change

It was not until the late 1970s that descriptions of the role of dietitians began to shift. At this time, it was recognised that simply instructing people with chronic illnesses such as diabetes or cardiovascular disease about what dietary change to make was not sufficient for change to take place; attention needed to be paid to eating as a complex behaviour that is influenced by interrelated developmental, environmental, psychological, social and individual dimensions (Barlow & Tillotson, 1978; Evans & Hall, 1978; Ferguson, 1978; Mahoney & Caggiula, 1978). To acknowledge this complexity of eating behaviours, many authors over the 1980s and 1990s explored the potential for behavioural science principles to inform expansion of the role of dietitians.

Common theories and models referred to in nutrition models of practice in the 1980s and 1990s included the transtheoretical stages of behaviour change model, the health belief model, social cognitive theory and ‘PRECEDE’1 (Neumark-Sztainer & Story, 1996). Neumark-Sztainer and Story argued that the integrated use of these models could help dietitians to understand more deeply patients’ past and current eating habits and factors influencing those habits, to better focus a nutrition treatment plan.

In acknowledgment of the need for dietitians to take on roles beyond information provision, dietitians were described as “agent[s] for behavioral change” (Ferguson, 1978, p. 237), guides for change (Vickery & Hodges, 1986) and facilitators of problem solving (Strychar, Simard-Mavrikakis, Blain, Mongeau, & Daignault Gelinas, 1997). Mahoney and Caggiula (1978, p. 372) argued that the “goal is not simply education; it is also persuasion” and part of the instruction role for dietitians became providing information about the negative consequences of not making change, to persuade patients of the importance of change. Developing a positive professional relationship between patients and dietitians, specifically to establish rapport, remained important in

---

1 PRECEDE stands for “predisposing, reinforcing, and enabling constructs in educational diagnosis and evaluation” (Green, Kreuter, Deeds, & Partridge, 1980, p. 11).
the role of dietitians (Caggiula & Milas, 1986; Danish, Lang, Smiciklas-Wright, & Laquatra, 1986; Julien, 1986; Vickery & Hodges, 1986).

Hehir (1993, p. 75) argued that, in a social context where consumers were faced with increasingly complex food advertising and marketing information, “education and skills development enabling individuals to consume a healthy diet is a priority”. However, Hehir, along with Brownell and Cohen (1995) and Hughes (1996) firmly acknowledged the broader social, cultural, psychological and environmental influences on eating habits and stated that provision of education should be only one strategy utilised to help people to improve their diets. Culturally appropriate nutrition counselling that took into account the “lifestyle, beliefs and values of the client” was emphasised by Laws and Fitzgerald (1997, p. 34) as important to ensure achievement of dietary goals and enhancing patient satisfaction with nutrition care. Their research reinforced the importance of individualising advice and acknowledging the influence of dietitians’ culture on their personal food habits in the interaction.

Some recent literature in relation to nutrition education and counselling for behaviour change has focused on the role of dietitians in advocating for improved health literacy among the public (Carbone & Zoellner, 2012). The authors used the definition of health literacy of Selden, Zorn, Ratzan and Parker (2000, Introduction, 2nd last para) as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions”. Being health literate has important implications for CDM, since it could be argued that health literate patients are likely to be actively participating partners in the decision-making process. Carbone and Zoellner argued that a key role of dietitians is to translate scientific information into practical advice for patients, and as health literacy is a strong indicator of health, dietitians should consider patients’ individual health literacy and provide advice accordingly.

2.3.3 Counselling for cognitive change

Cognitive and psychological factors have long been recognised as important in the contribution to diet-related behaviours as well as the management of diet-related conditions such as obesity (Stunkard, 1959; Young, Berresford, & Moore, 1957). Theories of counselling psychology that have been stated to have utility in informing the nutrition counselling role of dietitians include reality theory, rational-emotive
theory, patient-centred theory, social cognitive theory and cognitive psychology (Baldwin & Falciglia, 1995; Isselmann, Deubner, & Hartman, 1993).

Models of nutrition care and counselling published from the late 1990s have incorporated these principles of psychotherapy. Licavoli (1995, p. 751) described an approach whereby dietitians worked as “nutrition therapists” in partnership with patients, and took on any number of roles, including “teacher, coach, confessor, mother, or sounding board”. The importance of exploring psychological and emotional determinants of eating habits was emphasised. Dietitians were encouraged to consider the boundaries between dietetics and psychotherapy, as Licavoli argued that a “nutrition therapist helps a patient use what is learned through psychotherapy to understand or change behaviors or attitudes related to food, weight management, body image, self care, and eating” (p. 752). She identified a range of skills needed to implement this approach, which revolve around rapport building, verbal communication, encouraging dialogue through open-ended questions and developing awareness about practitioners’ and patients’ frames of reference.

Kiy (1998, p. 52) stated that the emerging skill of nutrition therapy could be considered as patient-centred and “combines philosophies and practices of dietetics, mental health counselling, and education”. She argued that the role of dietitians needed to change from being a teacher to becoming a facilitator of learning: unlike many other authors of dietetic practice models, Kiy drew on educational philosophy to inform her model. She stressed the importance of basing learning upon patients’ perspectives, interests and phenomenal experience of health. As such, facilitation of learning is interwoven within the counselling process. In her model, Kiy recognised the importance of the patient-therapist relationship in the effectiveness of therapy. She encouraged therapists to take a holistic view of patients, taking into account the effect of their family, work, community and culture on their eating habits as well as the history of their attempts to change their behavioural patterns. Patients were empowered to direct nutrition care, as education was based on patients’ interests, concerns, experiences and meanings rather than on practitioners’ interests. Empowerment, a holistic view, and developing a positive therapeutic relationship with patients were all important aspects of Kiy’s model. Kiy emphasised the importance of monitoring as a way of raising awareness and exploring behaviour in connection with patients’ personal contexts. Monitoring was thus seen as a
way of promoting the continual re-evaluation of treatment to enable patients and dietitians to ensure further treatment was appropriately focused.

Rosal et al. (2001) reported that in their patient-centred counselling model, the counselling process was based on a comprehensive examination of patients’ feelings, thoughts and behaviours with regard to making change, as well as inner strengths to help change. The authors argued that this process allowed dietitians to better appreciate patients’ experiences of health and illness, as well as promoting increased self-awareness and problem definition for patients themselves. They emphasised a number of other counselling strategies that dietitians could use to help patients to modify their cognitions and behaviours, including cognitive restructuring, problem-solving and relapse prevention.

MacLellan and Berenbaum (2003) argued that early approaches to practice in dietetics were more consistent with biomedical models of practice in that they emphasised compliance with dietitians’ advice and left the decision-making power with practitioners. In their review of patient-centred nutrition models, they agreed with Kiy (1998) and Rosal et al.’s (2001) advocacy of collaborative relationships and a more facilitative role for dietitians. They also argued, however, that Kiy fell short of providing practical advice regarding implementation of the models and Rosal et al. did not explicate who made decisions about care plans. MacLellan and Berenbaum (2006) found that there was little agreement on the meaning of patient-centredness and also subsequently asserted that there was uncertainty about whose role it was to determine the needs and wants of patients (2007). These authors found that a level of discomfort in practising in a patient-centred manner with patients, particularly in acknowledging and valuing patient expertise. Further barriers to working in a patient-centred way in dietetics were identified, namely lack of time and resources, expectations of doctors, unrealistic expectations and educational background of patients. In their research, MacLellan and Berenbaum (2003, 2006, 2007) emphasised the importance of the skills and knowledge of both dietitians and patients, as well as building relationships and learning about how to negotiate patient and dietitian expertise.

Chur-Hansen (2012, p. 236) argued that “the potential value of dieticians employing basic psychological strategies, behaviour modification techniques and learning communication skills to enhance their professional practice cannot be underestimated”.

21
She argued that, although dietitians should refer patients who need cognitive behavioural therapy (CBT) to specialists who can provide this therapy, a number of CBT techniques could be incorporated into the role of dietitians. These techniques were discussion of patients’ self-monitoring of eating habits; using open questioning to explore patients’ situations, beliefs and attitudes; using cognitive restructuring to challenge and modify distorted thinking; setting of goals; management of stress; discussing differences as to which treatment goals are perceived as important; and matching interventions to stage of change of patients. Motivational interviewing (see below) was claimed as a useful technique. Chur-Hansen argued that allocating time to undertake such discussions and appropriate training in these techniques were important for dietitians to be successful in expanding their role in this way.

2.3.4 Evidence-based dietetic practice

Technical knowledge underpinning dietetic practice grew exponentially in the first part of the 20th century, including that of vitamins and minerals, digestion and metabolic processes, the nutrient requirements of humans, caloric value of nutrients, the nutrient composition of foods, the enrichment and fortification of food and population-based dietary recommendations and standards (Hwalla & Koleilat, 2004; Todhunter, 1964). The value of technical knowledge to underpin dietetic practice was maintained and strengthened by the birth of the evidence-based practice movement around the 1980s. Evidence-based medicine (EBM), from which the more generic term evidence-based practice (EBP) arose, is defined as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996, p. 71). This philosophy has been taken on with vigour by a number of disciplines within health, and dietetics is no exception.

Porter and Matel (1998) suggested that prior to evidence-based dietetics, decisions in dietetic practice were based on the knowledge and experience of practitioners, as well as the scientific literature and advice from more knowledgeable or authoritative sources. These authors claimed that using evidence-based approach to decision making in dietetics added two elements to inform dietetic practice: first, a more thorough critique of the scientific evidence and second, individualised application of this evidence to each patient’s situation. Igo (2010) argued that due to the complex nature of dietetics and making dietary change, the scientific evidence used in evidence-based approaches to
nutrition care should incorporate knowledge derived from not only empirico-analytical research, but also from qualitative research and clinical practice. Furthermore, he acknowledged the importance of consideration of the complex ethical, political, economic and social factors that affect clinical practice, not least the individual needs of patients, when applying knowledge in decision making. He drew on Higgs and Titchen’s (1995) assertion that practitioners use their intuition, artistry and wisdom to apply this knowledge and that practitioners can use reflection as a way to explain and justify the decisions they make and how they have taken into account the complexity of practice.

Internationally, the International Confederation of Dietetic Associations has developed the following consensus statement: “evidence-based dietetics practice is about asking questions, systematically finding research evidence, and assessing the validity, applicability and importance of that evidence. This evidence-based information is then combined with the dietitian’s expertise and judgment and the client’s or community’s unique values and circumstances to guide decision-making in dietetics” (MacLellan & Thirsk, 2010, p. 2). This statement was developed with a number of intentions, including promoting good practice to dietitians around the world and strengthening the evidence base to argue for the efficacy of dietetic practice. It is important to note that this statement recognises that evidence-based dietetic practice is not simply about using research evidence to inform professional decision making, but also values other ways of knowing derived from experience, values and the unique situation at hand.

Apart from professional decision making, EBP has been considered useful for dietitians for continuing professional development, collaborating with other health care practitioners who practise within an EBP framework and at a broader professional level, to focus research and build an evidence base for dietetic intervention to improve practice (Gray & Gray, 2002; Kolasa, 2000; Smith, 2003). Splett and Myers (2001) have argued that there has been insufficient evidence for the effectiveness of nutritional care, and that this lack of evidence was in part due to the degree of variation in the way that dietitians practise. They contended that standardising processes of nutrition care as well as the language used to describe nutrition care in documentation would help strengthen the evidence base regarding the effectiveness of nutrition therapy and outcomes of nutrition care. Lacey and Cross (2002) further argued that development of a standardised model of practice was of high priority in developing this evidence base.
These arguments were the impetus for the development of the nutrition care process model (NCPM) with the intention of replacing other models of the nutrition care process (American Dietetic Association, 2011; Bueche et al., 2008). In the NCPM, the nutrition care process takes place across four steps of nutrition: “nutrition assessment, nutrition diagnosis, nutrition intervention, and monitoring and evaluation” (p. 1113). Making a nutrition diagnosis is a relatively new component of the nutrition care process, while the other steps are generally consistent with previous models. These steps are not necessarily linear and can be revisited at different times of the nutrition care process. The nutrition care process is described as evidence-based and recognises the situatedness of provision of nutrition care in terms of how the health care system, practice settings, social and economic context can influence the nutrition care process. “The essential and collaborative partnership with a patient/client” is argued to be the “central core” of the model (Bueche et al., 2008, p. 1113).

In Australia, the DAA has demonstrated its commitment to EBP by developing evidence-based clinical practice guidelines and endorsing the nutrition care process model for use as best practice in clinical dietetics in Australia. The DAA accreditation guidelines for university nutrition and dietetics degrees emphasise the importance of teaching the principles of EBP to early career and beginner dietitians (Dietitians Association of Australia, 2011a). Calls to adopt the use of standardised language in Australian settings have been consistently made at national conferences, and at the time of writing, workshops on implementation of standardised language in health care facilities and as part of the curriculum in the entry-level education of dietitians were taking place.

2.3.5 Integrative approaches to nutrition care

More recent views on the role of dietitians suggest that the role of dietitians has evolved to incorporate a complex blend of skills, theories and goals of nutrition care. Fine (2006, p. 199) argued that “integrating interpersonal, communication, and psychotherapeutic counseling skills to increase the efficacy of nutrition counseling, along with analysis of biomedical, psychological, social, and cultural factors affecting the client’s condition, can help improve compliance, clinical outcomes, and the client’s overall satisfaction with the nutrition counseling process”. Two approaches that have recently received
attention in the literature and broader dietetic discourse as potentially able to achieve these goals for nutrition care include motivational interviewing and health coaching.

Motivational interviewing was described by Miller and Rollnick (2002, p. 25) as a "client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence". Motivational interviewing has been considered helpful for providing a framework for dietitians to help people become more motivated to make dietary change by exploring how imperative change is to them and how convinced they are that this change can come about (Hoy et al., 2005; Thorpe, 2003). Chur-Hansen (2012) listed trust and relationship building, open questioning, use of affirmations and summarising as key skills for dietitians to use in motivational interviewing.

In comparison to motivational interviewing, there are fewer commentaries on health coaching in the dietetic literature. Lipscomb (2006) argued that health coaching is advice giving. This view is in direct contrast to the philosophies put forward by such organisations as Health Coaching Australia. Gale (2008) proposed a model of health coaching where the coach takes on a broader role than simply that of an educator. This model is informed by a complex array of behavioural and psychological theories, and motivational interviewing is heavily emphasised. Lipscomb and Gale are in agreement that communication skills and cognitive behavioural techniques are important for the successful application of a coaching approach. The use of health coaching is likely to be a future area of development for the role of dietitians.

The theoretical focus in current dietetic practice models appears to be on the behavioural and psychological aspects of facilitating change in eating habits. There remains an emphasis on propositional knowledge in professional decision making, despite acknowledgment that patients' perspectives and clinical judgment should play a role. In the broader professional context, dietetics is a relatively young profession seeking to establish an evidence base and arguing for its value, which could be a significant driver of the emphasis on technical knowledge and standardisation.

Although an understanding of the behavioural and psychological aspects of making dietary change is important to inform dietetic practice, foregrounding these aspects means that the social, cultural and pedagogical aspects of practice could be placed at the
periphery. My research explored the potential for a model of CDM that is conceptualised from a philosophical hermeneutics perspective, focusing on communicative, relational and discursive dimensions of decision-making in dietetics.

2.4 Australian context for this study

An important consideration relating to the context of my research is the nature of the factors that contribute to the professional socialisation of dietitians. Higgs, Hummell and Roe-Shaw (2009) argue that education to become a professional as well as during professional practice, reflective processes and relationships that are part of professional practice as being implicated in the process of professional socialisation of new practitioners. In my thesis, entry-level education and professional development are of particular interest rather than professional socialisation of new practitioners in the transition from student to graduate.

2.4.1 Entry-level education and professional development

The completion of a university nutrition and dietetics degree that has been accredited by the DAA is needed to practise as a dietitian in Australia and become a member of the DAA and APD program (Dietitians Association of Australia, n.d., d). The content and assessment utilised within DAA accredited degrees for dietitians are informed by the National Competency Standards for Entry Level Dietitians (NCSELD) (Dietitians Association of Australia, 2011a). The DAA has defined the NCSELD as “statements that describe the knowledge, skills and attitudes needed for successful performance as a dietitian in Australia” (DAA, 2011a, p. 7). Achievement of clinical competencies takes place predominantly in acute care settings where patients experience acute health conditions and have a short length of stay. Conducting placements in this way could mean that there are few opportunities to develop counselling and collaboration skills that are useful for patients with chronic health concerns, who are more likely to interact with dietitians in outpatient settings.

At least half of the first two years of study “must be composed of bioscience, chemistry, physiology and biochemistry, including a minimum 15% of a full year load each of biochemistry and physiology” (DAA, 2011a, p. 12). There are no such stipulations regarding minimum attention to the social, relational and cultural aspects of care, but these aspects are contained within the competency standards, with units and elements relating to communication skills and knowledge, determinants of dietary behaviour,
cultural awareness and working collaboratively with patients to determine goals and strategies for change. Cultural competency was also identified as an area for improvement in a recent review of the competencies (Ash, Dowding & Phillips, 2011).

There is some evidence that dietitians continue to seek out professional development after their university training to enhance their counselling and communication skills, as they feel their training has not adequately prepared them for listening to and dialoguing with patients and providing appropriate advice beyond biomedical facts. Cant and Aroni (2008b) reported that Australian dietitians observed that their dietetic training had too great an emphasis on the development of biomedical knowledge rather than communication and counselling skills. Although participants claimed there had been a shift in focus of their role from information provider to a counsellor who facilitated two-way discussion, some practitioners had sought training to further develop this aspect of their practice perhaps indicating that they felt the need to improve their skills to play this role. Whitehead, Langley-Evans, Tischler and Swift (2008) reported similar results, with dietitians valuing good communication skills for behaviour change but desiring further training to improve those skills. Anecdotally, there appears to have been an increase in training opportunities for dietitians in Australia on the topics of motivational interviewing and health coaching, similarly indicating that dietitians value the further development of skills and knowledge to enhance patient-centred approaches to nutrition care.

2.4.2 Rural and regional dietetic practice

As dietetics is not a registered profession it is difficult to estimate how many dietitians work in Australia. Further, membership of the DAA is not compulsory. Data regarding dietitians working in Australia was made available to me from the Australian Bureau of Statistics (ABS) 2011 Census. According to these data, 3707 people identified themselves as working as a dietitian across Australia. Further, this data revealed that dietitians are more likely to work in major capitals in Australia than regional, remote or very remote areas. In 2004, however, around 40% of new graduate dietitians in Australia were working in inner regional, outer regional, remote and very remote areas (Brown, Capra, & Williams, 2006). In 2011², 532 students graduated from 21 accredited university programs across 15 universities in Australia (F. Engeler, Registrar

---

² This may be an underestimation as not all universities provided information for this data collection.
Practitioners working in rural, regional and remote areas face unique challenges and opportunities. Allied health professionals who work in these areas are usually “generalists” in that they see a wide variety of patient types, can provide outreach services travelling long distances and work with patients from Indigenous and culturally and linguistically diverse communities (Centre for Allied Health Evidence Review Team, 2009). The Centre for Allied Health Evidence Review Team also found that allied health practitioners (including dietitians) were likely to be sole practitioners in rural and regional areas. Further, specialist advice and support is not always as readily accessible as it is in metropolitan areas (Standing Council on Health Commonwealth of Australia, 2012). Patients in rural, regional and remote areas have been shown to have greater health needs than their metropolitan counterparts. They have shorter life expectancies, higher rates of illness such as mental health problems and exhibit greater rates of risk-taking behaviours including being overweight and eating a poor diet (Australian Institute of Health and Welfare, 2008, 2012).

In mixed methods research on dietitians working in New South Wales, Brown, Williams and Capra (2010) found that dietitians working in rural areas valued the diverse opportunities and sense of autonomy in rural practice. In contrast, they reported problematic issues in rural areas of heavy workload and burning out, infrequent opportunities to progress their careers, feeling professionally isolated, time spent travelling, inadequate access to professional development and difficulty in recruiting and retaining staff. The authors further found that management support and overall job satisfaction varied among participants. If practitioners are not well supported to cope with these challenges they run the risk of burnout or leaving the profession. Enhancing awareness and reflecting on the interests that drive these dimensions of practice can be particularly relevant for early career practitioners who are grappling with these challenges.

2.5 Conclusion
Despite the evidence that there is a need for an approach to nutrition care that acknowledges the psychological, social and cultural aspects of eating habits, there appears to be a stronger emphasis on technical knowledge, EBP and empirico-analytical
research in entry-level education and the dietetic literature. Models of dietetic practice have been informed by home economics, food science and cognitive and behavioural theory. While the dietetic discourse reflects strong valuing of the experiential, emotional, social and cultural aspects of eating these are often not core considerations in dietetic models of practice.

Supporting patients to make dietary and lifestyle changes is not straightforward; dietitians need to flexibly utilise the range of roles across the health care continuum including prescription of therapeutic diets, provision of information about nutrition and diet, and counselling for behavioural and/or cognitive change. Making decisions about dietary change is complex and not always rational. Further, the context within which early career dietitians working in rural and regional areas develop professional identity and make decisions with patients is complex. The risks of burnout and leaving employment are significantly high if these dietitians are not better prepared and supported to work effectively with patients. An exploration of the decision-making experiences and perspectives of these dietitians as well as a better understanding of how they learn about collaboration in health care can help ensure that they are better supported to both flourish and remain practising in their chosen practice setting.
CHAPTER THREE

METHODS

In this chapter I present and substantiate my choice of methods to answer the research questions in relation to the phenomenon under study. I locate my research in philosophical hermeneutics as my chosen research approach and discuss the research design, strategies and criteria employed to ensure that the research is of high quality.

3.1 Research phenomenon, aims and questions

The phenomenon under study is the professional decision making, in particular the collaborative decision making (CDM) of early career dietitians. Although there is much research in the area of professional decision making, little research explores CDM with a particular focus on early career practitioners.

A large proportion of the research exploring the phenomenon of professional decision making in health care uses methods that seeks to observe or quantify this phenomenon. The literature on shared decision making focuses discussion on measuring the degree of use of shared approaches between practitioners and patients in practice (Braddock, Edwards, Hasenberg, Laidley, & Levinson, 1999), interventions to promote the use of a shared approach in practice via use of such tools as decision aids (Whelan et al., 2003), and health care outcomes of shared decision-making approaches (Franks et al., 2006). Common methods used in this body of research include observation and analysis of audiotaped interactions between patients and practitioners (Braddock et al., 1999; Franks et al., 2006) and questionnaires (Franks et al., 2006; Whelan et al., 2003).

Further, there is a body of literature exploring the preferences of patients for different professional decision-making styles as well as the extent to which patients feel involved in professional decision making (Hamann et al., 2007; Hancock et al., 2012; Murray, Pollack, White, & Lo, 2007; van den Brink-Muinen et al., 2011). A common question in this body of literature concerns the impact of the congruence between preference and actual approach used on biomedical health outcomes and patient satisfaction with care. This focus on measurable outcomes is aligned with quantitative strategies within an empirico-analytical research paradigm. The limitations of these methods is that they
ignore context and do not adequately recognise the diversity, uncertainty and complexity of the professional decision-making experience.

There is a body of research outside the empirico-analytical paradigm that explores the professional decision-making experiences and perceptions of practitioners and patients. This research is conducted predominantly in nursing and uses a range of methodologies including ethnography, grounded theory, philosophical hermeneutics and hermeneutic phenomenology. These studies explore the experiences of practitioners or patients or both. Examples include ethnographic research by Millard, Hallett, and Luker (2006), who explored the way patients were involved in nursing decision making, and philosophical hermeneutic research by Smith, Higgs, and Ellis (2010), who investigated the decision making of cardiorespiratory physiotherapists. Other examples include the work of Bottorff et al. (1998), who used grounded theory to explore decision making during palliative care, and Peek et al. (2008), who used grounded theory to explore how African-American people with diabetes defined shared decision making that took place between themselves and physicians. This body of research illuminates the complexity and provides deeper understanding of the phenomenon of professional decision making in health care.

An important aspect of the complexity of professional decision making is that it might be differently perceived and interpreted by each patient and practitioner. Even for the same patient, professional decision making can vary, for instance, according to how well the patient is at the time that decisions are made, and which practitioners and significant others are involved in making decisions. Patients might change their preference about whether they want to be involved in professional decision making according to each situation. Practitioners might change their preference for and approach to professional decision making for different circumstances, such as when there are language barriers between patients and practitioners. Further, professional decision making is shaped by the health care setting, which can bring with it various organisational and systemic pressures. For example, Watt (2000, p. 6) argued that the nature of decision making in the context of acute and chronic illnesses is likely to be significantly different depending on the “nature of the illness, the characteristics of the decisions themselves, the role of the patient, the decision making relationship, and the decision making environment”. The nature of decision making can differ for each
occasion of health care (Charles et al., 2000), and people can change their decision-making behaviours over time (Pierce & Hicks, 2001).

Patients might want to be involved in professional decision making at some times but not others (for example, due to their feelings of wellness, pain, and the significance to them of the decision and its consequences). Decisions might be made by patients, with or without practitioners, and with or without significant others, and during times of varying emotional and physical stress (Pierce & Hicks, 2001). Further, patients and practitioners make decisions within the complex and dynamic context of the broader health care team, health care systems, organisational pressures and broader societal and professional influences. Higgs and Jones (2008, p. 12) call this multidimensional context “the problem space” and these contextual pressures can enable or constrain involvement of patients in professional decision making. Professional decision making in health care practice is complex and situational. A deeper understanding of the complexity and situational nature of professional decision making can contribute to better preparing and supporting practitioners to work more effectively with patients. In my research I explored this space.

Making decisions about eating habits is complex, and involves habits, emotions and other psychosocial determinants. In dietetics, as emphasised in Chapter 2, it is acknowledged that patients do not necessarily make decisions or behave rationally or objectively, regardless of being given objective, factual or statistical information about food. There is also a unique temporal dimension to making decisions about eating habits. Decisions about eating are made by patients on an ongoing basis, at every meal and even mid-meal, and the social, emotional and environmental context of eating is different each time. With each new situation a new decision might need to be made. Further, making decisions about health-related behaviours such as diet is influenced not just by the patient’s understandings of the technical requirements of a diet, but by numerous other factors including but not limited to life stage, gender, personal preferences, economic situation, cultural background, environmental factors and social situation and support (McNaughton, 2012). This unique nature of decisions about diet adds a further layer of complexity in professional decision making in dietetics. An exploration of professional decision making in dietetics can help to identify and better understand the particular as well as common challenges faced by dietetic practitioners compared to other health professions.
Adding further complexity to the professional decision-making process is that practitioners who are at an earlier stage in their career are still forming their professional and sometimes personal identities (Grace & Trede, 2011; Trede, Macklin, & Bridges, 2012). Practitioners bring their culture, lives and personal background and professional attitudes, assumptions and values influenced by their professional socialisation to the decision-making process (Higgs, McAllister, & Whiteford, 2009; Trede & Higgs, 2008a). When personal and professional identities are developing or in flux, practitioners might find it difficult to determine which professional decision-making approach is appropriate for each clinical situation. Research that includes early career practitioners can enhance understanding of the challenges faced by these practitioners in carrying out professional decision making while developing their professional identity.

The nature of nutrition care needed by patients in rural and regional environments is highly variable and complex. Dietitians working in rural and regional environments are likely to face particular challenges in their professional decision making that differ from those of their metropolitan counterparts. A common challenge faced by these practitioners is that they are likely to be the only dietitian practising in their locality (The Centre for Allied Health Evidence Review Team, 2009). It is likely that their practice, like that of rural general practitioners in medicine, is more generalist and wider in scope than that of their city counterparts (The Centre for Allied Health Evidence Review Team, 2009). Patients might present with a wide variety of dietary concerns and requirements for dietary advice. As dietitians in rural and regional areas are often sole practitioners, they are responsible for providing nutrition care to all patients across a wide variety of concerns (Brown et al., 2010). Patients might need dietary advice for temporary dietary changes to help manage an acute illness or regarding long-term dietary change for a range of chronic illnesses such as eating disorders, diabetes, cardiovascular disease or food allergies. A team of dietitians with different specialties and depth of experience would manage this range of patients in city hospitals. Given their lack of experience, early career practitioners could feel apprehensive about their readiness to explore these concerns flexibly and to meet these requirements for dietary advice.

Note: the context of this study is Australia. Some factors mentioned here, such as distance, might not apply in other countries.
Rural and regional practitioners might need to travel long distances to provide services to patients in widespread communities and they might have difficulty accessing formal professional development due to travel restrictions (Struber, 2004). These circumstances can contribute to a sense of professional isolation (Brown et al., 2010) and can pose significant constraints for these practitioners to further develop professional decision making. An understanding of the observations and experiences of early career practitioners regarding professional decision making in this context would be useful to inform strategies to better support practitioners working in rural and regional environments. My research explores this unique aspect of professional decision making of early career dietitians working in Australian rural and regional environments, with a particular interest in CDM.

The aims of my research were to generate deeper understanding of:

- the nature of and approaches to professional decision making in dietetics
- the challenges faced by early career dietitians in shaping CDM
- the value early career dietitians place on collaborating in professional decision making

to generate a model of CDM practice for dietetics.

To achieve these aims, I posed the following over-arching question to guide the research:

- What core capabilities are needed for early career dietitians to enact CDM in their dietetic practice?

My research sub-questions were:

- What are key theoretical underpinnings of professional decision making approaches in health care in general and dietetics in particular?
- What is the value and significance of CDM in health care in general and dietetics in particular?
- What are the observations and experiences of early career dietitians regarding professional decision making and CDM in particular?
- What tensions and complexities do early career dietitians face in CDM?
• What can be learned from patients’ perceptions and observations that contribute to shaping CDM?
• What factors support and hinder the development and adoption of CDM approaches by early career dietitians?

3.2 Research paradigm and philosophical stance
To achieve congruence and coherence it is important that the chosen research paradigm and approach aligns with the phenomenon and the research questions (Trede & Higgs, 2009). Research regarding the phenomenon of professional decision making in health care practice that is conducted within the empirico-analytical paradigm is guided by a positivist perspective that accepts reality as objective, measurable and predictable (Higgs, Trede, & Rothwell, 2007). The phenomenon of CDM is complex, situated and dynamic, and is not a coherent and congruent fit with the empirico-analytical paradigm.

The use of an interpretive philosophical stance to inform my research was congruent with my interest in exploring the complexity and situatedness of professional decision making. The interpretive paradigm is based on the assumption that knowing occurs in a particular time and space and that knowledge is built on prior knowledge and from within particular cultural lenses (Gadamer, 1960/1992; Schatzki, 2010). Interpretive research seeks to uncover the meaning of phenomena in the social world, rather than measure them (Higgs et al., 2007). Fossey, Harvey, McDermott, and Davidson (2002, p. 720) argued that the focus of research conducted within the interpretive paradigm is the “understanding and accounting for the meaning of human experiences and actions”. Interpretive research takes the epistemological position that individuals construct meaning through perceptions and interpretations of experiences (Trede & Higgs, 2009).

The ontological position of the interpretive paradigm conceives the world as encompassing multiple constructed realities and multiple meanings of these realities (Higgs et al., 2007). As each individual’s experience of a reality, event or situation is unique and embedded in his or her sociocultural context, there can be many interpretations of experiences. I wanted to explore the observations and experiences of dietitians (and patients) involved in professional decision making as individuals rather than as a collective group. The aim of the research did not extend to changing the participants’ approaches to professional decision making, and thus a critical paradigm was excluded as a framework for the research. With respect to health care practice,
taking an interpretive stance to research meant that I was able to achieve my aims of deepening understanding and ensure that the diverse and unique perspectives of dietitians (and patients) of professional decision making were captured.

3.3 Research approach
A research approach is located in a research paradigm that guides the research strategies utilised to explore a phenomenon. Examples of common research approaches used in interpretive research include phenomenology, narrative inquiry and hermeneutics (Higgs et al., 2007). Hermeneutics means to interpret, to understand or to reveal (Trede & Loftus, 2010). In my research I wanted to explore the perceptions and interpretations of experiences and in this sense the hermeneutic tradition was a good fit.

Various research approaches located within the hermeneutics tradition are available to inform research. I recognise that a number of these approaches could have been appropriate to explore the phenomenon of CDM. For example, phenomenological hermeneutic research approaches would be appropriate if the emphasis was on providing rich descriptions of how people experience phenomena of everyday life (Schwandt, 2001). Critical hermeneutics would be an appropriate research approach when the aim of research is to collectively challenge and/or change current situations (Higgs & Trede, 2010). However, neither of these approaches provided a good fit with my research aims. I wanted to gain a deeper understanding of the observations and experiences of professional decision making through dialogue with my participants, rather than reveal rich descriptions of experiences. Further, while participants might experience transformation of their perspectives about practice or their practice itself as a result of participating in my research, the promotion of transformation was not a primary aim. My research aims excluded phenomenological and critical approaches as potential research approaches to inform my research.

I chose philosophical hermeneutics as my research approach because I wanted to explore the perceptions and interpretations that underpin CDM. In philosophical hermeneutics, the emphasis is on interpreting the ways individuals perceive their practices (Loftus & Trede, 2009). My participants were encouraged to deeply interpret their practices to further examine their ideas and interests about what they thought drove their professional decision-making approaches. I thought this approach was particularly fitting for my dietetic participants because they were in early career stages and might
not yet have considered what drove their practice at a deeper level. By undertaking a study of how the participants interpreted their professional decision-making experiences, I was able to develop deeper understanding of the participants’ ideas, values and beliefs about professional decision making in practice.

3.3.1 Philosophical hermeneutics

The theorising of Hans-Georg Gadamer (1960/1992) about philosophical hermeneutics provided a key foundation informing the methodologies of the research used in this thesis. Important Gadamerian concepts that informed my research were pre-understandings, provocation of pre-understandings, question and answer dialogues, fusions of horizons, and the construction and interpretation of texts.

Pre-understandings

Within the philosophical hermeneutic tradition, it is recognised that people come to situations with pre-existing meanings and prejudices; this was termed pre-understandings by Gadamer (1960/1992). He argued that “the foregrounding and appropriation of one’s own fore-meanings and prejudices” (1975/2004, p. 271) are important precursors to coming to a deeper understanding. Prejudice, in Gadamer’s (p. 273) view, is “a judgment that is rendered before all the elements that determine a situation have been finally examined”. He (pp. 271-272) did not see prejudices as always negative; he asserted that being aware of them is important because they flavour the way experiences are perceived and understood: “the important thing is to be aware of one’s own bias, so that the text can present itself in all its otherness and thus assert its own truth against one’s own fore-meanings”. It could be that in the process of meaning making of experiences, people are not aware of their pre-understandings and might submit to other people’s understandings without fully questioning or engaging with their own.

In my research, I wanted to develop a deep understanding of the observations and experiences of my participants regarding professional decision making. The participants were early career practitioners, who might not have undertaken reflection on the pre-understandings that they brought to practice before participating in my research. They might have been unaware of their pre-understandings during the dialogue that I undertook with them during the research. An important part of my research was
engaging with my participants in dialogue to become aware of these pre-understandings.

I brought my pre-understandings to the research. I came to my research with the goal of expanding practitioner-patient approaches to communication and encouraging dietitians to challenge the way they interacted and communicated with patients. I came with a strong belief in the inherent value of collaborative approaches and patient-centred care, and that these approaches should underpin all aspects of care. These pre-understandings came from my education and experiences in practice where I saw many practitioners, including me, deliver instruction and expect compliance, and be frustrated by it. My driving interest in undertaking my research with dietitians at this early stage in their careers was to explore collaborative approaches as an alternative to mainstream dietetic practice. In my research, reaching common ground and deepening understanding involved the exploration of participants’ and my pre-understandings.

Gadamer acknowledged the importance of tradition and the historical position of the interpreter in influencing pre-understandings and in the process of deepening understanding. He interpreted understanding to be “essentially, a historically effected event” (1975/2004, p. 299). In understanding a text, then, it was important to Gadamer that one appreciated the historical context and perspective from which the text was written. He called this perspective a horizon, which he defined as “the range of vision that includes everything that can be seen from a particular vantage point” (p. 301).

One of many scholars who built on the work of Gadamer and who stimulated further perspectives to frame research in philosophical hermeneutics is Nicholas Davey. Davey (2006, p. 15) described philosophical hermeneutics as taking place in the “in-between” space, between the once self that is familiar and unquestioned, and the future self, that is strange and open to different potential understandings. Davey (p. 15) argued that philosophical hermeneutics “attempts to articulate what occurs within the process of understanding”. Philosophical hermeneutics is an experience where knowing is acquired and the person becomes different from his or her past self. Part of the process of deepening understanding is a reflection upon and acknowledgment of one’s position in time and how this position could have influenced pre-understandings.
Part of the understanding I sought in my research was with respect to what drove my participants’ approaches to professional decision making. I was curious about how their past experiences as well as the current contexts of their practice influenced these observations and experiences. To facilitate this understanding, I encouraged participants to reflect on the impact of their historical and current context on their decision-making approaches. I reflected on my past and present experiences as my understanding evolved.

Dietetics can be thought of as a communicative practice that takes place between patients and dietitians (and others). The way dietitians and patients communicate with each other is shaped by the social and cultural groups to which each dietitian and patient belong. An example relevant to this thesis is the language used by dietitians that is unique to them as a group, which has come about through socialisation into and becoming part of the dietetic profession. Gadamer (1975/2004, p. 390) considered that language was the key element through which understanding becomes possible: “language is the universal medium in which understanding occurs”. Taking Gadamer’s view, a grasp of this language, the way it is used and how it has historically come to be used, is essential in making meaning of people’s experiences and actions. Because language is socially and historically derived by immersion in a particular tradition, Gadamer considered that the language used by the interpreter to derive meaning from the text would be different from the language used in the text.

Thompson (1990, p. 241) argued that the pre-understandings people bring to situations are “linguistically conveyed; they are produced, reproduced, and transformed in the course of cultural evolution”. Davey argued for the importance of the historical shaping of language and communication. He stated, “the words and concepts deployed in communicative practices are invariably shaped by complexities of historically formed meaning and insight” (2006, p. 4). Davey (p. 4) further argued, “in many practices acquaintance with such networks of meaning is more tacit than reflective”. The recognition that meaning making has a tacit and linguistic dimension adds weight to the importance of being able to make transparent these pre-understandings and use of language in the process of coming to a deeper understanding of the professional decision-making phenomenon.
Because the dietitian participants and I belong to the same profession, and because I have past experience working as a dietitian with patients, it was important for me to remain careful during interviews to question any uncritical assumptions of the meaning of shared language. Maintaining a curious stance during all dialogues was imperative to ensure that I did not take for granted that I understood the meaning that participants gave to the language they used. I actively clarified the meanings that were given to language used by participants.

**Provocation of pre-understandings**

Coming to a deeper understanding of a phenomenon needs provocation of one’s pre-understandings. According to Davey, a provocation of pre-understanding plays a key role in deepening and evolving pre-understandings. Provocation involves a realisation of difference between one’s pre-understanding and the pre-understanding of the other. In practice, this “other” could be a patient, a colleague, a journal article or book, or even conflicting points of view that practitioners uncover within their pre-understandings. Davey (2006, p. 8) stated that philosophical hermeneutics allows “coming knowingly to see, to think, and to feel differently”. This is not to say that the viewpoints of either dialogue partner become immersed in the other.

Gadamer (1975/2004, p. 304) argued that deeper understanding of a phenomenon needs us to rise “to a higher universality that overcomes not only our own particularity but also that of the other”. Davey (2006, pp. 7-8) argued that “it is not sameness – neither rendering the other the same as ourselves nor becoming the same as the other – but difference that is vital for philosophical hermeneutics”. The realisation of difference and understanding other viewpoints, without submitting or dominating, is important for deeper understanding of a phenomenon to be achieved. Gadamer (p. 271) reminded us to “remain open to the meaning of the other person or text” in coming to a new or deeper understanding of a phenomenon, and that “this openness always includes our situating the other meaning in relation to the whole of our own meanings or ourselves in relation to it”.

Because there is such an emphasis on the researcher’s interpretations in philosophical hermeneutics, it is important for researchers to reflect upon, become aware of and even challenge their pre-understandings and emerging understandings when interpreting texts. Gadamer (1975/2004, p. 272) argued for an open stance that enables the
researcher to be aware of the “hidden prejudices that makes us deaf to what speaks to us in tradition”.

Davey (2006, p. 7) stated that the aim of interpretation is to “discern in what we do (interpretation) the real character of our being”. Through confronting our pre-understandings that are brought to understanding, inadequacies of understanding can be revealed and different understandings can be contemplated. In my research, because I am a senior practitioner who participants might have perceived had greater experience or deeper understandings about practice, there was potential for participants to feel inclined to agree with any opinions I expressed during dialogues. It was imperative to ensure that I created a communication environment where participants were free to express their opinions and ideas without judgment.

It was important that I focused more on listening to my participants’ ideas than expressing mine, and that I continually reflected on my understandings and remained open to new ideas and the potential for my pre-understandings to be provoked to evolve my understanding. During my research, I experienced a number of situations where my understandings were provoked by coming into contact and dialoguing with the horizons of others, including participants, colleagues and the literature. During the research process I was able to challenge my pre-understanding that collaborative approaches were inherently better in all circumstances. I came to appreciate that practice is neither black nor just white but there are shades of grey, and that flexibility in understanding when being collaborative is appropriate and important.

The hermeneutic circle
A key mechanism for challenging pre-understandings and coming to a deeper understanding of a phenomenon in hermeneutic research is the hermeneutic circle (Thompson, 1990). Paterson and Higgs (2005, p. 345) explained that in the hermeneutic circle the “parts are integrated in the whole and define it. At the same time researchers recognize how the whole contextualizes each of the parts, seeking to illuminate the phenomenon within its context”. The use of the hermeneutic circle to deepen understanding necessitates a movement from a consideration of the parts of a phenomenon to a consideration of those parts as a whole, and back again. In using the hermeneutic circle in research when multiple perspectives are of concern, the meaning derived from immersion and interpretation of texts comes from the participants and the
researcher as each person considers the phenomenon from his or her unique horizon. These parts come together to inform a multifaceted whole to deepen understanding. Gadamer drew on the concept of the hermeneutic circle and argued that we must “understand the whole in terms of the detail and the detail in terms of the whole” (1975/2004, p. 291). He saw the hermeneutic circle as “neither subjective nor objective, but [it] describes understanding as the interplay of the movement of tradition and the movement of the interpreter” (p. 293). Gadamer’s view was that the horizon of the interpreter and the horizon of tradition itself are inextricably intertwined in the process of understanding.

The parts of my research were many; they included the observations and experiences of each dietitian at three different interviews, the perceptions of each patient, and my interpretations of dialogues that took place over the course of the research. My emerging understanding involved the intertwining and interweaving of these observations and experiences, and a movement from each of these parts back to the whole (my evolving understanding). Question-and-answer dialogues were an important component of facilitating this evolution of understanding.

**Question and answer dialogues**

In philosophical hermeneutics, dialogue is seen as an important mechanism to achieve deeper understanding of a phenomenon (Loftus & Trede, 2009). As Schwandt (2003, p. 302) argued, “understanding is something that is produced in that dialogue, not something reproduced by an interpreter through an analysis of that which he or she seeks to understand”. Dialogue helps to draw out understanding through engaging with and attempting to better understand the various perspectives of participants in research.

Dialogue in philosophical hermeneutics is considered as a question-and-answer process (Trede & Loftus, 2010). Dialogue is used to construct text sets and to then interpret these text sets. Questions and answers create an ongoing and developing dialogue. It is not one question and one answer. Answers lead to the next question. Thompson (1990) argued that the reason Gadamer saw dialogue to be important was because of his epistemological stance that reality can only be understood through shared understanding.
Meaning was seen by Gadamer (1975/2004, p. 368) as the answer to a question: “to understand meaning is to understand it as the answer to a question”. He saw the posing of questions to be important in uncovering alternative viewpoints and understandings: “questions always bring out the undetermined possibilities of a thing” (p. 368). Gadamer considered that pre-understandings had to be provoked in order for us to become aware of them, and that dialogue with texts could prompt confrontation of pre-understanding. He encouraged those who were seeking understanding to “question what lies behind what is said” (p. 363).

Dialogue in philosophical hermeneutics is not limited to questioning of the text but includes the questioning of self by the text (Loftus & Trede, 2009). Questions that emerge from the text are just as important as questions that are directed to the text (Thompson, 1990). Posing questions can lead to posing further questions.

Davey (2006) emphasised the importance of dialoguing, to gradually and over time allow insights to unfold and reveal themselves. Without engaging with the other person in dialogue, this aim of evolution of understanding cannot occur. He stated that “whatever I understand, I come to understand through the mediation of another” (p. 9). Davey argued that both dialogue partners must take an ethical stance to this co-construction of knowing and appreciate each other’s contribution. Further, dialogue partners must enter the dialogue with awareness that each partner might have different perspectives about the phenomenon at hand, and openness to other views. Dialogue for deeper understanding presupposes that there is a shared language that can enable shared new understanding to occur: “all understanding is dependent upon a prior acquisition of linguistic practices” (p. 9). In health care, differences in the language used by patients and practitioners can be problematic. There might be distinct social, cultural and professional differences between the language used by patients and practitioners. For example, patients from rural or regional environments who have grown up in predominantly Anglo-Saxon communities might experience difficulty communicating with practitioners from non-English speaking backgrounds; or practitioners might use discipline-specific jargon, which may or may not be accessible to other practitioners and patients.

Because my research was driven by a particular interest in a collaborative approach to decision making, it was important to choose a research approach that incorporated the
concepts of dialogue and creating an open space for reaching deeper understanding. Dialogue was a central component of the phenomenon under study as well as the construction and interpretation of texts to allow deeper understanding of my research phenomenon. Bringing together various perspectives in dialogue was essential to deepen understanding.

**Fusion of horizons**

In my research conducted in the interpretive paradigm, it was important to explore different perspectives on the phenomenon, including my perspectives as researcher, those from the literature, and those of the participants. Gadamer (1975/2004, p. 385) argued that “to understand what a person says is, as we saw, to come to an understanding about the subject matter, not to get inside another person and relive his experiences”. If the aim of hermeneutic research is to come to a deeper understanding of a phenomenon and find common ground (Loftus & Trede, 2009) then it is important to bring these perspectives together to form new understandings, a process that Gadamer termed fusion of horizons. It is important to recognise here that a fusion of horizons is not necessarily the only outcome of engaging in question-and-answer dialogue. It could be that people emerge from a question-and-answer dialogue unchanged and confirmed in their thinking, or with an appreciation of another horizon but without agreement and without adopting a new horizon. Gadamer’s hermeneutics focuses on the coming to a common and deeper understanding of a phenomenon, with acknowledgment and contribution from both dialogue partners.

In my research, my participants were in the process of developing their professional identity. Possibly, external influences such as the perspectives of the health care team or other senior dietetic practitioners had a strong influence on the outcome of dialogues. During my interpretation of participants’ reflection on their practice it was important to consider the stage of development as well as the possible external influences on participants’ practice.

Gadamer asserted that the hermeneutic circle and the process of fusion of horizons does not end; it only leads to continually deeper or more mature understanding and further questions. Gadamer (1975/2004, p. 298) believed that one’s pre-understandings are constantly changing with each new experience, and understanding continues to deepen and change: “the discovery of the true meaning of a text or work of art is never finished;
it is in fact an infinite process”. According to Gadamer, a person comes to understand something by considering it from his or her pre-existing perspective or vantage point at a particular point in time. At different times, different pre-understandings could be brought to the process of dialogue and seeking deeper meaning.

There is a practical interest in Gadamer’s philosophical hermeneutics: while there is a focus on seeking shared understanding and fusing horizons, once this shared understanding is reached, the dialogue finishes until there are further questions or a provocation to deepen the question and answer dialogue further. Davey (2006) contended that question-and-answer dialogues are an ongoing and continual process of coming to understand a phenomenon more deeply. He recognised philosophical hermeneutics to be concerned with “understanding as a transformative experiential process” (p. 5). Davey argued that how knowing comes about is just as important as the knowing that is derived. There can never be a final correct interpretation or understanding, but different ones at different times. For the purposes of my research, which does need to have an end point in order for findings to be shared, it was important to make clear where the circle was entered and left, to demonstrate that knowing can continue to unfold. In my research, I left my evolution of understanding after engaging with multiple horizons for the practical purpose of submitting my thesis, but my understanding will continue beyond my thesis journey.

**Construction and interpretation of texts**
The facilitation of a fusion of horizons comes about through the construction and interpretation of texts. Hermeneutics was described by Kvale (1996, p. 47) as the study of “human cultural activity as texts with a view to interpreting them to find out the intended or expressed meaning, in order to establish a co-understanding”. Texts in hermeneutics can be anything from written or verbal communications, such as interview transcripts or dialogues, to visual arts or music, as well as the interpretation of practices, events and situations (Crotty, 1998). To pursue the construction and interpretation of texts a researcher typically generates a text set through question-and-answer dialogue. The text set and individual text construction are facilitated by posing questions to the literature and participant interviews. In my research, because I wanted to explore different observations and experiences, a question-and-answer dialogue was conducted with dietitian and patient participants and with the literature. Text interpretation came about by posing interpretive questions to the constructed text and seeking a fusion of
horizons. In the construction of texts, dialogue takes place with “the other” and in the interpretation of texts dialogue takes place with “the self”. The dialogue that takes place in text set interpretation is a dialogue with self, stimulated by a provocation of one’s pre-understandings. The hermeneutic circle is important in the construction and interpretation of texts, as the interpreter moves from the parts to the whole and back again, leading to evolving and deepening understanding.

3.4 Research design
In this section, I demonstrate how the principles of pre-understandings, provocation of pre-understandings, question-and-answer dialogues, fusion of horizons and the construction and interpretation of texts were applied in creating my research design. The overall research design is represented pictorially in Figure 3.1.

This figure demonstrates that I entered the research process with certain pre-understandings. Based on my research aims and questions I constructed and interpreted three text sets. These text sets arose from the literature and from interviews with dietitian and patient participants. Question-and-answer dialogues facilitated this construction and interpretation. The spiral within the blue tube in Figure 3.1 represents the question-and-answer dialogue that took place and depicts the hermeneutic circle of moving from the parts to the whole as pervasive to the whole process. During this process, I first aimed to achieve a fusion of horizons between the ideas of the participants, the literature and myself. I had entered the research with certain pre-understandings and by engaging in a question-and-answer dialogue with participants and the literature, these pre-understandings were provoked and my understanding began to evolve. The questions that guided construction and interpretation of texts are shown in Figure 3.2. After this fusion of horizons with participants and the literature, the aim was to continue to provoke and evolve my understanding through dialogue and build on these new understandings I had gained. The red explosions represent the fusion of horizons and subsequent new evolving understanding derived from the dialogue with each text set. I exited the research process having undergone an evolution of understanding. The new understanding arising from this process of fusion of horizons remains my own, and is the product of bringing the perspectives of participants and literature together as a whole.
Figure 3.1 Overview of research design and reporting
Figure 3.2 Questions that guided construction and interpretation of texts
3.4.1 Text construction

The two key stages in my research design were text construction and text interpretation. In my research, three text sets were constructed: a literature text set, a dietitian text set, and a patient and dietitian reflection text set. These constructions were followed by my meta-interpretation of all text sets, which includes a model of CDM.

a) Literature Text Set Collation

Texts that explored professional decision-making approaches or models in the health care literature were collated from a range of sources, predominantly from peer-reviewed journals in the disciplines of medicine, nursing and allied health. Articles were located using health care databases, particularly Ebscohost Health and Medline (see Appendix 1). The primary reason for the construction and interpretation of this text set was to provide a theoretical framework of pre-understandings regarding professional and CDM from the broader body of health care literature. This framework then grounded the commencement of my question-and-answer dialogue with dietitian and patient participants in pursuit of a deeper understanding of their perceptions and experiences about professional decision making in dietetic practice.

b) Dietitian and Patient Text Set Construction

This text set comprised individual interview texts produced from a series of three in-depth interviews with dietitian participants and one-off interviews with patient participants.

The participants

To participate in the research, dietitian participants needed to have completed a tertiary degree qualifying them as a dietitian, have had at least 12 months’ experience in clinical dietetics with a maximum of 5 years’ experience and be working within a clinical context in a rural or regional setting within New South Wales (NSW). Patient participants needed to be over 18 years of age, have received at least two occasions of clinical dietetic care, be cognitively and physically capable of completing an interview and living in a rural/regional setting within NSW. Children, adolescents, and people with an intellectual or cognitive disability were excluded from the research, as it was considered that people within these groups might have difficulty in articulating their experiences.
A total of 10 dietitians and 6 patients who met the selection criteria were included in the research. Two dietitian participants had less than 12 months experience initially. During the course of the research these participants gained 12 months experience and were then included in my research. Only one dietitian participant withdrew from the research; she did so after the first interview as a consequence of leaving her place of employment. Her data was excluded as it was considered there was not the same opportunity to deepen understanding of her experiences and perspectives as with the other dietitian participants. A final total of 9 dietitians and 6 patients were included in the research.

The following provides demographic, educational and occupational information about the nine dietitian participants (see Table 3.1).

- All were female and were from English-speaking backgrounds.
- All were Accredited Practising Dietitians (APDs). Becoming an APD is optional in Australia. In October 2012, there were 5038 members of the Dietitians Association of Australia (DAA), 66% of whom were APDs (C. Cannon, Membership Officer, Dietitians Association of Australia, personal communication, October 9, 2012).
- Seven dietitian participants had a rural or regional upbringing. Of these seven, one studied at a metropolitan university and the remainder studied at a regional university. Two dietitian participants had a metropolitan upbringing. One of these participants studied at a metropolitan university and the other studied at a regional university. All had completed a DAA-accredited tertiary program to qualify as a dietitian.
- All had spent most of their career to date in rural or regional work environments.
- Eight participants had had fewer than 3 years’ professional experience and one had 3.5 years’ experience.
- Six of the dietitian participants were sole dietetic practitioners. Working as a sole practitioner means that dietitians need to see every patient who presents to the dietetic department.
- Three of the dietitian participants who were sole practitioners reported that they saw patients of any age and with a wide range of nutrition-related concerns. The remaining six participants, three of whom were sole practitioners, reported that they

---

4 Dietetics is a profession predominantly practised by females. The chance of a male volunteering was very small.
5 Tertiary Nutrition and Dietetic programs in Australia are accredited by the DAA as described in Chapter 2.
mainly saw patients who were middle-aged or older, with predominantly lifestyle-related chronic illness such as diabetes, obesity or cardiovascular disease.

- Dietitian participants reported various cultural backgrounds of patients, with all participants reporting that Anglo-Celtic Australians made up the majority of their patient group. Five reported that Aboriginal and Torres Strait Islanders were another key population sub-group among their patients.
- Each dietitian participant reported working with various other health practitioners: medical and nursing staff, speech pathologists, occupational therapists, physiotherapists, diabetes educators, psychologists and food service staff.
- Each dietitian participant undertook administration and health promotion roles in addition to her clinical duties. Dietitians working as the only dietitian in the clinical team are often expected to fulfil both clinical and extra-clinical roles.
- Three of the dietitian participants worked in one setting only (either community health, hospital or private practice) and the remainder worked across two or more of these settings.
- Seven of the dietitian participants travelled to provide services to other locations, with the time spent travelling varying from 40 minutes to 4 hours per week.

The recruitment strategy neither favoured or discouraged either male or female participants. Only females volunteered. Given the largely female profile of the profession this is not surprising. Whether male participants would have reported different positions or experiences is not a major issue (given this demographic profile) but is a question that could be posed in future research.
Table 3.1: Profile of Dietitian Participants

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
</tr>
<tr>
<td><strong>Location of upbringing</strong></td>
<td></td>
</tr>
<tr>
<td>Rural or regional</td>
<td>7</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>2</td>
</tr>
<tr>
<td><strong>Qualification</strong></td>
<td></td>
</tr>
<tr>
<td>DAA accredited – tertiary</td>
<td>9</td>
</tr>
<tr>
<td>Non-DAA accredited – tertiary</td>
<td>0</td>
</tr>
<tr>
<td><strong>Location of university</strong></td>
<td></td>
</tr>
<tr>
<td>Rural or regional</td>
<td>7</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>2</td>
</tr>
<tr>
<td><strong>APD status</strong></td>
<td></td>
</tr>
<tr>
<td>APD or provisional APD</td>
<td>9</td>
</tr>
<tr>
<td>Non-APD</td>
<td>0</td>
</tr>
<tr>
<td><strong>Years of experience as a dietitian</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;1</td>
<td>2</td>
</tr>
<tr>
<td>1-2</td>
<td>1</td>
</tr>
<tr>
<td>2-3</td>
<td>5</td>
</tr>
<tr>
<td>3-4</td>
<td>1</td>
</tr>
<tr>
<td><strong>Employment history</strong></td>
<td></td>
</tr>
<tr>
<td>First position</td>
<td>3</td>
</tr>
<tr>
<td>Second or later position</td>
<td>6</td>
</tr>
<tr>
<td><strong>Location of previous work experience</strong></td>
<td></td>
</tr>
<tr>
<td>Rural/regional</td>
<td>5</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total number of paid hours</strong></td>
<td></td>
</tr>
<tr>
<td>Full time (1FTE)</td>
<td>8</td>
</tr>
<tr>
<td>Part time (0.5FTE)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Type of service delivery</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>6</td>
</tr>
<tr>
<td>Community health centre</td>
<td>6</td>
</tr>
<tr>
<td>General practice surgery</td>
<td>1</td>
</tr>
<tr>
<td>Private practice</td>
<td>3</td>
</tr>
<tr>
<td><strong>Number of dietitians in current local health care team</strong></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>6</td>
</tr>
<tr>
<td>More than one</td>
<td>3</td>
</tr>
<tr>
<td><strong>Casemix</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatients only</td>
<td>2</td>
</tr>
<tr>
<td>Inpatients and outpatients</td>
<td>7</td>
</tr>
<tr>
<td><strong>Nature of local health care team</strong></td>
<td></td>
</tr>
<tr>
<td>Multidisciplinary, including medical</td>
<td>9</td>
</tr>
<tr>
<td><strong>Geographical location of service delivery</strong></td>
<td></td>
</tr>
<tr>
<td>Single site</td>
<td>2</td>
</tr>
<tr>
<td>Multiple sites (requiring travel)</td>
<td>7</td>
</tr>
<tr>
<td><strong>Hours spent travelling per week</strong></td>
<td></td>
</tr>
<tr>
<td>Less than 1</td>
<td>2</td>
</tr>
<tr>
<td>1-3</td>
<td>2</td>
</tr>
<tr>
<td>3-6</td>
<td>2</td>
</tr>
<tr>
<td>&gt;6</td>
<td>1</td>
</tr>
<tr>
<td><strong>Role expectations</strong></td>
<td></td>
</tr>
<tr>
<td>Clinical role only</td>
<td>0</td>
</tr>
<tr>
<td>Multiple roles (including health promotion, administration and managing other staff)</td>
<td>9</td>
</tr>
</tbody>
</table>

NB: As the number of dietetics practitioners working in the geographical areas where the research was conducted is small, some demographic information has been omitted to protect participants’ privacy.
From the above profile it is evident that these dietitian participants were people who were working in a rural area because they wanted to, with many coming from a rural background and having studied at a regional university where it is likely they had practical experiences in rural or regional health care settings. Yet they faced challenges in relation to factors such as working alone without mentors, being responsible for diverse caseloads and across diverse health care settings, taking on additional administrative and health promotion responsibilities and having to travel considerable distances in their working week.

All patient participants were female, middle-aged and lived in rural or regional environments. Each participant had children and four had grandchildren. Five were married and lived with their husbands only, as their adult children had left home. One participant lived with a parent and her children. Five of the participants regularly cooked meals for their families, with one participant having meals cooked for her by another family member. Four worked full-time and two had part-time paid work duties.

Access to patient participants was limited by the reliance on dietitian participants to invite their participation. The relatively small number of patient participants in this research is noted, however the focus of this research was on dietitians’ observations and experiences. Exploration of patients’ observations and experiences is an area for potential future research.

**Ethics approval**

Ethical approval for my research was obtained from Charles Sturt University, the Greater Western Area Health Service and the Greater Southern Area Health Service Ethics Committees (see Appendix 2).

**Recruitment**

Purposive sampling was used to recruit dietitian and patient participants (see Figure 3.3). Recruitment was non-coercive and there was no exclusion for participation based on gender. Permission was sought to attend regional meetings of dietitians working within two area health services. A brief presentation of the aims and methods of my research was given and questions were encouraged. An information sheet was provided and dietitians who wanted to participate were asked to provide their contact details.
These dietitians were then contacted to organise the date, place and time of the first interview.

Written informed consent to participate in my research was obtained from all participants before the commencement of the first interview (see Appendix 3.1 and 3.2 for a copy of the consent form and information sheet provided to participants). The basis of informed consent is ensuring that potential participants are supplied with information that they can understand about the research so they can make an informed decision about participation (Polit & Beck, 2010). Before recruitment, I fully disclosed the aims, methods, demands, potential risks and benefits of the research to all participants, and each participant had opportunities at each point of contact to discuss their questions or concerns regarding the research in full with me.

One of the potential risks of participation in my project was the potential for power imbalances between researcher and participants and the potential for emotional issues such as anxiety to arise when discussing experiences, leading to unanticipated negative outcomes (National Health & Medical Research Council, Australian Research Council, & Australian Vice-Chancellors’ Committee, 2007). I actively employed methods to minimise any power imbalances between researcher and participants.
Step 1: Selection criteria identified

**Dietitians**
- At least 12 months’ experience in clinical dietetics with a maximum of 5 years’ experience
- Working within clinical contexts, e.g. community health centres, hospitals, general practice or private practice settings
- Evidence of completion of a tertiary degree qualifying them as a dietitian
- Working in a rural/regional setting within New South Wales (NSW)

**Patients**
- Over 18 years of age
- Having received at least two occasions of clinical dietetic care
- Cognitively and physically capable of completing an in-depth interview
- Living in a rural/regional setting within New South Wales (NSW)

Step 2: Recruitment of participants

**Dietitians**
- Approached senior dietitians in two health services to request attendance at regional meetings
- Attended two regional meetings
  - Brief presentation regarding the aims and methods of research
  - Questions encouraged and answers given
  - Information sheet provided (see Appendix 3)
  - Interested dietitians invited to provide their contact details and it was made clear that dietitians were free to decline participation
- Contacted interested dietitians to organise date, place, time of first interview

**Patients**
- Dietitian participants were asked to provide potential patient participants with a sealed envelope containing a letter of invitation and information sheet regarding the research (see Appendix 3 for a copy of the information sheet and letter provided to patient participants).

Patients invited to contact me directly by reply pre-paid mail to indicate interest in participating

Step 3: Written consent to participate in the research was obtained from all participants prior to the commencement of the first interview (see Appendix 3).

Figure 3.3 Selection criteria and recruitment process
As I am a dietitian, participants could have been known to me and could have felt obligated to participate, or to express views that were consistent with my own. In fact, some of the participants were known to me, and in some cases we had pre-established relationships in which I had acted either currently or in the past as the participant’s lecturer, friend and/or work colleague. I was not in a position of power over any of the participants at the time of the interviews. I made a point of emphasising that all were free to decline my invitation to participate, and by inviting people to complete the form in a meeting, not as individuals in a face-to-face encounter, I allowed them space to choose to participate or not. At all times I clearly stated when I was acting in the research role.

It was possible that my participants, especially patient participants with underlying major psychological trauma such as anorexia nervosa, might have experienced distress as a result of the interview. Before commencing participation in the research, I made participants aware that if such issues arose, opportunities for debriefing or counselling would be made available. Further, I remained sensitive to discussing issues that could cause distress during the process of the interview and maintained awareness that participants might feel uncomfortable during the interview process. None of the participants demonstrated any such distress during the interviews. If they had I would have ceased the interview and provided support and/or referred to a counsellor.

I considered that patient participants could benefit from having the chance to clarify their preferred modes of working with dietetic practitioners, further increasing the likelihood of safe delivery of dietetic care. The new practitioners could have found critically reflecting on their practice to be uncomfortable. I reassured them that my focus was on their perceptions and that I was not there to judge them. Several dietitian participants indicated that they benefited from discussing and reflecting upon their approaches to practice in a private, non-judgmental setting. In this sense, the benefits (development of safe, appropriate practices and decision-making processes) were perceived to outweigh the risk (disclosing uncomfortable information in a confidential setting).

I made it clear that each participant was free to leave the research project or withdraw his or her interview text/s at any time. I advised participants that they did not need to
answer a question if they did not wish to and that they could stop the interview at any time.

*Dietitians' interviews*

For dietitian participants, in-depth dialogical interviews were chosen because they are a good fit with philosophical hermeneutics and its emphasis on question-and-answer dialogue and fusion of horizons. Such interviews provided opportunities for varied, extended answers and probing with dietitian participants to assist in deriving deeper meaning about the chosen phenomenon. They allowed me to engage with my participants more deeply than would a structured interview. Minichiello, Aroni, Timewell, and Alexander (1995, p. 73) argued:

> If we believe (as most researchers using qualitative methods do) that social reality exists as meaningful interaction between individuals then it can only be known through understanding others’ points of view, interpretations and meanings. If meaningful human interaction depends on language, then the words people use and the interpretations they make are of central interest to the researcher.

Because meaning about social phenomena is inextricably linked to language and dialogue, interviews provide an excellent medium to explore such phenomena. Minichiello, Aroni, and Hays (2008) argued that other methods such as observation do not allow for gaining understanding of perceptions and interpretations that inform actions and events. In my research the thoughts and motivations behind professional decision-making behaviour were of particular interest, and it would be difficult to access thoughts and motivations through observation. As a method, in-depth interviews give interviewees the opportunity to talk about what is meaningful to them in their words and in their way (Minichiello et al., 2008), which is consistent with a Gadamerian approach to exploring alternative perspectives and the horizons of others.

As professional decision making is complex and has many dimensions, reaching shared understanding of the points of view, interpretations and meanings between interviewer and interviewee about professional decision making is unlikely to occur in one interview. Further, from a Gadamerian standpoint, points of view, interpretations and meanings that one holds are understood to be temporal and based on one’s understanding at a particular time (Fleming, Gaidys, & Robb, 2003). Dietitian participants were interviewed on three separate occasions over a period of 3 months to allow reflection in between interviews and deeper exploration of the phenomenon.
Minichiello et al. (2008) stated that repeated interviewing is important to help build rapport and to deepen understanding. The initial interview with dietitian participants aimed to build rapport and explore experiences in making decisions with patients.

Questions were asked at the beginning of the interview about relevant aspects of the participants’ individual context. These questions were used based on Seidman’s (2006, pp. 16-17) assertion that “people’s behavior becomes meaningful and understandable when placed in the context of their lives and the lives of those around them”. Dietitian participants were asked about their employment and education history, as well as about the nature of their current employment (see Appendix 4). Asking for this information is in keeping with the Gadamerian stance that historical and social context is important for understanding pre-understandings that are brought to a conversation.

For the remainder of the dietitian participants’ interviews, I used an interview guide consisting of a list of discussion questions to help guide the discussion in each interview (see Appendix 5). The questions used in the interviews were piloted with a senior dietitian and two lay people to ensure suitability and clarity. As recommended by Paterson and Higgs (2005), I endeavoured to maintain flexibility in discussing the subject area to allow participants to discuss important topics in their terms and sequence. Each participant was asked questions relating to his or her experiences and perceptions in making decisions about dietetic care. The phenomenon CDM is of a tacit and often automatic nature, as it is not normally a process that is put into words or spoken aloud as it is performed. Tacit phenomena can be difficult to access (Paterson & Higgs, 2005). In her doctoral research exploring professional judgment, which is a tacit or automatic process, Paterson used discussion of less tacit and more familiar processes to assist participants to explore their perceptions (Paterson & Higgs, 2005). This approach was used in my research. The interview guide included topics that were familiar to the participants to enable them to access their thoughts about the phenomenon. The interview guide remained flexible and open to change throughout the interviews. In keeping with a philosophical hermeneutic approach, interviews were conducted in a conversational manner, to encourage dialogue about the phenomenon, rather than keeping to a structured and formalised list of questions.

Interviews were 45 to 60 minutes in duration. The interviews were taped and notes were taken throughout. Recording interviews allows the researcher to note tone and how
words are emphasised during the interview, giving a richer interpretation of the text (McDougall, 2000). Fleming et al. (2003) explained that it is not only the written word that comprises the text; nonverbal expressions and other observations contribute to and influence understanding. Further, while the overt dialogue between researcher and participant is taking place, both researcher and participant might be engaging in a critical inner dialogue, which feeds back to continue and shape the verbal conversation (Minichiello et al., 2008). Notes were taken after the interviews to capture some of my inner dialogue. Interviews were transcribed verbatim.

One particular risk of my research was the possibility for comments utilised in the findings of the research to be identifiable. This possibility could be amplified in my research where small numbers of practitioners were employed in the geographical areas involved. Participants’ identities remained confidential throughout the whole research process and were known only to me as researcher. I used pseudonyms in all coding, interpretation and reporting. In writing my interpretation I removed all identifying information, while paying close attention to ensure that meaning was not changed. I made every effort to ensure that participants would not be identifiable, by removing or altering identifying information by use of more generic terms (such as using the term “town” rather than the name of the town referred to). I removed contextual information that would have exposed the identity of participants in the process of presenting quotes to substantiate my interpretations. I informed participants about where findings might be published as well as the risks of participation and they were given every opportunity to withdraw from the research if they so chose. Further, I did not include parts of the text if participants clearly indicated during the interviews that their comments were “off the record”. I obtained permission to record the interview and to take field notes throughout the interview.

All information collected and texts constructed as part of the research were securely stored to protect confidentiality. I stored audiotapes, paper files and field notes in a locked filing cabinet in my home office. I stored electronic materials in a password-protected computer and password-protected external hard drive. This material will be stored for no longer than 5 years after collection to allow me to make reference to the material if needed for discussion or further publications, as recommended by the Australian Code for the Responsible Conduct of Research (Australian Government, National Health & Medical Research Council, & Australian Research Council, 2007).
After that period I will shred all paper-based information, all audio material will be blanked and removed from its casings and all computer files will be erased completely from the hard drives of all computers and external hardware utilised during the project.

Patient interviews

After the first interview with dietitian participants, I asked them to give potential patient participants a sealed envelope containing a letter of invitation and information sheet regarding my research (see Appendix 2 for a copy of these documents). Patient participants were invited to contact me directly by reply pre-paid mail to indicate their desire to participate in my research. They were then contacted to organise the date, place and time of their interview. This approach ensured that dietitian participants were not aware if patients had decided to participate or not, effectively maintaining the confidentiality of patient participants and minimising the impact of the research on the patient–dietitian relationship. I kept all information collected confidential and there was no sharing of any information collected between dietitian and patient participants, or between dietitian and employers or co-workers. These strategies were put in place to minimise the risk of patient participants feeling disempowered or vulnerable when discussing their experiences with me.

Patient participants were interviewed once, as the main focus of my research was on the perceptions and experiences of dietitians. One-off interviews were considered appropriate as they would be less burdensome to patient participants, with fewer questions and of shorter duration. At the beginning of the interview, patient participants were asked about their general health and previous experiences with dietitians. I used an interview guide to loosely structure the discussion (see Appendix 5). I maintained flexibility in exploring different topic areas and used a conversational approach in the interviews, which were between 30 and 45 minutes duration. Interviews were held at a location of patient participants’ choosing. One interview was held over the telephone. I used the same methods of taping, note taking and transcription as described previously for the interviews conducted with dietitian participants.

Dietitian Reflection Text Construction

Each interview with dietitian participants was interpreted before conducting the next interview so that my evolving understanding could be presented back to the participant in each subsequent interview for discussion, critique and clarification. After the initial
interview with dietitian participants, key points were revisited and participants were invited to clarify and further expand upon the interpretations of their experiences. Fleming et al. (2003) argued that this type of dialogue is essential for shared understanding to be negotiated by participants and researcher. These initial interpretations allowed for the development of questions and areas of clarification for the subsequent interview as well as fine-tuning of interview methods. Fleming et al. considered this process of fine-tuning to be in keeping with a philosophical hermeneutic approach in that it allows a deepening and building of understanding to take place.

Dietitian participants engaged in reflection activities between interviews to further deepen understanding of professional decision making. To assist dietitian participants to become aware of their frame of reference and interpret the way they viewed their practice, an element of critical self-reflection was built into the subsequent interviews. This critical self-reflection aimed to assist participants to engage in a deeper dialogue. At the end of the first interview, dietitian participants were invited to complete a reflective activity of their choice that aimed to illuminate their practice assumptions, choice of practice models and/or nature of collaboration with patients. These activities were selected by the participants and included undertaking discussions with patients or other practitioners, trialling new practice ideas and keeping reflective logs on critical incidents with patients. Higgs and Titchen (2001b) argued that when practitioners actively reflect upon or document tacit parts of their practice, these practices can be critiqued and become part of practice knowledge. Critical self-reflection was defined by Fook and Askeland (2006, p. 41) as “a process of reflection which incorporates analyses of individuals’ thinking with regard to the influence of socially dominant thinking”. This definition of critical reflection takes into account the context within which practice takes place and encourages a questioning stance about self and hegemonic ways of thinking.

In the second and third interviews participants were invited to further explore their practice by building on newly gained insights and reflecting upon whether (and how) these insights had affected their practice. The primary focus of these interviews was to reveal participants’ pre-understandings regarding the assumptions, intentions and motivations that could have influenced their professional decision making. It should be noted that some participants decided to challenge and change their practice as a consequence of these reflections. The insights gained through this process provided
greater depth for participants’ understanding of professional decision making, but change in practice was not an intentional goal of the research. The interviews were essentially critical self-reflection on action: through dialogue and debate, with me acting as a critical friend. My role as researcher was one of facilitator of reflection, and at times animator, to encourage practitioners to question their practice and the interests underpinning it. Practitioners were encouraged to identify areas of their practice that they were particularly intrigued by and to construct reflective activities that they considered would help to best explore them. As their dialogue partner, I provided assistance to facilitate developing deeper knowing about practice. The outcomes of these reflections in earlier interviews were used as a stimulus in subsequent interviews.

3.4.2 Text Interpretation
Text interpretation occurred during text construction. I commenced with interpretation of the first text set, which was the literature text set. I took my first literature text, my interpretations and my new understanding, to the next dialogue with the dietitian text, and then finally to the patient and dietitian reflection text. As well as interpreting each text set, I conducted question-and-answer dialogues moving from parts (literature text, dietitian text and patient and dietitian text) to the whole (the meta-interpretation) to facilitate a fusion of horizons across the text sets. During the process of fusion of horizons, the construction and interpretation of text sets often informed each other and did not necessarily occur in isolation from each other nor always in a linear fashion. The circular arrows moving between each text set in Figure 3.1 demonstrate how the question-and-answer dialogue moved back and forth between each text set to inform my evolving understanding. The posing of questions to the literature text inspired questions to ask of dietitian and patient texts, and vice versa. As a result of this ongoing process of construction and interpretation, my understanding evolved significantly.

Construction and interpretation of the text set are reported in the three findings chapters and the model or conclusion chapter. Chapter 4 represents the literature text set and provides deeper understanding of the professional decision-making approaches in the health care and dietetic literature. Chapter 5 represents the dietitian text set and provides deeper understanding of the observations and experiences of professional decision-making approaches used in dietetic practice by dietitian participants. Chapter 6 represents the dietitian and patient text set and provides deeper understanding of the challenges faced by early career dietitian participants in shaping CDM. Chapter 7
presents my CDM model and is a meta-interpretation of the text sets discussed in Chapters 4, 5 and 6. It is acknowledged that the fusion of horizons could continue to further deepen understanding, but for the practical purposes of my research, the process needed to be halted in order for findings to be reported in this thesis. My task was to ensure that this report portrays an achievement of significant new knowledge and understanding. Future research can continue this journey. To demonstrate that knowing can continue to unfold beyond the completion of my research, the beginning and ending of the thesis interpretation process are noted in Figure 3.1. Implications for future research are provided in Chapter 7.

3.5 Strategies for ensuring quality

Grbich (2010) argued that criteria used to evaluate research must be consistent with the epistemological and ontological stance of the paradigm within which it is conducted. In my research, I chose the three key quality criteria of rigour, transparency and credibility to review and ensure the quality of my research and its products. I aimed to ensure that my research method was rigorous and transparently reported so that readers could judge its credibility and consider how findings might apply to their context. I aimed to ensure that my research methods were rigorous through congruence of the philosophical and methodological approaches and through use of reflexivity throughout the research process. These aims were achieved by using a variety of strategies as described next to ensure and support the credibility of my findings and research product.

3.5.1 Rigour

Rigour in qualitative research refers to both the rigorous application of the method and the rigorous interpretation of the data (Guba & Lincoln, 2005). In my research I have explained why my chosen approach of philosophical hermeneutics was appropriate to answer my research questions and how this approach informed the research strategies I used. Presenting this argument is important to demonstrate that the philosophical underpinnings of the research and the strategies utilised are congruent. During the course of the research I kept documentation of both the practical decision making about the research and my theoretical reflections, which comprised the emerging interpretations of the phenomenon. I then used these reflections as the basis to provide a systematic and transparent account of the actual method used to generate findings. My use of hermeneutic strategies was underpinned by congruent philosophical and methodological tenets. I engaged with my research participants in cycles of text
construction (posing questions) and text interpretation (deriving answers) to meet my research aim of achieving a fusion of horizons and coming to a deeper understanding of the phenomenon.

Loftus and Trede (2009, p. 64) urged

In hermeneutics we need to be aware, as far as we can, of the prejudices and tradition that we, as researchers, bring to the work of interpretation. We cannot set these aside, but by recognising our prejudices, and recognising how they influence us, we can try to be more authentic and credible in our interpretations.

Philosophical hermeneutic research must incorporate mechanisms for researchers to make their pre-understandings and evolving understandings transparent to enhance rigour of interpretation. During the research process I utilised question-and-answer dialogue to be explicit about my pre-understandings, particularly my assumptions and perspectives on professional decision making.

In philosophical hermeneutics, findings are presented as interpretations of the dialogue that has taken place between the participants or texts and the researcher. Paterson and Higgs (2005, p. 352) stated that strategies such as “the dialogue of question and answer, and the fusion of horizons, make the analytical processes more visible to the reader”. I engaged in critical dialogues with supervisors and peers to explore and to pose questions to my pre- and developing understandings. Fleming et al. (2003) argued that conversations with colleagues can provide a stimulus for provocation of unrealised prejudices, as advocated by Gadamer’s approach to philosophical hermeneutics. The specific focus of the interactions with my supervisors was to discuss text interpretations and determine directions for upcoming interviews and textual interpretation. By making my evolving understandings and position in the world transparent in the research process, I could communicate to the reader how I came to these interpretations and in doing so pursue rigour of my research.

3.5.2 Transparency

To pursue rigour and credibility, I secondly sought transparency in my research. I particularly aimed to clearly document my research process and to report it transparently so that people reading my research could evaluate it and its application to their situations with a clear understanding of the context within which it was conducted, how it was implemented and how interpretations were made. Documenting my decision
making throughout the research process was the key strategy to allow transparent reporting of the research method I used.

Because of the emphasis in my research on deepening understanding of participants’ observations and experiences, understanding what the participants brought to the research in terms of their pre-judgments and their practice context was essential in order for an authentic and transparent interpretation to come to light. A key topic that I aimed to address in my research was to identify the contextual influences on why practitioners chose to make decisions with patients in particular ways. In this thesis, the geographical location and organisational setting of the research and of the participants were inherent components of how the method and findings chapters were written, and an exploration of the setting of practice are integrated into findings. Prolonged engagement with dietitian participants with three interviews over a 6–8 month period was a key strategy to ensure that readers can gain a rich understanding of the context of the participants in my research.

Prolonged engagement with participants is thought to assist in developing a relationship with them and in gaining a more comprehensive understanding of the context of the participant (Polit & Beck, 2010). Fossey et al. (2002) argued that this depth of understanding of participant’s context is important for gaining a deeper understanding of findings. The demonstration of this contextual location of the research is important to allow readers to consider, with respect to their personal context, whether the research findings are applicable to other settings (Fossey et al., 2002; Mays & Pope, 2000).

3.5.3 Credibility
The third quality criterion, credibility, draws and builds upon the rigour of enactment of the research and the transparency of reporting of findings to allow the reader to critique the importance and relevance of the product of research. Credibility has been defined as “confidence in the truth of the data and interpretations of them” (Polit & Beck, 2010, p. 492). Ensuring that the views of participants were respectfully, authentically and carefully represented was a key consideration in my research to confirm credibility of the final products of my research.

In philosophical hermeneutics, interpretations are derived from dialogue between researcher and participants, and the researcher’s insights are clearly articulated
alongside the interpretations of the participants (Loftus & Trede, 2009). It was imperative to communicate transparently how the views of participants were fused with mine to deepen understanding. Fossey et al. (2002) argued that the use of verbatim quotes, with clear statements that demonstrate the researcher’s interpretations, as well as including a range of viewpoints that have been dialogued with, are key strategies to ensure authenticity of participants’ views, and these were key strategies used in this thesis.

Another important consideration to ensure credibility of the findings of my research was that, as a more senior and more experienced practitioner, I was interpreting the views of less experienced practitioners who were still learning about their practice. I spent considerable time reflecting on how quotes should be interpreted, particularly in light of the ongoing nature of my relationship with the participants (especially with dietitian participants) and ensuring that the views of my participants were contextualised in relation to their stage of learning about practice. Further, for ease of reading and to ensure confidentiality, quotes and reflective activity questions were often edited. In this process I remained vigilant to ensure that the original meaning was not lost and that my interpretations resonated with the evolving and deepening understanding of the phenomenon in question that came about through fusion of horizons.

3.6 Conclusion
My research adopted a philosophical hermeneutics approach located within the interpretive paradigm. Question-and-answer dialogues, fusion of horizons and the hermeneutic circle were applied with texts from the literature and patient and dietitian participants, to deepen understanding of the nature of and approaches to professional decision making in early career dietetics. A number of strategies were employed to ensure that this deeper understanding was rigorous and sufficiently transparent to enable readers to determine its credibility and transferability to their context.
CHAPTER FOUR

THEORETICAL PERSPECTIVES OF PROFESSIONAL DECISION MAKING

The next three chapters comprise the findings of my research. In Chapter 4, I present the findings of my philosophical hermeneutic study of the literature on the topic of professional decision making in dietetics and health care practice. In Chapter 5, I present the findings of my philosophical hermeneutic study of the perspectives of early career dietitian participants’ observations and experiences and my interpretations of professional decision making in dietetic practice. In Chapter 6, I present the findings of my philosophical hermeneutic study of the reflections of dietitian participants and the perceptions and observations of patient participants in order to illuminate the challenges in shaping collaborative decision making (CDM) in dietetic practice.

Reading extensively across the literature, influenced by my research questions and my core research phenomenon (CDM in early career dietitians), I identified the following key issues and topics as the core dimensions of my philosophical hermeneutic study of the set of relevant literature texts I collated:

- The key theoretical framework dimensions that informed the approach I wanted to take to examine CDM (i.e. cultural, relational, discursive and interest dimensions)
- The core dimensions of professional decision making in health care practice
- Professional decision making in dietetics: implications and conclusions.

Through dialogues around each of these topics I identified key aspects of each of these important aspects of CDM (see Figure 4.1).
4.1 Theoretical framework for professional practice: key dimensions

The literature on professional decision making reports a diversity of conceptual models (see Section 4.2). Within these models it is the collaboration aspect, the active and deliberate participation of the various stakeholders (particularly patients and practitioners) in the process of reaching a mutually acceptable and realistic decision, that is the phenomenon I explored in this research.

Professional decision making is part of the broader phenomenon of professional practice, and the understandings that people have of practice as a whole shape their expectations, assumptions and perceptions of professional decision making. Since professional practice is both situated and contextualised, professional decision making is embedded in the situation at hand. To provide a platform to locate and inform understandings of the dynamic and complex variations of professional decision making, examination of the theoretical understandings of professional practice was warranted.

In this thesis I draw upon the theoretical work of Higgs and Titchen (2001a, b), Beeston and Higgs (2001), Kinsella (2012) and Kemmis (2010) to more deeply understand the phenomenon of professional practice. From this literature my theoretical framework portrays professional practice as having cultural, relational, discursive and interest
dimensions. These core ingredients of practice create an environment where practice is driven by the motivations and interests of people and organisations, where the way people relate is shaped by individual and collective cultures and where the language of inter-relationships and discourse frames interactions, processes and dialogue. This theoretical framework aligns well with my philosophical framework of philosophical hermeneutics, where a key element is reaching deeper understanding through interpreting the horizons of people and texts and through repeated engagement in dialogue.

In this thesis, coming to a deeper understanding of each decision making partners’ circumstances, perspectives and values and of how health care can be realised through dialogue between patients and practitioners are seen to be key dimensions of CDM and the related actions that comprise collaborative, patient-centred dietetic health care.

4.1.1 Cultural dimension
The cultural dimension of professional practice relates to the perspectives, values, traditions and knowledge that practitioners bring to practice as a consequence of their membership of different groups (Kemmis, 2010). These groups can be of social, recreational or professional nature and individuals can be members of numbers of cultural groups. For example, practitioners are members not only of particular social cultural groups but also of professional and organisational cultural groups. Professions each have their own recognisable culture and tradition (Beeston & Higgs, 2001) and practitioners work within a particular workplace setting or organisation that has its distinct culture. The cultural groups to which people belong and the cultural environments in which they work influence the way they practise.

As Kemmis (2010) argued, practice is characterised by understandings and presentations of self that are flavoured by the cultural perspective of the particular time and place. This viewpoint means that people’s unique experiences, knowledge, values, beliefs, expectations, needs and preferences that are brought to practice will shape how they think and behave (Kemmis, 2010). People bring expectations, conventions and cultural traditions to clinical encounters. During professional decision making, it could be that some patients find it culturally unacceptable to challenge practitioners. In these cases practitioners will be the more powerful people in relationships. It could also be that patients who have access to technical knowledge and are encouraged by the broader
society to be more autonomous, enter relationships with practitioners with expectations of more democratic power sharing. Kemmis (2010, p. 140) also emphasised that practitioners are not the solitary agents of construction of practice, suggesting that the “histories, cultural and discursive resources, social connections and solidarities, and locations in material-economic arrangements and exchanges are all implied in the construction of practices”. This view further reinforces that the cultural dimension of practice is interlinked with how people relate to each other (the relational dimension) and how conversations within practice (the discursive dimension) take place in particular spaces and at particular times.

Gord (2011) suggested that the contemporary culture of dietetics is conservative in nature. She proposed that this culture might be in part due to the self-perceived lower status of dietitians among the health care professions, the privileging of the medical model above other wellbeing models, and the feminisation of the profession. She argued that the feminisation of the profession has led to a professional culture where the emphasis is on service to others rather than self-promotion or gain. This professional culture may be reinforced by the workplace or organisational culture within which dietitians work, which often emphasises the care of others above self-promotion or even self-care. However, the workplace or organisational culture within which dietitians work can vary regarding expectations of the role dietitians play, the workload they are expected to carry and the perceptions of different discipline groups with respect to status and hierarchy. An understanding of the culture of the profession of dietetics is of relevance in this thesis in that it assists reaching a deeper understanding of why dietitians may use certain approaches to professional decision making in their practice.

4.1.2 Relational dimension
Practice does not occur in isolation. In health care practice, practitioners relate to a range of people in a range of situations. They relate to patients and their families and carers, as well as other health care practitioners. These professional relationships are important in that they have significant implications for the nature of dialogues that take place in practice, as well as whether deeper understanding of each decision-making partners’ circumstances, perspectives and values can be achieved during these dialogues.
Each of these relationships that exist in practice is unique. Kemmis (2010, p. 152) argued that “social connections and relationships, with these particular people, here, building or changing local and particular solidarities with particular others and building different kinds of relationships with different groups” characterise practice. This viewpoint is particularly relevant for health care practice, where practitioners and patients form professional relationships with a number of others in the health care experience. For example, a person with diabetes might have professional relationships with his or her general practitioner, endocrinologist, dietitian, diabetes educator, podiatrist and optometrist, to name just a few. In turn, each of those practitioners has professional relationships with many patients. The particularity of these relationships in health care means that they are situated. They each have their own nature, occur in particular times and spaces, and have trajectories according to patients’ unique health journeys. People relate to each other in different ways during practice encounters depending on the specific situation. The approach to professional decision making used in each of these specific situations varies depending on the relational conditions that are present.

Kemmis (2010, p. 143) contended that practice “realises and is realised in social (and political) interactions and relationships”. A distinctive feature of relationships in practice, he argued, is the realignment of perspectives by people within them in order to make a connection. He further argued that usually it is the patients, as the less powerful partners in the relationship, who realign their perspectives to fit with practitioners’ perspectives. This realignment of perspectives has implications for professional decision making where coming to a deeper understanding of each decision-making partners’ circumstances, perspectives and values is the goal. As Higgs and Titchen (2001a, p. 10) argued, practitioners as members of a profession are awarded a responsible position of “status, power and authority”. Practitioners need not only to understand their patients’ interests and situations, but also to act professionally in their patients’ interests, rather than abusing or taking for granted their own power.

From their perspective, patients expect high quality of care but also want to be respected as individuals (Higgs & Titchen, 2001a). In dietetics, as in other health professions, patients no longer need to rely on health care practitioners to provide them with technical knowledge about nutrition and health care. Patients now have greater access to technical knowledge via such sources as the Internet and the food industry, and bring a
variety of topics to health management conversations (Stein, 2006). Patients may ask focused questions and lead the decision-making process or they may prefer practitioners to make decisions for them. Practitioners need to be flexible and use their professional power appropriately during professional decision making.

When practitioners do not recognise that power differentials in patient–practitioner relationships have this dynamic nature (based on patient education, empowerment, preferences and agency), relationships may be characterised by practitioner dominance or at the least ambivalence about patients’ perspectives. Higgs and Titchen (2001a) advised that practice should be characterised by relationships where the perspectives of the key people involved are acknowledged. Such relationships allow the perspectives and interests of each participant to be heard in professional decision making, and privilege the rich experiences that people bring to practice.

Since my research focuses on early career practitioners and patients it is important to reflect on the relationships that they encounter in practice. These practitioners not only develop relationships with patients, they also experience socialisation and enculturation into their profession and its cultural norms through their relationships with more senior practitioners and their practice communities (Higgs et al., 2009b). Learning about how to work with power differentials that exist in relationships, as well as a commitment to democratic professional decision making, can lead to relationships characterised by mutual respect and transparency (Trede & Higgs, 2008b). In making decisions, the key is to be aware of these power differentials, to purposefully use professional authority when warranted and to refrain from using power when not warranted. In this sense, the relational dimension is related to the discursive dimension, in that power differentials can determine the nature of dialogue.

4.1.3 Discursive dimension
People interact with each other in practice through dialogue. These dialogues include conversations with others during and about provision of care. Practitioners engage in dialogue with patients (such as in the provision of care) and other practitioners (such as in provision of care, or in reflection on care) (McAllister & Street, 2008). Dialogues can take place in various combinations, such as between patients and practitioners, between practitioners, or between patients and a group of practitioners. People can also conduct internal dialogues, such as when practitioners think about what they could have done
and said differently (Kinsella, 2012). Dialogues are an important aspect for consideration in professional decision making, particularly in professions such as dietetics where verbal communication is utilised for discussing behaviour (dietary) change.

The purpose of dialogues in professional decision making is to come to an understanding of self and the other and to reach new understandings. Histories, stories and ways of knowing are shared during these conversations (Higgs & Titchen, 2001a). Higgs and Titchen (2001a, p. 9) argued that this sharing is essential in assisting practitioners to “understand the roles, needs and realities of participants in professional practice”. People also conduct internal dialogues or self-talk on such things as reflecting on decisions, evidence, actions and how knowledge has come about (Kinsella, 2012). This self-talk can inform the conversation that takes place between practitioners and patients. The deeper understanding that develops from these dialogues is important to enhance the potential to reach mutually acceptable decisions about how to proceed.

During self-talk, dietitians may reflect on patients’ experiences in making dietary change in the past and adjust the nature of the conversation accordingly. Some patients might have had significant experiences regarding changing their eating habits in the past. In these situations, dietitians can direct the conversation to explore these experiences more deeply, to appreciate how they inform the future direction of care. In this thesis, the self-talk of dietitian participants was brought to the surface and made explicit through the series of interviews.

The dialogues that take place between practitioners and patients and among practitioners are an overt part of the relationships that exist in practice. The nature of the relationships between patient and practitioners, including the degree to which dialogue partners truly listen and engage with each other, can impact upon the ability of dialogue partners to come to a deeper understanding of circumstances, perspectives and values (Arnason, 2000; Svenaeus, 2000).

Arnason (2000) argued that when patients or practitioners have sole control of decision making the dialogical and interpersonal relationship is ignored, and it is unlikely that a joint decision based on mutual understanding will be reached. He explored the nature of this relationship, informed by the work of Gadamer. He argued that developing an
understanding of the other person is difficult when a decision-making participant unreflectively brings his or her pre-judgements to the decision-making process. Arnason (2000, p. 20) suggested that the central component of a good human relationship as seen by Gadamer is “openness to oneself, openness to the other, openness to the subject matter, and openness to tradition”. It was the lack of questioning of tradition that Arnason found concerning, in terms of its potential impact on patient autonomy. In medicine, decision-making power traditionally rested with practitioners. Arnason argued that an unquestioning reliance on traditional practices means that it is unlikely that conversations between patients and practitioners will be open. Gadamer (1975/2004) urged individuals to remain open to tradition through critiquing and questioning it. In this sense, some aspects of traditions are worthy of keeping and others need to be transformed. This stance of examining and questioning one’s perspectives and being open to alternative perspectives is important in professional decision making where the goal is to come to a deeper understanding of each other’s circumstances, perspectives and values.

I have a particular interest in the observations and experiences of practitioners and patients of the dialogues that take place between patient and practitioner, rather than monologues. Svenaeus’ (2000) application of the philosophical hermeneutics of Gadamer in discussing the importance of dialogue in coming to a new understanding between doctor and patient is helpful to inform the conceptualisation of dialogue for my thesis. Svenaeus (2000, p. 182) emphasised the importance of empathy in coming to this understanding: “It is only through empathy that the doctor can reach independent understanding that is truly productive in the sense of shared and independent”. He also argued that the sharing of patients’ stories is central for practitioners to come to a deeper understanding of individual patients’ circumstances, preferences and values. He proposed that dialogues in health care practice are characterised by asymmetry, wherein there is a power imbalance between patient and practitioner, and by estrangement.

Svenaeus (2000) used the word *estrangement* as he argued that patients and health care practitioners are, at least initially, strangers. Svenaeus’ views have implications for understanding how dialogues are structured and also what is considered to be important and not important content, or even allowed and not allowed dialogue topics. The emphasis on coming to a deeper or new understanding in the context of a relationship where dialogue partners are initially strangers also implies a temporal aspect of
relationship building, which means that the dialogue partners need time to get to know each other before sharing their stories. Further, in dialogues where partners seek to reach common understanding by eliciting and sharing stories, there needs to be an openness to sharing content that is deemed important by both dialogue partners. These dialogues are distinct from patient history-taking, where predetermined data is quickly acquired from patients by using some sort of check-box approach. To reach a deeper understanding of the circumstances, preferences and values of decision-making partners in CDM requires power sharing in the decision-making process. The nature of the dialogue can be influenced by power relations and in this sense the discursive dimension is related to the relational dimension.

4.1.4 Interest dimensions

In his seminal work, *Knowledge and Human Interests*, Jürgen Habermas (1971) argued that what people do and how knowledge is constructed is driven by technical, practical and/or emancipatory interests. These interests can be seen to underpin and drive how the cultural, relational and discursive dimensions of practice are interpreted and subsequently shape practice. Interests can influence the way dialogues take place and the nature of relationships in practice. The interests that people bring to practice are shaped by a complex web of the cultural, social and historical conditions of their upbringing, tertiary education and practice development, as well as the discursive nature of practice itself. Interests also impact on whether practitioners accept current practices and take them for granted or seek to question, challenge or change practices.

Interests can be seen as concerns, attention and values that practitioners bring to their practice. In Habermas’ view, technical interests are consistent with an empirico-analytical stance towards knowledge construction, whereby the world is viewed in objective terms and theory is applied to practice by adherence to rules based on empirico-analytical evidence. The emphasis is on facts derived from studies that seek to prove or disprove hypotheses and the researcher’s personal framework is discounted in explaining knowledge. Practical interests are consistent with an historical-hermeneutic stance to knowledge construction, where understanding of shared meaning is the key aim. Finally, emancipatory interests are consistent with a critical stance towards knowledge, where the key aim is to become aware of and act on conditions that hinder human freedom and social justice. Interests that inform practice at any one time (there
may be multiple interests that inform practice) have implications for how professional decision making is enacted, as well as what the practitioner values and does not value.

Acknowledgement of researchers’ pre-understandings is also important, and there is a need to explore the contextual, relational and discursive dimensions of practice with respect to their intentions and interests, since these influence the way knowledge is created through the research. Practice that is based predominantly on technical interests is characterised by giving preference to facts that have been derived from objective research that seeks to exclude or control the cultural, discursive and relational practice dimensions of contextual variables. Practice based on practical interests focuses on relationships and dialogue. Practice based on emancipatory interests critically questions how these relationships and dialogues are influenced by hegemonic practice traditions and ideology. Habermas emphasised power relations and the influence of political and economic agendas on dialogue. In my research, which focuses on CDM, the constructs of relationships, dialogue and power are important because practical and emancipatory interests inform the understanding of this phenomenon.

Models of health care practice and their associated interests shape practice and professional decision making and understandings of professional roles, expectations, the nature of power relations, the type of knowledge that counts, preferred perspectives on health and health outcomes, what goals are set, and how decisions are justified (Trede & Higgs, 2008a). Trede and Higgs (2008a, p. 32) described practice models as “abstract ideas of what practice should look like if it followed a given framework”. Practice models inform and shape practice, including professional decision making approaches, whether “knowingly or unknowingly adopted, tacit or espoused, implicit, explicit or embodied” (Higgs et al., 2009b, p. 107). It should also be noted here that practitioners often traverse practice models and that practice is characterised by a range of practice models (Trede & Higgs, 2008a). Trede and Higgs drew on Habermas’ theory to identify three categories of health care practice models informed by technical, practical and emancipatory interests, and these three categories are now discussed in turn.

Practice models driven by technical interests have a reductionist focus that separates matters of mind from matters of body, and health is viewed mechanistically, with a focus on physical outcomes (Engel, 1977; Trede & Higgs, 2008a). Ill health is a problem to be solved; problems have one best solution and all health problems can be
attributed to biomedical explanations (Engel, 1977). In the biomedical model, ill health is attributed to biological or physiological dysfunction, which must be corrected, and social, psychological, cultural and interest dimensions of illness are not considered important (Engel, 1977). Practitioners have professional authority and their role is to act upon patients, such as to perform a procedure or to provide technical knowledge, whereas patients are passive, disempowered and expected to be compliant (Trede & Higgs, 2008a). Practitioners who operationalise this model make decisions for the patient based on technical knowledge without consideration of the patient’s perspective.

Engel (1977) contended that the biomedical model was limited as a framework for understanding a person’s experience of ill health or as a means to assist in improving health status. Engel argued for a broader, more social perspective of health that extends beyond a focus on the biomedical to encompass the social and psychological aspects of health and the social aspects of health care practice. A notable approach to care that is based on this model of practice is the patient-centred approach to care.

Patient-centred approaches to care are aligned with practical as well as technical interests. Understanding the lived experience of patients means developing a greater empathy for their feelings, values, beliefs, concerns, ideas, expectations, preferences, priorities and needs, and using this understanding to underpin care (Epstein et al., 2005; Rycroft-Malone et al., 2004). Aspects of health that relate to the psychological, social and cultural context of patients are also likely to be considered as important as biomedical changes. Patient-centred approaches aim to shift the power balance of patient–practitioner relationships more towards patients by increasing their active participation and agency in care. Such a shift may create greater equality between patients’ life worlds and practitioners’ scientific worlds (Black, 2005; Sumasion, 2000). A patient-centred approach implies coming to a shared understanding of the issue at hand as well as facilitating the desired level of involvement of patients in decision making (Epstein et al., 2005). Stewart (2001) also argued that patient-centredness is about flexibly responding to patients’ preferences for participation in care. It is likely that different patients prefer different levels of involvement in health care and making decisions, and engaging with this patient diversity is part of being patient-centred. Being patient-centred can also mean supporting patients who prefer to be told what to do based on technical facts and practitioners’ professional advice. Being guided by a patient-centred approach broadens the roles that patients and practitioners can play in
professional decision making, as well as the ways of knowing that are considered important.

Use of a patient-centred approach has been argued to be beneficial in ensuring that flexible, individualised, culturally appropriate care can be realised, rather than the use of blanket prescriptions that may not be relevant to the individual patient (Black, 2005). More recently, Mcclimans, Dunn, and Slowther (2011) argued that previous interpretations of patient-centred care in the literature did not pay sufficient attention to the moral underpinnings of such care. They argued that informing patients and giving them greater power in decision making processes is not sufficient to meet the goal of respectful and dignified patient-centred care. They suggested that patient-centredness “requires serious engagement with moral theory, normative ethical reasoning, and the careful translation of ethical arguments into the delivery of health care to individuals in circumstances of moral uncertainty” (p. 918). They also suggested that the provision of individualised care requires a careful consideration of the way that the technical knowledge provided is shaped by social values. Having a greater understanding of ethical issues implies a practical and critical interest in patient-centred care approaches. As well, by placing emphasis on questioning the way that the social context shapes the way practice takes place, these authors extended the concept of patient-centredness to further include an emancipatory perspective to practice. As previously argued, for CDM to take place it is important for practitioners to question their own perspectives as well as how the social, cultural and political context might have shaped these perspectives and those that are brought to practice by others.

Practice driven by emancipatory interests values political knowledge as well as technical and experiential knowledge (Trede & Higgs, 2008a). An example of a practice model driven by emancipatory interests is the capacity model described by Trede and Higgs (2008a). In this model, health is viewed from a political standpoint. Attention to the political forces and power relationships that affect the way conversations take place are of importance in this model. Social justice is a strong guiding force of the model, whereby the expression of the viewpoints of marginalised groups is facilitated by paying attention to the power relations within health care interactions.

The capacity model described by Trede and Higgs (2008a) draws on the same diverse ways of knowing as models underpinned by practical interests, including propositional,
technical, experiential and political knowing, because practice is situated and cannot be
generalised. However, the philosophical approach upon which the capacity model is
based is a critical one, in that its key features are knowledge that is generated by
questioning current practices and exploring other possibilities in a collective fashion.
One of the key goals of practice of the capacity model is to facilitate critical awareness
and the liberation of people from unnecessary constraints towards sharing power.
Patients are encouraged to participate and contribute to the care process, to be self-
determining and to co-construct realistic solutions. A critical exploration is necessary of
both patients’ and practitioners’ interests, values and beliefs about health, illness and
care. These constructs are well aligned with the concept of CDM that is utilised and
further explored in my research.

The theoretical framework of professional practice discussed above suggests that
professional decision making is negotiated, situated and context-dependent. In that
perspective, professional practice has multiple dimensions that inform practice. All
these dimensions are interdependent and influence each other. I also argue that human
interests influence the way these dimensions are interpreted. Interests shape the
discursive and relational dimensions of practice, and membership within particular
cultural groups shapes the interests of practitioners.

4.2 Professional decision making in health care practice: core dimensions
There is a significant body of literature regarding decision making in health care
practice, particularly with respect to decision-making approaches that advocate for
patients to be active participants in care (Barr & Threlkeld, 2000; Black, 2005; Ersser &
Atkins, 2000; Higgs, Jones, Loftus, & Christensen, 2008). This literature is of particular
significance in contemporary health care, where promoting patient autonomy and
greater control over their health is seen as a key principle of people-centred care (World
Health Organization, 2013).

I collated 38 articles describing decision making models (see Appendix 6). The papers
were mainly published in the medical literature but there were some from nursing and
allied health contexts. Texts that explored the nature, traditions or models of decision-
making approaches in health care practice were included in the text set. For further
details of this text construction see Appendix 1. Articles that discussed only
intrapersonal decision making of practitioners and the cognitive processes involved in
decision making, and those that described decision making regarding other aspects of health care such as scope of practice or management of health care systems, were excluded from this dialogue as I was interested in interpersonal decision making. Other strategies to source relevant articles included the examination of reference lists of collected articles. The following sections outline the interpretations that arose from my dialogue with those texts. Key messages are identified with selected texts as examples.

4.2.1 Theoretical underpinnings that provide a basis for professional decision making models

An understanding of the theoretical underpinnings of models can provide insight into the value that authors give to dimensions such as the cultural, relational, discursive and interest dimensions of practice. The theoretical frameworks, evident or implied, in the decision making texts I interpreted were varied. Many of the decision making models included in this dialogue drew on existing empirical research literature and did not necessarily elucidate the theoretical underpinnings of the models. Failure to explicate a theoretical framework made it difficult to determine the values and beliefs that drove these models.

Lack of clarity in the values and beliefs that drive practice models can be problematic for practitioners in two ways. First, a lack of clarity of theoretical underpinnings makes it difficult for practitioners to critically reflect on which interests are driving approaches to professional decision making. Second, this lack of clarity can hinder practitioners from making critical decisions about which decision-making approach would be most appropriate in different clinical circumstances.

Some authors did describe the theories that were utilised to develop decision-making models. Theoretical underpinnings included social constructivism (Cottone, 2001), theory of goal attainment (Goodwin, Kiehl, & Peterson, 2002) and social systems theory (Kasper, Légaré, Scheibler, & Geiger, 2011). The use of these theories reflected these authors’ views that professional decision making has a social and relational nature.

Other theories utilised to inform models in this text dialogue included the “theory of communicative action” (Sandman & Munthe, 2010; Trede & Higgs, 2003), relational communication theory (Siminoff & Step, 2005), feminist theory (Faith, Pinhas,
Schmelefske, & Bryden, 2003), self-determination theory (Collins & Street, 2009) and philosophical hermeneutics (Betan, 1997). These theories are located in a mix of the interpretive and critical paradigms. In using these theories, authors not only gave consideration to patients’ social and cultural contexts but also recognised the central political importance of involving patients in professional decision making. For example, the model described by Trede and Higgs (2003) is underpinned by critical social science theory. These authors argued that practitioners who adopt their “collaborative clinical decision making model” broaden their perspective on health, moving from a technical perspective to one that places the context and the capacity of patients at the centre of care. They argued that this perspective focuses on optimising patients’ health and human potential, rather than only on biomedical outcomes. This text is a good example of the importance of clearly aligning models of practice within paradigms, making the values and beliefs that drive practice transparent and providing practitioners with a framework for reflecting upon practice. The location of an approach to professional decision making in the interpretive and critical paradigms is aligned with the theoretical framework for understanding practice and with the cultural, relational, discursive and interest dimensions of practice that I presented in Section 4.1. In the collaborative clinical decision making model, decision making has a social and relational as well as a political nature, where critical self-awareness and challenging any existing constraints on practice are of central importance.

4.2.2 Role/s of patients and practitioners

The role/s that patients and practitioners can play in professional decision making have implications for the power differentials within patient–practitioner relationships as well as for the nature of the conversations that take place during professional decision making.

I found that the role delineation between patients and practitioners was not consistently clear in the texts in this dialogue. Some authors did not explicitly describe the roles of one or both decision-making partner. In models where practitioners were described as being in control of decision making, the role of practitioners appeared to be to make decisions based on biomedical data and the role of patients was to passively receive care and adhere unquestioningly to the advice given (Charles, Gafni, & Whelan, 1997, 1999; Cribb & Entwistle, 2011; Elwyn, Edwards, & Kinnersley, 1999; Sandman & Munthe, 2010). In models where patients were in control of decision making, their role was to
make decisions based on technical knowledge they received from health care practitioners that enriched their knowledge derived from their experiences (Charles et al., 1997, 1999; Cribb & Entwistle, 2011; Elwyn et al., 1999; Myers, 2005). In models where decision making control was shared, patients and practitioners shared knowledge with each other, deliberated on this knowledge, devised possible solutions and came to a decision together (Braddock et al. 1999; Charles et al., 1997, 1999; Elwyn et al., 1999).

Each of these roles might be appropriate at different times, depending on particular clinical circumstances. An important ability of practitioners is to reflect upon each particular clinical circumstance and flexibly move between the roles according to what is most appropriate.

Other texts emphasised a more facilitative role of practitioners that acknowledged the discursive and relational dimensions of practice (Faith et al., 2003; Kasper et al., 2011; Trede & Higgs, 2003). These authors argued that a facilitative role involved coming to an understanding of patients’ contexts and experiences and exploring the meaning that patients ascribed to the knowledge used in professional decision making. A facilitative role also encompassed advising and assisting patients to critique and challenge the constraints they might have experienced in improving their health and identifying strategies to help patients take control over their health and lives. A facilitative role might also involve providing technical knowledge, knowledge derived from the practitioners’ experiences or access to resources. Playing a facilitative role in professional decision making is consistent with a philosophical hermeneutic view of dialoguing to come to a deeper understanding of other people. Coming to this deeper understanding requires that patients and practitioners both be aware of the interests they bring to practice. Playing a facilitative role also brings a political perspective to professional decision making that encourages patients to make decisions about their health that are best for them. These decisions are less likely to be influenced by the constraints of the health care or social system or by the needs or values of practitioners.

During my dialogue around this sub-topic I found that authors tended to describe the steps required to enact their decision-making model more clearly than the roles of patients and practitioners. This emphasis on the procedural aspects of professional decision making was particularly the case for models that were described as shared. The wide range of steps suggested for implementing shared decision making (SDM) was also noted by Stacey, Légaré, Pouliot, Kryworuchko, and Dunn (2010), who conducted
a review of the processes in SDM models. They found six common features across all models: “1) equipoise (recognition of a decision to be made), 2) knowledge transfer and exchange, 3) expression of values/preferences, 4) deliberation, 5) the decision, and 6) implementation of the decision” (p.169). An emphasis on the procedural aspects of professional decision making could mean that practitioners, particularly early career practitioners, are tempted to rigidly follow the steps of a model, rather than responding to patients’ needs and concerns as they arise during practice. This view is also supported by Charles et al. (1997) who, rather than providing steps for SDM, argued for key elements that characterise the approach. An understanding of the different elements of different approaches to professional decision making would be of more assistance in allowing practitioners flexibility in enacting an approach that suits each instance of care.

The roles of patients and practitioners across different elements of decision making were portrayed by Charles et al. (1999) as falling into three categories: “1) information exchange, 2) deliberation, and 3) deciding on treatment to implement” (p. 653). In comparing these findings with other publications, I found that some authors acknowledged that patient preferences for participation in each element of decision making were likely to be highly varied (Deber, 1994b; Elwyn et al., 1999). Some authors also claimed that patients’ preferences for participation may vary at different stages of care as well as within the same consultation (Charles et al., 1999). Some authors argued that preferences for involvement in decision making should be checked on an ongoing basis (Elwyn, Edwards, Kinnersley, & Grol, 2000; Towle & Godolphin, 1999). Due to these varying preferences, the elements of information exchange, deliberation and decision making are likely to be iterative and non-linear, rather than occurring in step-wise fashion. Practitioners need to choose flexibly between different professional decision making approaches to acknowledge these varying preferences. It is also important to critique the process of professional decision making rather than simply focusing on the outcome of decisions. Consideration of decision-making processes allows broadening of the possibilities for evolving deeper understandings between practitioners and patients beyond a single decision-making event. Discussions can be undertaken to determine whether a decision even needs to be made, as well as to understand the experiences of patients in implementing the decision. An approach such as this recognises that care is ongoing and that many decisions often need to be made, or that decisions need to be revised when they are no longer suitable.
Some texts included the argument that a determination of preferences should take place prior to engaging in decision making and reaching a final decision (Elwyn et al., 2000; Goodwin et al., 2002; Sandman & Munthe, 2010; Slingsby, 2004; Sulmasy & Snyder, 2010). The main advantage of undertaking a dialogue such as this is that practitioners and patients can come to a deeper understanding of each decision making partner’s circumstances, perspectives and values through dialogue. In this sense, the potential for power imbalances where one person feels compelled to align his or her views with the other person may dissolve because through dialogue the best decision becomes apparent to both communication partners.

Some authors also noted that the outcome of this dialogue about preferences might be to agree that the decision is to be made by either practitioner or patient alone (Elwyn et al., 1999), or that nothing will be done (Charles et al., 1999). It could also be that making a decision is deferred. This differentiation between models according to who makes the final decision has important implications for practice. When one person makes the decision on behalf of another it is important to ensure that the decision maker has in-depth understanding of the other’s perspectives, context and values to ensure that the decision is appropriate and acceptable. It would also be important to transparently communicate and discuss the decision that has been made, to ensure that it does indeed align with these perspectives, contexts and values.

In situations where dialogue does not lead to mutual understanding, practitioners need to ensure that any authorisation of the other partner to make decisions on his or her behalf is “voluntary, non-coerced and well-informed” (Sandman & Munthe, 2010, p. 66) and that the preferences for who makes decisions is revisited as time goes on. This viewpoint reinforces the importance of vigilant critical reflection and self-insight on the part of practitioners regarding the nature of power differentials in relationships with patients.

Decisions are made across the scope of the health care process, including decisions about what individual patient factors may be relevant to explore during an assessment of patients’ needs, what are the most important health concerns and goals of patients, as well as what the nature of follow-up care might be. In my dialogue with the text set, one text was particularly supportive of broadening the scope for SDM throughout the entire health care process. Entwistle and Watt (2006) argued that patient involvement should
be considered in the broader decision-making processes throughout care, not just in light of choosing between health care options. Practitioners should be encouraged to contemplate where patients are able to participate further in decisions about care.

Exploring patients’ contexts, values, beliefs and concerns was recognised as a key element in professional decision making by a number of authors, but it was often implied that the parameters for this exploration were determined by practitioners. Facilitating an open dialogue where patients can more freely express their concerns without being prescriptive regarding ways of knowing that are of importance could help develop deeper understanding of the issues of concern to patients. Patients might also have different perspectives from practitioners regarding which of their health concerns are most pressing or important to consider at a particular time. Engaging patients in making decisions about which health concern to address helps patients feel listened to, and the decisions made about care are more likely to be sustainable and acceptable.

4.2.3 Ways of knowing and sharing meaning
Technical, practical and emancipatory human interests underpin not only practice models but also ways of knowing and types of knowledge that are employed and valued in professional decision making. The ways of knowing that inform professional decision making in the texts included in this dialogue were varied. Most authors suggested that technical knowledge (such as research and clinical knowledge about the available options for health care and their risks and benefits) was of key importance in informing professional decision making. The valuing of other ways of knowing (e.g. patients’ values, fears, beliefs, expectations) was also acknowledged. To gain such knowledge requires other ways of engagement and other more practical ways of knowing, such as professional craft knowledge and personal knowledge, both of which are forms of knowledge derived from the processing and critical appraisal of experience rather than theorising or research (Higgs & Titchen, 2001b). Practitioners may need to expand their concept of how knowledge is derived to incorporate these latter ways of knowing in professional decision making.

Each of these different ways of knowing is of value in informing professional decision making in practice, albeit to different degrees in different situations. It would be more important to consider the technical knowledge aspects of decisions made in acute care contexts where technical precision is of great importance, such as determining nutrient
requirements. In contrast, when making decisions about long-term lifestyle changes, a consideration of sociocultural factors would be of importance in ensuring that decisions are acceptable and fit within these life circumstances. In the latter situations, privileging technical knowledge assumes that the input of patients, including knowledge derived from their experiences, is less relevant, and further that the goals and preferences of patients are shared with those of practitioners (Deber, 1994a). That approach would result in a much poorer understanding on the part of practitioners of patients’ experiences of health and illness, including their ability to carry out treatment regimes (Ersser & Atkins, 2000). Today, patients have access to technical knowledge and statistics; what well-informed patients often require most is expert advice to inform their decisions for their particular health situations (Stein, 2006). As discussed in Chapter 2, however, the provision of technical knowledge is not enough to ensure that long-term decisions will be sustainable. Balancing different ways of knowing appropriately is important to inform the identification of appropriate and acceptable decisions.

Patients’ experiences, perspectives and inclination to make decisions are highly relevant to CDM. For some of the authors, shared and CDM was seen as an inter-subjective undertaking, where the perspectives of a number of people, including patients, practitioners, family members, carers, friends and other health practitioners, come together in making decisions. For example, Moats and Doble’s (2006) negotiated model of decision making for occupational therapists acknowledged the interdependence among patients, family members, the health care team and the greater community to ensure that multiple perspectives informed decisions about care. The authors emphasised the emotional and social meanings that patients place on their health conditions and need for change. This negotiated decision making model has implications for the several ways of knowing that are given value as well as for the way dialogue takes place. If several perspectives are of value, it is important for practitioners to facilitate a dialogue where all these perspectives are shared, explored and negotiated, to reach a deeper understanding.

An understanding of the contexts (physical, cognitive, psychological, social, spiritual and relational) of patients was also frequently argued to be important. For Trede and Higgs (2003), context was of central importance to collaborating with patients, and they argued for the need to adapt technical knowledge to suit this context in decision making.
Wiggins Frame and Braun Williams (2005) and Garcia, Cartwright, Winston & Borzuchowska (2003) also paid specific attention to context, particularly the importance of an understanding of the cultural identity and degree of acculturation of both patients and practitioners. Wiggins Frame and Braun Williams (2005, p. 170) argued that such consideration “invites reciprocal cultural understanding between client and counselor, such that each grasps the historical/cultural factors that contribute to the other’s subjective experience”. Garcia et al. also argued that practitioners needed to consider external contextual influences on professional decision making, such as collegial, professional, institutional, societal and cultural perspectives.

Charles, Gafni, Whelan, and O’Brien (2006, p. 263) suggested that because values about health and goals for health care are culturally informed, practitioners must consider how “cultural expectations will influence the nature of the encounter and how it proceeds, e.g. who is involved, their status, beliefs, role expectations (norms of interaction) and behavior”. The acknowledgement of the impact of sociocultural background on professional decision making is an important consideration given today’s growing social and cultural diversity. For example, economic incentives and existing community ties have led to a diverse range of immigrant and refugee populations settling in rural and regional Australia (Federation of Ethnic Communities’ Councils of Australia, 2012). It could be that attempting to share decision making is culturally inappropriate or irrelevant for some of these individuals. Taking into account the sociocultural context of people who will be influenced by professional decision making is of central importance to achieving outcomes that have personal meaning and value to patients.

Alongside evidence-based practice and the dominance of technical (research-based and theoretical) knowledge, other forms of knowledge were less frequently claimed to be of value to inform professional decision making. Examples were practice knowledge (Trede & Higgs, 2003); the technical knowledge and knowledge derived from experience of other practitioners (Garcia et al., 2003; Wiggins Frame & Braun Williams, 2005); patient experience (Politi & Street, 2011; Zoffmann, Harder, & Kirkevold, 2008); feelings and intuitions of practitioners (Wiggins Frame & Braun

---

6 For example, a recent review of regional settlement in Australia in four regional areas found that refugees were predominantly from a range of African and Middle Eastern countries.
Williams, 2005); and feelings about patients’ and practitioners’ roles and relationships (Entwistle & Watt, 2006). However, these less frequently valued ways of knowing and being are important when professional decision making is viewed as a relational and discursive endeavour.

Understanding the experiences of patients means that decisions made are more likely to be acceptable to patients and fit with their circumstances and world views. The sharing of practitioners’ practice knowledge during professional decision making can also contribute to a deeper understanding of both the context of the health issue being discussed as well as possible alternatives for care. Trede and Higgs (2003, p. 69) also argued that utilising “practice knowledge with an emphasis on cultural, personal and experiential knowledge ensures the elimination of any unreflected, unnecessary clinical dominance”. Actively paying attention to and discussing how both patients and practitioners feel about their relationship, as well as the roles they play, can facilitate a more open and transparent dialogue regarding concerns, goals and expectations during professional decision making.

The linear exchange of knowledge from one person to the other was a focus of many texts. It was proposed that this knowledge is then utilised in the deliberation phase of professional decision making. Yet there was little mention in these texts of any transformation of this knowledge into new understanding. Other texts focused on the construction of new knowledge by patients and practitioners together as part of the decision-making process (Betan, 1997; Collins & Street, 2009; Cottone, 2001; Kasper et al., 2011; Politi & Street, 2011; Zoffmann et al., 2008). This focus on co-construction of knowledge was based on the argument that without co-construction there is a danger that people interpret and make sense of information in different ways.

For example, Kasper et al. (2011) argued that information can also be selectively interpreted; that is, only parts of the information may be interpreted and used to inform decisions. Because of these variations in the way information is interpreted, they argued for the centrality of an interpersonal and social co-construction of knowledge to inform professional decision making. This approach is consistent with a philosophical hermeneutic view of professional decision making, where decision-making partners bring their pre-understandings to the decision-making process and dialogue together to create new shared horizons of understanding.
Some authors claimed that reflection was a key process in coming to a shared understanding. For example, Zoffmann et al. (2008, p. 681) advocated an approach where patients and practitioners undertook reflection either together or apart: “time together gave time for mutual reflection, whereas time apart gave patients time for independent reflection”. The aim of mutual reflection was to help patients to identify issues that needed further independent reflection. This independent reflection was considered to be important to help patients gain greater insight into their attitudes towards their illness and whether these attitudes could be a barrier to making change. These authors strongly emphasised the importance in professional decision making of understanding the experiences and perspectives of patients living with chronic illness. It is also important for practitioners to undertake independent reflection and critically examine their own experiences, values and beliefs, in order to assess any potential impact on the decision-making process and to reach a shared understanding.

Knowledge derived from critical appraisal and reflection upon practitioners’ experiences, values and beliefs was claimed by a number of authors to be of importance in informing professional decision making. Kasper et al. (2011) argued that previous conceptions of SDM employed a limited perspective on knowledge sharing, where practitioners shared technical knowledge derived from scientific evidence and patients shared their values. The authors suggested that this approach was limited because it potentially ignored the importance of also including patients’ experiences and understandings of technical knowledge as well as practitioners’ values in the professional decision making process.

In their “multicultural ethical decision-making model”, Wiggins Frame and Braun Williams (2005) argued particularly for consideration of the potential power imbalances arising from cultural differences. They suggested that practitioners should consider the location of patients and themselves in cultural and community power structures and how power differences affect decision making. They particularly claimed that the cultural dominance of Anglo-Saxon groups was potentially problematic, suggesting that practitioners in this cultural group need to be mindful of the potential consequences of their “white privilege” (p. 172). Consideration of these power issues is important because they can have a significant impact on the development of a trusting relationship in which patients feel they can share their concerns and expectations with practitioners.
Wiggins Frame and Braun Williams also suggested that practitioners should ask themselves how a better understanding of others’ world views might assist in making decisions.

Charles et al. (2006) suggested that practitioners might benefit from consideration of their own cultural expectations, how they might be influencing their ideas about decision making and how they might be perceived by others from different cultural backgrounds. These authors lend weight to the importance of reflecting upon the pre-understandings that are brought to practice as well as considering the sociocultural conditions that have influenced their development. This reflection can assist in enabling decision-making partners to come to a deeper understanding together through dialogue. Practitioners should be encouraged to be aware of the prejudices they bring to the decision-making process and how these prejudices influence how the decision-making process takes place. Of particular importance to professional decision making is a critical reflection on roles, knowledge, power, professional relationships and dialogues.

Some authors also highlighted the importance of dialogue in exploring and communicating pre-understandings during the process of professional decision making. In the collaborative clinical decision making model proposed by Trede and Higgs (2003), open transparent dialogues during the decision-making process that aim to expose underlying interests and enable critical understanding of each other’s perspectives are considered imperative. This co-construction of meaning presupposes that both dialogue partners are aware of and incorporate the values, beliefs and perspectives they bring to professional decision making. Betan (1997, p. 348) also emphasised “the roles of interpretation and subjectivity in understanding” and the importance of the context of the relationship in making ethical decisions. A philosophical hermeneutics perspective informed Betan’s model, and the author argued that it is important to consider subjective views of the world, particularly in ethical dilemmas that are influenced by context, culture and relationships. Trede and Higgs (2008b, p. 46) argued that decision-making participants need to be “aware of their own interests and motivations; this clarifies the reasoning process and enables collaborators to reach critical decisions that include objective, emotional, political, cultural and other factors”. A distinctive characteristic of a collaborative approach to decision making, then, is an emphasis on identifying and exposing these interests during the dialogic
process of exploring pre-understandings, fusing of horizons and coming to a shared understanding.

4.2.4 The nature and complexity of the decision/s to be made

CDM is influenced by the nature of the decision to be made. Decisions made in health care practice can vary from straightforward to more complex. For example, when patients and practitioners have similar world views (such as what they value and believe about health) and sociocultural backgrounds it is likely that coming to a shared understanding about the health issue at hand and making a decision that is acceptable to both is relatively easy to achieve. However, when patients have different cultural, social, religious or spiritual views from those of practitioners it can be harder to come to a shared understanding and reach an acceptable decision. It can also be that a number of people are involved in making decisions beyond the patient–practitioner dyad, such as family, carers, friends or other health practitioners, who each bring their own world views that are important to explore and incorporate in the decision-making process. The degree of complexity of decisions to be made has significant implications for the relational and discursive dimensions of decision-making approaches.

In this text dialogue, some authors specifically highlighted the influence of complexity of decisions on decision-making activities and suggested that a number of factors contributed to this complexity. These factors included the impact of the decision on patients, the certainty of which decision might be optimal for patients, the complexity of the health issue at hand, balancing the evidence to inform decision making (including clinical, personal and health information about the patient and scientific evidence) and weighing up practitioner responsibilities to the individual as well as the community (Braddock et al., 1999; Trevena & Barratt, 2003). These findings were helpful for appreciating the complexity of professional decision making. The suggestions provide a framework for practitioners to make decisions flexibly with patients according to the unique context of the occasion of care. The authors’ insights support the notion that decisions in health care practice are complex and not always amenable to one particular approach. However, the authors did not elucidate how they integrated quantitative research evidence with each of the other dimensions. Furthermore, the focus on characterising dimensions could reflect a desire to reduce this complexity and offer a more prescriptive approach to professional decision making. This focus on
characterising dimensions appears paradoxical when these researchers were engaging with complexity.

The need to adapt decision-making processes according to the nature of the decision, task and complexity was evident in the work of Braddock et al. (1999), who argued that as complexity increases, there is a greater need for discussion of treatment alternatives, including their pros and cons and the uncertainties associated with them and with patients’ understanding of the chosen treatment. Makoul and Clayman (2006) also stated that there are essential and ideal features of SDM. They suggested that although certain aspects of decision making should ideally take place, such as coming to a mutually agreed decision, reaching a shared decision might not actually happen despite other aspects of the process being shared. The utility of this view of professional decision making for practitioners lies in assisting practitioners to identify which aspects of decision making have high priority and which do not. It is important to recognise, however, that although the identification of essential and ideal features might encourage practitioners to focus on ensuring that these key features are prioritised in practice, they can also serve as an uncritical focus and a barrier to practising in a flexible and responsive manner to the entire situation.

The complexity of the clinical circumstances within which decisions are to be made was also suggested to be an influence on how professional decision making takes place. The feminist-informed model proposed by Faith et al. (2003) was developed to inform decision-making relationships in the context of caring for adolescents with eating disorders. The model is based on a feminist sociocultural perspective that encourages patients to critique and challenge the way that society and culture influence the way patients feel about their bodies. A consideration of patients’ sociocultural background and how it influences beliefs, values and preferences, as well as those of the many individuals participating in care, was seen as important to inform a shared understanding of the care situation and the potential acceptability of health care alternatives.

The many options available for health care, the uncertainty of outcomes of various health care options and the various settings in which health care takes place can complicate deliberations between patients, families and caregivers prior to coming to a decision. Faith et al. (2003) argued that these factors should be carefully discussed with
patients and their families as part of the decision-making process. The authors also stated that there can be difficulty in balancing the promotion of autonomy of patients with the perspectives of the family and health care team, particularly when these perspectives are in conflict. Because of such conflicts, Faith et al. emphasised the need for transparent and frequent communication among all members of the team, patients and family members to ensure that each perspective is heard and respected. There was also acknowledgement of the complexity of these contextual elements and of how psychological, emotional, interpersonal and ethical dilemmas can arise during the process of decision making and providing care.

Faith et al. (2003) provided a framework for practitioners to consider the complexity and intricacy of the pre-understandings, perspectives, clinical circumstances and the various ways of knowing, each of which needs to be taken into account in making decisions in highly complex or uncertain situations. At the root of this consideration is the importance of critically reflecting on the effect of social, political and cultural influences on the development of health issues such as eating disorders. This discussion of complexity highlights the importance of taking into consideration how these sociocultural contexts can constrain or facilitate relationships between practitioners and patients and the way that dialogues take place during professional decision making.

In another text, Rapley (2008, p. 432) argued for a conceptualisation of decision making that recognises the complexity of its contexts: “decision making evolves over multiple situations, involving different people, technologies and knowledges”. Rapley focused on the temporal, sociocultural and organisational aspects of decision making in an attempt more realistically to capture the decision-making approaches used in situated practice. Temporal aspects are important to inform an understanding of professional decision making for a profession such as dietetics, where patients may engage with dietitians on a long-term basis and also with a wide range of other practitioners. A consideration of how various relational aspects impact on professional decision making can also be of use for early career practitioners who are in the process of developing professional identity and learning about their role in the health-care team.

A number of authors acknowledged that making decisions was not always restricted to patient–practitioner dyads. Family members, surrogates and other health practitioners also play roles in making decisions. For example, Charles et al. (1997) proposed that
when decision making is shared there are always at least two decision making partners – the patient and the practitioner – but there may also be family members, carers, friends or other health practitioners involved. They argued that the views and perspectives of these people could have significant implications for the decisions that are made as well as the power differentials that form within the group making the decisions. They stated that in health care it is likely that patients may want family members, carers or friends involved in making decisions, to assist in deliberating on options or on the potential outcomes of different decisions. They also pointed out that decisions may also directly or indirectly affect these people, who may have particular preferences in encouraging the selection of a particular pathway of care. Consideration of how the involvement of these people and the contribution of their perspectives and preferences affect professional decision making is important because it contributes to a deeper understanding of the situation. It can also inform practitioners how they can best support patients and their significant others in making decisions that are most likely to be acceptable for all involved.

4.2.5 Power differentials

Power differentials between patients and practitioners can have significant implications for the nature of interactions and conversations that take place in professional decision making and the ability of each to come to a deeper understanding of the other’s circumstances, priorities, perspectives and values. A deeper examination of how authors treat power differentials follows.

The presence of power imbalances between patients and practitioners was recognised by a number of authors included in this dialogue. Some authors discussed power differentials at a surface level, simply with respect to who had the power to make the final decisions. Power was seen to rest with one or the other decision-making partner, or it was suggested that power should be shared between the two. Others claimed that it was more likely in practice that the sharing of power would be on a continuum (Makoul & Clayman, 2006) and that practitioners should consciously reflect on how their power was being used (Trede & Higgs, 2003). Power was acknowledged as a key concern by these authors, although they brought different views of how these power differentials affected the dialogic and relational dimensions of professional decision making.
Power differentials in professional decision making have implications for the likelihood of practitioners and patients coming to a shared understanding through dialogue. When practitioners dominate the decision-making process it is highly unlikely that a deeper understanding of each partner’s circumstances, perspectives, priorities and values between patients and practitioners will be reached through dialogue. It can also be that patients or practitioners feel disempowered or disinclined to communicate to the other how the final decision might or might not be acceptable to them.

Authors frequently viewed good interpersonal communication as important in developing a trusting and respectful relationship where patients could freely express their views without judgement. Some authors, however, asserted that communicating well is not sufficient to address power differentials in patient–practitioner relationships and that a frank discussion of the nature of the relationship is also required. For example, Entwistle and Watt (2006) argued that patients and practitioners needed to explicitly discuss their views and feelings about the process of decision making, as well as how they feel about their relationship. They argued that this discussion pays more attention to the subjective experience of making decisions as well as to the importance of the interpersonal relationship between patient and practitioner. Conducting these open discussions avoids misunderstandings and the silencing of implicit but unchecked perceptions.

Other authors argued that practitioners also need to pay attention to the temporal nature of relationships. For example, Kasper et al. (2011, p. 6) saw relationships as ongoing and dynamic, and “established anew by each interaction in a communicative process”. This viewpoint has particular relevance when patients have a long-term relationship with practitioners. An explicit discussion of how patients and practitioners feel about their relationship is important in such contexts to ensure that appropriate approaches to professional decision making are used at different times. In these situations, patients can experience significant variations in their health status, such that their preferences for participating in making decisions might vary. Over time, patients might feel more able to voice their concerns about the roles they are playing (or not playing) or contributions they are making (or not making) to decision making. Including relational dimensions in a decision-making model allows patients to have a greater voice regarding these facets of professional decision making and increases the likelihood that they will experience decision-making approaches that are most suitable for them.
The onus for management of power differentials in the patient–practitioner relationship was frequently placed on practitioners by authors of texts in this dialogue. Some authors argued that, given the inherent power differentials in patient–practitioner relationships, it is unrealistic to expect patients to be able to equally participate in negotiations about health care and it is therefore important for practitioners to create an environment where patients feel comfortable to share their ideas and concerns (Charles et al., 1999; Chewning & Sleath, 1996; Collins & Street, 2009; Elwyn et al., 1999; Elwyn et al., 2000; Faith et al., 2003; Siminoff & Step, 2005; Towle & Godolphin, 1999; Trede & Higgs, 2003). This supportive environment is an important precursor to sharing pre-understandings and coming to a deeper understanding of circumstances, perspectives and values.

Other authors argued that patients could and should have active involvement in the management of their relationships and should participate in the creation of the communication climate within which professional decision making takes place. For example, Makoul and Clayman (2006) argued that neither patients nor practitioners require particular capabilities to share decision making, and that discussion about any of the different features of decision making can be broached by either of the decision-making partners. These authors also acknowledged that power imbalances between patient and practitioner always exist, even when decision making is shared. Arguing for shared responsibility in establishing a trusting environment is in line with an argument for shared power in patient–practitioner relationships. However, it may be difficult for patients to influence the decision-making approach used. On the basis of this literature it is reasonable to suggest that practitioners need to take the lead in creating an environment where patients are empowered to contribute to the direction that care takes. This environment includes creating sufficient time to undertake dialogue leading to deeper understandings.

In contrast to Makoul and Clayton, Siminoff and Step (2005) suggested that the communication climate is created by both communication partners. They based their “communication model for shared decision making” on the assumption that communication is transactional and has both content and relational aspects. In terms of responsibilities, they suggested that it is the role of patients to express their preference for participation and the role of physicians to set the communication tone of the
interaction. The authors argued that there are both pre-existing and “real-time” factors that influence communication during the decision-making process, and acknowledged that the combination of these factors in a consultation means that professional decision making is not always based on technical knowing; moreover, not all patients want to actively participate in professional decision making. The need for explicit discussion between patients and therapists to ensure appropriate professional decision making approaches are employed is reinforced.

Another issue identified that requires consideration in addressing power imbalances concerns impact of how and when practitioner perspectives are communicated during professional decision making. Elwyn et al. (2000) argued that sharing practitioners’ perspectives before exploring those of patients can distort patients’ views and inadvertently lead to practitioner dominance. Others argued that exploring both decision-making partners’ perspectives in a transparent manner, which includes sharing practitioners’ values and beliefs, is important to ensure that a shared understanding can be reached (Cribb & Entwistle, 2011; Faith et al., 2003; Quill & Brody, 1996). In advocating their “enhanced autonomy model”, Quill and Brody (1996) asserted that the perspectives of each participant in decision making, as well as any attempts to influence the other by expressing these perspectives, should be open, transparent and free of coercion. This discussion about who should discuss decision-making preferences, and when, highlights the need for sensitivity to power differentials and attention to detail.

Sandman and Munthe (2010) stressed the importance of the ability to autonomously express what each partner sees as relevant in professional decision making, openness to question each other’s interests, and equal weight being given to the goals and interests expressed. An important component of their model was that “all interests, goals and reasons should be openly displayed” (p. 78), implying that both dialogue partners should be aware of their interests, goals and reasoning in the decision-making process. They proposed a “professionally driven best interest compromise model” when patient and practitioner cannot come to a consensus. This model was based on Habermas’ “theory of communicative action”. Sandman and Munthe argued that attempting to reach a compromise with patients by encouraging them to reconsider their point of view was acceptable as long as it was transparently communicated that this was practitioner’s intention and that decisions were not coerced. With the use of strategies that allow both patients and practitioners to communicate their views and preferences as transparently
as possible it is much more likely that the root of different understandings is uncovered, a compromise around the issue at hand can be reached, and an optimal decision made. By clearly communicating their views and preferences, practitioners can ensure that patients do not feel compelled to realign their perspectives with practitioners, who could be seen as the more powerful decision-making partner.

4.2.6 Nature of decision-making dialogues
The way that conversations take place in professional decision making has important implications for the ability of patients and practitioners to come to a deeper understanding of each other’s circumstances, perspectives and values about care. In this thesis I take a philosophical hermeneutic perspective to conversations, in that coming to a deeper understanding requires a question and answer dialogue where both partners seek to understand their own horizons of understanding, openly and transparently share and expand upon their pre-understandings, and seek to achieve a shared meaning or a fusion of horizons.

The majority of decision-making models included in this text dialogue did not specifically mention the use of dialogue in professional decision making and were more likely to use words such as conversation or discussion to describe the talk that goes on during decision making. The way that these conversations would take place was more likely to be implied or contained within a description of each step of a model. In these texts, there seemed to be a silence regarding the impact of the nature of dialogue on professional decision making, and I explore that issue in my research.

It appeared that decision-making models in which either patient or practitioner has sole control of decision making were characterised by conversations where one person asks the other many questions and uses the answers to inform his or her decision making. In contrast, when decision making was shared, authors described conversations or discussions where answers lead to the next question. A number of authors provided practitioners with suggestions as to how to phrase questions and statements and make responses to facilitate the decision-making process. For example, Trede and Higgs (2003) encouraged the use of open questions to reach a deeper understanding of patients’ circumstances and a commitment to search for a number of alternative solutions to broaden possibilities for patients to achieve their health goals. Open rather than closed questions encourage both decision-making partners to share their
knowledge, stories, values, ideas and preferences and come to a mutually satisfactory
decision. The nature of open questions facilitates deeper understanding between
decision-making partners.

The nature of conversations has implications for the depth of understanding that can be
achieved concerning each decision-making partner’s perspectives about the issue under
consideration. Monologues are shaped by a closed question-and-answer technique.
Closed questions are the quickest strategy to obtain knowledge that one seeks. Such
questioning is an efficient way of gathering necessary data, but it runs the risk of
limiting opportunities of the person answering to provide context and personal
preferences. In question-and-answer decision-making formats, knowledge is collected
according to what the person making the decision might deem important. Simply
providing knowledge and leaving the other person to make the decision represents a lost
opportunity to discover crucial unanticipated details that can inform CDM.

Individual, monologic decision-making models are also much more susceptible to
misunderstandings and miscommunications. Sandman and Munthe (2010) suggested
that, when patients take control of decision making, practitioners are still required to
frame the decisions that patients may make, for example by selecting and
communicating a range of options for health care from which patients could choose. As
the authors suggested, communicating in this way can ensure that practitioners support
patients’ choices while still being assured that the outcome will be within best practice
standards. However, there may be no further opportunity to discuss all the options of
care available to patients. By opening a dialogue with patients, practitioners can
combine their own perspectives and ideas with those of patients, leading to a greater
likelihood that the decision made about care (regardless of who makes it) is based on a
deeper understanding of the issue at hand.

When decision making is shared, the aim is to come to a deeper understanding of the
issue at hand as well as of each other’s perspectives and values, and then make a
decision that is considered mutually acceptable. The emphasis on practitioner self-
awareness means that dialogues also involve practitioners sharing their beliefs and
values during professional decision making. Quill and Brody (1996) and Collins and
Street (2009) were the few authors who specifically suggested strategies to promote
dialogue with patients. Both texts highlighted the importance of openly sharing perspectives during dialogue.

Quill and Brody (1996) suggested that a full exploration of the assumptions, values and perspectives of all decision-making partners should be part of the dialogue in decision making. They argued that, apart from leading to an enhanced understanding, this approach could facilitate the identification of new solutions or meaning transformation for one or both decision-making partners.

Collins and Street (2009, p. 1508) based their model on self-determination and dialogue theory and the key assumption that understandings are “socially constructed through conversations” (p. 1508). The authors were particularly concerned with conversations about the risks of cancer treatment. They proposed a model that advocated key roles that practitioners need to play in such conversations: explaining and articulating risk concepts, explaining the purpose of different steps of the decision-making process, clarifying differences of opinion and values, inviting reflection on the meaning of each other’s perspectives and being open to alternative perspectives. Collins and Street also suggested that practitioners use strategies such as partnership building and overt questioning to promote a dialogue in this conversation.

These conceptualisations of dialogues are enhanced by returning to Gadamer’s philosophical hermeneutics (1975/2004). People bring pre-understandings to the process of professional decision making. There is an active attempt to communicate and understand each other’s point of view, with the aim of coming to a deeper understanding through dialogue. Dialogues conducted in this manner can lead to fusions of new horizons and a shift in understandings. Managed sensitively, with a strong sense of self and reflection on the potential impact of professional power relations between patients and practitioners, a dialogical approach to professional decision making has the potential for individualised and appropriate decisions. Practitioners can also become more aware of the interests that inform professional decision making and there is potential for transformation of perspectives of patients and practitioners, if warranted.

4.3 Professional decision making in dietetic practice

There is limited literature on CDM in dietetics, and there appears to be none that deals directly with the CDM experiences of new graduates, apart from presentations I have
given (Olsen, Higgs, & Trede, 2008a, 2008b, 2008c, 2008d; Olsen, Trede, & Higgs, 2007a, 2009a, 2009b, 2010a, 2010b). This work is reflected in later chapters in this thesis.

The most current model of practice that is recommended for use in clinical dietetics by the Dietitians Association of Australia (DAA) is the “nutrition care process and model” proposed by Bueche et al. (2008). The model, as discussed in Chapter 2, has four key steps: “nutrition assessment, nutrition diagnosis, nutrition intervention, and monitoring and evaluation” (p. 1113). The term decision making was mentioned by the authors as a part of the nutrition care process, but they did not provide in-depth discussion of its theoretical underpinnings, meaning and implications for practice roles. A collaborative partnership between dietitians and patients was claimed by Bueche et al. (2008, p. 1113) to be the “central core” of the nutrition care process and model, particularly in the intervention phase of the model, but the implications of this collaborative partnership for the professional roles of dietitians and for professional decision making were not further explored. There is a significant gap in the dietetic discourse regarding this phenomenon.

Patients’ views of dietetic care have been researched in the past, with particular interest in how dietetic intervention influences biomedical, emotional and psychological outcomes (Cook, Nasser, Comfort, & Larsen, 2006; Hancock et al., 2012; Jones et al., 2007; Morley Hauchecorne, Barr, & Sork, 1994; Schiller et al., 1998; Vivanti, Ash, & Hulcombe, 2007). This body of research revealed that patients valued relational aspects of care as much or in some cases more than the perceived benefit or outcomes of care. Of particular relevance to my research is the study conducted by Hancock et al. (2012), who used focus groups and interviews to explore patients experiences of their consultation with a dietitian. These authors found that patients valued the information they received from dietitians, especially if it was individualised, consistent with other sources and explained clearly to them. Patients had varied preferences for a prescriptive approach to dietetic care and identified the importance of a partnership with dietitians where they worked together to solve problems. A non-judgmental, empathic and ongoing relationship with the same dietitian where patients felt accepted was valued. Patient participants described communication strategies of value, including provision of positive feedback, use of nonverbal communication and feeling listened to. However, patients did not feel they were supported well enough to make behaviour change, they
reported varied success in being motivated by dietitians and frustration if their expectations were not met. The reviewed research literature here highlights the importance of further exploring the relational, dialogical and situational aspects of professional decision making with early career dietitians.

Desroches et al. (2008) explored shared decision making (SDM) in inpatient and outpatient settings of clinical dietetic practice. This research was informed by the theory of planned behaviour and involved focus groups with dietitians, measured aspects of SDM during audiotaped consultations between patients and dietitians, and questionnaires for dietitians, all to explore salient beliefs about SDM. The focus group component of the research explored the salient beliefs of dietitians regarding two aspects of SDM: describing available options for treatment to patients and helping them to determine their values and preferences about these options (Desroches et al., 2011). Salient beliefs encompassed dietitians’ attitude to these SDM behaviours, the people they thought would approve or disapprove of these behaviours, and the barriers and facilitators to using the behaviours. Compliance with treatment, targeting of treatment, and enhancement of a trusting relationship were the advantages claimed for SDM. The identified disadvantages of providing treatment options to the patient were the potential for patients to feel less secure in the care process and also that presenting options to patients may increase dietitians’ feelings of competence to provide care. It could be argued that these findings, particularly regarding the importance of adherence to treatment advice and a concern about appearing incompetent, revealed an underlying concern of these dietitians regarding the maintenance of professional authority in decision making. However, the findings that targeting of treatment and enhancement of trusting relationships were identified as advantages of SDM also reflect a desire of these dietitians to address potential power imbalances in patient–dietitian relationships.

Key people who dietitians identified as approving these behaviours were physicians, patients’ families and the rest of the multidisciplinary team. However, physicians were also identified as possibly disapproving of dietitians giving patients treatment options. Dietitians also claimed that patients’ diagnosis, degree of motivation, social and family circumstances, personality and depth of understanding, as well as the dietitian participants’ perceived time constraints, were barriers to presenting evidence-based knowledge. The main barrier to clarifying patients’ values was a perceived lack of time. It is interesting to note that these barriers were attributed to external influences; it was
not clear whether dietitians had questioned their own values and beliefs regarding SDM. The relationships of dietitians with others were also influential, further confirming that the relational dimension to professional decision making is of importance for further exploration in my research.

Vaillancourt et al., (2012) found that there was little overall involvement of dietitians’ patients in shared decision making. However, the longer the consultation the more likely patients were to be involved. Dietitians were more likely to explore patients’ expectations about how to manage their health, but they were least likely to ask patients about their preferences for involvement in shared decision making. The focus of this research was on quantifying the presence of and asking for opinions about defined aspects of SDM. Although these findings provide a good starting point for understanding the attitudes towards, barriers to and potential influences on professional decision making approaches in dietetics, taking a predominantly quantitative approach in this manner limits the potential to explore the complexity and context of professional decision making.

There are two key remaining areas of the literature on professional decision making in dietetics, namely decision making in an evidence-based practice framework in dietetics and decision making in ethical dilemmas. The remainder of this section outlines the interpretations that arose from my dialogue with these texts.

Evidence-based practice in dietetics focuses on the importance of combining evidence generated from empirico-analytical research results with professional judgement and the individual patient circumstances in decision making (Gray & Gray, 2002; Hise, Kattelmann, & Parkhurst, 2005; Porter & Matel, 1998; Vaughan & Manning, 2004). The key message for dietetic practitioners in this body of literature is how to critically appraise research results and to keep the focus on practitioners’ own clinical reasoning, with less emphasis on promoting an interpersonal dialogue. A focus on intrapersonal reasoning and scientific evidence is important for a relatively new profession like dietetics because it needs to claim expert technical knowledge. It is also important, however, to not lose sight of the contextual, sociocultural, relational and discursive aspects of professional decision making.
The second area of focus for decision making literature in dietetics is decision making about ethical dilemmas. Frameworks for guiding this ethical decision making process have been underpinned by the ethical principles of autonomy, non-maleficence, beneficence and justice (Andrews & Marian, 2006; O'Sullivan Maillet, 2008) and Codes of Ethics (Gallagher-Allred, 2012). The importance of considering patients’ abilities or preferences about involvement in making decisions is also recognised in these frameworks. These frameworks have been applied to a variety of clinical contexts where ethical dilemmas might arise, such as for patients with human immunodeficiency virus (O'Sullivan Maillet, Vyas, & Rodrigues, 2004), for enteral feeding of older adults in residential aged care (Dorner, Posthauer, Friedrich, & Robinson, 2011; Volkert et al., 2006) and for those who are incapacitated and unable to participate in making decisions (Lyons, Brotherton, Stanley, Carrahar, & Manthorpe, 2007).

The complexity of ethical dilemmas in decision making in working with patients with eating disorders has also been explored (Matusek & O'Dougherty Wright 2010). Matusek and O'Dougherty Wright claimed that ethical dilemmas in eating disorders centre on conflicts between respecting patient autonomy and preserving life in a situation where cognitive function is compromised by starvation. They argued that the use of coercive strategies to enforce care decisions is common in the care of patients whose competence to make decisions is thus impaired. Another complication they described in eating disorders care is that patients may be in the transition between childhood and adolescence, developing a sense of self and autonomy, but may not yet be legally recognised as able to make their own decisions. The authors suggested that there may be a conflict between making decisions for these patients and encouraging them to develop their own sense of self and autonomy in their own care. They argued that decision making in these situations requires an approach that recognises the relational, contextual and cultural features of care and suggested the use of Garcia et al., (2003) “transcultural integrative model” of decision making as a guide.

This discussion of ethical dilemmas acknowledges the complexity of legal, clinical, social, cultural, financial, emotional and ethical issues in professional decision making. This complexity involves not only patients but also their family and other team members. It should be recognised that consideration of these factors is important in professional decision making in dietetic practice even when ethical dilemmas do not exist. People living with chronic illness, for example, are most likely to take into
account the social, cultural, financial and emotional consequences of making certain changes to their lifestyle. Dietitians need to be able to engage in dialogue with patients to more deeply understand these issues as they apply to individual patients as a precursor to and during ongoing professional decision making about dietary change.

Empirical research has explored the perceptions of dietitians, patients, carers and other health professionals regarding professional decision making, particularly in the area of artificial nutrition and hydration. Brotherton, Abbott, Hurley, and Aggett (2007) found that the perceptions of parents of children receiving tube feeding about involvement in decision making were significantly different from those of dietitians and nurses involved in children’s care. Dietitians and nurses believed that the parents were involved to a greater extent than parents did. Brotherton and Abbott (2009) later found similar results with adult patients receiving tube feeding, in that the majority of patients interviewed did not feel included in decision making, due to poor communication, lack of information provision and paternalistic attitudes of practitioners. Carers of these patients agreed that lack of information and paternalistic attitudes of practitioners were problematic. The carers felt that it had been communicated to them that there were no decisions to be made regarding tube feeding and that tube feeding would go ahead regardless of their opinion. The authors argued that decisions relating to tube feeding might not always be amenable to SDM, particularly in situations where there was no other way to feed patients and to not feed patients would be negligent.

These authors’ viewpoints raise the issue of who determines which actions are be considered negligent, and may relate to how practitioners interpret different ethical principles. It may be considered by a practitioner that to withhold nutrition compromises patient wellbeing and this overrides patient autonomy. Yet it could also be argued that to exclude patients from decision making about whether to be fed by a tube is also negligent as it compromises patients’ sense of self determination. Regarding situations when there is a decision-making choice, the findings from both these studies highlighted the importance of overtly discussing the preferences of patients and their carers in making decisions about care. However, this research also highlighted the importance of carefully and sensitively discussing ethical issues where it is possible that practitioner and patient values might be different.
Research has also been conducted to explore the opinions, attitudes and beliefs of dietitians regarding end-of-life nutrition support. Taper and Hockin (1996) used a questionnaire to explore the attitudes and beliefs of Canadian dietitians regarding nutrition support for terminally ill elderly patients. The authors found that whereas dietitians wanted to be involved in the decision-making process within the context of the health-care team, they were more likely to give the autonomy and individual wishes of patients precedence in decision making. Langdon, Hunt, Pope, and Hackes (2002) also used a questionnaire to explore the opinions of a group of American dietitians regarding end-of-life nutrition support. They found that dietitians wanted patients and their families to make the decisions. Although the dietitians felt they should play a role in the decision-making process, half of those surveyed did not feel confident in providing information to help patients and families make an informed choice. The authors postulated that this lack of confidence might be due to a lack of experience in engaging in this type of decision making.

Although respecting patient autonomy is important in making decisions about end-of-life nutrition support, dietitians can play an important support role in helping patients make these difficult choices. As Langdon et al suggest, dietitians could benefit from reflection on their own values and beliefs about end-of-life care to help inform this decision-making process. Other studies have found that dietitians recommended tube feeding even if they were in doubt as to its benefit (Enrione & Chutkan, 2007). Dietitians’ judgements about tube feeding vary. Indeed, there appears to be no consensus on when it is appropriate to tube feed (Healy & McNamara, 2002). Making situated and contextualised decisions in collaboration with patients and their significant others is important in these situations.

The preceding interpretation of the literature highlights the complexity that dietitians face when making decisions in ethically fraught situations, such as when there is a clash in ethical values between patient autonomy and doing no harm. Dilemmas arise for dietitians when they can foresee potential physiological benefits of feeding and hydrating a patient but patients and their families wish to discontinue feeding and hydration, for quality of life or other reasons. This literature on tube feeding informs greater understanding of professional decision making in this area of dietetic practice and acknowledges the contextual, socio-cultural, relational and discursive aspects of practice that may inform professional decision making. However, it falls short of
grounding decision making in theoretical frameworks and providing insight into professional decision making for the diversity of other patients with whom dietitians work.

Considering the answers I derived from the dietetic ethics texts, it was important to conduct a further dialogue with texts from other fields of dietetic practice, such as chronic illness including diabetes and obesity. Although there is literature regarding professional decision making in chronic illness in other disciplines (Holman & Lorig, 2000; Zoffmann et al., 2008), the dietetic literature provided little opportunity for a question and answer dialogue on professional decision making in dietetics for these illnesses.

Furthermore, there is little critical analysis of the practice reality of dietitians in terms of external impacts on their autonomy to collaboratively make decisions with patients. It may be that, in some situations, barriers exist to make decisions collaboratively with patients. The Practice Advisory Committee of the DAA (2006) has provided a Scope of Practice Decision Framework to assist in determining whether certain activities are within the scope of dietetic practice. The framework is of use here in considering potential barriers to collaborative approaches to decision making in dietetics. Although collaborative decision making itself is not specifically mentioned in the National Competency Standards for Entry-Level practice, working collaboratively with patients to set health care goals and implementing the nutrition care plan are key elements of competence relating to individual case management. Professional decision making in itself would be considered a regular practice activity, and making decisions collaboratively is consistent with the DAA Statement of Ethical Practice (2011b) which encourages practitioners to respect the needs, values and culture of the people they work with.

On the basis of this analysis, working collaboratively appears to be within the general scope of practice for dietitians. However, the framework also encourages dietitians to consider that guidelines and protocols for practice, restrictions imposed by position descriptions, specific institutional policies and protocols or legislation may mean that they cannot collaborate with patients about certain issues (Practice Advisory Committee, 2006). There may also be the need for employers to provide authority for certain decisions to be made, as well as the need for practitioners to seek additional
insurance to cover decisions they make (Practice Advisory Committee, 2006). Lastly, it is suggested that consideration be given to the experience level of practitioners with respect to their ability to collaborate effectively with patients to assist in decisions about dietitians’ scope of practice. This framework assists practitioners to consider some of the professional and organisational influences on professional decision making, but it does not make reference to the relational, discursive or interest dimensions that are of interest in this research. Deeper understanding of how early career dietitians make decisions with patients and the challenges they face in doing so with respect to all these dimensions of practice is the key goal of my research project.

4.4 Implications for professional and collaborative decision making in dietetics

With increasing patient diversity and complex co-morbidities in the 21st century, dietitians, like any other health care practitioners, need to flexibly move between various professional decision-making models. Different professional decision-making approaches are appropriate in different stages along patients’ health care journeys. Stroke patients require practitioner-driven decisions for enteral nutrition in the acute phase in order to survive if they cannot physically or cognitively participate in decision making. For most patients in such situations it is unlikely that practitioners are making decisions alone, as family members, friends or the guardianship board may assist in decision making about care. As argued by White, Malvar, Karr, Lo, and Curtis (2010), even in these situations there can be varying levels of input from others in the decision-making process. Patients may subsequently prefer a more collaborative approach in the rehabilitation phase to regain functionality and return home to self-manage their health.

At times, dietitians need to support patients to make decisions between different courses of action to treat a condition. For example, dietary modification and physical activity are core management strategies for people who are morbidly obese, but patients could also have been presented with surgical or pharmaceutical options for management. Dietitians are well placed to provide knowledge to these patients to help them make their decision about health care. Dietitians are also well placed to participate in the deliberations regarding health care and to help patients come to a realistic decision, as would be the case in a CDM approach.

A CDM approach is more appropriate for patients who are living with chronic diseases such as diabetes or cardiovascular disease, because of the emphasis on the sociocultural,
relational and discursive dimensions of professional decision making. Patients living with such chronic disease need to make changes to their lifestyles and a consideration of their sociocultural contexts is of utmost importance here. When dietitians work with patients who have these chronic illnesses, decision making is revisited time and time again, through acute exacerbations as well as during periods of good health. Many relationships and conversations take place between patients, their families and carers and practitioners during this time span. Relationships with patients who experience a lifetime of chronic illness need to be based on respect, trust and mutual understandings. Hence attention to the situational, cultural, relational and discursive dimensions of professional decision making is of importance in my philosophical hermeneutic study of the perspectives of early career dietitian participants’ perceptions and my interpretations of professional decision making in dietetic practice.

More broadly, the text interpretation in this chapter has implications for the theoretical underpinnings and practice culture for dietetics. These findings support the argument that dietetics needs to move beyond a biomedical-technical focus in professional decision making to one that also gives value to the social, cultural, relational and discursive aspects of professional decision making. These findings also clearly show that the ability to flexibly choose the approach to professional decision making that best suits the unique circumstances of the clinical situation at hand is imperative. Through critical self-awareness and engaging in transparent dialogues to come to a deeper understanding of each patient and each individual clinical situation, practitioners are more likely to employ a decision-making approach that results in acceptable and sustainable decisions being made.

These findings also have implications for the three conditions that are required for dietitians to make decisions collaboratively with patients when collaborating is appropriate. First, the establishment of a relationship that is based on trust and transparent consideration of the impact of power differentials is essential to create the space for an open dialogue and communication of ideas. This text interpretation implies that using a CDM approach requires a significant level of insight as well as confidence on the part of practitioners to challenge themselves, their practice and the context in which it takes place. It is of critical importance for practitioners to reflect on their interpretations of power, autonomy, compliance and empowerment if decision-making
approaches that allow the appropriate sharing of power and multiple ways of knowing in the context of an open and democratic dialogue are to be realised.

Second, an understanding of each dialogue partner’s point of view, sociocultural background and history is essential for reaching a deeper understanding of each partners’ circumstances, perspectives and values about care and for co-constructing new meaning. CDM requires the appropriate application of different ways of knowing and experience in practice. A good technical knowledge base is essential to inform professional decision making. However, acknowledgement of and engagement with the complexity and dynamic nature of the patient’s sociocultural context is equally important. Patients bring to the clinical encounter different experiences of wellbeing and illness, as well as beliefs, values and preferences about health and health care. An understanding of these experiences, beliefs, values and preferences is important for achieving deeper understanding of patients’ health concerns as well for making mutually acceptable decisions.

Third, due to the power imbalances between practitioners and patients, practitioner awareness of the experiences, beliefs, values and preferences that they bring to professional decision making is also important, in order to consider potential barriers or facilitators of different approaches to professional decision making. Models of shared professional decision making have been criticised for not going beyond the surface aspects of implementation of the approach to consider how the interests and motivations of practitioners drive decision-making approaches (Trede & Higgs, 2008b). Professional CDM models that are informed by a critical social science perspective to practice acknowledge the complexity of practice as well as the importance of becoming aware that practice is driven by interests that are often taken for granted or assumed (Trede & Higgs, 2008a).

Certain practitioner attitudes have been identified in the literature as potential barriers to SDM, such as reluctance to relinquish professional power and difficulty in accepting patient expertise as equally valuable to practitioner expertise (Weston, 2001). Weston’s research suggested that practitioners’ desire to preserve their dominance could be a key driver for not involving patients in professional decision making.
One of the more commonly claimed barriers to sharing decision making with patients is lack of time, particularly with respect to the processes of information transfer and exchange and deliberation on treatment options (Charles et al., 1999; Deber, 1994a; Elwyn et al., 1999; Légaré et al., 2008). Ford, Schofield, and Hope (2003) claimed that allowing adequate time for exploring perspectives and stories as well for discussing treatment options is important for SDM. Having adequate time during and after the interaction between practitioners and patients can also help patients reflect on changing priorities of care. Citing time constraints as a barrier indicates the low perceived priority of shared approach by these practitioners. It could be argued, however, that although more time is spent in reaching a deeper understanding of the issue at hand between patient and practitioner, in the long term more time could be saved, as this understanding could mean that more realistic and acceptable decisions are made.

The identification, exploration and critique of interests such as these deserve greater attention and consideration in the development and use of professional decision making models for practice. Further, Inglis (1997) argued that while the aim of SDM is to empower individuals to make changes within their current environment, the realisation of optimal health may require the environment itself to be critiqued, resisted or challenged, which is outside the scope of most of the SDM models presented in this text interpretation. Identifying and questioning taken-for-granted aspects or assumptions of practice enables practitioners to hear the perspectives of less powerful decision-making partners. When practitioners are sensitised to listen they are more likely to understand what patients’ real intentions or needs are, and to respond appropriately and effectively.

4.5 Conclusion
Through my philosophical hermeneutic study of relevant literature I have identified:

- Key theoretical dimensions (cultural, relational, discursive and interest) of practice that can provide a theoretical framework for CDM in professional (clinical) practice
- Core theory and practice dimensions of professional decision making in health care practice (i.e. practice theories, roles of patients/practitioners, ways of knowing and sharing meaning, decision complexity, power differentials, dialogues)
- Key implications for realising CDM in dietetics.
This study focused on developing a deeper understanding of professional decision making approaches in the health care (including dietetic) literature. As shown in Figure 4.2, my text interpretation has highlighted the key dimensions in facilitating exploration and better understanding of the core dimensions of professional decision-making. I have also drawn a number of implications of this framework for the implementation of CDM in dietetic practice. From this interpretation I understand that CDM requires three key capabilities. The first is the establishment of a relationship where open dialogue and communication of ideas can take place. The second, an understanding of one’s dialogue partner’s points of view, sociocultural background and personal history, is essential for reaching a deeper understanding of the decision-making partner’s circumstances, perspectives and values for co-constructing new meaning. The third capability is self-awareness of each dialogue partner regarding the values, beliefs and perspectives they bring to professional practice.
Figure 4.2 Key dimensions of a professional practice framework, core dimensions of professional decision making, implications for CDM in dietetics and key capabilities for CDM in dietetics

Implications for CDM in Dietetics:
- Move beyond biomedical-technical decision making focus to a sociocultural and relational one
- Be flexible in decision-making choices
- Use CDM where appropriate (especially with patients with chronic conditions)
- Recognise and address barriers to CDM
- Recognise workplace expectations/norms
- Match decision-making strategies to practitioners (experience, choices) and patients (preferences, capacities)
- See decision making as dynamic and situated in time, space (and for each) person
- Frame CDM in relationships
- Share decision-making power
- Respect patients’ choices and knowledge
- Consider changes to the environment as well as to the person’s lifestyle
- Create a supportive communication climate for dialogue where each partners’ circumstances, perspectives and values are transparently shared and explored
- Give adequate time to decision making both within and outside of the dietitian–patient interaction
- Become aware of and, if necessary, challenge one’s practice models

Figure 4.2 Key dimensions of a professional practice framework, core dimensions of professional decision making, implications for CDM in dietetics and key capabilities for CDM in dietetics
I now move from abstract and theoretical consideration of professional decision making to the empirical component of my research. I interpret the observations and experiences of early career dietitian participants regarding their professional decision making in practice. I also examine how the three conditions that I have established in this chapter relate to my participants’ observations and experiences of decision making.
CHAPTER FIVE

DIETITIANS’ OBSERVATIONS AND EXPERIENCES OF PROFESSIONAL DECISION MAKING

In the previous chapter I concluded that collaborative decision making (CDM) needs certain relational and discursive dimensions, as well as self-awareness of the values, beliefs and perspectives that are brought to practice. In this chapter I consider the application of these findings to practice in the real world and answer the research question: What are the observations and experiences of early career dietitians regarding professional decision making and CDM in particular? My question and answer dialogue is presented in this chapter with particular emphasis on relational and discursive dimensions and awareness of key influences on decision-making approaches of dietitian participants.

Having immersed myself in a question and answer dialogue with the text constructed to understand in greater depth the observations and experiences of dietitian participants I have identified that the relational, discursive, cultural and interest dimensions of their practice were significant influences on their choice of decision-making approach. These dimensions are explored in detail and my interpretations reveal that they are closely interwoven and interdependent. The dietitian participants focused on developing professional roles and status and establishing successful professional relationships with patients. There was varied discussion and perception of external influences and depth of insight into the pre-understandings they brought to professional decision making.

5.1 My interpretive lenses
In this component of my research I set out to interpret the participants’ texts using theoretical lenses that emerged from my theoretical dialogue with the literature in Chapter 4. Each lens was used to understand in greater depth dietitian participants’ observations and experiences, with a particular interest in considering the implications for CDM in dietetic practice. The reasoning for using each lens was as follows:
a) Relational dimension: how dietitians relate to patients and how dietitians see themselves in relation to others involved in professional decision making may have implications for the extent to which decision-making power can be shared.
b) Discursive dimension: the nature of the conversations that dietitians undertake during professional decision making has implications for establishing open dialogues that allow the sharing and exploration of pre-understandings and coming to new understandings.
c) Cultural dimension: the culture of the external work environment of dietitians as well as the educational and professional culture within which they were educated and socialised may have a significant influence on the value that is given to CDM as well as the development and utilisation of the capabilities needed for CDM.
d) Interests dimension: the interests that drive the decision-making approaches of dietitians have implications for the nature of the relationships that dietitians form with the people around them and the nature of the conversations that take place in professional decision making. There may be dominant interests apparent within different cultural groups. The impact of these dominant interests on the practice of my participants is of particular interest in my research as the participants were early career dietitians who were still undergoing the process of being socialised into their profession and workplace culture.

5.2 Relational dimensions of professional decision making

In this section, the observations and experiences of participants regarding their relationships with patients during professional decision making are discussed. Questions I posed to myself as researcher to guide my interpretation included: What is my interpretation of dietitian participants’ perceptions of the conditions for successful relationships with patients? What is my interpretation of dietitian participants’ understandings about the power relations between themselves and patients and the influence of this relationship on professional decision making?

I interpreted two key aspects from the participants’ texts in relation to the way they construed and facilitated positive and successful relationships with patients. These were (a) identifying and creating conditions for successful relationships and (b) acknowledgement and management of power relations between dietitians and patients.
5.2.1 Conditions for successful relationships

All dietitian participants valued building a positive therapeutic relationship with patients, based on openness and trust. Dietitian participants appeared to perceive that being non-judgemental and building an environment of trust where patients could be open and honest was important to humanise relationships and provide a positive and successful basis for patients’ health care. Dietitian participants commonly held the expectation that patients would be open and honest in sharing their experiences, thoughts and feelings:

It’s not just me telling someone to do something. I need to negotiate with them, I need to know that they’re going to take on board what I’m saying, I need to work with them and they’re honest with me and they’re open with me. [Sabrina 7]

Sabrina appeared to relate the extent to which she perceived patients to be open and honest to her ability to negotiate change with them. She wanted her patients to listen to her advice, but also emphasised that she did not want to be dominant in her communication with patients, and she wanted to hear their point of view. During her reflections in Chapter 6, Sabrina further explored the impact of inconsistencies in communication on her practice to try to come to a shared understanding with patients. This finding suggests that when shared understanding is sought in professional decision making, it may be important to identify any potential practitioner dominance and unreflected assumptions about others, to avoid misunderstandings and the silencing of patient perspectives.

Dietitian participants were particularly aware that patients may indeed expect them to be controlling and the more dominant partner in the decision-making process. They appreciated that patients came to them with a sense of trepidation that they might be expected to follow perfect diets and achieve perfect outcomes. Some dietitian participants actively sought to soften the harsh image they observed that patients held of them, as in the following example provided by Natasha:

By the time you get to the end you can tell that it wasn’t as bad as they thought, they kind of go “Oh it’s not that bad”, like they were thinking it was going to be the absolute [removal of unhealthy foods], and especially if along the way during the education if they’ve got like a couple of bits of bad food here or there, a couple of pieces of chocolate every few nights and you say “No, you’re allowed, you’ve still got to have some things you like”. They start to relax a little bit with you once they realize you’re not the “food police”. [Natasha]

---

7 All names used in the findings chapters are pseudonyms to maintain participants’ anonymity.
Natasha believed that it was important to indicate to patients that being a dietitian did not mean that she was judgmental and expected adherence to a perfect diet. Dietitian participants each saw the negative impact that being judgemental could have on working effectively with patients. They frequently mentioned the importance of building rapport with patients, which particularly involved demonstrating that they would not be judgemental and that they would listen to patients’ concerns and attend to their needs. Sabrina described seeking to build a degree of rapport when first working with eating disorder patients, so they felt more comfortable working with her in the future:

> Sometimes I won't even talk about food. In the first visit I'll just talk about what they're interested in and a bit about myself or something like that just to get rapport so that they then will open up to me, because [then] they know I'm not going to force anything down their throat. [Sabrina]

Sabrina understood the significant and complex relationship that eating disorder patients had with food and eating, and that taking the first step to changing often highly self-controlled eating habits can be extremely threatening. An interpretation of her use of language is telling here. She uses a metaphor of not forcing something down patients’ throats to emphasise the importance of the care she took to ensure that patients trusted that she would not impose decisions onto them. Developing rapport and trust first meant that Sabrina deliberately chose to create relationships where patients felt encouraged to share their beliefs and values openly. Participants revealed a sense of awareness of *what it might be like for patients* to see a dietitian and they discussed how they created conditions for patient-centred professional relationships.

### 5.2.2 Power relations between dietitians and patients

Dietitian participants were aware of the negative implications of being prescriptive and controlling, and they avoided them. They frequently sought to democratise their professional relations with patients. Some dietitian participants used sharing their personal experiences or their practice experiences gained from previous patients as one strategy to shift power relations and to come to a deeper understanding of patients’ concerns. Among these dietitian participants there were varied views as to which experiences were acceptable to be shared and in which ways.
Kate was adamant that openly sharing her personal health experiences could be of value for patients during the decision-making process. She had a personal understanding of what it was like to live with a health condition and considered that it was important to disclose this shared experience. She felt that this sharing helped her to build a relationship of trust and mutual understanding and to show she was human:

K: I think just from what I’ve done in my mentoring, having that personal spin on things. Once they can relate it back to someone being a person, someone having done it. I think that really helps. So you see people who’ve come in, they don’t care, you’re just the dietitian and they don’t think you can appreciate their situation until you say “well hang on this has happened to me in the past” or “I had a friend who … whatever. So I can appreciate, I have some type of empathy on your situation”.

MO: So you see that empathy is important?

K: Yeah for a lot of patients it’s, take away the clinical/medical side of it and put a more personal type spin on it. [Kate]

Kate wanted to show her empathy for patients’ situations and that she could empathise with their perspective. She claimed that sharing encouraged patients to talk about their experiences without feeling judged. Recognition of patients’ concerns and expectations, as Kate elucidated here implies that she was aware of the extent of her professional authority in relation to patients. Revealing that she was human too demonstrated that she wanted her professional relationships with patients to be less hierarchical and technical.

In contrast to Kate’s views on the benefits of sharing her experiences, Holly considered that it was inappropriate to share any overt information about herself with patients. Holly indicated in the following quote that her focus was firmly on patients and there should be little of herself as a person visible in the health care process:

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]

Holly directed patients’ attention to their situations and used a questioning strategy to help patients consider their position. This reflective questioning approach differs from Kate’s sharing of personal experiences, but both display patient-centredness. They both engaged wisely in creating professional relations that were based not on hierarchical

8 MO – Marissa Olsen – refers to me as researcher
knowledge but rather on patients’ perspectives. Although Holly valued sharing experiences, she considered that sharing her personal eating habits had the potential to be manipulative and dominant. The difficulty here is that it might not always be appropriate for practitioners to disclose personal information. There is no one best approach or strategy for all practice situations; rather, there are diverse possibilities and practitioners need to create professional relations that are the best choice in a given situation. One possible disadvantage of Holly withholding personal experiences to avoid being authoritarian is that she could have denied patients a chance to know her as a person as well as a dietitian. These findings suggest that emphasising that there are multiple perspectives regarding the achievement of health goals may be an important role of practitioners to help reduce practitioner authority, particularly when CDM is the appropriate decision-making approach.

Most dietitian participants wanted to share knowledge they had derived from their experiences, but they appeared hesitant to invite patients to share the knowledge that they had derived from their health experiences in professional decision making. In the following quote, Belinda reflected on working with a patient group with whom she had limited experience. When asked if she could consider inviting patients to share their personal knowledge about their health situation, in effect reversing roles so that patients taught her instead of the other way around, Belinda was hesitant:

B: I don't know. I don't know whether...
MO: 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.
MO: Yep. 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]

It can be interpreted that Belinda thought that admitting to patients that she had gaps in technical knowledge and experience risked her patients’ trust in her professional expertise and added to patients’ uncertainty. However, Belinda also described times when she did admit these gaps and communicated to patients that they were welcome to express any unfulfilled needs. Despite her initial uncertainty, Belinda’s thoughts here potentially represent an openness to learn from patients’ experiences in living with their
health condition, which can consequently change the power differentials in her relationships with patients.

Holly was receptive to the idea of learning from patients and reflected on whether gaining a deeper understanding of patients’ experiences and perspectives could help to address power imbalances in her relations with patients. Holly appeared to be open to seeking to learn from patients, in light of her willingness to admit to patients deficits in her technical knowledge and experience. In the following quote, I asked her to reflect on her approach when working with parents of children with eating issues:

Because with the introduction to solids sometimes it’s a bit awkward, but often I’ll go in there and make a bit of a joke of “I don’t have kids, I’m only here to offer you the theory, I’m offering you the textbook, I might have some ideas, your kids are going to be different. I might have some ideas for you, but I obviously don’t know the first thing when it comes to actually feeding a baby. I can only tell you what I know”. [Holly]

From Holly’s account of letting patients know that she does not have children, and that the ideas she had needed to be adapted to their individual situation, I interpreted that she might have reduced the professional power imbalance because she acknowledged parents’ expertise and pre-empted parent judgment. Learning from patients as a way of reducing power imbalances between Holly and her patients was the focus of her reflections, as discussed further in Chapter 6. After the second interview, Holly described how she had tried to engage patients by asking them for their ideas and opinions to inform professional decision making:

I think it was more that openness: “you know your child better than I do. I’ve known you for 20 minutes by this stage. Can you tell me what you think the issues are? Or how would this work? What are you concerned about?” And just working with the parents more than just “This is what I see is the issue and this is how you fix it”. Sort of loosen that prescription. [Holly]

This quote shows how Holly had begun to become aware of how powerful learning from patients could be for her in acquiring a greater understanding about nutrition and dietetics. She saw what learning from patients could do for dietitian-patient communication and for the nature of the discussions about treatment that followed. This approach is aligned with the emancipatory interest of enabling patients to be in control. Practitioners can learn about the experience of living with a condition, such as what it is actually like to implement difficult and lifelong dietary changes. These findings suggest that inviting patients to share such experiences can enhance the potential to come to a
deeper understanding of patients’ circumstances, perspectives and values and bring them to the core in the professional decision-making process. It can be concluded that, by learning from patients, dietitians may be better able to model sharing and collaborating.

5.3 Discursive dimensions of professional decision making

In this section, I interpret the way that dietitian participants perceived and interpreted the conversations they had with patients. Questions I posed to myself as researcher to guide my interpretation included: What is my interpretation of how dietitian participants perceived and interpreted the conversations they had with patients? What is my interpretation of how dietitian participants perceived who had control of conversations? What is my interpretation of how dietitian participants perceived what knowledge was exchanged during conversations?

There were two key aspects that I interpreted from the participants’ texts in relation to their perceptions of discursive dimensions. These were (a) control of conversations and (b) knowledge exchange during conversations.

5.3.1 Control of conversations

Dietitian participants appeared to be in control of the majority of their conversations with patients. They utilised various techniques to direct conversations: direct communication of decisions they had already made about care, provision of information to set parameters for professional decision making, and question and answer techniques to gather information about patients to inform professional decision making.

Direct communication of decisions

Dietitian participants often described conversations in which they directly communicated to patients decisions they had already made about patients’ health care, in effect establishing a monologue where their ideas were given highest priority. In these situations the role of patients was to listen; they were not invited to contribute their ideas. For instance, patients’ preferences for the professional decision-making approach were not overtly sought. Dietitian participants appeared to be in charge of choosing which professional decision-making approach to use to guide overall health care, including what their role as dietitian was. Dietitian participants overwhelmingly expressed hesitance about prescribing diets for patients as they saw diets to be
unsuitable for promoting sustainable change in the long term. If patients expressed a
desire for a prescribed diet, dietitian participants were more likely to tell patients that
prescribing diets was not their role, as in this example provided by Kate:

At the start of a consult for the last few months since I’ve been to the mentoring I
always ask “What are your expectations of the consult today?” or “What were you
expecting me to do for you?” and they usually come out with “Oh I just want you to
give me a diet sheet and I can be on my way”. So then I explain what a dietitian
does and why they are here and that type of thing. [Kate]

The mentoring that Kate described here was from a senior dietitian as part of the
Accredited Practising Dietitian (APD) program. Based on discussions with this senior
dietitian, Kate had trialled inviting patients to tell her what they would like as an
outcome of the health care provision. This meant that she was creating an opportunity
for a discussion about the scope of dietetics and potential roles practitioners and patients
can play. Kate may have interpreted that patients were not aware of what dietitians do
and in such circumstances describing her role was a useful part of this discussion. It
might be, however, that in certain circumstances patients would prefer a different
approach to dietetic care. This finding suggests that by extending the discussion with
patients to include what their role could be, practitioners could adapt their role to ensure
patients’ needs were met. Kate had a strong sense of her duty of care being to provide
technical knowledge to her patients and ensure they followed her advice. She also had a
strong commitment to being patient-centred and her reflections focused on how she
could bring patients’ perspectives into this discussion. These reflections are presented in
Chapter 6.

Some dietitian participants linked their confidence in their technical knowledge with the
likelihood of taking greater control of conversations with patients. Kate and Margot
described a lack of confidence in inviting patients to participate in the conversation
when working with patients with unfamiliar conditions. Margot reflected here on how
familiarity influenced her decision-making approach:

But if it’s something I haven’t seen a lot of, I’ll launch into “this is what we’ll do and
let’s not stray from the path because I don’t know how to…” yeah so it’s probably
more diabetes or weight loss that I’d be more comfortable to do that [engage the
patient in discussion] with because I know if it went off on a tangent I’d know where
to get back to, because I’ve done it so many times, it’s a bit like second nature. But
if it’s someone who has something slightly out of what I normally see, yeah, I’d
really be quite structured. [Margot]
Margot didn’t want to stray from “the path”, which implied that her “fallback” position for practice when she lacked confidence was taking control of the conversation. Kate experienced discomfort when she saw a patient with a condition she had not encountered before and similarly became more likely to take charge during professional decision making:

Maybe every time a new disease comes up that I’m not really sure about and I have to research it. Then I get kind of stuck again. Rather than doing the client-centred thing, I just use a… “step one, two, three, this is what we’ll do”. [Kate]

Holly described situations in which she related a sense of low confidence in her technical and practice knowledge to her likelihood of engaging patients in a conversation about dietary change. I interpreted that this may have been more a lack of confidence with regard to engaging with complexity, or simply having had insufficient exposure to complexity at this early stage in her career. She felt that she was more open to exploring complexity and sharing professional decision making in situations she was more comfortable with:

When you think about it, you go into a weight loss client without knowing what the problem’s going to be. Yet you’ve got a whole specific list – you’ve got diet sheets for every other issue – so someone comes in with high cholesterol you can say “Well, this is a list of things you should and shouldn’t do”. But I am doing better about – I don’t tell them “Well, just don’t eat this, don’t eat that”. We have a look at how they can make changes, but I do have to start doing that to more of those paediatric [cases], I guess, where I’m not as comfortable. Like, if I had a renal client and I don’t feel comfortable there, I would be very prescriptive. I don’t think I would actually be able to counsel in that sense. [Holly]

In these cases, confidence and technical knowledge went hand in hand. The possession of technical knowledge was accorded high value, and technical interests appeared to be driving practice. Holly perceived that her comfort with her technical knowledge was proportional to her comfort in exploring patients’ concerns and needs. What Holly experienced represented a paradox of sorts whereby until her technical knowledge base of felt secure, she was more likely to be practitioner-centric. Until her need to “know enough” was satisfied, she did not feel comfortable to engage patients in a conversation that could expand the discussion to facilitating a deeper understanding of the issue at hand, which is of particular usefulness when practice is complex.
Setting the parameters for professional decision making

Setting the parameters for professional decision making through provision of technical and practice knowledge was another strategy that dietitian participants described to direct conversations. Dietitian participants described setting the parameters for professional decision making at a number of points throughout the dietetic care process, most commonly when setting and prioritising overall goals for care and deciding what the arrangements for follow-up care would be. Kate described an example of how patients were advised about goals for care here:

K: That's usually something I'm doing in my head as I'm talking to them and taking the information and I send back to the doctor what my goals [for health improvement] would be and then it's mainly negotiating the strategies [for dietary change] with the clients.
MO: So is there any time ever that you would share those goals with the patient? The things that are in your head?
K: I guess I explain to them that weight loss is going to be something we need to achieve and looking at how much weight I'd like them to aim for and what type of timeframe… but I would never go “these are the goals I've set” like, 1, 2, 3, 4 or listing them out for them or anything. [Kate]

In this conversation, Kate described the application of technical knowledge to patients’ contexts to suggest to patients what might be realistically achievable in relation to weight loss. These parameters were then used to determine what patients’ goals for care might be. Eliza described a similar approach to set weight loss goals based on a commonly cited evidence-based recommendation:

I suppose a really good end is them achieving a realistic goal. So if it's someone coming for weight loss it's them achieving 5 to 10% weight loss not the 40 kilos that the doctor told them that they have to lose. I think for me that's a good outcome for them, though they might not feel that. If it's something like an infant that isn't feeding and gaining weight well it is that they have achieved weight gain or they are eating a nice amount of food or I suppose that they've got what they want, but a realistic goal. [Eliza]

Eliza acknowledged that a goal that she saw to be realistic and guided by empirico-analytical evidence might not match patients’ desires, but that the aims of patients and other health practitioners might not be achievable. Eliza perceived one of her roles to be sharing her expertise with patients to set goals that were based on empirico-analytical evidence. I interpreted that both Kate and Eliza valued using their experience to inform a sense of what was realistically achievable for patients in their given circumstances. Eliza was aware that she gave advice against a backdrop of conflicting social messages about weight loss in particular, and when patient circumstances such as financial
difficulties can be significant barriers to or enablers to making change. This finding suggests that the blending of technical knowledge with an understanding of patients’ circumstances, beliefs and values is important to ensure that sustainable and achievable decisions about dietary change are made.

**Question and answer techniques**

Question posing appeared to be a common strategy that dietitian participants described to direct conversations when sharing information was the goal. Dietitian participants commonly asked patients questions when deciding on strategies for dietary and lifestyle change. They asked questions of patients to encourage them to express their views. Natasha provided an example that was indicative of this approach:

> Then I said, “well, what about the alcohol? Is there any way you think you could reduce the intake?” He said, “well, if I don’t go down to the pub for as long…” and so we wrote a few things like maybe not going as early, not staying as long and only staying for one shout of the six men instead of going round twice and that sort of thing. But [drinking] middies and lights were a big no, which I thought they would be. It was a very social thing, I guess, being a bachelor. And his number one goal was to get back to work full time because as soon as he got back to work his exercise would increase and he would lose the weight anyway. [Natasha]

Natasha’s use of open questions and briefly interspersing her practice knowledge with these questions was a common approach in conversations used to decide upon strategies for dietary change. Each dietitian participant used variations of this conversation style when helping patients to determine suitable strategies for dietary change. It can be interpreted that this approach is aligned with a dietitian’s practical interest in more deeply understanding patients’ circumstances and helping to engage patients in the professional decision-making process. However, this approach could also create a monologue where patients’ voices are the loudest. This finding points toward the importance of practitioners being able to choose flexibly a decision-making approach based on a deep understanding of patients’ circumstances, preferences for participation and goals for care, as well as each other’s beliefs and values. Facilitating a dialogue where both patients’ and dietitians’ perspectives are heard is an important skill to develop to achieve this aim.

### 5.3.2 Knowledge exchange in conversations

Each dietitian participant placed high value on providing technical knowledge, often referred to as “the evidence”, to patients. This evidence was used to set the scene for the
ensuing conversation. Margot reflected here on how she drew her patients into making decisions by sharing her technical knowledge during her conversations with patients:

[I would explain] “this is the recommended thing to do, how's that going to [work]?, can we work on any of these?” Or sometimes if we've got a big list of things to do, I'll say alright well you don't have to do all of them but try and pick out a few that you might want to work on or if you can do all of them then do all of them. Then I leave it up to them and then they'll come back and say “I did this or I didn't do that” [Margot].

For Margot, the provision of technical knowledge during conversations was seen as one of their key roles and an important precursor for dietary change to take place. The dietitian participants also recognised, however, that patients’ social, cultural and familial contexts were important to consider alongside technical knowledge in making decisions about dietary change. Eliza saw this to mean that patients often chose to make changes that were different from the changes she would have selected herself, and she found it important to involve patients in conversations about making change:

It [making change] is something that they have to be ready to work on. I do explain that my role is to provide them with the education and help them think of strategies and maybe ways to change, but what they actually change is up to them, because it is their condition and their disease, and what I think is easy and what they think is easy could be two different things. And again, I generally give a suggestion, like if changing to low fat milk from full cream milk is something that they're never ever going to do then there's no point setting that as a goal. [Eliza]

Eliza considered that providing information was of importance for making change and understood that patients might have a different perspective regarding which changes were of importance. She saw the limitations of prescribing change solely based on technical knowledge and understood that patients needed to consider the information she was sharing about nutrition in light of their personal circumstances and preferences. She understood that patients might perceive situations differently. It could be interpreted that Eliza saw the importance of understanding the difference between agreeing with the theoretical need to change and making the change in practical terms.

There were occasions that dietitian participants described when they chose not to seek further information from patients about their sociocultural and familial context to inform professional decision making. In the following quote, Sabrina described a situation where she felt that it was clear what the patient’s expressed needs were and she sought to accommodate those needs without entering into further discussion:
The other day we had people come in and the husband had cancer and his wife was wondering, “I’ve got him on supplements, is there anything else I can do?” I said “Well, we’ll talk about it when you come in”. So when she came in, to go through all these [assessment] questions they were just getting frustrated, they were just like “I just wanted to come in and find out if there was anything else I could do”. So if I had sat there and went through “Have you got vomiting and have you got a family history of cancer?” or anything like that they would just, the body language was telling me they just wanted me to go through just was there anything else they could do. So I just skipped that and just went straight to, “Well maybe you could do this or you could do that” gave them recipes, gave them some [different] supplements to try, just pretty much what they wanted. They were happy as Larry and off they went. [Sabrina]

Sabrina recognised that provision of information was sufficient and what this patient wanted at this point in time. In this case, by being open to this patient and his wife’s body language and listening to their responses, Sabrina was able to vary her decision-making approach depending on the situation at hand. Sabrina’s thoughts here suggest that encouraging early career dietitians to think about how drawing on their observation of patients’ nonverbal communication can help balance and blend technical knowledge with other ways of knowing in practice. In this case, however, Sabrina might have needed to ask further questions about this patient’s tolerance of the supplement before making a final decision. If this patient was vomiting, for example, the decision to take the supplement might not be optimal. These interpretations of Eliza and Sabrina’s experiences suggests the importance of the skill of practitioners not only in being open to and listening to patients’ needs but also in being able to question patients appropriately to reach a deeper understanding of their circumstances, perspectives and values, and blend appropriate ways of knowing in coming to a decision about care.

There were some attempts to blend different ways of knowing in professional decision making. For some participants, technical knowledge sharing was not given centre stage; rather it was seen as part of a process of negotiating decisions with patients. Here Lisa described how she made decisions about strategies for dietary change with a patient who was eating in response to stress:

I thought that the first step was just to acknowledge the situation and talk about what was happening. We worked on if she currently binges seven days a week, to limit it to five days and the strategies to stop doing it on those two days. I emphasised that the activity had to be fun. It had to somehow substitute for the serotonin kick. We talked about what was fun for her, even though it was an unusual thought to think about something that was fun for her. I pushed for the walk, or the swim, or the Tai Chi [Lisa]
Lisa suggested that she interspersed her technical knowledge and practical suggestions while discussing strategies for change. She acknowledged that her ideas might not be readily accepted or easy for patients to take on board. Lisa adapted her advice depending on the way patients responded to it. Other dietitian participants described posing questions on aspects of nutritional care beyond determining strategies for dietary change. At the beginning of the research, it was evident that Holly, Eliza, Belinda, Margot and Natasha had already started to explore question posing when prioritising care, setting goals and exploring barriers to making change. Holly provided an example:

A lot of my patients say, “Oh my doctor wants me to be here” and I’ll always then say “Well how do you feel, are you happy to be here? How do you feel about that?” and “Oh the doctor wants me to lose 10 kilos”. “Ah well, what would you like to lose? How do you feel about that? Do you think that’s realistic?” [Holly]

Holly recognised that patients might not necessarily agree with their doctor’s advice, and she invited them to voice their opinions and ideas. It can be argued that responding to patients’ reactions and adapting the conversation accordingly in these examples is aligned with patient-centred decision making. These findings suggest that these practitioners may have been less likely to be practitioner dominant in the decision-making process and patients’ perspectives were more likely to be heard, which is a condition for CDM.

5.4 Self-awareness of influences on professional decision making

In this section, observations and experiences of participants are discussed regarding the influence of their membership within different cultures on decision-making approaches. Questions I posed to myself as researcher to guide my interpretation included: What do I interpret to be key influences on decision-making approaches of dietitian participants? What do I interpret to be the perceptions of dietitian participants regarding the influence of these factors on professional decision making? What is my interpretation of how self-aware dietitian participants are of the nature of these influences on professional decision making?

A range of factors appeared to influence approaches to the professional decision-making approaches utilised by these dietitian participants. These factors included the educational experiences of dietitian participants, perceptions of professional role, relationships with other health practitioners, time pressures, the rural and regional environment and cultural background of patients. The dietitian participants varied in the
way they interpreted the influence of each of these factors on professional decision making and the extent of their awareness about how these factors influenced their practice.

5.4.1 Educational experiences

Educational experiences in this thesis refer to the tertiary education dietitian participants undertook to commence practising as dietitians and the formal and informal professional development the dietitian participants had experienced since graduating.

Dietitian participants did not often make an explicit link between what they had been taught and what they had learned about professional decision making in their tertiary education and how they practised professional decision making now. Dietitian participants were more likely to discuss feeling underprepared to face particular challenges after they graduated from university. These challenges related to working with complex patients who needed long-term support or nutrition counselling. This finding is consistent with recent Australian research conducted by Cant and Aroni (2008b), who found that dietitians of all experience levels had sought out further study after their entry-level training to further develop their nutrition counselling skills.

My interpretation was that the educational experiences that dietitian participants described appeared to emphasise technical ways of knowing. Lisa’s main critique of her university education was that the different domains of dietetic practice were not well integrated, which had implications for her use of technical knowledge in real-world situations:

> When I was studying it was more “There’s this, and there’s this and there’s this and this” and they were separate units and then you’d go off and you’d do community placement, do your food service, do your clinical but it wasn’t like what happens in the real world, [with one exception. This exception] gave you the opportunity to interact to see what happens and to test your knowledge under pressure, which is different to what happens when you sit down and write it in an exam. [Lisa]

Lisa was disappointed that she had had few opportunities during her tertiary education to learn how to use her technical knowledge in an integrated way in real-life situations. Lisa claimed that her education was compartmentalised. She considered that she was not given the opportunity to draw together her knowledge to make decisions in situations where her knowledge about food service, clinical and community domains of
practice came together. Second, Lisa suggested that her university curriculum placed strong emphasis on technical knowledge and valuing technical interests in practice.

One participant directly linked the inadequacy of her tertiary education to her professional decision-making approaches. Holly described being taught to tell people what to do rather than to explore what patients would or would not do or how they felt about making changes:

We had one particular course in counselling and we were just taught... you just tell the people what to do and there was no [consideration of] "Well, I'm not really going to actually do that" in terms of asking the client how do you feel about that. You just say "Well this needs to be done and this needs to be done and this needs to be done and I'll see you later". So I realised that talking to clients that way wasn't actually going to help them, they weren't actually going to do things and they just lose respect for you. [Holly].

Holly had found that speaking to patients didactically was not useful and had negative implications for the relationships she had with them. Prior to participating in my research she had sought out formal professional development to explore how she might work differently with patients other than telling them what to do. She wanted to help patients realise lasting change beyond just ensuring compliance to dietary advice, which she claimed was not sustainable in the long term. I interpreted that the educational experiences of Lisa and Holly appeared to be aligned with a practitioner-centric approach to practice without acknowledgement or preparation to use a situated approach to inform professional decision making. A practitioner-centred approach to practice strongly privileges technical knowledge and can silence other forms of knowing, which is problematic when social, cultural or political ways of knowing are of use to inform professional decision making.

In the period between graduation and participating in my research, some dietitian participants had already started to explore alternative approaches to practice. A number of dietitian participants had recently attended a workshop regarding the use of Health Coaching in dietetic practice. Health Coaching is an approach that is receiving much attention and support as a useful way to facilitate long-term behaviour change in the dietetic community (Lipscomb, 2006). A common perception among dietitian participants who had attended the Health Coaching workshop was that practitioners’ viewpoints are to be withheld during professional decision making. Belinda was
struggling to use this approach in that she had found it difficult to completely withdraw her opinion:

According to the Health Coaching and according to other people like Dr Rick Kausman, yeah, you’re supposed to, just really not offer any suggestions at all and just clarify misinformation [Belinda]

Belinda seemed to think sharing her point of view was manipulative, and considered that by withholding her point of view while discussing dietary change she might be able to reduce the likelihood that she dominated the decision-making process. When asked to further interpret her experiences with health coaching, Belinda suggested that she found this approach difficult, particularly as she would like to have an input into making decisions. Belinda’s experience had already told her that withdrawing her opinion was not effective. I considered that it was possible that she maintained her belief in the value of this approach because of the value she perceived that her profession gave to it. Because of this value, it might be that Belinda was concerned that questioning the validity of this approach in her practice was inappropriate. She alluded to her lack of time to commit to exploring issues with patients and she indicated that she liked to have input:

I know with the health coaching approach that you are supposed to provide them with information and they pick things out, but I emphasise and I go “Ok in this section here, where a lot of fat tends to come from, I noticed in your diet, is there anywhere that you would like to reduce?”…[pointing at foods] [Belinda].

The approach utilised by Belinda may be less controlling than she perceives. In this context, she described providing patients with ideas and helping them to choose between appropriate dietary changes. This finding suggests that maintaining awareness and consciousness of how patients react to the decision-making approach used is important to ensure that their preferences for participation continue to be upheld.

After attending the health coaching workshop, Joanna and Eliza had found it too difficult to completely withdraw their opinion and had abandoned their attempts to do so. Eliza had come to the conclusion that it was acceptable to give suggestions if patients were struggling to come up with ideas, and if patients’ ideas were inappropriate:
I would then have to maybe give suggestions as to, “Ok well we could look at this type of meal that we’re having or this type of food”. So one gentleman the other day, he identified that his supper wasn’t the best choice and he suggested to get rid of supper altogether and I explained to him as a diabetic why that was probably not the best thing to do, but then for him trying to think of suitable food choices was quite difficult. So then I had to provide him with a list of things that were suitable but that he liked. So I think they are the areas where you do have to step in and help them. [Eliza]

In this case, Eliza claimed that sharing her ideas in the decision-making process was important and she consequently abandoned the idea to withhold her input. Eliza had the confidence to make this decision and work in a different way. This confidence may have come through her previous experiences where she had seen positive results of using different approaches with different people. I interpreted that Eliza seemed comfortable to use her practice knowledge derived from her experiences to inform her practice and to discount alternative approaches that she felt were not appropriate. These practitioners’ experiences suggest that rather than trying to amplify patients’ voices alone, practitioners should seek to blend patients’ and practitioners’ voices. Furthermore, it suggests that promoting the acceptability of and supporting early career practitioners in questioning dominant ways of thinking about practice may enable practitioners to then challenge and change their practice if need be.

5.4.2 Perceptions of professional role

All dietitian participants declared that they perceived their key role to be information provider to patients to promote dietary change. Some dietitian participants identified further roles they could play, such as supporting patients who were ambivalent about change, but were unsure about how to enact these roles. These challenges are described further in Chapter 6.

I interpreted that the perceptions of dietitian participants regarding their role had implications for their conversations with patients and what they could and could not make decisions about. Many dietitian participants saw their role as an information provider, which can be interpreted to be strongly aligned with a biomedical stance to practice, where power and expertise lie firmly with the practitioner. Common topics of conversation that were perceived as appropriate by dietitian participants were patients’ eating habits and biomedical parameters of health. I interpreted that these topics were considered important because each dietitian participant saw her role as primarily to
increase the technical knowledge of patients about food and nutrition and to promote biomedical improvements:

Often in the initial assessment, say they're [referred for] weight loss and they have come in for healthy eating advice, after I've asked them the question of "what areas [do they think they need to improve]", and they come up with "I don't know", I'll show them the Guide to Healthy Eating and I'll compare their food to the Australian Guide to Healthy Eating and then say "so maybe you are not eating enough breads and cereals or your meat's a little bit too high... what do you think of that?" It might be that through the diet history I might see they are not having any fruit or they're not having enough dairy or they're using full dairy products, then I'll, if they still don't have any idea, that's when I'll lead into "well this little bit here and this little bit here, what do you think of that?" and try to go into it that way. [Joanna]

This remark emphasised the value that Joanna attributed to providing information to help her patients make dietary change and could be related to her perception of her professional role as information provider. She also described how she tried to draw patients into the professional decision making process and asked for their ideas first. This finding reinforces the importance of taking into account a holistic view of patients and their aims of health care in ensuring that decision-making approaches were appropriately utilised. Valuing only biomedical outcomes and the provision of technical knowledge in professional decision making may mean that attention to factors that are also important to achieve these aims of independence, such as self-efficacy and self-confidence, are neglected.

It is important to note here, however, that each dietitian participant also valued non-biomedical outcomes of their care, such as improving patients' self-confidence and self-efficacy. There were different perceptions about what valuing these kinds of outcomes meant for their role as dietitians. In particular, opinions varied about whether it was an appropriate role for dietitians to suggest strategies based on behavioural or cognitive change to help patients who experienced emotional or psychological influences on eating habits. The majority of dietitian participants perceived that it was important to refer these patients to psychology or counselling colleagues. However, there appeared to be disagreement about the appropriateness of discussing non-biomedical influences on eating habits in conversations with patients. Joanna tended to refer patients to counsellors when it became apparent that emotional issues were of significant concern:

I went to talk to the counsellor at work and she said when it [emotional issues] gets too big then that's what she's there for and just to refer on and if they don't accept it then that's up to them. [Joanna]
In contrast, Holly was becoming comfortable with exploring the nutritional impact of issues that patients might raise:

If they say, “My relationship problems lead me to eat” I might identify, “Well maybe you need to look at your relationship more than we need to look at food right now.” So they might need to get help that way. I’m not going to talk to them about their relationships ‘cause that’s not my role. But I still need to know that those issues are leading to eating because if I tell them you’ve got high cholesterol and you shouldn’t eat chocolate and their relationship problem is what leads them to eat chocolate they’re not actually going to make that change. So I guess it’s putting together that middle man in terms of “Why are you doing what you’re doing?”. [Holly]

Both Holly’s and Joanna’s experiences suggest concern to ensure that patients’ needs are appropriately attended to, and an awareness of the boundaries of their practice. They considered that issues such as the nature of patients’ personal relationships were beyond their expertise to discuss. They also, however, acknowledged the potential importance of these issues in determining patients’ eating behaviours and whether patients would be ready to make dietary change. It is understandable and appropriate that Joanna, as an early career practitioner, might choose not to facilitate a dialogue when she felt it was outside her boundaries of practice. However, dialogues like those Holly conducted can contribute to a richer appreciation of the social worlds of patients. This finding suggests that by challenging the idea that dialogues about non-biomedical issues are not appropriate for dietitians to enter into, practitioners may be better supported to dedicate more time to integrate the whole person into decision-making processes and facilitate coming to a deeper understanding of patients.

When patients appeared already to have good technical knowledge about nutrition, some dietitian participants expressed uncertainty regarding their role. In the following example, Joanna expressed hesitation about being able to explore barriers to making dietary change that did not relate to a lack of technical knowledge:

J: I’ve had people who have come in with good knowledge and they know what they need to do. People I see with good knowledge, they tend to know what they need to do it’s just reinforcing them along the right track again. I’ve had a few people like that. So they know how to read a food label, they know which of the food groups they [should eat], and they just can’t remember how to put it back into practice.
MO: So for them it’s been more reinforcing rather than anything else?
J: Yeah and sometimes I suppose I do wonder why they do come in, I guess.
MO: Is it worth exploring that a little bit further with them?
J: Yeah it could be but I suppose I don’t know how to do that, sometimes I get a bit stuck. [Joanna]
In this dialogue Joanna claimed that some patients did not always need information, but at this stage she was not sure how to explore what it was they might need. This finding suggests that the development of conversation skills that help facilitate a discussion of the issues relating to behaviour or cognitive change might be of importance to help practitioners like Joanna in this exploration.

5.4.3 Professional relationships with other health practitioners

The key relationships that influenced the practice of dietitian participants were those that existed between themselves and patients and other health care practitioners. Dietitian participants were less likely to mention the impact on practice of relationships with other people such as managers, patients’ carers or significant others and other dietitians. A connection between the relationships of dietitian participants with other health practitioners and the choice of professional decision-making approach was not often overtly made by dietitian participants but it was implied in the interviews. On further interpretation, I suspected that the nature of the relationships of dietitian participants with other health practitioners might have the potential to influence their approaches to professional decision making. This warranted deeper interpretation of the relationships of dietitian participants with other health practitioners.

Some dietitian participants described their relationships with other health practitioners as master-and-apprentice style. The relationships that Margot, Joanna, Natasha and Kate described appeared to be characterised by a less experienced practitioner seeking direction from a more experienced mentor or colleague. When Margot was reflecting on her difficulty working with a particularly challenging patient, she asked a professional colleague to help her reflect on the situation:

I had a chat with the other dietitian who was looking after them as well. She said, “Don’t stress, they’re very difficult to work with, it takes a lot for him to accept change. You can say it’s probably better to do this and you’d have to tell them quite a few times”. So she reassured me that it’s not what I was doing. [Margot]

As an early career practitioner it was important for Margot to check her reasoning, and she invited dialogue and mentoring with a more experienced colleague. However, it also seems from Margot’s description that the complexity of this particular challenging situation was not further explored with the experienced colleague. It could be interpreted that the viewpoint of the senior colleague might in turn have been shaped by a perceived need to reassure her junior colleague, or her advice might represent the
organisational culture. In this sense, Margot may have been enculturated to the dominant discourse of her workplace that encouraged her to exclude the patient’s perspective in this situation. Sabrina related a similar instance when she had reflected upon an aspect of her practice with a more senior dietitian, specifically in relation to her ability to individualise health care for patients:

So I think I learnt from them [dietetic colleagues] too that you just have to do what was relevant for that patient. And it’s going to be different like I do different things with everyone. I don’t have a set pattern for anyone; everyone is completely different, the way I’ll think up a new thing I can use things for someone else. [Sabrina].

Here, the senior colleague encouraged Sabrina to open up possibilities for alternative approaches and viewpoints to health care based on individual patient needs. These quotes lend support to the suggestion that more senior colleagues can act as role models. The examples highlight the potential influence of the relationships between early career practitioners and their more senior colleagues on the valuing of different decision-making approaches.

I also found that participants described relationships in which others did not invite open communication, which meant that opportunities for exploring statements for deeper motivations were absent. In reflecting on one such situation, Eliza claimed that a medical colleague’s lack of communication with her demonstrated her lesser power in the team:

MO: So, have you ever had a doctor respond to that message you’re leaving or the letters you’re writing back?
E: No.
MO: How does that make you feel?
E: Oh, like an allied health professional! [laughing]. You kind of get used to just sitting in the corner and having not a lot of feedback. But then when you do get feedback it is quite good from a GP, so they will occasionally say, “Following dietitian’s advice”, so that’s kind of nice when it does happen but it doesn’t happen often. [laugh] [Eliza]

According to Eliza, interdisciplinary communication was generally lacking. It is interesting to note that Eliza said she felt like an allied health professional rather than saying she felt like a dietitian. She did not place dietitians or early career professionals at the bottom of the health care team ladder but allied health professionals as a group. The example of the GP communication she provided is not so much feedback as an endorsement. It can be interpreted that this lack of dialogue would have implications for
relationships within the multidisciplinary team as well as reinforcing a practitioner-centred approach to practice. Drawing from Eliza’s experience, it can be argued that early career dietitians may need guidance in reflecting on the reasons for difficulties in communicating with other members of the health care team, as well as how to address these difficulties.

As early career dietitians these participants at times appeared to have lacked confidence to address communication difficulties, particularly to question the ideas and beliefs of people who they may have perceived to be more powerful, and to initiate reflective dialogues. I interpreted that the relationships they experienced did not appear to allow their perspectives and those of their patients to be integrated into the decision-making process. This lack of acknowledgment of multiple perspectives appeared to be the case particularly if dialogues were ended quickly by the other dialogue partner and did not allow opportunity to explore statements for their deeper motivations. Furthermore, I interpreted that dietitian participants felt less confident in questioning the ideas and beliefs of people outside their profession, particularly those they perceived to be more powerful, such as those in the medical profession. Sabrina reflected on a situation where she claimed that other health practitioners had unrealistic expectations that could potentially hamper the progress of eating disorder patients:

The doctors just want the weight gain. They don’t care how you get it, they just want the weight gain and the more weight gain the better. So I see this issue with the doctors, they just freak them [patients with eating disorders] out. They need to get a certain amount of calories in to gain the weight so most of the time I do it with supplements in hospital just to make the doctors happy. But then when they get out they freak out that they’ve put on all this weight. Some dietitians might write down a meal plan of all of the minimum requirements for the food that they should be having but that just freaks them out too and they’re not going to get to that for a long time. So I’ll just work out if they only feel safe with having a tub of yoghurt for the day that’s all I will make them do and I’ll see them weekly and we just slowly build. [Sabrina].

Sabrina felt that the team disregarded the deeper underlying causes of eating disorders and that the concerns of patients regarding gaining weight were given insufficient consideration and importance by medical staff. This presented a conundrum for Sabrina. She recognised that in some cases there was an urgent need to deny the wishes of patients with eating disorders and to feed them to ensure their medical safety. However, she also alluded to an understanding that relationships with eating disorder patients are long-term and based on maintaining a good rapport and a trusting relationship. The difficulty here was that by placing the goals of the medical staff above the concerns of
patients, Sabrina was highly likely to put at significant risk any positive strides she had made in developing such relationships. She needed to ensure that patients remained well and medically safe, reinforcing the importance of carefully reflecting upon and weighing up the goals, beliefs and values of all involved in the health care process. This situation highlights the need to provide mentoring for early career practitioners when there is significant decision-making complexity.

Later, Sabrina related a second situation where she did challenge her fellow team members who she considered were being overly judgmental about a patient’s ability to make dietary change. Initially, Sabrina had agreed and made the assumption that this patient would find it hard to make dietary change. After visiting and talking with him Sabrina came to realise that this assumption was incorrect and she challenged the attitudes of the other health practitioners involved in support of this patient. She argued that lecturing this patient to make change and being critical of his inability to do so was not going to be of benefit for him:

I think a lot of the health professionals are really hard on them [patients] and just make them [feel bad]... I mean of course he's going to fail if that's what we expect of him as well. Then being a lecturer and going off about his food and stuff on the weekend... Well, he'd seen me, he'd worked out a plan, so I mean, that's his normal diet with his having hamburgers and chips. At least if he stuck to his portion control so they could get his insulin right in hospital, I was fine with that and we'll try and work on getting them to eat proper meals later on when they go home, so yeah, so things like that it's really difficult with other health professionals... So by them not building a healthy relationship with him, he wouldn't want to accept help from a health professional, if they are going to be making him feel bad or that he's going to fail, that type of thing. [Sabrina]

In this situation, Sabrina observed that the other health practitioners involved demonstrated a lack of understanding of the complexity of reasons why patients behave the way they do, the process of change, and how important it is to allow patients time to make change. She could see that this type of attitude could have a negative impact on the patient–practitioner relationship as well as undermining patients’ motivation to change. These two quotes show that Sabrina reacted differently in each situation, because being part of the team influenced her day-to-day practice.

As members of a young profession, as relatively new members of the health care team and as early career practitioners, dietitian participants appeared to feel compelled to prove their usefulness to other disciplines. This usefulness appeared to be communicated in terms of what outcomes are important to be realised for patients. Most
dietitian participants elucidated that their role was to achieve biomedical outcomes for
patients, and evaluated their success as a practitioner in light of whether these were
achieved. Dietitian participants consistently claimed that the key aim of their
relationship with patients was helping them to achieve predominantly biomedical and/or
bio-psychosocial outcomes, such as weight reduction or improved self-confidence.
Belinda’s preference was to care for patients in a structured way where she could
prescribe change and realise biomedical end points:

I like the analytical work. I like the prescriptive work. They’re very clear end points. I
like to know that this is the end … “You are organised”. Or if you’re doing a menu
plan, they come back and see you and say, “I can do this” – that’s fabulous. You
can get all your nutrients right and away you go. [Belinda]

In these situations, there was no anxiety for Belinda, as she was able to see the results of
her labour and demonstrate that patients had achieved a good outcome. However, when
asked to further interpret situations where she was not able to achieve these outcomes
for patients, Belinda described feeling anxious about her responsibilities to her patients:

I do need to learn not to take so much of that on board. It’s just with this patient
that’s supposed to go home Monday, I’m tossing and turning… “Oh my God the
giving sets [used to deliver enteral nutrition] aren’t here”. Where do you go? This
feeling… that responsibility… and once they’re set, I’ll be fine, I’ll be fine. But I’m not
fine with it. [Belinda]

Belinda worried that if she did not achieve quantifiable treatment outcomes she would
be seen as not doing her job properly:

I guess you worry when it hasn’t worked, whether it’s a reflection on you and a
criticism– well you mustn’t have done your job, because they’re not doing what
they’re supposed to be doing. [Belinda]

Her concern about whether she had fulfilled her role as a dietitian to demonstrate
biomedical changes could be interpreted to mean that there was a strong influence of
peer pressure on Belinda’s practice. It appeared to me that it was important to Belinda
to be seen by others, including her team-mates, to be able to offer something of value to
patients. This concern may have contributed to her drive to assume prime responsibility
in making sure that patients made the changes she had suggested, in order for her
competence to be demonstrated. This was despite an understanding that dietary change
takes time and can be difficult for patients. This finding suggests that for practitioners
like Belinda in these situations, there may be a need to reflect on other ways to
demonstrate value within the health care team. Belinda’s reflections on the tension she experienced between advocating for patients and seeking recognition and respect from the health care team is further discussed in Chapter 6.

Lisa claimed that biomedical evidence was most important to other health practitioners, although she herself did not agree:

L: I should have statistics. I think maybe all dietitians should have statistics.
MO: What would they be about, those statistics?
L: I think you’d have to have them as quantitative.
MO: So what sort of measures?
L: You’d have to have, and again I’m talking here with diabetes, cardiovascular disease, weight loss, that whole sort of thing there, since weight loss is like the underpinning thing to success with all the others, I think you would have BMI, waist circumference, kilograms. You’d do that I would think. [Lisa]

In this quote, Lisa reflected on the pressures of an outcome-driven and technical-rational health care model and the pressure from other health care disciplines to produce measurable outcomes. Lisa was responding to what she thought other health practitioners saw as important. Lisa alluded to the possibility that there were psychological improvements that could be realised through dietetic input. Yet she felt external pressure to perform in a health care system that was driven by economic rationalism. These dietitian participants may have felt compelled to prove that their services were a cost effective means of achieving organisational goals. In this context, as practitioners in the early stages of their career, they might have felt the need to prove themselves as individuals who were effective and capable of contributing to team goals. Lisa’s experiences lend weight to the suggestion that early career dietitians should be supported to develop the skills and confidence to question or challenge the opinions of other health practitioners when they disagreed, particularly when there was a greater risk of patients’ perspectives being silenced.

5.4.4 Time pressure
Most dietitian participants worked in organisations where they were the only dietitian in the health care team with several role responsibilities. Of the six dietitian participants who worked as sole dietitians, Belinda, Sabrina and Eliza all claimed that being a sole dietitian had a significant impact on their perceived ability to engage participants in making decisions. Belinda claimed that the combination of a heavy workload and multiple role expectations coupled with being an early career dietitian meant that she
felt significant time constraints. I interpreted that when Belinda was time poor, she felt rushed and compelled to take control of making decisions. Belinda gave me the impression of a person who was highly motivated to keep on top of her workload and appeared to be seeking ways to be more efficient in working with patients:

So I’m getting better, not saying I’m good by any stretch of the imagination, but I am getting better at sifting through and I guess the whole goal setting. I miss that a lot when I do assessments because again you’re pushed for time and you want to come up with the solutions. [Belinda]

In this quote, Belinda described placing the greatest importance on solving patients’ dilemmas when she was time pressed. The efficiency she spoke of could be interpreted to mean that she had become better at collecting information that she needed and determining the highest priority health concerns of patients. Belinda’s priority of becoming more time-efficient could be interpreted to reflect her vulnerability to the need to manage heavy workloads. Furthermore, as a new graduate, it would be expected that Belinda would need to spend more time with patients than more experienced practitioners, further compounding the situation. Early career practitioners have been demonstrated to take longer than experienced practitioners in conducting the same services (Burger et al., 2010). Experiences like the one Belinda describes suggest that early career practitioners working as sole practitioners may struggle even further to find the courage and agency to withstand the push to practise in a technical-practical manner, while encouraging patient participation in making decisions when it was warranted.

Despite the time pressure to solve patients’ issues quickly and efficiently, Belinda had also begun to question the notion that the health conditions that some patients presented with could be resolved in a single interaction. She had experienced situations where spending time with patients helped her to more deeply understand their context:

I guess what you learn in practice that you certainly can’t learn at university is adapting to the person that’s sitting there, adapting what you’re doing, kind of on the run, to how the session is going. Whereas I think when I just left university and what you do then at university is that everything needs to be contained within that session, if they start to ramble, bring them back, and if they start to talk about something but you don’t think it’s related... This woman was telling me that she was looking after her sister. It was all for weight loss and she said “Oh it’s really hard because I look after my sister and she’s got cancer” and it was really quite sad and she was kind of going on a little bit about it but the crux of it was – her eating habits were so skewed because of this situation, and she needed to talk about it. That was it – she needed to talk about, whether it had anything to do with her food or not,
she needed to tell someone about it, and she ended up crying and it had absolutely nothing to do with food, but no, she wouldn’t have listened to anything. [Belinda]

Belinda understood that patients often had priorities in life other than nutrition, or there were other issues that could impact on eating habits that were important for patients to talk about. She acknowledged in the quote above that spending time with patients was important at times because it helped her to identify the needs and concerns that were of highest priority to them. It helped her gain an appreciation of the circumstances within which patients experienced their health concerns and gave her an insight into whether patients were ready to contemplate making change or not. Providing this patient with space to talk about her sister and how she felt about the situation gave Belinda some insight into the patient’s eating habits and potential difficulties in making change. Belinda claimed that it communicated to this patient that she cared about her as a whole person and valued her input. An important further consideration was how much simply listening to a patient’s monologue could help Belinda in coming to a deeper understanding of the patient’s concerns and needs. When interpreting Belinda’s experiences, it is evident that in this latter case she had chosen to take a collaborative approach, regardless of the pressures she interpreted as working against being collaborative. Belinda was able to make a choice about her professional decision-making approaches. Belinda’s experiences suggest that the identification of organisational constraints on CDM is an important part of reflecting on practice, as it can provide opportunities for learning to prioritise, considering how constraints are interpreted and how they relate to the deeper interests and values driving practice.

Sabrina indicated that if she were pushed for time, she would be less likely to explore patients’ histories and stories in depth. Her high workload, combined with frequent experience of similar patient types who found similar difficulties in making dietary change, frustrated her and increased the likelihood of choosing a practitioner-centric approach:

If I know that I’ve got to get them out within a certain time, I’m more likely to push things through but if I know that like I’ve definitely got an hour, or maybe the next one mightn’t turn up or something like that and they’re telling me their life story and it’s going to help me out with their treatment, well then I might let them go on for an hour and a half. So, it just depends as well. Yeah but I think time, mainly and I know when I was in [town] and I used to get, like eight patients in a day and they’d be all weight loss and diabetes. By the end of the day, I just couldn’t listen to any more excuses and I’d be like, “OK, I think I just want you to do this”. [Sabrina]
Sabrina’s approach to health care when she was time pressured meant that she took control and there was limited input from patients. Sabrina was the dominant conversation partner who was allowing others to talk. Furthermore, in these time-pressured situations Sabrina appeared to feel constrained to further explore the difficulties that patients experienced in making change. This quote also demonstrates, however, that when Sabrina does have time, she feels more able to take on a listening role to better understand patients’ circumstances. This finding has implications for the way dietitians may take on the listener role. It could be interpreted that by passively listening, dietitians could miss an opportunity to consider how they might come to a deeper understanding about patients’ situations. This listening time could be used to consider questions to ask patients to facilitate developing this deeper understanding.

Sabrina’s reflections also emphasise the importance of early career dietitians learning to work within workplace cultures and cope with heavy workloads. These findings suggest that in this learning process, practitioners need to be supported in deciding when their workload is irresponsibly heavy and does not ensure good practice.

5.4.5 The practice setting
Dietitian participants referred to the way that living in a rural or regional community affected issues such as the perceptions of power that other health practitioners are afforded by community members and access to formal professional development. The impact of the geographical location of dietitian participants’ upbringing, education and current workplace was rarely mentioned with respect to professional decision-making approaches. This omission might occur because, as early career dietitians, the focus of these dietitian participants is on learning about the technical and practical aspects of dietetics practice and developing a professional identity rather than on considering how belonging to broader community cultures impacted on their practice.

Belinda claimed that working in rural environments had implications for power differentials between herself and the medical practitioners with whom she worked. In this quote, she alluded to an amplification of the power of medical practitioners who work in rural environments:

I think that a lot of the specialists at [town] have the country doctor god-syndrome, so they don’t like to be… they tend to brush you off when you walk past. The specialist, he’s very, very straightforward – “This is what I’m doing”. Lovely man, but doesn’t like to be questioned. [Belinda]
These power differentials have implications for the professional decision-making approaches of early career dietitians. Belinda would have liked to engage in a dialogue with her medical colleagues about patient care, yet felt that she was denied this opportunity. Working in a culture where dialogue was not encouraged might have given Belinda the message that there was little inter-professional collaboration, and that professional authority was not to be questioned. This finding suggests that such a cultural environment can indirectly influence patient–dietitian dialogue and may nurture a practitioner-dominant approach to decision making.

The other key consequence of working in rural areas that dietitian participants consistently mentioned was limited access to formal professional development such as attending workshops and conferences. This limited access was attributed to geographical and discipline isolation and the limited funds available from their employers to support attendance at professional development events away from their home location. The lack of opportunity to attend such events was lamented as a missed learning and networking opportunity. However, dietitian participants also valued learning that took place during practice itself, such as self-reflection and reflection with peers. Eraut (2004, p. 250) proposed that formal and informal learning sit at opposite ends of a continuum, with informal learning being “implicit, unintended, opportunistic and unstructured” in nature. Eraut argued that informal learning extends beyond planned learning such as self-reflection to include unplanned learning from practice experiences. The self-reflection and reflection with peers that dietitian participants undertook appear to sit somewhere in the middle of this continuum, as evidenced by this quote from Holly:

As students, we got to practise the nuts and bolts of it, but it's only when we get into clinician status that we get to practise actually what are clients getting out of what we're telling them and we start to see clients on a continued basis and we start to get familiar with what's working and what's not. I think I've just self-adjusted that way. You can't read about that stuff so it's good to learn from someone more experienced. Definitely, rurally, when there's that limited dietitian support. [Holly]

In this quote, Holly identified her valuing of the knowledge that could be derived from the experience of seeing patients over long periods and learning what worked and what did not. She also described learning from more experienced practitioners rather than reading from textbooks or journal articles, claiming that opportunities like those were lacking in rural environments.
5.4.6 Cultural and contextual background of patients

The cultural backgrounds of patients influenced some dietitian participants’ decision-making approaches. Some dietitian participants assumed that particular patients preferred particular roles in professional decision making. Patients who were younger, female or of a higher socioeconomic status were commonly perceived to be likely to prefer to have greater input into making decisions, as evidenced by this quote from Lisa:

Middle-aged lady, educated, dieted since she was 15. Steady weight gain over time, been to Weight Watchers, been to Jenny Craig, lost a few kilos, very much all-or-nothing mentality, very strongly held opinions and will tell me within the first two minutes that she knows everything that there is to know and I think 90% of that she’s right but I often think that there’s maybe that 10%... I think the types of approaches like motivational interviewing, that’s where that has a place – with people like that. [Lisa]

Patients who were perceived to be more knowledgeable, more experienced in managing their health, more motivated, or who were perceived to have a good match with dietitian participants’ expectations and values about nutrition and health were thought to be more likely to want to have input into professional decision making.

Conversely, dietitian participants described taking control of decision making when working with older people, males, people of low socioeconomic status, people with mental health conditions, people with impaired cognition, people with new diagnoses and people with acute or severe health conditions. Eliza found it difficult to engage patients in making decisions if they were of lower socioeconomic status or had a mental health condition:

I tried to do goal setting quite a lot with them [patients] and I was selective with the clients that I did that with because especially with a lot of mental health referrals ... they just, they can’t process that and then I think that that’s when I also come back to the appropriateness of the referral. If they’re unable to think of ideas for themselves, how are they going to make those changes? [Eliza]

In these situations, Eliza considered that it was more appropriate to instruct these patients about the dietary changes she thought were appropriate to make. She based this on her previous experiences, but also alluded to her perception of the appropriateness of the referral from other professionals. She recognised that for some people making dietary change might be difficult given their other health circumstances, but she did not
appear to be completely comfortable with taking a prescriptive role, even when it might be appropriate.

One interpretation of these ideas about which approaches would best suit different patients is that dietitian participants were potentially more comfortable to collaborate when patients’ cultural or social background was similar to their own and lacked confidence when it was not. A lack of confidence is to be expected in this group of dietitian participants who were in the early stages of their career. Furthermore, as indicated by Eliza, it might be that the dietitian participants had been armed with few strategies to engage with diversity and complexity thus far in their tertiary education or continuing professional development, particularly when patients were able and preferred to participate in making decisions. These quotes may also imply that dietitian participants did not discuss with patients their preferences for participation in making decisions, and decided which approach would be most appropriate sometimes on the basis of only one or two characteristics. Preferences for participation in making decisions based on sociocultural characteristics such as a person’s age, socioeconomic status or gender have been explored extensively in the literature with varying results, as discussed in Chapter 4. This variance in results may indicate that single sociocultural characteristics are not likely to be the only predictors of a person’s preference to participate in decision making; such preference might be mediated by other factors such as the severity of illness (Hamann et al., 2007) and the nature of the relationship with practitioners (Murray et al., 2007). Given these findings, it can be suggested that decision-making preferences are complex, and exploring preferences for participation in health care on a regular and ongoing basis with each patient can help ensure that decision-making approaches used in health care are appropriate. It is particularly important to ensure that decision-making approaches used in health care are not utilised simply on the basis of patients’ particular gender or socioeconomic status, to avoid using decision-making approaches that might not be acceptable to patients.

5.5 Conclusion
The observations and experiences of these dietitian participants regarding professional decision-making approaches were complex, interwoven and dynamic in nature, as represented in Figure 5.1. The phrases in red font represent my interpretations of the way professional decision making took place. The black font represent the factors that I
interpreted to influence the professional decision making approaches of dietitian participants.

The relational, discursive, cultural and interest dimensions of professional decision making were intricately interwoven, where each dimension influenced other dimensions. The first lens was the relationship dimension. Dietitian participants claimed that developing and maintaining open and honest relationships with patients was important for ensuring successful outcomes of care. The dietitian participants valued relationships with patients and with other health practitioners where they could relate with others at an open, non-judgmental and respectful level. There was less evidence, however, of dietitian participants’ confidence to facilitate dialogues involving an active and transparent sharing of values, beliefs and perspectives. Dietitian participants predominantly maintained their biomedical expert stance, in that they defined success of care in biomedical terms, and who they were as subjective human beings was often de-emphasised.

The second lens was the discursive dimension. Dietitian participants were working in workplace environments that presented no easy opportunities for dialogues. Furthermore, in some situations participants felt that others actively avoided or shut down dialogues. Being early career dietitians may have strongly influenced their confidence to establish and maintain open dialogues. Dietitian participants valued gaining an appreciation of patients’ social, cultural and familial context, but nonetheless persisted in emphasising technical knowledge in their conversations with patients and others.
Figure 5.1 Perceptions and interpretations of dietitian participants regarding professional decision making
The third lens was the cultural dimension. Dietitian participants were more likely to be influenced by external forces, such as the values of other health care team members, than by their own values. As early career practitioners, they were focused on establishing their position as nutrition expert within the team. Only a few participants showed glimpses of awareness of the cultural values of their workplace. Most participants had not reflected on their assumptions about the relational and discursive dimensions of practice that influenced patient participation in professional decision making.

The final lens was the interest dimension. In their professional decision-making approaches the dietitian participants appeared to be emulating accepted mainstream practices, although they each described a unique mix of technical and practical interests. For instance, technical interests driving professional decision making were manifest in terms of acting or seeking to establish a position as the expert in relationships; limiting topics of conversation to biomedical parameters of health and technical knowledge about dietary change; and acting as the decision makers, informing patients of their decisions. However, when practical interests drove professional decision making, the dietitian participants used different communication strategies, such as advising and question posing in conversations; they sought to humanise relationships to gain better understandings of patients’ situations and they extended conversations to include non-biomedical parameters of health and influences on eating habits. The sparse evidence of emancipatory interests driving practice was shown when dietitian participants were open to learning from patients and were beginning to recognise the importance of breaking down power imbalances to facilitate CDM. No participant was influenced by one type of interest alone. Their professional decision-making approaches were not particularly deliberate but rather were influenced by the expectations of the wider health care team, the workplace culture and personal preferences.

It is important to keep in mind that these participants were early career dietitians, often working as sole practitioners, in regional and rural settings. In these settings there was little opportunity for collegial guidance to boost their confidence in establishing themselves as professionals. Although participants were building relationships with other dietetic practitioners, there appeared to be only a few instances where participants were encouraged to question their practice. CDM needs careful consideration of patient situations, organisational demands and pressures, as well as personal preferences. There
was evidence that some participants had started to engage with complex and dynamic aspects in choosing their professional decision-making approach. The implications drawn from Chapter 4 resonate strongly in this text here. Due to the novice status of my participants, “creating supportive communication climate for dialogue”, “giving adequate time to decision making” and “becoming aware of challenges” are particularly relevant. Encouraging the expansion of practitioners’ perspectives on practice beyond biomedical-technical decision making to also consider sociocultural and relational aspects of professional decision making is also relevant for tertiary education and early career practitioners. These findings point to the potential for developing approaches to professional decision making that help novice dietitians become aware and mindful of the relational, discursive, cultural and interest dimensions and how they can shape (i.e. facilitate or impede) different decision-making approaches. They suggest that what is important in supporting learning about professional decision making is consideration of what practitioners choose to engage with, what they value and how they respond to clinical situations in a given context. Reflecting on their engagement and responsiveness gives practitioners insight into which perspectives on health care and professional decision making they value, as well as which professional decision-making approaches might be most appropriate at different times, spaces and for each practitioner and patient.

In the next chapter, I explore further the complexities of enacting CDM in dietetic practice informed by the perspectives of both dietitian and patient participants, with a particular focus on the relational and discursive aspects of CDM.
CHAPTER SIX

COMPLEXITIES AND TENSIONS OF COLLABORATIVE DECISION MAKING IN EARLY CAREER DIETETIC PRACTICE

In the previous chapter I reported that my dietitian participants valued relational and discursive aspects of collaborative decision making (CDM). However, they also experienced challenges in facilitating dialogue in their decision-making approaches. There appeared to be varying levels of self-awareness of the drivers for professional practice and at times a lack of conscious choice between decision-making approaches. My key aim in this chapter is to further illuminate the tensions and complexities of enacting CDM in dietetic practice.

I present the findings of my philosophical hermeneutic study of the observations and experiences of dietitian participants and the perceptions and observations of patient participants on professional decision making. First, I draw on my interpretation of the series of interviews I conducted with dietitian participants and the reflection that dietitian participants engaged in between and during interviews, to further explore the tensions and complexities of enacting CDM that are inherent in the perceptions and observations of these dietitians. The series of interviews and intervening opportunities for reflection provided an opportunity to extend the dietitian participants’ awareness of what influenced their practice and their perceptions of support and barriers to realising CDM. Through this reflective dialogical process a deeper understanding of these issues was developed between participants and me.

Second, I draw on my interpretation of the interviews I conducted with patient participants to explore the following research question: what can be learned from patients’ perceptions and observations to contribute to shaping CDM? The interpretations I derived from the perceptions and observations of patient participants helped to understand more deeply patient participants’ life-worlds and to further provoke my evolving understanding of the tensions and complexities of CDM.
Lastly, by bringing together my interpretations of the dietitians’ and patient participants’ horizons regarding the tensions and complexities in enacting CDM, I answer the research question: what factors support and hinder the development and adoption of CDM approaches by early career dietitians?

6.1 Dietitian participants’ reflections on challenges in professional decision making
In this section, I interpret dietitian participants’ observations on their perceptions and experiences of professional decision making, with a particular focus on the tensions and complexities. I found that tensions and complexities were related to their professional relationships with patients and members of the health care team and establishing dialogues, as well as to developing a professional identity.

6.1.1 Professional relationships
The dietitian participants frequently discussed the complexities they experienced in building relationships with patients and other health care practitioners. As newcomers to the profession of dietetics and to the health care field in general, they were learning about these relationships through their practice. Often they emphasised these relationships rather than CDM directly.

There seemed to be a difference between how dietitian participants related to patients and how they related to other health care practitioners. With respect to relationships with patients, I noted that a common tension existed for dietitian participants between their respect for patient autonomy and their desire to provide expert guidance in the decision-making process. With respect to relationships with other health care practitioners, I found that dietitian participants were struggling to be respected and listened to by other health professionals in relation to their effectiveness in advocating for patients in order to improve decision making about treatment. It appeared that a main focus for these dietitians was to gain recognition from other health care professionals for the value they brought to professional decision making and overall patient care. Their professional identity appeared to revolve around how other professionals valued their contribution to patient care.
Relationships with patients: balancing patient autonomy with expert guidance

A common underlying tension evident in the dietitian participants’ reflections was in balancing their respect for patient autonomy with wanting to share with patients their expert knowledge to inform professional decision making. This finding represents a potential tension between practical, emancipatory and technical interests. Dietitian participants wanted to have an input into decision making and appeared to struggle when that did not happen. Natasha, for instance, found it easier to make decisions alone or use her ideas to inform decisions about care:

You need to give the information [so they can] know what they are doing wrong in some cases. For the people that don’t know [what goals to set], you can say “these would be my ideas of what goals [you should set]. What do you think? Are there any of those that you think you might be able to change? It’s just, it’s really tricky, it’s just so easy to do your own thing and just educate, it’s so much easier. [Natasha]

This quote highlights a potential tension between technical and practical interests for Natasha. On the one hand, she acknowledged the potential for a difference of opinion or perspective and wanted to explore patients’ contexts and how she could draw patients into decision making. On the other, there were elements of technical interest in the decision-making approach that she described. Natasha appeared to be struggling between facilitating patient input into decision making and having an input herself. She felt that patients expected her to have an input but she did not want to be dominant in the process:

I think it’s the clients sometimes. They sit there and just look at you, like they expect you to just educate. [That is] their expectations of what your job is, that you know the information, like you know what they need to know. You just want to pass that [the information] on. Particularly when they’re not coming up with ideas, like you’re saying “well how do you think you could do that?” and they just sit there and give you this idea that you think “that’s not going to work for you” and you have all these other ideas, it’s really hard not to just say, “well what about this?” and then I’m sure they go “that sounds great”. Because if you’re being so positive about it they’re not going to tell you that that’s not going to work for them. But some will. [Natasha]

Natasha was aware that being too dominant in the decision-making process could silence patients’ voices, and mean that decisions made might not be truly acceptable to patients. My interpretation of her reflections was that she seemed unsure how to engage with a deeper understanding of her patients’ circumstances, perspectives and values when making decisions in a shared manner was more appropriate.
During her reflections, Sabrina expressed uncertainty about whether her approach was too aggressive with patients who were not ready to make change. She wanted to make sure she did not make patients respond negatively if they were not ready for change, and was not sure how to have an input without patients feeling pressured:

Well you don't want to make them feel guilty. I don't know. I think I would need practice in how to word it so you weren’t lecturing those people. But um, yeah, I don't know. I think I have felt like other people I've seen at that stage get their feathers ruffled if you harp on at them that their cholesterol is really high and if they don’t do something about it they are going to have a heart attack later on. I find those patients are a bit difficult. [Sabrina]

In this quote, Sabrina demonstrates that she appreciated the importance of patients being ready to make change, but did not want to send mixed messages to patients about the negative consequences of not making these changes in a timely manner.

Another common tension with respect to the relationships between dietitian participants and patients was supporting patient autonomy while still fulfilling a sense of duty of care. Kate felt that making sure that patients had complied with her advice and that their technical knowledge was sound was part of her duty of care, and felt uncomfortable when she did not have the chance to do so:

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]

Kate wanted to make sure patients understood the complexity of dietary interventions for particular health conditions and understood that she could not hope to provide all this technical knowledge during one visit. It was important to her that patients returned to see her for follow-up appointments so she could provide this advice, but she had found patients were not returning to see her as often as she would like. Kate particularly focused her reflections on the question of whose responsibility it was to make decisions about following up and discharging patients. Kate had a strong commitment to getting to know the individual needs of patients so she could provide technical knowledge as well as knowledge derived from her experiences, and facilitate behaviour change according to their individual situation. She decided to talk with patients about their preferences for follow-up and discharge. She found that patients were happy with her
approach. She also talked to her peers about how they went about making these decisions and was directed to a protocol that was in place in the department:

I knew about failure to attend and if you failed to attend twice then it’s automatic discharge. I thought “the whole time I’ve been here, I’ve been thinking when do I know it’s time to discharge?”. So [I guess the answer is] any time they’re not making progress or they’re non-compliant, discharge. [Kate]

Kate initially appeared relieved that she had found a practical solution to her challenge and felt more confident that she could make decisions about discharging patients who did not attend or were not making progress. On further reflection, she wondered whether such a simple solution might not be appropriate for all patients, acknowledging that some patients might have a perspective different from her own:

But instead of trying and trying, and like [other dietitian] had told me, sometimes maybe you try too hard; it’s that you want them to change too much or that you’re not ready to give up on them but they’re quite happy to give up. [Kate]

Kate perceived here that it could be her desire for an outcome that was driving her ideas about what her duty of care was, rather than considering what patients might see as valuable. On further reflection, it became apparent to me that Kate could extend her reflections to question why patients may have expressed a different perspective, or whether the perspectives of her colleagues were consistent with her own. Kate’s reflections were predominantly informed by the perspectives of others in the health care arena as well as by her aim to comply with organisational rules and regulations, all of which can reasonably be expected of an early career dietitian seeking to establish her place in the health care team. It should be particularly noted that Kate wanted to do the right thing for patients. She had a strong belief in and commitment to her responsibility to help patients make appropriate changes to their diets and to achieve good health outcomes. She was aware of the negative implications of patients feeling judged by dietitians, and valued the reduction of her professional power as a health practitioner. At this point of her practice, even though the technical interests of the organisation and the encouragement of others to maintain professional power had influence over her practice, she was beginning to see that practice can be more complex.

Kate’s reflections demonstrated the importance of engaging patients in discussions about how decision making can occur. During her reflections, Kate had found some
areas where she could potentially involve patients in professional decision making and how she might go about doing that:

I guess [regarding] the direction of their treatment – that was something I didn’t really ask patients. But I just noticed in my consults stopping and thinking “right well this is what I would do” and then I would ask “what were your expectations of today’s consult; what were you expecting me to do?” and spending more time on that and the patient saying “well I was expecting you to give me a bit of paper and I’d be on my way or expecting you to teach me this or show me how to do this” or, lots of people want me to do label reading. So getting them to tell me. Or they’re expecting me to give them a diet plan, off you go, and so then it’s explaining, “no, no, no we can try this, if you want to do that, we can try that first”. [Kate]

The transformation in Kate’s practice at the end of the reflection activity in my research was that she was now pausing to think about the difference between patients’ and her ideas about the appropriate path forward. She appeared more likely to consider trying patients’ ideas as well as her own. This pause for contemplation suggested that Kate was becoming more open to other possibilities of providing dietetic care. Kate appeared to be on a constructive journey to expand her professional horizon and develop her professional identity.

One of the key tensions for these early career dietitians in developing relationships with patients was negotiating difference in patient and dietitian perspectives in decision making. I concluded that this tension was due to a complex interaction of personal preference for control of decision making, perceptions of one’s role and duty of care, the influence of more senior staff and organisational policy and procedure. It is understandable that these dietitians, as early career practitioners, were strongly influenced by the perspectives of others and were attempting to establish their professional credibility with others. Professional credibility was equated with professional authority rather than with reasoning together to reach the best possible decision in a given situation. For participants who were sole practitioners, there could have been a pressure to prove their value and meet organisational objectives, resulting in silencing of patient voices.

**Relationships with other health care practitioners: claiming respect and recognition**

One of the key difficulties that the dietitian participants described in their relationships with other health care practitioners was their impression of how their contribution as a team member was respected or recognised by the health care team. All the dietitian
participants were passionate about the value of their input as a dietitian and, as early career dietitians, they were actively seeking to build their technical knowledge and skills.

The need for recognition of this input was evident in the reflections of Belinda. She used her technical knowledge to inform the advice she gave patients and to argue for her position as the nutrition expert within the team. In the following quote, she described a situation where other health practitioners had not acknowledged her value, and as a consequence she became distressed and disheartened. Her reaction was evident by the emphasis she gave to her words in the following quote. It is noteworthy that this was one of the few times that she became angry during the interviews:

B: [The other health practitioner said] “anyway all the diets are the same aren’t they?” [big sigh] And I think “well if they are then why am I here?”
MO: How does that make you feel as a professional?
B: Really cranky. Really, really cranky. Because I would no sooner turn around and say “oh, all medicines are the same aren’t they?” [cynical laugh] “This is a white pill, this would do the same job”. It’s respect. It’s respect for your profession and respect for your knowledge. It’s a four year degree. We’re not just playing. [Belinda]

Belinda wanted respect for her technical knowledge as she felt it played a valuable part in helping patients make appropriate dietary changes. However, in her determination to gain respect it could have been that Belinda downplayed the value of other ways of knowing. This finding has implications for the nature of dialogue in CDM when clashes in perspectives exist between practitioner and patient ways of knowing. I concluded that, to reach mutual decisions, there is a need for willingness to listen and explore the deeper assumptions and expectations that cause this clash in perspectives. A habitual and non-critical placing of emphasis on technical knowledge might serve to damage open discussions.

Belinda felt that patients were likely to have more faith in their doctors’ dietary recommendations than her own. I interpreted that this greater faith in doctors’ advice meant that she felt disempowered by the attitudes and opinions of other health practitioners when it came to making decisions with patients:

As important as we think we are about food the doctor is always more important. So the doctor has told them to not eat certain foods. I have a particular doctor in [town] who tells clients that when they want to lose weight not to eat certain foods. And she’s a quite respected doctor, so when you get them in here you just [can’t get them to listen to another view] … they will not [take notice] [Belinda]
Belinda wanted patients to trust her and trust her technical knowledge. She felt powerless in this situation and was frustrated by patients’ lack of trust in her expertise. It could be interpreted that at the root of this situation is a struggle for recognition of respect between Belinda and the doctor, rather than a difficulty in working together with patients to come to a mutually acceptable decision. She remained fearful of being judged by other health practitioners if she did not achieve quantifiable treatment outcomes. Belinda did not clearly connect her concern about being criticised to the potential for practitioner dominance, but it is apparent that she worried that it reflected badly upon her value as a practitioner when patients did not achieve a good outcome:

Maybe an insecurity of “have I missed something? Have I missed something?” Like you do want to baby them a little bit and help them by doing it for them. You think “well have I done it? Have I missed something? Do they need to come back one more time just so I can tell them something else and they can do what I want?” [Belinda]

This quote highlights Belinda’s lack of certainty about how decisions had been made. She wanted to promote autonomous choice for patients, but when she felt uncertain she fell back into a technical role of taking control and providing solutions to problems. I interpreted this finding to mean that Belinda had the flexibility and ability to use different decision-making approaches, but it also seemed that she was concerned that taking control and providing solutions was never an acceptable approach. This finding suggests that first having the ability to use different approaches is important because it helps to meet the various needs of different patients and different clinical circumstances. Second, it is important that practitioners reflect on when each approach is useful because not all approaches are appropriate at all times.

Belinda appeared at times to lack confidence in asserting her dietetic expertise with medical practitioners. She told a story about a doctor who did not want to enter into a discussion with her about the nutrition care of a patient. She had discussed a variation of the management plan with this patient and sought to advocate on behalf of her patient to affect this change:

He started getting really upset and I said “well, we’ve suggested a multi-dose of insulin” and then he just turned his back. And I just sat there and then I left, and I thought “oh, Belinda, you should have – you were there, you were there, you should have just ...” so consequently, he’s not going to change the medication. We [dietitians in general] are fairly powerless then, in what we can recommend, and her
It is evident here that Belinda was experiencing significant barriers to advocate for her patients’ perspectives in the professional decision making of the health care team. She wanted to be listened to and her frustration at not being able to communicate assertively and on equal terms with other health practitioners was evident. A potential impact of these power imbalances on professional decision making in this situation is that patients’ views in professional decision making have been diminished. The onus may subsequently be on Belinda to be more strategic in communicating with this doctor to foster a collaborative approach to care. However, it is possible here that she simply was not confident and would continue to accept these difficulties in communicating with her colleagues, feeling powerless and lacking in strategies to address this situation.

Dietitian participants often perceived that they were valued for the technical knowledge they could provide or the biomedical outcomes they could achieve. This perception discouraged them from advocating for patient involvement in decision making to the team. Further, they felt that other health practitioners and patients saw their profession as having less value.

### 6.1.2 Dialogues

My interpretation of the reflections of the dietitian participants revealed that there were a number of tensions and complexities in establishing the type of open dialogue that is needed for collaboration to be effective. It appeared that participants struggled with identifying their own and their patients’ preferences for participation, dialogue, reconciling alternative viewpoints and confronting inconsistencies in communication.

**Identifying preferences for participation**

In my research it appeared that dietitian participants rarely overtly discussed with patients their preferences for an approach to professional decision making, nor the decision-making roles that they and patients could play. In some cases, dietitian participants did not want to hand over the leadership in decision making and felt uncomfortable with patients making their decisions with limited input from themselves or other health practitioners. In these situations, dietitian participants actively sought to have a useful and responsible input into professional decision making, with varying reception from patients. A good example is provided by Margot, where it appeared that...
she and her patient were in conflict about how decisions should be made. On the one
hand, Margot wanted to have an input about the dietary regimen this patient should
follow to meet his nutrition needs and reduce the risk of poor health outcomes. On the
other, this patient had his own ideas about what he wanted to do and appeared to want
to make his decisions largely alone:

So he was still on the same plan as in the hospital, which was fine, he had
something to work with and I've just been reviewing his plan. He's been changing
things… and all these different issues are coming up but we're not sure whether
they hear a little bit and go with that and not, I don't know, it's very ... [difficult]
[Margot]

In this quote, it is evident that Margot’s patient was making decisions that she was
concerned about. She wondered whether other team members had given him conflicting
messages, and was unsure about why he was making adaptations to the instructions he
had been given. Over the course of the interview, Margot described struggling along in
this situation without overtly raising a discussion over how she could work with her
patient or what his thoughts were on the situation:

MO: 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: 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”.
MO: 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]

In this quote Margot did not appear to feel comfortable about the possibility of having a
discussion about how both her own and the patient’s need to be involved in the
decision-making process could be met. Understandably, she appeared worried that if she
had opened such a discussion with this patient regarding his needs for care, he might
have chosen to discontinue care. This patient eventually made the changes she had
suggested, but it was apparent that Margot’s struggle centred on balancing patients’
desire for autonomy with her strong concern that she had not fulfilled her duty of care to
this patient:

Because he's been particularly difficult, I think I'm happy at the moment being that
support person. In the back of my mind I'm thinking, “I should be doing this and I
Understandably, Margot worried that this patient might have decided to act in a manner that was unsafe, even with all the relevant technical knowledge provided to him. She questioned where the responsibility for a negative outcome would lie. Towards the end of my interviews with Margot she noted that the reflection time between interviews had been useful to help her stop and think about her practice more deeply. She continued to value listening to patients, and was trying to work out how to balance her input with patients input:

I guess [I learned to value] really listening to what people want and also trying to judge how much to help without getting people annoyed, enough that they'll listen and make changes but not trying to force them into anything that they don't want. So [it was good to] let them take the direction I guess and sort of push them back in the right direction when they're going off track. But it's much more productive than me trying to go this way and they're wanting to go this [the other] way. [Margot]

Margot’s reflections here are a good example of the need for critical reflexivity and responsiveness to the situation for CDM to be effective. Critical reflexivity requires a sceptical consideration of the status quo and how things have come to be, and focuses on social construction of knowing such as in a critical dialogue with a peer (Kinsella, 2012). I interpreted this to mean that Margot might have been hesitant to give greater decision making freedom to this patient due to her perception that her duty of care was to ensure he remained safe and made appropriate feeding decisions. This finding suggests that the ability to actively listen to patients and pick up cues that indicate patient preference for decision-making control, and to sensitively provide guidance or suggestions when warranted, is important for determining when collaboration is an appropriate decision-making approach.

Engaging patients in dialogue

All dietitian participants in my research valued engaging patients in care, which appeared to be a major reason they decided to participate in my research. However there were frequent discussions throughout the series of interviews about negative or uncomfortable reactions from patients or other practitioners when dietitian participants sought to involve them in professional decision making. One area that Joanna wanted to explore in her reflections was how to engage patients in setting health improvement goals. When she trialled a health coaching strategy with patients, which involved asking
patients to set their health goals, she experienced a different reaction than the one she expected:

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]

While Joanna believed that engaging patients in decision making to determine their own health goals was beneficial, it could have been that these patients were not used to working in this way or did not even want to work in this way. When asked why they might have reacted that way, Joanna wondered whether patients had certain expectations about care:

I think the assumption is that they come to see the dietitian and they just want the meal plan. I think that’s probably the reason and they are a bit confused about “why I’m writing it down and why is she not giving me this [the goals]”. And some of them say that and I say “well if I just gave you a list of things and a diet sheet to go away and do, would you do it?” and they usually say no. [Joanna]

Joanna did not appear to perceive her experience to mean that engaging patients in decision making was the wrong approach to use, but her use of words here could be interpreted to mean that she had not checked her assumptions with patients about their preferences for participation in decision making. Based on some of her experiences as a patient, she then described practical ways she could prepare patients to feel more comfortable with being involved in goal setting or taking a more limited role in decision making if that was what they were better able to deal with:

I have started to go back to probably more what I was taught at university and say “well this is what we’re going to do, I’ll get some basic information on your food and we’ll go through the diet history and then we’ll work some goals out”. They seemed a bit happier with that, yeah I did do that. I suppose I got that idea because I went to a health professional for myself and she was really good and she went through all those basic things and told me everything she was doing where other people I’ve been to just do it without saying anything. [Joanna]

Joanna found that patients responded more positively to her attempts to involve them when she explained what her intentions were. She recognised that using a different approach could cause anxiety and uncertainty in patients, and saw the benefit that explaining a new or different approach can have.
Eliza had explored using a health coaching approach to engage her patients in decision making about goals and strategies for nutrition care. She had found that there were certain groups of patients who she did not feel were appropriate to engage in decision making in this way, particularly people of lower socioeconomic status and with mental health conditions:

I don’t think you can use it [health coaching] with everybody. Well I know that I can’t use it with a lot of my mental health clients. They just don’t seem to process what we’re trying to do. You can give them so much knowledge but I still don’t think they could put it into practice, sometimes because they just don’t function like you and I function on a day-to-day [basis]. For them it is just about getting up and getting dressed. [Eliza]

Eliza recognised that making dietary changes might not be the highest priority of patients who had mental health conditions, and she had experienced situations where trying to engage patients in decision making had not been successful. She felt at a loss to help these patients to fulfil their dietary needs:

Well it’s kind of failing them to a degree, because I think we’re not supported well enough to be able to give them maybe some more [basic] lifestyle support or giving them resources [to help them with] day-to-day functioning. Whether this is because we are working in our silos and they [the mental health team] are just referring and I’m seeing them and not much communication [is taking place] with each other. But then I also think, you’re not getting the outcomes that I suppose we should be looking for with our clients. [Eliza]

This quote revealed the tension for Eliza between the external expectations to achieve certain outcomes (which she had described previously as biomedical) for her patients and also recognising that for some patients, the expectation to achieve biomedical improvement through dietary change was unrealistic. It appeared that this tension was further compounded by inadequate communication about the differences of opinion regarding patient care that seemed to exist between Eliza and the mental health team.

Only one dietitian in my research, Holly, appeared to prefer to use a collaborative approach for all patients and experienced frustration when patients did not respond by engaging in decision making as she expected. Holly claimed in the initial interview that when she could not develop a relationship with patients where she could engage them in decision making she tended to withdraw from the conversation. She found this tendency to withdraw frustrating in light of her apparent perception that her most important role was to help patients make change. She felt the best way to help patients make change was by working together with them in a collaborative manner. When questioned about
why she found these situations challenging, Holly initially raised issues that were directly related to patients, such as how honest they were with her or whether they were really ready to make change. When asked how she felt about this situation, Holly acknowledged that her frustration arose from her lack of control:

Oh, I really didn’t have any control in that situation and again she failed to attend an appointment yesterday. She has called me all apologetic and said “can I book another appointment” but then she’s going away and I’m going away so she’s coming later, so a long time with really no structured goals in terms of what to do with her diet. She agrees with something while we’re sitting here together but then she takes it and turns it and does something else. [Holly]

This quote suggests that there might have been more to this situation than meets the eye. There appeared to be a communication breakdown between this patient and Holly. The breakdown could have stemmed from the initial disagreement that Holly described on the cause of this patient’s health challenges or disagreement about the strategies that could bring long-term success. This disagreement could have led to this patient feeling unable to express her concerns or needs in the presence of a powerful practitioner. Relationship building needs to be more free and open to people to clarify such needs and concerns.

After reflecting on these difficulties, Holly came to think that the way she communicated with patients could have been influenced by her beliefs and values, and she wanted to look at deeper reasons for the challenges she faced communicating with some patients. During her reflections she went on to describe an experience with a woman who presented with her child for advice regarding fussy eating. Holly found it difficult to engage this woman in any discussion. With the premise that this patient might have felt judged, Holly considered ideas about how she could possibly shift the power balance in this situation:

Maybe doing what I’ve been doing, but I like the [idea of] more empathy and especially in those client groups that I haven’t [had experience with]… yep, it is, it’s the kids, because I find I have more success when I work with older children. There was a 16-year-old girl for weight control so that was a lot more successful than if I had a 10-year-old for weight control, so maybe it is working better with the parents, in terms of sharing experiences and empathy and [asking them] “can you teach me”… ? [Holly]

Holly felt that she lacked knowledge from experiences with children and liked the idea of asking patients to tell her their perspectives, rather than the emphasis being on her providing technical knowledge. Holly came to my research with a clear idea of her
beliefs and attitudes towards nutrition and dietetics and how things should be done. Prior to my research, Holly had discounted being directive as the key mode of working with patients in dietetic practice; she valued being able to make a connection and build a good working relationship with patients. Over the course of her reflections, Holly appeared to begin thinking in greater depth about patients’ perspectives, how they might be different to hers and how that could possibly explain the challenges she faced:

We’re there to help people. They’re our clients and we need to look after them. Sometimes I do personalise things – you know, I think more about clients. Maybe that’s just the nature of health care that you do care about your clients and when they don’t lose weight you think “how can I help you?” rather than just saying “well, you’re not losing weight, what do you need to do to lose weight, how can I assist you and support you in getting that way?” I’ve started doing more of that. I think it’s also about my boundaries, where I feel I can – you know, “oh you shouldn’t say that to a client” or feeling more confident about the fact that you can say certain things. Even when you’re told you can definitely refuse to see a rude client, for example, if I didn’t know that you can refuse a rude client, I wouldn’t feel as confident in doing it. So I just feel more confident that yes I can talk to clients about that. I can be very transparent when I talk to clients that “this is what I think about the issue, what do you think about the issue?” [Holly]

This quote highlights Holly’s awareness of her stance towards health care. She recognised that one of her desires as a health practitioner was to help people and that she had defined that in the past as helping them achieve biomedical or tangible outcomes. During her interviews, Holly observed that she often assumed that she and patients were in agreement about which of their needs and concerns were most important, without openly discussing their agreement. She had subsequently tried asking her patients about their needs and concerns, and found that sometimes it took time for these to be explored:

So I asked at the start why they were there and the real reason why she was there didn’t come up until I asked her the second time. So I asked her “what brings you here today?” Failure to thrive – I just didn’t worry about it. I asked again, “what is the issue, why are you really here”, because I didn’t seem to be getting anywhere with her. I asked again and it didn’t come out until the second time. So we left the session with the goal of talking to her partner about what they’d like to do. We couldn’t agree on anything in the session, because she said “I don’t know”, and I said that it’s really important the whole family’s involved, that the partner’s involved. So our goal for that session was just to talk to the partner about what they wanted to do as a unified team and I gave her some things to start off with. Like, “this would be good to talk to your partner about” and just said book another appointment, and they haven’t, because it might still all be too hard. But I did still feel like I got somewhere better with her because even though you ask “what brings you here today?” – they might be there for weight loss – but [it’s important to ask] “what issue is it today that you… or what is it that you want to get out of today’s session?”. So from that I have started asking more often “why are you here, what exactly would you like from today?” [Holly]
When Holly gave the patient some space (in her attempt to explore the needs and concerns of patients), she felt she was more likely to create an individual action plan with the patient and to bring about a successful outcome that both she and this patient were happy with. She appeared more comfortable with patients leaving the consultation without a firm intention to make change if they had had an open discussion about the patients’ needs, even though change was something she would ordinarily hold in higher value than other outcomes such as raised awareness. These quotes demonstrate how, during the reflection, Holly became more confident in her beliefs and values about drawing her patient into the decision-making process. Her reflections reinforced her ideals that patients should be involved in professional decision making. It would be important to encourage Holly to consider when being collaborative would not be appropriate, to ensure that decision-making approaches used in practice continue to be acceptable to and appropriate for patients.

I concluded that a preference to engage patients in dialogue could be because the dietitians who participated in my research were receptive to the idea of engaging patients in decision making about care. The majority had undertaken continuing professional development that encouraged participation of patients in care. However, a potential barrier to these practitioners choosing an appropriate approach to professional decision making for each clinical circumstance could have been an “all or nothing” approach to practice that favours one decision-making approach as always preferable to others. Furthermore, unquestioned assumptions about the needs and concerns of patients that practitioners bring to a dialogue with patients as well as unresolved tensions between expectations of others and dietitians about appropriate approaches to professional decision making can also be a barrier to seeking to adopt an appropriate approach to professional decision making.

**Reconciling alternative viewpoints**

In general, dietitian participants were clear about their ideas about nutrition and making dietary change. They were, however, also mindful of the potential for dominance by health care providers and did not like patients to view them as the “food police”. During her reflections, where she sought to consider how she might explore patients’ needs more deeply, Eliza spoke of the challenge she faced in balancing the negative implications of preserving professional authority with developing a positive relationship with patients:
E: I think if we can get past that [sense of] *I'm the health provider* – and become more, I suppose, *normal*… but then you don't want to go too far down that way either because then…

MO: What would be too far?

E: I suppose when you start sharing too much personal stuff and they start maybe seeing it as a social visit instead of "I'm here to get education and I'm here to make changes" [Eliza]

Eliza wanted patients to see her in a humanistic light, but she did not want to lose the opportunity to fulfil her professional role of providing education either. Eliza’s views about health and nutrition were strongly held, and she valued being able to communicate to patients and correct any misconceptions about nutrition. She valued patients having a holistic view of their health and not being restrictive in their eating habits. Understandably, she disliked health programs and products that in her view offered unrealistic solutions and promises. In the second interview, it became apparent to me that Eliza used her personal views as well as her technical knowledge and experience to determine and communicate which goals and strategies for change were realistic and appropriate. She tried to take patients’ circumstances into account to inform these decisions. When patients’ ideas were in conflict with her own, Eliza claimed that she would be blunt about whether she thought what they were doing was going to be helpful or not:

E: I'm thinking there is just so much competition, and there are so many promises out there, that “yes you'll have so much success and all you will have to do is have milkshakes for the rest of your life”. And I think I'm quite blunt with people as well. I have this one gentleman that is on a popular diet and I'll very bluntly say to him, “how boring!” [laugh]…I suppose I shouldn't be as blunt. But, yeah, I just say to them “are you going to eat that for the rest of your life?”

MO: How do they respond, if you are being blunt like that?

E: Some are a bit like "Oh, I thought that's what you would want me to do". Yeah, some of them may have had that preconceived idea that they would be on a very boring horrible bland diet for the rest of their lives. I really try to get that across to people that's it not boring and bland and repetitive, and it's no different to what we recommend for everyone else. So I think they can be quite actually surprised by that [laugh]. Some people can even avoid eating bananas or grapes. “I thought grapes were so full of sugar and were so bad for you”. Yeah, there's so much surprise from them about how diverse the diet can be. [Eliza]

Eliza was mindful of the importance of a positive relationship with patients. Nevertheless she did not recognise how bluntly communicating her opinion reinforced her position of power as the nutrition authority, and was perhaps missing the opportunity to become a decision making partner with her patient by exploring other points of view, preferences or experiences. In this case she had not considered whether she needed to be more open to exploring her patients’ points of view and finding
common ground. I concluded that it is important for practitioners to consider how they balance providing advice with critiquing alternative viewpoints about nutrition to preserve their relationships with patients.

**Confronting inconsistencies in communication**

Maintaining rapport and building a trusting and non-judgmental relationship with patients was a key concern of the dietitian participants. So when situations arose where it became apparent to them that patients were describing inconsistent feelings, thoughts or experiences, most dietitian participants were hesitant to raise these inconsistencies for fear of damaging the relationships they had built with the patients.

Sabrina told a vivid story about a patient who had strong beliefs about the relationship between her symptoms and particular foods. Sabrina felt this patient had been open to collaborating and that she had successfully negotiated changes with her, but it later became apparent that this patient did not want to make the changes at all. On reflection, Sabrina thought she could have tried to question this patient more to work out what exactly the patient wanted from her. If this patient had been insistent that foods were causing her symptoms, Sabrina would agree to disagree and leave it at that. She would not want to further explore this difference of opinion or challenge the person’s beliefs, as she felt that to do so would be disrespectful and did not want to damage the rapport she had built:

> 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 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 these diseases can cause these symptoms. So yeah I was sort of taking it from that point of view with them. [Sabrina]

Sabrina appreciated the fragility of the patient–practitioner relationship, but I concluded that sharing her experiences as a professional could have unwittingly served to reinforce her dominance. In this scenario, Sabrina perceived that it was useful to provide information based on what she had learned from other patients. Interpreted in another way, however, that could mean that this patient might have felt that her own opinions about nutrition were not being heard and/or accepted by Sabrina as a valid point of discussion. The potential for reaching common understanding for an appropriate way
forward for nutrition care could have been hampered, leaving both Sabrina and this patient with little benefit from the consultation.

This finding suggests that sometimes it is not known what a patient’s perception is of the care being provided, and this highlights the importance of transparency and openness of both decision-making partners in dialogue between patients and practitioners. Hesitation and lack of transparency on the part of either decision-making partner can foster distorted conversations that are not based on sincere intentions. I interpreted this to mean that by opening the conversation space, a deeper understanding of how patients might want to work with dietitians can be further explored and reached.

6.1.3 Developing professional identity

During reflections on professional decision making, it became apparent to me that a number of the challenges that dietitian participants were reflecting upon related to developing their professional identities. As they were early career dietitians, it can be expected that these participants were still trying to define their roles and responsibilities, as well to understand their professional boundaries in providing nutrition care. I concluded that key tensions related to developing professional identity included reconciling internal and external perceptions of their role, blurring the boundaries between professional and personal identity, expanding the role of dietitians and managing shifting role boundaries.

Reconciling internal and external perceptions

A key challenge for these dietitian participants was to reconcile their beliefs about practice with what they perceived to be the expectations of others with whom they interacted. Most dietitian participants believed that making dietary change takes time and that a more positive attitude towards food was an important outcome of care. However, there was a sense that dietitian participants struggled when patients took too long to make change or were making changes that were not biomedical in nature. That is, these patients were not working within the dietitian’s “comfort zone”.

I've been finding it really difficult when – I've had a few patients that I've had right from when I started here and they just won’t lose weight and they just won’t make the changes but mentally when they talk to me they're a lot better about food. So they are changing their mentality and they’re not dieting as much anymore but they are still just eating the stuff that’s stopping them from losing the weight. It’s like, well, you’re not really ready to change because you’re not changing your eating
behaviour but then you are changing your mentality. So it’s really hard to know – is this successful or is it not? [Natasha]

Later, when questioned why she appeared to value weight loss over an improved attitude towards nutrition and eating, it appeared that there was tension here for Natasha. This tension appeared to be linked to Natasha’s perception of what other people thought her role should be or the professional image that people have of dietitians:

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]

Natasha saw the value of other outcomes such as a raised awareness or change in attitude towards nutrition but there was still a tension there for her between her ideas about what was important about achieving better health and the pressure she perceived from others to prove her worth. She equated the value of her input to the achievement of biomedical outcomes such as weight loss. As an early career dietitian Natasha was not confident in her ideas about working more holistically with patients, and her colleagues had a significant influence on her practice.

Despite this apparent tension, Natasha had good awareness of the importance of challenging the expectations of others, and this was helping her to learn to articulate and stand by her values. This finding reinforces the importance for early career dietitians of critically reflecting on how they define their roles and responsibilities as practitioners and how these views might fit with the views of others. Further, encouraging early career dietitians to advocate for alternative views of practice and outcomes for patients could be useful to ensure that the diverse needs and preferences of patients are recognised and respected.

Blurring the boundaries between personal and professional identities
Some dietitian participants were struggling to reconcile their personal and professional identities. Kate wanted patients to see her imperfections and shared her personal experiences to demonstrate her humanness in relation to food and nutrition. This approach was aligned with practical interests. However, she was also driven by the
technical concern of how living and working in an environment with a smaller community affected her professional credibility. Kate appreciated the friendliness and warmth of the people in the community within which she worked, but she felt that the high degree of visibility in her town was a potential threat to her professional credibility:

Oh, it's terrible when you go to McDonalds and you haven't been to McDonalds for 3 months and all of a sudden there are patients in the line next to you and they say “Hello, what are you doing here?” Ah, that's just, it's embarrassing but I just think “I haven't been to McDonalds for 3 months!”. [Kate]

In this quote Kate expressed concern that patients might perceive her presence in a fast food outlet to mean that she did not follow a healthy balanced diet herself – that she did not “practise what she preached”. In contrast, Kate actually wanted patients to know that eating a balanced diet allowed for occasionally enjoying fast food. My interpretation of this quote is that Kate seemed to feel the need to explain her eating behaviours, even when they were consistent with her professional stance on what healthy eating entails.

This finding demonstrates the difficulty that early career dietitians can experience in blurring the boundaries between their personal and professional persona. This may particularly be the case when living in a small community where privacy is harder to maintain. Some participants were over-anxious about these personal/professional boundaries whereas others had not reflected on the potential differences between the way that they presented themselves in both professional and social arenas. A key consideration here is not that there should be a separation between personal and professional personas, but rather that learning to deal with both was a challenge.

**Expanding the professional role of dietitians**

All the dietitian participants saw their key role as helping patients achieve biomedical outcomes/improvements. Another important role stated by some dietitian participants was to empower patients. Yet this latter group struggled to determine how they could enact this role in practice. Empowerment can be viewed as a goal of care, such as to have control over the contributing factors to one’s health, greater confidence- or consciousness-raising, as well as a process in care, namely the creation of conditions that help patients to take this control (Tengland, 2008). Empowerment as a concept can be viewed in different ways, depending on the interest driving practice. It could be seen
as having the technical knowledge needed to make decisions about change, or being aware of the impact of psychosocial factors on health behaviours. Empowerment can be seen as the ability to challenge constraints in people’s lives that affect their ability to improve their health. Dietitian participants claimed that empowerment was important, but their perspectives about empowerment were at times muddled. Joanna described empowering patients through technical knowledge provision and did not appear sure about how she could empower patients otherwise:

I’ve got no idea, um…I’d have to have a think about that for a long time, I don’t know how else they could be empowered… by making them feel good… not making them feel worthless or useless or they haven’t done a good job, so… giving them the power to feel good will help them in the long run. Someone without self-confidence is hard to motivate. [Joanna]

Joanna claimed that self-confidence can be empowering and related to a person’s motivation. Later she suggested that providing reassurance that patients were making good progress might help in this situation. Joanna’s reflections hinted that she suspected there was more to empowerment than knowledge provision, but she was not sure how she could help foster patients’ self-confidence in her role as a dietitian. Belinda claimed empowerment as an outcome that would eventuate when she adopted counselling approaches:

She wanted her daughter to lose weight, so I acknowledged that it was an issue for her and her daughter and that it was really emotional. And I guess I normalised what she was feeling and normalised in her mind how she’d seen her daughter as “oh my god, she’s going to turn out exactly like me with all these issues with food” rather than “well look, she’s actually tracking [on the growth charts] okay and the foods that you’re giving her are pretty good. These are a few suggestions that might make it a little bit more balanced”. And I guess for her to walk out feeling a bit more empowered about “well I’m not hopeless. My child is fine”. [Belinda]

Belinda not only provided technical knowledge to her patient, she acknowledged and worked with the emotional aspects of this patient’s situation. By acknowledging the mother’s fears, Belinda was more likely to instil empowerment of her patient by promoting awareness of the emotional factors that influenced her eating habits.

I interpreted this finding to mean that these participants had only just started to consider other ways for dietitians to empower patients apart from technical knowledge provision. The perceptions of these early career practitioners about their roles were still developing. These role perceptions could have come about for these participants through their professional socialisation during university education and their
engagement with the profession through working alongside other health professionals, continuing professional development and reading professional literature. Although the participants acknowledged that there were often likely to be significant links between eating behaviours and emotion, this acknowledgement and exploration of these emotions had not led to the realisation that it could be an important role for dietitians to consider building into their communication with patients empowerment of those patients to modify their behaviour.

Managing shifting role boundaries
A number of dietitian participants questioned the role boundaries that existed in their work. Lisa’s reflections eventually led to questions about the potential roles that she could play as a dietitian to be of value for patients. Between interviews, her reflection started with a question regarding what her role could be in providing ongoing support to patients. She had observed that many patients needed more than technical knowledge to improve their health and she wondered what her role could be as a dietitian beyond providing this knowledge to her patients. Lisa had not previously considered asking patients for their thoughts about what role they and she might play in the long term:

I think it would be a good question to ask. I haven’t asked it. I would like to ask it. I think it would work particularly well with that group I think I had success with. I don’t know what the answers would be but I bet it might be very interesting. [Lisa]

Lisa found it difficult throughout her reflections to define the role dietitians could play beyond providing education about nutrition, particularly in the long term, once clients had started making change and were progressing towards their goals.

L: I also think one of my areas of weakness is, this is great for a period of time, but then what do you do from there, where do you go from here? It's a very slow process.
MO: Can you explain that a bit more? What do you mean?
L: OK so one of my favourite types of client – has good knowledge, done everything and it's working well, so maybe you're about 6 weeks in, [with a] good success rate. Things are going well and I'm not very good at saying “things are going well, but things can [go off track]…” I know that if you keep coming back statistically you’re going to have better results, but I’m not comfortable, I don’t know, I don’t know if it's a lack of confidence on my part… Well I feel, yes, I am contributing heaps here but then I get to a point “well am I really offering anything new and fresh…?”[Lisa]

Lisa was not convinced that a technical knowledge provision role was adequate or appropriate for patients, but she was not sure what her role could be for these patients in the long term. Her reflection questions became about whether she could redefine her
role as a dietitian to be more “useful” to patients. Despite learning that patients did benefit from long-term input, Lisa remained unconvinced that she was being useful for them:

I think I was happy that it [the reflection activity] encouraged me, to at least a couple of times, to ask the question “is this any use?” “Do you get any benefit out of coming back?” A couple of times it was all very good. It was all very definite. “Yes I do.” I thought that was good. But still niggling away at me. I know there’s people like the girl who comes with her mother that I feel I’m not actually useful and I think that that happens. [Lisa]

The question remained here for Lisa of whether this “something else” was actually dietetics and what she could do for patients beyond providing technical knowledge that is of value. Lisa seemed to remain concerned that her usefulness was viewed by others only in technical terms. This finding highlights the importance of encouraging early career practitioners to consider how usefulness could be defined in practical or emancipatory terms, as well as developing advocacy skills to argue to the broader team about other roles that dietitians can play.

Sabrina’s reflections focused on what her role could be when patients were not ready to make change. When she felt patients were not ready to make change, Sabrina was less likely to actively pursue a biomedical outcome with them. She tried to switch her focus to strategies that helped patients explore their thoughts about making change and what approach they might like to take in the future to improve their health. This approach was against a backdrop of pressure from the rest of her team to achieve measurable outcomes:

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]

Sabrina emphasised here the discomfort that most dietitian participants seemed to feel in working with patients who needed more time to consider whether they wanted to make change or not. This discomfort could have been due to the lack of confidence of these early career dietitians in advocating to other health care practitioners that patients were not ready to make change and that emphasising biomedical outcomes of nutrition care at this stage would be inappropriate. Advocating for patients was particularly
difficult for dietitian participants who worked with other practitioners who were focused on biomedical outcomes.

Dietitian participants experienced tensions when building relationships and establishing dialogues with patients, and in managing reactions of others to their attempts to encourage participation of patients in the decision-making process. They were struggling to reconcile a range of multilayered and conflicting intrapersonal and interpersonal expectations, perceptions, preferences and values that were driving practice. Dietitian participants experienced tension between their sense of professional identity, perceptions of preferences and capabilities for participation in making decisions and the expectations and perceptions of others (particularly other health practitioners, members of the community and other dietitians) about their role, responsibilities and value.

6.2 Patient participants’ perceptions and observations about professional decision making
Because this thesis focused on CDM, it was important to include the perspective of patients and how they shaped decision-making approaches. I assumed that patients would play a role in influencing dietitian participants’ decision-making approaches whether it was implicit or explicit. To critically understand CDM I interviewed six patients to explore how their perceptions and observations could contribute to understanding and shaping CDM in dietetic practice. In this section of the chapter, I focus solely on patient participants to illuminate their perceptions and observations of professional decision making.

All patient participants were female, middle-aged and lived in rural or regional environments. Each participant had children and four had grandchildren. Five were married and lived with their husbands only, as their adult children had left home. One participant lived with a parent and her children. Five of the participants regularly cooked meals for their families, with one participant having meals cooked for her by another family member. Four worked full-time and two had part-time paid work duties.

My interpretation of patient perceptions and observations emphasised the complexity of CDM. Many conditions needed to be in place for successful collaboration to take place, including certain dispositions and relationship characteristics as well as coming to a
deeper understanding of each other’s roles, expectations and preferences for conversation style and sharing of knowledge. For the patient participants, factors that were valued in professional decision making included acknowledgement of a variety of preferences and expectations for outcomes and processes within dietetic care, a disposition to both listening and talking, a desire for a trusting and honest relationship and having time to think and talk.

### 6.2.1 Patient expectations for nutrition care

A key driver for the way dietitians shaped professional decision making was for the patients to achieve biomedical outcome (improvement). However, patient participants had various aspirations for dietetic care which went beyond biomedical improvement. Bernadette described her aspirations for working with her dietitian:

[I wanted] to feel better within myself too because I think that’s very important. You have a different outlook on life when you start to feel better in yourself. [Bernadette]

Bernadette wanted to feel better about herself, and saw this as including not just her physical wellbeing but her emotional and psychological wellbeing as well. The experiences of patient participants with their dietitians demonstrated the value they gave to these non-biomedical outcomes, as described by Monica:

She gave me more information and a bit of confidence building I suppose, I don’t know what you’d call it. [Monica]

Acknowledging the possibilities of diverse capabilities and insights of patients and their diverse goals is important because it can extend the focus of dietitians beyond physical outcomes to a more holistic view of care, patient journeys, practice and professional decision making. An implication of these patient participants’ views might be that for collaboration to be effective, transparent discussions about aspirations for nutrition care needed to take place. Such discussions could include not only what outcomes could be achieved but also how patients and dietitians preferred to engage with each other. More broadly, the finding that these patient participants desired more than biomedical outcomes has implications for the nature of CDM in dietetics. A reorientation of dietitians’ expectations of outcomes to include non-biomedical outcomes could mean that the dialogue within CDM could be broadened to include a much greater range of determinants of eating habits, such as emotion, confidence and self-efficacy.
Patient participants had various expectations for the role that dietitians could play. They wanted their dietitians to share their technical knowledge and knowledge derived from experience, but they also described other roles that dietitians could play. Technical knowledge provision was of varied importance to the patient participants as they came to their dietitian feeling they had different levels of knowledge about and experience with changing their eating habits:

MO: So did you know much about nutrition at all?
M: I had a fair idea but it's one of those things, you know what you should be eating but you've got no reason to put it into action. [Monica]

Most patient participants claimed that they had a good grasp of the nutritional or biomedical concepts of healthy eating to improve their health. They presented with conditions that they had been managing over the long term and had learned much about these conditions and their management over time. For these patient participants, the possession of this technical knowledge had not been enough to translate into behaviour change. They were looking for more from their dietitian to achieve their aspirations, which is a useful insight for dietitians who see their role primarily as a technical knowledge provider. I interpreted this to mean that dietitians could look beyond the didactic educator role to consider how they could help patients explore and examine the other reasons why behaviour change is difficult, and go further to enable patients to take action.

Indeed, patient participants did perceive that technical knowledge provision was not necessarily always sufficient, and wanted dietitians to provide encouragement and support:

MO: So it was that ongoing support that you found valuable?
P: Oh I desperately wanted that. I found that good. It's no good going, in my opinion, with diabetes, and just getting the information and going home because I think you tend to get a little bit casual. You take your readings, your blood glucose levels, and you tend to get a bit casual about it but I think it's good to have that ongoing support. [Patricia]

Patricia described the value she found in the dietitian’s support in improving her motivation for pursuing self-management. Having the support of her dietitian meant that Patricia was encouraged to keep abreast of the management of her health in the long term. Patient participants appreciated that dietary changes meant long-term lifestyle changes, as articulated in the following quote from Katherine:
I like the idea of a long-term approach because then I know it's long-term and it'll become more of a lifestyle rather than just this quick and easy solution and then once you're finished, well that's it. [Katherine]

Katherine had a history of trying to change her diet and related the provision of long-term support to being able to make sustainable changes to her lifestyle. Patricia agreed that the difficult process of making change and achieving biomedical goals was well understood by her dietitian:

It's never a negative. Like even sometimes I might only lose part of a kilo and still that was good at the time. They were very supportive. You can't always keep losing weight. And mainly the blood sugar levels in my case were all going well. [Patricia]

For Patricia, it was important that her dietitian acknowledged that biomedical changes were not always possible to achieve. Even though her blood glucose levels were well controlled, she wanted support through the times that she was not losing weight. I concluded that a reorientation of thinking about how nutrition care provision is evaluated might be important to ensure that patient needs are met. This reorientation might mean broadening the indicators of success to include not only biomedical achievement but also the relational aspects of nutrition care provision such as whether patients feel supported.

Patient participants wanted to know they could still access support in the future, even if they had made good biomedical progress. Bernadette, Katherine and Monica were at a point in their nutrition care journey where they felt they would like to reduce the frequency of their sessions with their dietitians, but they still wanted to see their dietitian again if necessary. Bernadette felt a follow-up appointment would be of use if she could not keep herself on track:

I think that's important because I think it's too easy for us to think "oh yes I'm right now" and then go away and fall off the rails like I've done and then have to get yourself back on track. But if you knew that in 3 months' time that you were going to go along and have another check, well I think that would be good. And I think that's probably something that they probably think that we're going to be right but we probably just need that knowledge that 3 months down the track we're going to go back again and it's in the back of your mind well I've got to make sure I keep going. [Bernadette]

This regular check-in was important for Bernadette as an additional motivator to continue to maintain a healthy lifestyle. I interpreted this to mean that after technical
knowledge is provided, patients may then need dietitians to take on different roles, such as providing long-term support or helping to navigate barriers to change. Being aware of the different types of knowledge needs of patients and being able to adapt to them accordingly can be an important role of dietitians to help address those long-term needs. Provision of the long-term input that Patricia and Bernadette described is important to many patients who have chronic conditions to assist in the fine tuning of nutrition care provision as well as ensuring that patients do not feel isolated in managing their health. For example, long-term input might be especially important for patients in rural and regional environments where family and friends often live at a distance.

6.2.2 Patient preferences for participation

The importance of the ability to choose from a range of professional decision-making approaches was reinforced by the views of patient participants, who expressed preferences for a variety of approaches. Some preferred different approaches at different times and others preferred a more consistent approach. Evelyn, for instance, preferred being in control of decision making, with her dietitian acting as a professional advisor throughout the whole dietetic process. Instead of a technical knowledge provision role, it appeared that Evelyn saw the primary role of her dietitian as a critical friend and support person to help her reflect on her progress:

But it’s really making me weigh myself every second week. Now, I’ve had a bad week last week so I know this week I’ve got to be on track. After this I’m going to go off and do a half an hour of walking because I know I’ve got to be weighed next week and I found continually going over 18 months has helped to keep the weight down. [Evelyn]

In Evelyn’s case, an ongoing relationship was important as she did not feel she could make long-term changes alone. However, she strongly expressed her preference for being the dominant decision-making partner, as she was the person who would make the dietary changes being discussed. Evelyn’s experiences are useful for informing the practice of dietitians who are accustomed to playing a lead role in the decision-making process. If a patient preference for taking the dominant role in the decision-making process is denied, the patient–dietitian relationship might not be successful and could explain why some patients do not continue the relationship with their dietitian.

Other patient participants expressed preferences for their dietitian making the decisions or playing an advisory role during the decision-making process. Bernadette found that
because her dietitian had not insisted that she return for another appointment, she lost motivation. She thought that in the future her dietitian should make the decision about when she should return for a follow-up appointment:

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]

Wanting her dietitian to take control in this way might have been be an attempt on Bernadette’s behalf to share some of the responsibility for motivation with her dietitian. One interpretation of this quote could be that Bernadette was not sure how dietitians could help her further, raising the possibility that she was not aware of her agency in being able to access follow-up support from her dietitian. Bernadette’s perceptions have a number of potential implications for the way CDM could be implemented in dietetic practice.

First, dietitians could facilitate the sharing of responsibility by asking direct questions of patients about who should be in control of particular decisions. Bernadette was trying to manage a chronic illness over the period of a lifetime. It would be reasonable to expect that she might need support in the form of encouragement or motivation to persist with dietary change over the long term, and that the degree of contact between patient and dietitian would vary with fluctuations in her health situation. I concluded that it could be useful for dietitians to discuss follow-up plans with patients such as Bernadette, as well as the existence of support groups in the community they could access if they so chose.

The professional decision-making approach that was most commonly valued by most of my patient participants to shape strategies for dietary change was characterised by a sharing and blending of technical knowledge and knowledge derived from experience of both dietitians and patients. Communication between dietitians and patients was described as a dialogue that resulted in shared decisions:

I think it’s a matter of sitting down, like what 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]

Monica wanted a personalised eating plan that was sustainable and based on her existing eating patterns. This approach is situated and person-centred and can help dietitians and patients to work together to uniquely and cooperatively determine what changes might need to be made. The finding that patient participants had a variety of preferences for professional decision-making approaches underlines the importance of creating opportunities for dietitians and patients to explore role preferences in professional decision making. It is important for dietitians to maintain an open stance, with the potential to change or reverse their roles from key decision maker to a more supportive companion, to minimise professional authority. I interpreted this to mean that dietitians need to be mindful that not all patients prefer the same approach to professional decision making and that minority views like this need to be acknowledged.

Patient participants in my research did not describe instances where they had discussed the manner in which professional decision making would take place during nutrition care with their dietitians. Instead, they spoke of their expectations about the way nutrition care might be provided, based on previous experiences. Alice expected to be provided with a structured diet plan and her initial visit confirmed this expectation:

I did wonder whether it would be a formatted sort of diet, whether it would be a structured thing. I wondered, but no, I didn’t know what I was expecting. Because I’d been involved with several dietitians before and after the initial visit, yeah, I did have expectations of a bit more structure. [Alice]

Alice later discussed her preference for a degree of structure as a way to help her remain motivated to make changes. Alice wanted guidance and structure from her dietitian. Against a backdrop of a busy family and work life, Alice had found it difficult to adhere to a heavily regimented routine in the past. These preferences represented a paradox for Alice, in that she wanted structure in her relationship with her dietitian, but found it difficult to follow a structured routine. She felt that being provided with technical knowledge and a set diet to follow in the past had not been sufficient for her to make lasting change:
I like the structure. And also I just found it really helpful being given any recipes that tell you if you do this you’ll get that, you’ll have that many calories and that’s something that’s happened now [with this dietitian]. I find I like that. I suppose I get lazy in a way, of looking things up. I would normally just throw the usual thing on the table, in the pan or in the steamer, go with that whereas now I’ve got more structure. And there’s been a lot more suggestions of just little things. Before it was “you can’t have this and you can’t have that” but this time there’s been suggestions that “yeah you can have ice cream but you make it this way.” [Alice]

Alice knew she needed something more than just basic technical knowledge. She appeared to like structure to help her with her “laziness” in relation to food, but she also alluded to a preference for an approach that allowed her to have choices rather than being directive about what she could and could not have. Structure seemed to have made it easier in the past for her to modify her diet. Alice wanted independence in that she did not want to be told what to do, but she did not want her dietitian to leave her to make all the decisions alone. Alice wanted some sort of guidelines or options from which she could choose and make her decisions. In this situation, the role of dietitians would be to share ideas and clarify key principles to enable CDM with patients. In the quote above it seems that Alice has had her needs for guidelines and input met by her dietitian, but it was unclear whether she had had an overt discussion about these needs with her dietitian.

I concluded that an overt discussion about preferences for professional decision-making approach could be a key component to facilitate CDM in dietetic practice. The aim of such discussion would be to ensure that mutual agreement for professional decision-making approach does not occur by chance and that interests driving practice are made more transparent.

6.2.3 The nature of conversations

The majority of patient participants wanted to participate in a dialogue with their dietitians. Bernadette preferred professional decision making that took place within a shared conversation where patients and dietitians were accepted as equals. She felt that the way practitioners shared their opinion was just as important as the opinion itself. Here she talked about the power of the words that are used by practitioners. She felt that if the opinion of practitioners was expressed as an absolute (“you must”) it communicated that practitioners did not recognise that patients are individuals who could have difficulty in or need for agency in implementing their advice:
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]

Bernadette felt that taking a collaborative approach in this manner demonstrated that practitioners cared about patients. Bernadette wanted her individuality to be recognised and to feel that she had a trusting relationship with her practitioner. In her view, this recognition and type of relationship would not be realised by using a practitioner-dominant approach. Recognising the humanness in patients automatically softens power relations. Patricia agreed and preferred to be given ideas rather than to be told to adhere to something:

You can’t have someone sitting up there who is very officious and says “well this is what you’ve got to do. If you do that [there will be negative consequences]…” and get a little bit bossy. I think that would, in my case, have been a disaster. But I think if it is someone who is gentle and explains things to you and then you realise, well if you don’t do this or that well… like in my case, diabetes, if you don’t look after yourself you’re in big trouble. [Patricia]

Patricia used the word gentle to describe the same approach that Bernadette valued, one that is not free of practitioner input, but is not dominating or dictatorial. These quotes from Bernadette and Patricia highlight the importance of the way that a practitioner uses language. Giving value to language in this way speaks to the importance of a shared reasoning process and an understanding of the shared use of language. Patients and dietitians could benefit from an open discussion of how they each view the decision-making process and how decisions can be made given the current circumstances. Using directive or instructive words can communicate an intention to dominate, whereas using more facilitative language can communicate an intention to work with patients.

6.2.4 Sharing knowledge in decision making

Some dietitian participants were exploring the approach of withholding their point of view during decision making with patients. For the patient participants, however, sharing knowledge depended on individual patient circumstances, preference and needs. Evelyn had had over 20 years of experience in managing her health and felt that the
knowledge she had derived from her experience was important in the decision-making process. She appreciated any new ideas her dietitian could provide about nutrition and felt an important role of her dietitian was to have some input:

Well they’re there, we want them to have some sort of input, don’t we? We don’t want them just sitting there. We’d want them to have an opinion or to say something that’s relevant. Or otherwise I might as well go to Weight Watchers or work it out for myself. [Evelyn]

Evelyn wanted a collaboration with her dietitian which incorporated sharing ideas and values. She implied that she could find technical knowledge about nutrition from other sources, but that she valued her dietitian sharing her expertise. Evelyn felt that the importance of her dietitian’s input was to monitor her progress and facilitate a discussion about what progress she had made and what she did to facilitate or hamper that progress:

If things aren’t working she would give another suggestion but I think when I go next week and I haven’t lost what I should have lost whatever it is she’s going to say “well what went wrong?” You know I don’t even think it’s going to be a decision as such to say “well, what if I try and do something”. It’s more working with me rather than against me. Because she knows there’s no use telling me because I’m not going to take any notice. [Evelyn]

This finding can help inform the way that practitioners can balance their input without dominating the professional decision-making process. By highlighting to patients in an appropriate manner their technical knowledge about the positive or negative consequences of certain eating habits, practitioners can help patients to make better choices and consequently achieve better health outcomes.

Patient participants appreciated hearing their dietitians’ stories about personal experiences in making dietary changes as well as their technical knowledge. Sharing these experiences allowed the inclusion of less scientific and more emotional and personal understandings of the process of making change towards biomedical outcomes. Bernadette felt that by sharing these experiences, her dietitian gave her more confidence in being able to manage her health:

MO: 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]
Having her dietitian share these experiences helped Bernadette feel more motivated to make changes and work towards improving her health. Sharing these experiences recognises that simply giving technical knowledge about foods and nutrients is not easily translated into the practicalities and challenges of choosing and preparing foods that are enjoyable and suitable to each individual. I concluded that verbalising and discussing the acceptability of being flexible and making choice with regard to implementing a healthy diet could be useful in CDM in dietetics. Further, the perception that dietitians should have a certain body type to be seen as a credible source of dietary expertise could be challenged and discussed with patients. This discussion might be even more relevant in rural environments because practitioners participate in a smaller social network and are more “visible” than in metropolitan areas where it might be easier to remain anonymous.

6.2.5 Trust, honesty and shared worldviews

Patient participants wanted relationships where dietitians would value patients’ points of view and experiences. Trust and honesty in relationships were key themes for patient participants. Patient participants wanted to be able to trust dietitians to share difficult experiences, uncertainties or strong emotions about food and eating. They wanted relationships that allowed them to feel they could discuss sensitive issues with dietitians. Katherine spoke at length about feeling comfortable to share the ups and downs of her weight loss journey with her dietitian:

If you can’t talk to them or if you think they’re snobbish or something, or looking down your nose, it won’t work. I find she is very likable, she talks to you rather than at you. And you feel at ease, you can just yap away, you could really talk to her about anything. So you feel very, very comfortable with her and I do think that’s important, to feel comfortable enough to talk to them about anything because sometimes different things crop up. Like sometimes I felt like I was having a loss of energy after starting and then she just said “well maybe you need to put more red meat into your diet”. So that’s what we’ve worked on. [Katherine]

This quote speaks to the importance for Katherine of her dietitian’s positive outlook and non-judgmental manner. Katherine appreciated her dietitian’s attempts to help her see her overall success rather than focusing on the small setbacks she had experienced. Patient participants valued suggestions that dietitians provided about changes that could be made, but importance was also given to patient participants sharing their perspectives and ideas. Katherine came to her dietitian feeling that she had developed her insights
about nutrition from her past experiences and described here how her ideas were incorporated into professional decision making:

I do give ideas about what tools I want to use or with the CSIRO cookbooks where they base it on 200 grams of meat whereas that’s not what’s recommended by dietitians, she’d say “well maybe you can still use those recipes but halve the quantity of meat and maybe increase your veggie intake”, so we sort of worked together. [Katherine]

The way Katherine’s ideas were integrated into the decision-making process suggested that her dietitian was successful in communicating to Katherine that she valued her ideas and input in making decisions. It further demonstrates that her dietitian was skilful at adapting the ideas Katherine brought to the decision-making process in such a way that they were in accordance with her dietitian’s technical knowledge about nutrition without ignoring or belittling Katherine’s ideas.

The success of the approach here could speak to the amount of trust in the patient–dietitian relationship. Katherine felt she was able to actively participate in professional decision making by asking questions and sharing her ideas about cooking. The development of this type of trusting relationship might have taken some time. However, this finding highlights how the sharing of technical knowledge and experience, as well as the critique and integration of alternative viewpoints during professional decision making, could contribute significantly to the development of mutual respect in the relationship between patient and dietitian.

The majority of patient participants talked about the importance of honesty in communication between themselves and dietitians. They wanted dietitians to be honest with them during communication and felt it was important that they too were honest with their dietitian about their behaviours, thoughts and feelings.

I guess the patient’s role is to be honest with the dietitian because if you go back and you haven’t lost any weight and you say “but I’ve stuck to exactly what you say” she’s probably going to think “well have you?” I think probably to be honest with the dietitian and be honest that “yes I did have three hot chocolates with full cream milk last week and only one per week with skim milk”, things like that, yeah. [Monica]

Monica felt that an important role of patients was to be frank with dietitians about her intake so that together they could work out the way forward. Evelyn felt she needed honest communication from her dietitian about her progress towards her goals:
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]

These quotes from Monica and Evelyn imply that honesty between patients and practitioners needs to be reciprocal in order for deeper understanding of circumstances, perspectives and values to be reached. This finding suggests that each decision-making partner needs to take responsibility to ensure that their views, values and interests are transparent. If the conversation partners are not genuine in their communications, the effort to collaborate is futile. This sharing of views, values and interests would be easier to realise in a relationship characterised by trust.

The sharing of life experiences was specifically raised by one patient participant as particularly important for a successful relationship to ensue. Evelyn stated that she did not feel connected to young practitioners and preferred to build a relationship with someone who was her age:

Well I think as you get older you look at things differently. Your expectations are different of yourself too. I think it’s harder when a person’s older to keep weight off, to keep away from the food. Believe it or not I could keep away from the food when I was younger, if I set my mind to it. Now it’s a lot harder. So, I think it’s just getting older, plus we have the middle age spread. It is harder… Emphasise with them. Walk in their shoes. See things through their eyes. They can [then] understand where the person’s coming from. But as I’ve already said that’s quite hard. It would be very hard for me to walk in the shoes of somebody who is 22, by the way. I don’t think I could do that any more. [Evelyn]

Evelyn felt that a similarity of age between herself and a dietitian would help them to connect. At the same time, she empathised with younger dietitians who might not have been through similar life experiences. I interpreted this to mean that Evelyn acknowledged that while having a shared sense of understanding about life experiences can be useful for developing rapport and empathy, it is not always possible that dietitians and patients are alike. The remainder of patient participants did not perceive that a difference in life experiences was an issue, but at least one patient participant spoke about how important it was for young health practitioners to understand and appreciate a broader variety of lifestyles:

Because then you get to find out the lifestyle that the person’s got and if you’ve got children and you’re running and doing things for them what happens. You don’t eat
properly and so I think… it can be hard for a young person that’s never had that responsibility of children or never been in a family situation where there’s more than two children or three people in that house or something like that and they find it then hard to realise that there might be five or six people in this house and this person has come to see you is trying to look after them and do everything. [Bernadette]

Rather than seeing a difference in age as a potential barrier to communication, Bernadette felt it was important to share her family situation with younger dietitians to help them better understand her perspective. This finding highlights the importance of dietitians maintaining empathy and an openness to exploring each patient’s unique personal circumstances, health challenges and life experiences to develop a sense of connection and understanding, in effect coming to a fusion of horizons.

6.2.6 Time for thinking and talking
Some patient participants valued relationships that allowed for adequate thinking time. They wanted time to contemplate decisions that needed to be made, along with the freedom to undertake this contemplation both with and without dietitian input. Katherine described the value she saw in being able to spend time thinking about issues that her dietitian had raised during previous consultations:

She often brings in different topics, such as when you’re sick or angry or you’re bored do you feel like eating? And the first time I said “oh not really” and then when I went away I thought “hang on a minute” and I went back to her the next time I said “well you know what I said before?” and I said “No, no I do. I do eat when I’m bored”. So then we talked about ways to overcome that and what I could have, maybe fruit instead of a sausage roll or something to overcome those little things, and to eat more regular meals. To stick to a regular routine rather than changing it. [Katherine]

Having adequate time outside of dietetic consultations meant that Katherine had had the chance to think about other potential factors contributing to her health. This finding could imply a role for dietitians in posing questions for patients to think about outside the dietetic consultation to discuss at subsequent consultations. It meant that Katherine felt supported and encouraged to make decisions alone without her dietitian’s input. She appreciated her dietitian asking questions to help her to reflect on her behaviour as it helped her to contemplate her situation and what she could do to improve her health. Bernadette agreed, and wanted time to think about certain behaviour changes:

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]

This quote emphasises that patients often need time away from the confines of the dietitian patient relationship to contemplate aspects of their lives that they had not previously considered, to make and follow through with action decisions about change. Being flexible and having patience in supporting patients in this process is important in a field such as dietetics where lifelong changes are needed and patients’ needs can vary over time.

Allowing adequate time for thinking and talking was important in facilitating the way some patient participants wanted to work with dietitians. Monica preferred to be given small amounts of technical knowledge at one time to think about. As one would expect, Monica emphasised that when she found the dietary changes that were suggested by her dietitian to be acceptable, it was more likely that decisions could be made easily there and then at the time of the consultation:

Well I suppose I was very pleased she said to me I didn’t have to give up sweets, or fully chop them out because I have a husband who likes sweets twice per day and I find if I’m not dishing them up I don’t want them, but if I’m dishing them up I dish myself up some, but now it’s virtually a taste to get that meaty taste out of your mouth, so I suppose I thought well I’ll go home and try doing what she says. [Monica]

Monica also wanted time to contemplate technical information before making any decisions about implementing behaviour change:

[I prefer] not filling up your head with too much at once, so whether you go home and tell them [patients] to read it and try and put a few things in practice and then come back in 2 weeks or so. [Monica]

Monica found this approach valuable because it was not overwhelming and she could learn which food choices were appropriate according to her individual circumstances. Because of this approach Monica felt she was better able to make decisions and follow them through when her expectations for nutrition care provision were met. I interpreted this to mean that while she was clear about the initial health goal she wanted to work towards with her dietitian, Monica’s preferences for the way nutrition care was provided were not overtly discussed. This finding reinforces the conclusion that discussions about
the nature of nutrition care provision (including time-frames for knowledge provision), should be an overt topic in discussions about dietetic care.

The patient participants reported a range of perceptions and observations of professional decision making in dietetic practice, which is to be expected if patients are considered as individuals with different needs and values. As well, the length of long-term experience of these patients in managing their health through diet would probably have influenced their expectations and preferences for decision-making approach. This could have influenced their desire for long-term support and for adequate time to think about decisions. These patients’ emphasis on trusting, non-judgmental and collaborative relationships could have been due to negative experiences with other practitioners in the past, and indeed there was mention of this from some participants. There was a variety of perceived roles and valued outcomes of dietetic care. Patient participants wanted dietitians to provide technical knowledge but they also wanted to be understood as individuals and have their ideas incorporated into decision making. Patient participants described a range of decision-making approaches that they preferred or found acceptable, depending on the situation.

Regardless of which decision-making approach was used, patient participants consistently described valuing relationships that were non-directive and where they felt they were working with their dietitian to solve problems. They described a range of characteristics of these relationships, including honesty, confidentiality, openness, privacy, being non-judgmental and positive, empathy and a relaxed atmosphere. Some patient participants spoke about the importance of time for thinking and talking, as well as the impact of the type of language that practitioners used on power relations.

Central to CDM is the fusion of horizons of patients and dietitians to achieve new understanding. My interpretations of the perceptions and observations of patient participants is that the world views or horizons of patients about professional decision making had the potential to be different from those of dietitians and both needed to be considered in shaping decision-making approaches. To further appreciate how these horizons may be fused in CDM, closer examination of the tensions and common ground between the perspectives of dietitians and patient participants is warranted.
6.3 Tensions and common ground between dietitians’ and patient participants’ horizons about CDM

In the discussion so far in this chapter I have demonstrated that CDM is complex. It cannot be assumed that making decisions about dietary change is straightforward and simple. In this section, I aim to bring the horizons of patient and dietitian participants together to come to a new understanding of the complexities of CDM and how patients and dietitians could work together for a more meaningful decision-making experience. I sought to discuss the tensions that are evident in the details of these horizons and to find common ground. To facilitate a fusion of horizon between patient and dietitian perspectives, I posed the following question: how can the perceptions and observations of patient participants inform the challenges identified by dietitian participants?

My interpretations suggest that professional decision making is complex, contextual and dynamic, and influenced not only by the way dietitian and patient participants view professional relations and dialogue but also by their core concerns about professional authority and professional roles, knowledge and power, preferences for participation and creating time for the process of decision making. I identified that while there were some common fundamental values that appeared to underpin the way dietitian and patient participants viewed professional decision making, there were also complex differences in the way these core concerns were viewed.

6.3.1 Caring and trusting relationships

A positive relationship was commonly described by patient and dietitian participants as one in which patients felt they could trust dietitians sufficiently to disclose their thoughts, experiences and feelings fully and honestly during an open dialogue without feeling negatively judged. I concluded that patient and dietitian participants wanted the same thing for the same reason – to establish a caring and trusting relationship where patients and dietitians knew each other as people and worked together towards a common goal of improved health.

Dietitian participants did not want to appear judgmental and were sometimes hesitant to be honest with patients about their own or their patients’ views or ideas about nutrition, for fear of damaging their relationship. In contrast, patient participants wanted dietitians to be honest with them about their health and progress, which included providing feedback when things could be improved as well as when progress was being made. For
these patient participants, however, there appeared to be a fine line between feeling negatively judged and feeling engaged in an open dialogue about progress. They felt that it was acceptable for dietitians to be honest in the context of a relationship where trust has been established, suggesting the importance of a trusting relationship for an open dialogue to be established as a precursor for CDM. Maintenance of confidentiality, privacy, being positive about progress, being relaxed and being empathetic were also identified during my discussions with patient participants as characteristics of a positive relationship. Dietitian participants did not overtly cite these characteristics as important, which implies that they might not have fully appreciated the complexity of these facets of relationships.

6.3.2 Transparency and language in dialogue

My findings suggest that certain things might have remained unspoken between the dietitians and patients in my study, as well as unreflected and taken-for-granted perceptions about professional decision making. There were tensions evident for dietitian participants between asserting professional authority and developing caring and trusting relationships, and these tensions had implications for whether conscious or deliberate choices were made about the roles they and their patients played, how knowledge was valued and informed professional decision making, and whether the emphasis in professional decision making was on process or outcome. There did not appear to be dialogue that focused on an exploration of each other’s assumptions and expectations, or coming to a deeper understanding.

Few comments were proffered by either patient or dietitian participants about actual discussion of these preferences between dietitians and patients. Dietitian participants appeared to choose a decision-making approach based on their socialisation/training, their perception of the situation, and (sometimes) what they thought patients’ preferences might be. Dietitian participants seemed to take the lead and patient participants did not overtly discuss seeking to influence the dietitians’ approach. Even though these patient participants appeared happy with their relationship with their dietitian, these findings suggest that there might have been lost opportunities for the dietitians to gain a better appreciation of patients’ preferences for participation.

This lack of dialogue could have come about for a number of reasons, including lack of confidence on the part of dietitian participants to open this dialogue, or that dietitian
participants were not prepared during their university education for being part of such a discussion that can take place with patients.

Dietitian participants described their conversations with patients as largely comprising questions and answers to help come to a decision about which dietary changes should be made. Patient participants described a similar process, where dietitians and patients worked together and shared knowledge to come to a decision. Dietitian participants were more likely to describe dialogue where they directly communicated decisions to patients, with only one patient indicating a preference for guidance and structure in conversations.

Another influential factor in establishing an open dialogue could be the appropriate use of language. There was specific mention by patient participants of the language (and mode of engagement) that dietitians used to facilitate these discussions, which they believed helped to dispel authoritarian stances in relationships. They expressed a strong dislike of a directive approach to discussions during professional decision making, regardless of who made the final decision. In contrast, dietitian participants did not specifically discuss the use of language and how it might impact on power differentials in relationships. This silence on the part of dietitian participants could suggest that as early career dietitians they had not yet considered their use of language important in establishing dialogue: an area for further consideration when implementing a collaborative approach to decision making.

6.3.3 Professional authority and professional roles

All dietitian and patient participants viewed overt displays of dominance in their relationships as negative. Dietitian participants did not want to be seen as behaving in an overtly authoritarian manner towards patients. Dietitian participants mostly related being authoritarian to whether they would be likely to overtly tell patients what to do, and preferred not to take this approach. In contrast, patient participants had various preferences for being prescribed a diet or advice, depending on the stage of their health care journey. Despite these different preferences, none of these patient participants actually described dietitian participants as authoritarian. On the contrary, each felt they had established positive relationships with their dietitian and this possibly related to being content that their preferences for participation were being upheld. The difference of opinion as to the value of prescription might have been due to different beliefs held
by the dietitians and patients about making dietary change. These patients might have learned through experience that there were times when a prescribed diet would be of use, particularly when they were first diagnosed, and perhaps felt overwhelmed by concerns other than deeply considering long-term dietary change.

Both dietitian and patient participants thought that an important role of dietitians was to provide technical knowledge. Being a listener and managing barriers to change were also perceived as important roles of the dietitian by both patient and dietitian participants, with slightly less emphasis placed on these roles by patients than dietitians. Patient participants also identified further roles for dietitians of providing motivation, encouragement and emotional support. These are important roles for dietitians to consider if patients’ needs beyond technical information provision are to be met. Patient and dietitian participants all agreed that the role of the patient was to take responsibility for making change. It appeared that patient participants also felt that an important role for them was to share their ideas and knowledge from experience, and to help dietitians understand their context so that decisions made would be suitable for their circumstances and preferences.

Dietitian participants had various views regarding the impact of sharing their personal experiences with ill health or making lifestyle changes on professional authority, and whether sharing their experiences was an appropriate part of their role. On the one hand it was felt that sharing personal experiences could reduce their professional credibility, which could be interpreted as a risk to professional authority. On the other hand, sharing personal experiences was seen as an opportunity for presenting themselves as more human to patients and as a way of empowering patients and reducing the perception of themselves as the more powerful decision-making partner. Dietitian participants held various views about whether they should share their technical knowledge to inform professional decision making. Views on sharing this knowledge included a concern that doing so would reinforce practitioner dominance, as well as the concern that neglecting to do so would mean that they were not fulfilling their role and were neglecting their duty of care.

Patient participants were receptive to dietitians sharing their personal experiences and felt that doing so improved self-efficacy and engendered more trusting relationships. Patient participants also valued dietitians’ technical knowledge and wanted to receive it.
Withholding technical knowledge could serve as a barrier for some dietitians to collaborate with patients, rather than being the positive step (to avoid perceived dominance) which was the dietitian participants’ intention.

These differences in opinion regarding which ways of knowing are appropriate to share during professional decision making could have been shaped by a variety of forces. Dietitians may have felt that as practitioners their role was to maintain professional authority, and it could be that their professional socialisation during university education and in the organisational context within which they worked had reinforced this view. In contrast, patients reported learning through their own experiences that technical knowledge was not sufficient to help them make change. These patients also lived in rural and regional environments where specialised food products were often not available. It is advisable that adaptations are made to generic technical information about alternative appropriate foods for various contexts. It is also advisable to acknowledge the importance of the knowledge dietitians derived from experience in modifying standardised advice for patients and their situations.

6.3.4 Knowledge and power
Dietitian participants appeared to have different levels of awareness of how the value they gave to different ways of knowing affected their dominance in relationships. Patient and dietitian participants both valued technical knowledge and wanted it to be shared in a manner that was understandable and useful. Dietitian participants acknowledged that patients brought their experience and expertise to the decision-making process, but they often appeared to give their technical knowledge precedence to inform professional decision making. Patient participants, on the other hand, appeared to give equal value to dietitians gaining an understanding of their personal circumstances and potential influences on their diet and ability to make change. All patient participants most valued dietitians developing a sense of the individual patient as a person and believed this understanding would impact on their current and future diet. Patient participants emphasised that they too brought knowledge and experiences about nutrition and making dietary change, which needed to be acknowledged and used to inform professional decision making. This different emphasis on valuing ways of knowing could be due to patients’ and dietitians’ different perceptions of what it is of value that they brought to the decision-making process. Dietitians appeared to
emphasise technical knowledge, because they saw themselves as expert, and one of the purposes for patients to see the dietitian was to benefit from their technical knowledge.

For dietitian participants, there appeared to be a difference between gaining an understanding of patients’ personal circumstances and influences on their diet on the one hand, and learning from patients’ knowledge derived from their experiences making changes to their diets on the other. Discomfort was expressed by some dietitian participants about learning from patients. They did not want to admit deficits in their knowledge and appeared to feel that their professional authority was threatened. Patient participants did not explicitly mention taking on a role of teaching dietitians, but they felt they had much to bring to the decision-making process that could benefit dietitians.

6.3.5 Preferences for participation
Dietitian participants had different views on whether patient participation should be encouraged routinely. Opinions ranged from patient participation in making decisions as the gold standard of practice, something to aspire to at all times, to valuing various approaches which included taking control of decision making when it was considered appropriate. Patient participants wanted to be involved in making decisions, but not necessarily at all times, and had a range of preferences for how this involvement should take place. Involvement ranged from dietitians acting as companions to assist patient decision making to decision-making approaches that were based on an open dialogue and engaged both dietitian and patient. There were times, however, when patient participants wanted dietitians to take control of decision making, such as in making decisions about follow-up.

As would be expected, these dietitian participants were still learning about which decision-making approaches were appropriate at which times for a range of patients, but they were willing to experiment and try out other approaches. Others had learned through experience in their practice that practitioner-centric approaches were not always successful, and were experimenting with an approach more aligned with CDM, albeit with varying success. Patients were clear about their preferences for participation, which I interpreted could have been due to their (typically extensive) previous experience as patients and also to the situation in which they were speaking for themselves rather than a range of patients.
6.3.6 Creating time for the process of professional decision making

The core concern of dietitian participants in professional decision making appeared to be to assist patients to achieve biomedical improvements. Even though they acknowledged that psychological and emotional outcomes were important, they often perceived the success of nutrition care predominantly in light of whether biomedical improvements were achieved or not, and often whether they were achieved quickly. In contrast, patient participants gave biomedical, psychological and emotional improvement equal value. Each patient participant emphasised the importance of the process of making change, not just the outcomes. They indicated that they wanted long-term support and time to make decisions. Long-term support did not necessarily entail continued provision of advice, but included the provision of motivation and encouragement to continue achieving goals, often over a long or indefinite period of time.

Dietitians and patients had different concepts about time. Dietitian participants as a group were less clear about the importance of time in professional decision making. The dietitians perceived that it was important for patients to consider when it was the right time to make change, and also that patients should have enough time to make these changes. However, I interpreted this to mean that they also wanted to come up with solutions and achieve outcomes quickly. Furthermore, there was some uncertainty about what their role could be in supporting patients in the long term, particularly if they saw their role as primarily to advise patients regarding appropriate dietary change. Dietitian participants acknowledged that change was a long-term process but were not always sure what their role should be when patients were not ready to change. In contrast, patient participants wanted to have sufficient thinking time to contemplate decisions that needed to be made, and they expressed a preference for long-term relationships with dietitians to assist in making change over time.

It appeared that dietitians emphasised the outcomes of care, whereas patients emphasised the process as well as the outcomes. This could have been due to the differences in external pressure upon dietitians and patients. Dietitian participants might have felt pressured by the expectations and perceptions of others around them, most particularly the other members of the health care team, to prove themselves in technical terms. Patients might also have lacked motivation or encouragement from external sources or found it difficult to manage external constraints on making change to eating
habits, and placed strong value on this support coming from their dietitian. The rural and regional environment can also present unique challenges for people in changing their diet. For example, interactions within smaller social networks meant that attempts to change eating habits might be more visible. Ongoing support from dietitians could be useful in discussing how to manage these issues.

These findings suggest there are a number of factors that can enhance the adoption of CDM by dietitians. These factors are shown in Figure 6.1, which distinguishes between factors that support or hinder CDM. The figure illustrates how the supporting factors contribute to key features of successful CDM and how CDM requires the blocking of hindering factors.

6.4 Conclusion
In this chapter I have emphasised the tensions and complexities that faced this group of early career dietitians in professional decision making. First, by exploring their reflections and observations, I highlighted the challenges that dietitian participants faced in collaborating with patients. I started by searching for tensions and complexities related to relational and discursive dimensions, and identified that tensions and complexities also existed in relation to the development of professional identity. The way dietitian participants reflected on their approaches to professional decision making indicated that they were seeking to sort through and in some cases reconcile a number of conflicting technical and practical interests. Dietitian participants did not significantly change their professional decision-making approaches, and changing practice was not the intention of my research. However, as early career practitioners they appeared to be open to exploring opportunities for change, even in environments that were not necessarily supportive of making these changes.

I found that the core concerns of the patient participants were different from those of the dietitian participants. The perceptions and observations of patient participants were diverse, underlining the importance of flexibility in decision-making approaches to ensure that individual needs and preferences are met. The relational and discursive dimensions of professional decision making appeared to be most important to the patient participants, and value was also given to the temporal and linguistic dimensions of professional decision making.
Dietitian participants used a range of professional decision-making approaches and some dietitian participants were able to choose approaches according to the situation. The ability to choose the appropriate professional decision-making approach, based on the complex factors that comprise each individual and the possibility that each patient might bring different ways of knowing to professional decision making as well as have different preferences for participation in professional decision making, needs commitment to critical reflexivity and attention to situational factors. There appeared to be little indication that discussions took place with patients regarding this choice.

To reduce the tensions present between the horizons of patients and dietitians, it is important for dietitians and patients to develop a deeper understanding of each other’s circumstances, perspectives and values. The onus is on the practitioner to facilitate this. Patients are not responsible for (but may seek to influence) practitioners’ behaviours. My findings highlight the significant complexity and difficulty inherent in fusing dietitian and patient horizons to come to a better understanding of each other’s circumstances, perspectives and values. Furthermore, it can be difficult for early career practitioners to challenge the opinions and ideas of other health professionals around them, but doing so is an important part of advocating for patient care and for developing professional identity. I argue that for early career dietitians to successfully implement CDM, the development of certain capabilities is needed. In Chapter 7 I present a meta-interpretation of the text sets discussed in Chapters 4, 5 and 6, and a model of CDM to assist early career dietitians to undertake CDM in early career dietetic practice.
Figure 6.1: Factors supporting and hindering CDM in dietetic practice
CHAPTER SEVEN

THE INTERPRETIVE ENGAGEMENT MODEL OF COLLABORATIVE DECISION MAKING AND CONCLUSIONS

In this chapter I present the final product that I generated from my research, the Interpretive Engagement of Collaborative Decision Making model. This model is the grounded findings from my empirical research and is theoretically and philosophically underpinned by the work of a select group of thinkers on practice, decision making and fusions of horizons. The model illustrates the tensions and complexities of collaborative decision making (CDM) in early career dietetic practice that I have produced from my research. The model incorporates the core capabilities and required conditions to enable CDM in practice and illustrates the journey towards CDM capability and ownership. The model also illuminates the processes and action of CDM. In presenting this model I acknowledge the potential threats to and difficulties for early career dietitians in enabling CDM, given its complex nature.

I started this thesis with the assertion that decisions about food and eating are complex. They have a temporal dimension (whereby they are made on an ongoing basis) and are influenced by numerous personal, economic, cultural and social factors. People make decisions about food based on personal preferences, likes, dislikes, cost of food, access to food, and cultural and social taboos and norms. As early career practitioners working in rural and regional environments, my dietitian participants were facing additional decision-making complexity. They were new to professional decision making and taking responsibility for their practice. They were working in environments that were characterised by unique challenges to and variability in practice, such as working as sole practitioners, across various settings and geographical locations, and undertaking multiple tasks as well as working with patients.

Professional decision making is a complex and situational process that involves several/many people with different preferences, perceptions and experiences and is dependent on the unique circumstances of each health care situation. Making decisions
can involve many combinations of practitioners and patients, as well as carers, friends and family members. Decisions can be made at many points within the health care process as well as during patients’ overall health care journeys, and can be influenced by complex and dynamic feelings, values, beliefs and circumstances of all the people involved. In this thesis I explored the idea and practice of collaborative decision making which involves practitioners and patients (and potentially carers, friends and/or family members) coming to a deeper understanding of each other’s circumstances, perspectives and values, and making decisions together through dialogue.

In my research I explored the observations and experiences of early career dietitians in professional decision making, with a particular focus on collaborative decision making (CDM). My key aim was to generate a deeper understanding of the complexity, situatedness and challenges of CDM in early career dietetic practice. As a researcher in nutrition and dietetics, I wanted to better understand the capabilities that early career practitioners might need to cope with the challenges they face in helping people to make sustainable and realistic decisions about their eating habits. My choice of philosophical hermeneutics as a research approach allowed for this deepening of understanding of CDM by dialoguing with the multiple perspectives of dietitian and patient participants, the literature and my evolving understandings.

7.1 Synthesis of findings
In my research I posed the following research questions:

- What are key theoretical underpinnings of professional decision making approaches in health care in general and dietetics in particular?
- What is the value and significance of CDM in health care in general and dietetics in particular?
- What are the observations and experiences of early career dietitians regarding professional decision making and CDM in particular?
- What tensions and complexities do early career dietitians face in CDM?
- What can be learned from patients’ perceptions and observations to contribute to shaping CDM?
- What factors support and hinder the development and adoption of CDM approaches by early career dietitians?
The answers to these questions are discussed below.

The literature on professional decision making models was found to be limited about theory and philosophy underpinning decision-making models, particularly in dietetics. The focus was largely on the procedural aspects of professional decision making rather than epistemological stances relating to professional decision making. This focus implies that the interests and motivation behind professional decision making had undergone limited review. Although procedural aspects of professional decision making are important, an emphasis on procedure runs the risk of professional decision making that lacks the deeper purpose of addressing the whole patient’s needs and remains disconnected from the social, cultural and relational context of patients’ situations and lives.

I found only a small body of literature focusing on professional decision making across the scope of dietetic practice. The limited literature in dietetics regarding professional decision making mostly explored decision making in complex areas of dietetic practice such as end-of-life care, artificial feeding and eating disorders, with little on other areas of dietetic practice such as chronic illness management. Focusing on these high stakes scenarios in dietetic practice makes professional decision making in less immediately life-threatening chronic illness management appear relatively uncomplicated. However, I argue that complexity is inherent in the contextual, sociocultural, relational and discursive aspects of professional decision making in all areas of dietetic practice.

A collaborative approach to decision making requires a re-thinking of professional decision making, to give contextual, relational, sociocultural and dialogical aspects of professional decision making greater emphasis. Awareness of the pre-understandings and assumptions that both patients and practitioners bring to the decision-making process is also necessary. This view of collaborative decision making implies a shift in the role of practitioners from didactic information provider to facilitator of dialogue. This dialogue is undertaken with the aim of helping patients become more aware of how their broader sociocultural and environmental circumstances might constrain their health choices, as well as finding common ground between patients and dietitians. Practitioners must also come to this dialogue having reflected upon the pre-understandings and assumptions that they bring to their practice as well as how they might be influencing professional decision making. The value of such an approach to
professional decision making lies in achieving a genuine partnership between patients and practitioners, resulting in decisions that are meaningful, relevant, realistic and sustainable.

I found that the deeper purpose of CDM had not been fully appreciated by my dietitian participants and I found little evidence of enactment of intentional CDM in their practice strategies. As early career dietitians, my participants were preoccupied with establishing their professional authority and building their self-confidence. These dietitians expressed a lack of confidence in communication skills such as posing questions to facilitate dialogue; their focus was on establishing their technical knowledge base and achieving biomedical outcomes. Professional authority was more often linked to having good technical knowledge than being able to dialogue with patients and find common ground to make sustainable and relevant decisions together.

What mattered most to the dietitians in my study were relational aspects of professional decision making and what other people (including patients, team members and dietitians) thought of their (the dietitians’) role, responsibilities and value. These matters were highly important to these dietitians and strongly influenced the way they made decisions with patients. They particularly wanted to demonstrate their value to others in the health care team but, paradoxically, they were self-conscious regarding their lack of experience and confidence in working with patients. Working in a rural and regional environment added further complexity to the relationships of dietitian participants with patients and other practitioners.

These findings highlight the importance of critical reflection on perceptions of professional roles, responsibilities and value, and how relationships with others impact on these perceptions, in enabling practitioners to appreciate the value of utilising a range of professional decision-making approaches, including CDM. This reflection may also help practitioners to advocate for different ways of working with patients and to communicate an expanded perspective on their value to other practitioners. Effective CDM could also be facilitated by reflection on strategies to manage the power differentials and personal/professional boundaries in relationships between dietitians and patients and with other practitioners.
Dietitian participants varied in awareness of their interests that drove professional decision making, which is to be expected. They did not overtly identify organisational, social and geographical influences as influences on professional decision making, but it was apparent that the culture of the organisation, community and broader society in which they worked and lived did play a significant role in driving their practice. I found that the observations and experiences of dietitian participants and the perceptions and observations of patient participants regarding professional decision making were quite different. Without an exploration and understanding of patients’ perspectives, dietitians cannot knowingly and effectively implement decision-making approaches that are acceptable to patients. Understanding, respecting and being responsive to the sociocultural, clinical, emotional, ethical, organisational and temporal context of professional decision making enables practitioners to pay attention to the complexity of CDM and to identify when working collaboratively with patients might not be appropriate.

Development of self-awareness is dependent on the opportunities one has to undertake reflection as well as one’s disposition towards doing so. I found that the practice environment of these dietitian participants was not particularly conducive to awareness raising that could enable CDM. CDM needs adequate time for dialogue, as well sensitivity to the timing of such dialogue and how assumptions, values, perspectives and feelings are communicated, given the potential power differentials that can exist in patient–practitioner relationships. Key influences that need to be addressed in order to learn and implement effective CDM include university educational experiences that emphasise technical ways of knowing and practising, relationships that are non-critical, limited opportunities for dialogue, organisational time pressures, and lack of support associated with being a sole practitioner. At the individual practitioner level, critical reflection on how these factors can influence decision-making approaches could raise awareness of constraints on CDM and identify areas of health care practice that practitioners could question and challenge as appropriate.

Figure 7.1 summarises the key points from each of the findings chapters, showing how they contribute to the development of the model.
Key points in Chapter 4

A model of CDM requires theoretical underpinnings.

Key capabilities for CDM include:

- Establishing a relationship that enables an open dialogue
- Gaining an understanding of the other person’s view and situation
- Self-awareness

Key points in Chapter 5

Key capabilities for CDM are not present or only beginning to emerge in early career dietitians.

Key influences on professional decision making practices of early career dietitians are multifactorial and relate to the individual as well as the external environment.

Key points in Chapter 6

Specific challenges associated with enacting CDM in practice for early career dietitians relate to conflicting intrapersonal and interpersonal expectations, preferences, perceptions and values.

Key supports for CDM involve encouraging critical reflection on the differing core concerns of patients in comparison to practitioners, situational factors that support or hinder CDM and the pre-understandings practitioners bring to practice, the nature of relationships, language and transparency in dialogue, professional authority and roles, values relating to knowledge and power, preferences for participation and the value given to time for decision making.

3 part model of CDM in Chapter 7

Figure 7.1: Summary of key points from findings chapters
7.2 The Interpretive Engagement Model of CDM

The synthesised answers to my research questions indicate that CDM requires theoretical underpinnings to enhance its purpose. They also indicate the enabling conditions of the wider practice context that are needed for early career dietitians to enact genuine and effective CDM in their dietetic practice. Patient preparedness to actively participate and engage in seeking for deeper understanding of the benefits of collaboration is required to enact truly reciprocal CDM. To enact such CDM, the core capabilities needed by early career dietitians are nested within these theoretical, contextual and interpersonal themes.

7.2.1 Conceptualising my model

During my research journey I came to appreciate more deeply the nature of hermeneutic interpretation. This process of constructing and interpreting texts was a powerful strategy for understanding research as a process of inquiry, engagement and actions to produce – through dialoguing of questions and answers and interpretation and re-interpretation of a dynamic feast of texts – a fusion of horizons between my evolving horizons (perspectives, interests and understandings) and those of the authors (both literature authors and my participants) of my texts.

This awareness of research as a dynamic and evolving process of inquiry, dialogue and engagement to the point of deeper understanding and fusion was accompanied by a realisation of the applicability of this interpretive framework for my research phenomenon, CDM. My model for CDM in early career dietitians thus gained the title of the Interpretive Engagement Model of Collaborative Decision Making.

This model is richly grounded in my research and arose from deep immersion and engagement with the texts I generated during my research journey. These processes involved ongoing interpretation and re-interpretation of the texts to contribute to my deepening understanding of the phenomenon of CDM in early career dietitians. These processes of ongoing interpretation and engagement parallel the learning journey of practitioners in developing their capability to engage patients in CDM, as well as the engagement and interpretation that takes place in the process of CDM itself.

My model has three parts, each reflecting a critical aspect of my interpretation of CDM as a process of interpretation and engagement. I illustrate each of these three parts with
a figure to visually represent how the various components can be understood. In later sections I critique the model and examine the implications of these components of the model for education, practice and research.

1) The journey of early career dietitians towards CDM capability and ownership

In this journey the practitioner learns to interpret what CDM involves and builds capabilities to engage in CDM genuinely and effectively.

2) The dimensions of CDM as a process of interpretive engagement.

3) The intertwining processes of CDM including practitioner and patient interpretation and engagement.

The Interpretive Engagement Model of Collaborative Decision Making is based on the argument that CDM is an interpersonal process, and that the process of making decisions is just as important as the outcome of a mutually acceptable decision being made. Practitioners need to learn about CDM and come to an understanding about this process. This learning occurs both before they are able to enact CDM in practice and continually during their practice. Interpretation is pervasive across each component of the model, in that it is inherent in each notion, act and level and is a perpetual part of the process of CDM. Also, the iterative processes of engagement and interpretation that comprise the journey towards CDM capability and ownership parallel the engagement with and interpretation of patients’ texts during CDM that practitioners undertake (with their patients) in order to provide care. Through this ongoing engagement and interpretation, practitioners revise and re-develop their understandings of CDM, including their roles and responsibilities and those of patients. In this sense the three parts of the model are interrelated.

The Interpretive Engagement Model of Collaborative Decision Making represents a significant contribution to a deeper, richer understanding of what CDM is and what it involves, the journey towards learning about CDM and the challenges early career practitioners face in CDM. More specifically, my research makes a significant theoretical and practical contribution to understanding and enabling CDM in early career dietetic practice.
7.2.2 The Model – Part 1: The journey of early career dietitians towards CDM capability and ownership

See Figure 7.2. In this Figure I illustrate this journey as follows.

At the left side of the figure are factors influencing CDM in early career dietitians. These factors can either enable or constrain CDM. They include:

- **Relationships with other health care practitioners and patients:**
  The expectations and perceptions of others about their role, responsibilities and value can influence dietitians’ interpretation of whether CDM is acceptable or not, in the given situation. As well, the nature of the dialogue that dietitians undertake with other practitioners can communicate to them the acceptability of a collaborative approach to decision making at a team level. Non-critical and non-dialogic relationships with others can hamper CDM.

- **Practice settings:**
  The nature of the practice setting can influence the availability of comprehensive and critical mentorship, which nurtures critical self-insight into the complexity of interests that drive practice. There may also be a scarcity of good role models who are supportive of CDM in practice environments. For example, increased personal visibility in rural and regional environments can lead to difficulties for early career dietitians in managing personal and professional identities. Working in regional and rural environments might mean that there is only one dietitian locally available, so referral to other dietitians for advice is difficult and often impossible if patients and dietitians are not able to develop the relationship required for CDM.

- **Time pressure:**
  Early career dietitians are still learning about professional decision making and may take longer to perform tasks than more experienced practitioners. For example, in rural and regional environments, early career dietitians may be expected to take on roles beyond their immediate clinical responsibilities within the organisation, meaning that there can be less time overall to spend with patients to explore and identify common ground.
Figure 7.2: The Interpretive Engagement Model Part 1: The journey of acquisition of capabilities and understanding about CDM
• **The cultural and contextual background of patients:**
The perception of early career dietitians regarding patients’ preference and capability to participate in making decisions can be influenced by the cultural, sociocultural and demographic background of patients. Factors such as older age, poor cognitive function, male gender and the presence of mental health problems could mean that early career dietitians perceive patients as less likely to prefer or be able to collaborate.

• **Perception of professional role:**
The way early career dietitians perceive their role can influence the ways of knowing that they consider acceptable to use and share in professional decision making, the patients’ role in professional decision making, and what their duty of care entails. CDM is less likely when practitioners view their role as simply a technical knowledge provider and their duty of care as promoting biomedical outcomes. Dietitians’ assumptions about their professional roles and their expectations of the roles patients should play influence not only the nature of relationships but also the dialogues with patients on professional decision making. Power differentials in relationships can be perceived as barriers to collaboration, especially if authority rather than reason dominates the dialogue.

• **Educational experiences:**
University education and professional development opportunities have a significant influence on early career dietitians who are still developing their professional identity. Educational experiences that emphasise technical ways of knowing and doing in practice are barriers to CDM being valued and realised.

In the centre of the figure are the capabilities that practitioners need to develop on their journey towards becoming capable and genuine collaborative decision makers. They include:

• **Developing self-awareness:**
CDM requires practitioners to engage in an ongoing critical reflection of the pre-understandings that they bring to professional decision making, as well as how these understandings are shaped and informed by their personal background as well as the current, past and future social, political, clinical, organisational and
cultural context. It is particularly important to consider how the expectations and perceptions of others may be influencing professional decision making. Early career dietitians who want to use CDM need to consider their pre-understandings – assumptions, values and beliefs – regarding the following: patient autonomy; acceptable topics for dialogue (such as whether it is appropriate to discuss emotional determinants of eating habits); patient advocacy; duty of care and professional authority; the roles and responsibilities that dietitians and patients should and could play in professional decision making. They also need to consider what ways of knowing should inform professional decision making and to recognise the importance of patient preferences and capabilities for participation in making decisions.

- **Building caring and trusting interpersonal relationships:**
  CDM requires honest, trusting and non-judgmental relationships where there is a genuine co-contribution to dialogue and respect for differences of values, beliefs and perspectives. Such relationships can create an atmosphere where patients feel supported to engage in a dialogue regarding the complexity and dynamic nature of their eating habits and the difficulty of making long-term dietary change. Acknowledging and exploring these difficulties not only strengthens supportive relationships and demonstrates empathy for patients’ experiences but also reduces power differentials. In CDM, practitioners and patients need to acknowledge that understanding comes about through engagement with and learning from each other. CDM cannot occur without participation and needs a stance of respect for the input of both decision-making partners and communication of acceptance of different points of view. Practitioners need to pay close attention to how and why they communicate their values, beliefs and perspectives and to be mindful that coming to a deeper understanding does not mean that their beliefs must dominate.

- **Establishing and maintaining open and transparent dialogues:**
  Dietitians need to be committed to opening a dialogue where patients and dietitians can share their interests and motivations. This dialogue will assist early career dietitians, who might not have worked with a great variety of patients as yet, to appreciate the diversity and complexity of patients’ needs and situations. Important aspects of establishing and maintaining open and trusting
Dialogue include the use of open questions, facilitative rather than directive language, remaining open to new topics being introduced to the dialogue, and sensitively discussing alternative views, inconsistencies and misunderstandings. Dialogue takes the form of questions and answers, where both dialogue partners ask questions of each other and listen to each other’s remarks. The ability to sensitively discuss alternative views and express disagreement in such a way that does not shut down dialogue is an important aspect of this capability.

- **Responding to the given situation:**
  To foster appropriate engagement in CDM it is important to be able to determine when CDM is and is not useful in practice. Practitioners should pay attention to verbal and nonverbal cues that indicate that patients are receptive to collaboration and adapt their decision-making approach accordingly. For early career dietitians to engage with diversity, it is important to develop a variety of approaches to professional decision making rather than adopting a single approach with all patients, and to consider which approach is most appropriate. To choose an appropriate professional decision-making approach, practitioners need to interpret and engage with the complexity and dynamic nature of the sociocultural contexts of patients. Decision-making approaches are shaped by pre-understandings about diet, dietary change, making decisions, health and illness, and preferences for decision-making approaches and the nature of the professional relationship. Through flexibility, dietitians can gain a better understanding of patient perspectives and preferences for the nature of decision making, which in turn enables them to facilitate engagement in CDM.

- **Identifying and exploring common ground:**
  In the language of hermeneutics, people bring their texts or interests and stories into dialogues and seek ways of working together or fusing their horizons. These texts are rich sources of experiences, values and beliefs. For many patients, these texts are constructed from years of experience and long journeys of making dietary change and working with dietitians. Identifying and exploring pre-understandings of both patients and dietitians and interpreting where common ground is located between the two is the precursor for coming to a deeper understanding of each other’s circumstances, perspectives and values. In CDM this co-construction of new knowledge needs development of self-awareness,
open and transparent dialogue and development of a caring and trusting relationship. In this way the capabilities in the model are interlinked. Decision-making partners need to understand which topics of conversation are acceptable to each other to raise and explore further, as unreflected assumptions about what is and what is not acceptable to discuss can lead to difficulties in dialoguing with patients. Practitioners could benefit from reflection on which contextual factors are appropriate to explore during conversations with patients; in dietetics this has particular relevance for whether an exploration of the emotional and psychological determinants of eating habits is acceptable to patients and dietitians.

- **Finding time to think and talk:**
  Time is needed to develop trusting, non-judgmental relationships. Spending more time in establishing these relationships can save time in the future as patients and practitioners trust each other to dialogue openly. Patients and dietitians need to take time alone to contemplate and reflect upon their pre-understandings and evolving understandings. Decision making is not fixed in time and is situational. Decisions made as a result of dialogue are not necessarily made in a linear, straightforward manner. Decisions can be made in the moment or left open-ended. Decisions can be made, revisited, remade or delayed. In CDM, dietitians and patients can move in and out of a dialogue to further deepen understanding to make further decisions. Dialogue can be re-entered a number of times within and between each occasion of dietetic care, across the nutrition care process and throughout patients’ health care journeys. It might be that there is a need to revisit a decision, such as when a dietary change was not considered acceptable, or to continue and make a new decision regarding another facet of eating habits. A further dimension of this capability is understanding when it is the appropriate time to dialogue with patients to make a decision about care.

By moving towards development of these capabilities, practitioners can develop a deeper understanding of CDM as a practice.

Early career dietitians do not typically graduate with a deep understanding of or well-developed capabilities to enact CDM in practice. My research shows that CDM is a skilled set of practices that cannot simply be taught but can be developed during an
ongoing reflective journey of engaging with and interpreting practice experiences, in open and critical dialogue with self and with others. The curved reflective arrows in the centre of the diagram represent these processes. External conditions of practice might not always be conducive for engagement in CDM, and it can be especially difficult for early career practitioners to engage in CDM if they are not sufficiently supported or encouraged to do so through critical reflection and role modelling.

Some contextual influences present in the literature and in my empirical findings with practitioners as barriers to using certain decision-making approaches include a lack of time to spend reaching a deeper understanding of circumstances, perspectives and values with patients during professional decision making. These influences might be a result of unquestioningly accepting hegemonic practices and could be challenged during these critical dialogues. I also found that when early career practitioners had conflicting ideas about professional decision making, particularly about roles, responsibilities and patient capacity, expectations and preferences, it was more difficult to realise an approach to CDM that focused on coming to a deeper understanding of each other’s horizons through dialogue. A critical dialogue, more deeply interpreting the nature of these conflicting ideas, could be of assistance to develop towards enacting CDM.

At the end (right-hand side) of the figure – but not at the end of the career-long journey of becoming CDM-capable – is the resulting (and emerging) point of readiness to bring the practitioner’s evolving understanding and capabilities into CDM in practice.

7.2.3 The Model – Part 2: The dimensions of CDM as a process of interpretive engagement

In this figure, the capacity to implement CDM as a process of fusion of horizons – a bringing together of the practitioner’s and patient’s texts – is illustrated as having two groups of components:
a) the capabilities for CDM (in the navy blue ovals in the figure); and
b) the conditions required for CDM (in the spaces in between the ovals in the figure).
Figure 7.3: The Interpretive Engagement Model Part 2: The core capabilities and conditions required for CDM
As discussed in the previous section, certain capabilities need to be developed in order for CDM to be enacted in practice. However, my findings also suggest that simply developing the capabilities to facilitate CDM is insufficient; there are other dimensions that can influence CDM as a process of interpretive engagement. These include:

- **Patient preference, readiness and preparedness:**
  CDM is likely to be the appropriate choice when patients prefer and feel emotionally and psychologically ready to engage in professional decision making in this way. Patient preference, readiness and preparedness vary across patients but can also vary for individual patients at different times of their health care journey. The dialogue at diagnosis of a chronic illness, where the focus is on coping with the news, might be different from the dialogue during the long-term self-management phase of the chronic illness, as is dialogue during acute events and palliative or end-of-life care. Physical, emotional or cognitive changes in a person’s health status might mean that the person is unable to or prefers not to participate in a dialogue at that time. It might also be that patients find participation to be culturally unacceptable or inappropriate. For dialogue and sharing of perspectives to work well, the personalities and preferences of dietitians and patients should be well matched. When there is a mismatch in personalities, it would be appropriate for dietitians to refer patients to another dietitian where there might be a better personality match.

- **Supportive organisational, professional and health care team/system culture:**
  CDM is more likely to be implemented when collaboration is valued within the broader context of the expected roles and responsibilities of practitioners in practice at both a professional and organisational level. This context includes the discourse that takes place within and across particular professions, as well as the accepted practices that early career practitioners are exposed to. CDM is most likely when practitioners and patients feel supported to express their views freely and without judgment. Practitioners who model a (self-)critical stance to interpreting their practice and engagement in dialogue are more likely to encourage early career practitioners to view this way of being in practice as acceptable.
• **Adequate communication infrastructure:**
Inviting early career practitioners to engage in critical dialogue where they are encouraged to interpret and re-interpret their decision-making approaches in an ongoing manner signifies that senior practitioners accept a collaborative approach to decision making. This implies not only that senior practitioners have the capability and inclination to employ these dialogues, but that opportunities for such dialogue are facilitated. For example, in rural and regional environments, where practitioners are not always physically in the same place, adequate technological infrastructure is needed, such as Skype or videoconferencing, to support these dialogues.

• **Adequate time:**
Finding adequate time to experiment with and interpret experiences with a CDM approach is essential for early career practitioners. This might especially be the case for practitioners working as sole practitioners in a rural or regional environment where workload expectations are high. The capabilities for CDM can be facilitated by critical self-reflection and through engaging in critical dialogues with others, including other health care practitioners or mentors. Practitioners can reflect on their dialogues with patients during the course of nutrition care to inform the development of capabilities.

### 7.2.4 The Model – Part 3: CDM in action

See Figure 7.4.
Figure 7.4: The Interpretive Engagement Model Part 3: CDM in action
The final component of the model is the result of my deep interpretations of CDM in action and is represented visually in Figure 7.4. The core of interpretive engagement in CDM (represented by the yellow words at the centre) is a fusion of horizons through engaging in dialogue to make decisions about care. The fusion of horizons is a key point of cumulative interpretation. Practitioners and patients share their interests, needs, preferences, circumstances, experiences, values, beliefs and knowledge (shown in the circle surrounding the core of the figure) on an ongoing basis as care is enacted, to come to a deeper and evolving understanding of each other. Engaging in an open and transparent question and answer dialogue is the dynamic phase of the interpretation, where the horizons of dietitians and patients (as well as any others who are involved in making decisions, including family members, friends and/or carers) can be uncovered and explored. Common ground is identified and both partners come to a deeper understanding of each other. The key interest for dietitians and patients in CDM is to reach a continually deeper mutual understanding of how nutrition care might be realised for each occasion of care and that decisions made are realistic, sustainable and achievable. Once this mutually accepted understanding is reached, a decision based on mutual understanding about how to move forward in nutrition care is made and action can be taken.

For CDM to be successful, a supportive context must exist. Practitioners must make the choice to engage authentically in CDM and have the capabilities to be able to facilitate a fusion of horizons. In the figure, these supportive conditions encircle the core process of fusions of horizons and engaging in dialogue. If practitioners are not ready, willing or supported to engage in CDM it is unlikely that authentic and deep collaboration will take place. An interpretation by the practitioner of the unique combination of capabilities, context and choices of patient and practitioner at each occasion of care will determine whether CDM is the appropriate decision-making approach and also to what extent engagement in CDM might take place. The concentric circles represent the multiple layers of professional decision making scenarios in practice, where horizons of patients and dietitians shift and differ depending on the situation.

The appropriate decision-making approach varies from patient to patient, from occasion of service to occasion of service, and across the nutrition care process. This means that in the process of CDM there is repeated understanding and engagement, in an ongoing cycle of meta-interpretation. There is potential for the use of a range of professional
decision-making approaches at different stages in the current nutrition care process. Collaboration is not always the best choice. Flexibility here means that dietitians incorporate a variety of ways of knowing and roles in their CDM processes. Being collaborative can incorporate a range of approaches, from sharing technical knowledge and advising patients regarding dietary change to listening to and supporting patients to make change on their own. This flexibility is needed due to the dynamic and complex range of situations that dietitians might encounter, not only with different patients but with the same patient at different points of his or her care.

The situational nature of CDM means that practitioners need to come to an ongoing interpretation of the deeper dimensions of patients’ texts in terms of their preference, readiness and preparedness to engage in collaboration. Put another way, dietitians need to have a practical understanding of each occasion of care, to decide whether engagement in collaboration is appropriate for the situation and also to what extent the patient might want to engage in CDM. If patients and dietitians have collaboratively decided that dietitians will make decisions unilaterally, this is a form of CDM as long as both partners collaborated on this decision. Despite current moves in health care towards encouraging and allowing greater power of patients in health care decision making and actions, it is still largely the case that practitioners have the greater power in healthcare relationships. The role of the practitioner in CDM, then, as represented by the large blue text, is to come to an understanding of the extent of and possibility for engagement in CDM that is appropriate for the given situation at hand.

Patients are active participants in CDM, and they are empowered (or allowed) by practitioners to participate in interpretation and engagement according to their preference, agency and capability (patients and their carers /significant others are represented by the smaller green text). The nature and motivations of patients’ participation in engagement and interpretation during CDM could be an area for future research.

In Figure 7.4, the way the large outer (dietitian) ring of text wraps around and encompasses the next inner (patient) circle symbolises a trusting, open and transparent relationship wherein dietitians can empower patients to engage in collaboration in an authentic manner. In CDM, practitioners make purposeful decisions about how to work with power dynamics. CDM is based on honouring patients’ autonomy. The onus is on
practitioners to create environments where patients feel comfortable to share their values, beliefs and perspectives.

The encircling by the blue (practitioners) text circle of the whole process of CDM symbolises the importance of practitioners having a clear conceptual and practical understanding of the core activity of CDM, as the fusion of horizons through engaging in dialogue. This means that they need to engage in ongoing interpretation before, during and after CDM. At a meta-level, practitioners must strive to understand the interests driving professional decision making and how these interests have arisen, and continue to be influenced through and by practice. At a more micro-level, practitioners need to engage in understanding how these interests could be impacting on the core activities of fusion of horizons and engaging in dialogue.

Practitioners should remain open to reinterpreting their pre-understandings as they continue to dialogue with patients. Dietitians dialogue with patients at different times of the health care journey. With each new dialogue, pre-understandings of dietitians and patients evolve. At the beginning of the health care process, patients bring expectations and assumptions about various issues, which could include how they conceptualise health and illness, the importance of diet in their treatment, how patients feel about making dietary change, and preferences about actualising health care (including the roles patients and practitioners should play). These pre-understandings might change as dietitians and patients dialogue together, find common ground and share knowledge with each other. Dietitians also need to re-interpret their own expectations and assumptions at each point of care, and these might evolve with continued dialogue with patients. In this sense, interpretation is an ongoing and pervasive process as the dialogue and understandings between patients and dietitians evolve.

The Interpretive Engagement Model of Collaborative Decision Making is based on the philosophical hermeneutic perspective espoused by Gadamer (1975/2004) and Davey (2006). Further, this model is based on empirical research with early career dietitians and patients.

Other authors have drawn upon Gadamer’s philosophical hermeneutics to inform the dialogue in clinical practice, and the Interpretive Engagement Model of Collaborative Decision Making builds on these views. Svenaeus (2000) argued that relationships
between patients and practitioners in medicine are characterised by asymmetry of power, and therefore an important aspect of building caring and trusting interpersonal relationships is to be mindful of power differentials. The *Interpretive Engagement Model of CDM* adds a deep understanding of the nature of power differentials in dietetics, which are likely to be quite different from those in medicine, as well as how early career dietitians can learn to manage these power differentials in practice. The *Interpretive Engagement Model of CDM* also builds on the views of Arnason (2000) regarding the importance of openness to the other person’s point of view. The *Interpretive Engagement Model of CDM* adds to these ideas by more deeply exploring both the difficulties that early career practitioners experience in establishing this openness and the complexities of how they may learn to do so effectively in practice.

### 7.3 The researcher’s reflexive journey

As an academic in nutrition and dietetics, I brought to my research the ultimate goal of pursuing a deeper understanding of how to better prepare students for the dietetic work environments they were likely to enter as early career practitioners. I developed my research passion in this area early in my career, initially as a practitioner and then as an academic, in rural and regional environments.

Through my professional practice experiences I brought a number of pre-understandings about professional decision making and dietetic practice to this research. I favoured the idea of CDM over other approaches and believed that a collaborative approach to care was appropriate at all times. I strongly considered good communication to be imperative in facilitating dietetic practice and that engaging patients in a dialogue was important in each occasion of care. I believed in placing patients at the centre of care and felt strongly about the importance of understanding their circumstances and incorporating their needs and preferences into decisions about care.

Throughout my PhD journey I questioned these biases and assumptions of professional decision making in dietetic practice. My reflexive journey was underpinned by my dialogues with my participants, my supervisors, my fellow students, doctoral master classes and countless other people around me. Through these dialogues with peers, scholars and research participants, I was constantly reminded to continue to question evolving understanding. These dialogues also enabled me to maintain reflexivity, which
allowed me to maintain transparency in the way that I constructed and interpreted texts. I shifted my thinking from “there is one best way of being” to “choosing and valuing the approach that best fits the situation”. I came to appreciate the complexity and challenges inherent in professional decision making, particularly in CDM for early career dietitians working in rural and regional environments.

When I initially asked my participants why they had agreed to participate in my research, they commonly stated that they were curious to learn about how to work more effectively with patients and were curious about how others managed challenges of working with patients. I was careful to avoid imposing my assumptions about dietetic practice and professional decision making onto my participants. I maintained a sceptical and curious stance, and tried not to accept taken-for-granted assumptions of shared understandings without inviting participants to further explain or expand their observations. Here are some examples of questions that I asked my participants in order to capture their understandings: How does that make you feel? Can you explain that a bit more? What do you mean? My aim in questioning was to encourage participants to reflect deeply on their assumptions so I could come to a shared understanding of their perspectives on professional decision making.

7.4 Critique of the model
The Interpretive Engagement Model of Collaborative Decision Making is grounded in philosophy and empirical research, but it is important to discuss some limitations and difficulties in its development and in enacting it. The Interpretive Engagement Model of Collaborative Decision Making is not intended to fit all situations. CDM may be difficult to develop and enact in practice environments where the dominant view of practice is to operate within a strong biomedical model and where there are limited openings to transform or supplant this model. Privileging technical knowledge and practitioners’ authority provides a context that makes CDM a potentially alienating approach to practice. Challenging this context is a particularly difficult undertaking for early career practitioners who are still developing professional identity, might lack confidence to advocate for a different way of practising to those they perceive as more powerful, and are potentially working to establish their position in the health care team, as was the case for my participants. Exploring CDM with early career practitioners can be seen as a limitation as they are at the cusp of developing their decision-making approaches.
Continuing pressure on early career practitioners, particularly those in sole positions who have a high caseload and other workplace roles, can mean that the recommendation to take time for engaging in dialogues, thinking and talking, as well as reflection on professional decision making, is difficult to realise. It is recognised that there may also be an inconsistent presence of senior practitioners, especially in rural and regional environments who could take on the role of facilitating the learning journey of early career dietitians.

Given these challenges, the Interpretive Engagement Model of Collaborative Decision Making can appear utopian or unrealistic. With this in mind, the model is offered as a framework for practitioners to work towards collaboration in decision making, which might be of use in increasingly uncertain and complex times. I have illustrated that the CDM capabilities identified can move current early career dietitians’ approaches of professional DM towards an approach that is underpinned by fusion of horizons. I present a model of capabilities, processes and actions, not a generalisable theory. It reflects my deepened understandings of CDM. The model offers a potential CDM approach in dietetic practice that comprises capabilities and conditions, processes and actions that are needed to enable CDM to be realised in clinical situations. My participants were particularly positive towards engaging patients in making decisions about care; my findings might have been different with practitioner volunteers who had a more sceptical attitude towards CDM. Readers need to consider how this model applies to early career practitioners in other disciplines or to experts in dietetics or other disciplines.

It could be argued that exploration of CDM in early career practice has inherent limitations in that CDM is an advanced and complex process of working collaboratively with patients. Early career practitioners would not be expected to enact advanced collaborative approaches to professional decision making because of their practice inexperience. However, I chose to explore CDM with early career dietitians because I was interested in exploring their readiness and willingness to enact such an approach at the early career stage. I found glimpses of a collaborative approach to professional decision making and my participants were open to and willing to explore CDM approaches in their practice. Grace and Trede (2011) found that students in dietetics and physiotherapy needed explicit support and guidance in interpreting their practice-based
experiences in order to shape their meanings of professionalism and guide their future practice. My research findings suggest that enabling practitioners to more deeply understand and critique their approaches to professional decision making early in their careers is important to further develop and own CDM in practice.

The number of dietitians in this study could be seen as another limitation. As with many qualitative studies, a relatively small number of participants is deemed satisfactory if in-depth analysis of findings is pursued and saturation is achieved (i.e. no new findings emerge in repeated analysis of the participants’ data). This was achieved for my dietitian participants.

In relation to the scope of my findings it could be argued that my patient participants did not contribute greatly to the findings. A focus on patients was not the goal of this study. I was interested to explore the professional decision making approaches of early career dietitians. I started from the assumption that dietitians have a stronger influence on the nature of relationships and dialogue in professional decision making than patients, due to their professional authority and despite a call to empower patients in health care decision making. With this assumption, I reasoned that the observations and experiences of dietitians would be the logical first point for exploring the tensions and complexities of enacting CDM. I acknowledge and am aware that in CDM there are two parties involved and both need to be explored. The low-level engagement with patient participants in this study was considered appropriate to fulfil the purpose of providing a snapshot of their diversity and complexity. Patients’ perspectives on professional decision making are likely to be infinitely more diverse than those of a contained group of professionals. Further research could explore patients’ perspectives in more depth, as indicated later in implications for further research.

Although my phenomenon encompassed rural and regional environments, my focus was directed towards the individuals involved in professional decision making and their observations and experiences. Although the context and setting of practice featured strongly in my findings with respect to the restrictions on available support for the early career dietitians in the study and the conditions (such as receptiveness of the setting and other colleagues to CDM) that enable CDM, my intention was to focus primarily on the impact of being in the early stages of practitioners’ careers and only secondarily on rural and regional environments. I did not intentionally incorporate methodologies to
more deeply explore this context and the setting, such as examining policies and procedures that enable or constrain CDM or interviewing other key people in the work settings who might influence the enactment of CDM. Further research could more deeply explore the impact of organisational issues on enactment of CDM in rural and regional settings. For pragmatic reasons, I excluded early career dietitians working in metropolitan areas. Future research could explore the experiences of early career dietitians in metropolitan environments and consider the unique impact of that setting on enacting CDM.

Born out of this critique is a list of implications for further research, practice and education.

7.5 Implications for education and practice
I have identified that CDM is complex and contextual and that it requires supportive environments to nurture early career dietitians’ capabilities to engage in CDM. From my model I deduced several implications for consideration in undergraduate entry level university education and in professional development for early career dietitians.

7.5.1 University education
Dietitian participants in this research struggled with CDM and reported that they had not been taught this approach at university. The starting point to nurture CDM needs to be the university. Curricula in the classroom should explicitly include exposure to theoretical underpinnings of learning to reason about decision-making processes, and in clinical placements should provide opportunities for developing capabilities for CDM. As well, students need to be supported to understand and critique the conditions of practice that shape their professional decision-making approaches.

Higgs and Titchen (2001a) have argued that understanding of the origins of theories that underpin practice is commonly neglected in professional education. Students need to appreciate that theories are developed within a historical context and are a reflection of certain interests which shape and are shaped by the “political, social and moral” attitudes of the time (Fish & Coles, 1998, p.51). More specifically, dietetic education for entry-level practice has been criticised for its scientific focus on nutrients and its lack of acknowledgement of the social, cultural and individual influences on food choice (Cuddy, 2012; Sharp, 2012). There has also been a broader call within the
profession to extend perspectives informing dietetic practice to include dialogical, relational and critical perspectives (Anderson, 2011; Aphramor, 2011; Chapman, 2011; Fox, 2011; Power, 2011).

Students should be introduced to the notion that dietetic practice is – in its optimal form – a relational, social, cultural and dialogical practice. This will enable them to more deeply understand the potential for enhancing dietetic practice and how this practice can be informed by learning about the philosophy of CDM as well as developing capabilities required for CDM. This development can take place in the classroom as well as in the workplace. Preparation for entering the workplace environment is essential in order for students and new graduates to engage meaningfully with the context and conditions they will encounter during professional decision making. Particularly relevant is an understanding and appreciation of the challenges and opportunities of rural and regional practice, and what additional supports in the potential absence of readily available mentors are present for students and early career practitioners in these environments to nurture their professional decision-making approaches.

A key strategy for development of capabilities and engagement with the conditions of practice for CDM is critical reflection. Fish and Coles (1998, p. 35) argued that practice informs theory, that knowledge is “temporary, dynamic and problematic”, and that practice itself is in constant evolution. Critical thinking skill development should start early and can be encouraged at different points in the university dietetic curriculum to encourage students to see critical reflection as something that needs to occur across practice and practice careers rather than as a discrete activity. Students should be provided with opportunities to develop the skills necessary to undertake critical reflection and practice development alone and with peers and mentors during their university education.

On the basis of my research findings, I contend that learning and teaching strategies including assessment need to be redesigned across the curriculum to sensitise students to practice contexts, choices and capabilities. Classroom discussions could also address various professional roles and responsibilities of both patients and dietitians, ways of knowing that can inform professional decision making, concepts and interpretations of duty of care, and promotion of patient responsibilities.
Beyond classroom discussions, the practice environment is an important setting for professional identity development (Trede, 2012b). Trede suggests that taking a critical dialogic approach to reflection can help students in the development of professional identity. Debriefing with supervisors in the practice context during placements is commonplace in dietetic education in Australia. My findings suggest that students could be encouraged by their supervisors to extend reflections to encompass questions about the assumptions that drive professional decision-making approaches. During placements, students could be encouraged to problematise their decision-making approaches and the practice conditions in which they find themselves, to question simple solutions and to consider alternative professional decision-making approaches. They could be encouraged to engage with conflicts and not see uncertainty as a weakness.

Supervisors have a significant but not always positive influence on the professional socialisation of dietetics students (MacLellan & Lordly, 2008). Trede (2012b) acknowledged the risks and challenges for students and supervisors in engaging in critical dialogues, if these dialogues are hijacked by the power differentials that often exist between students and supervisors. Educators can share their professional judgment when describing how they decided to respond to a given situation. Building caring and trusting interpersonal professional relationships, establishing and maintaining open and transparent dialogues and identifying and exploring common ground can be modelled (with patients and students) and observed by students, to enable them to develop this capability within themselves. Educators can demonstrate their value of finding time to think and talk with patients, and can also ensure that they claim time for students to undertake reflection on professional decision making to deeply understand CDM.

In my research I found that the relationships of my dietitian participants with patients and other health care practitioners had a significant impact on decision-making approaches. The concept of patients as teachers could be considered, to help students develop greater understanding of the broad diversity of patients’ interests, needs, preferences, circumstances, experiences, values, beliefs and knowledge. Interprofessional education (IPE) strategies, in the classroom as well as in the practice environment, might also be useful to help in developing capabilities for CDM. IPE was recognised by the WHO Study Group on Interprofessional Education and Collaborative
Practice (2010) to be effective in raising and expanding awareness of the roles and responsibilities of team members as well as helping practitioners to feel more comfortable to challenge and question each other appropriately in the provision of care. Opportunities to practise advocacy and relationship-building skills within health care teams can be provided by IPE. IPE is particularly important in regional and rural settings where there is limited mentoring by senior colleagues of the same profession. However Baker, Egan-Lee, Martimianakis, and Reeves (2011) argued that careful consideration of the power relationships between health care professions is needed when planning IPE. These authors found that even with the best intentions to promote collaboration and teamwork, IPE can equally lead to reinforcement of hierarchies in health care teams. Exploration of IPE and patients-as-teachers in facilitating learning about CDM in university dietetic education is a potential area for further research.

7.5.2 Professional development for early career dietitians and implications for practice

My interpretations of the challenges experienced by dietitian participants in professional decision making revealed that they often needed to pose deeper questions about professional identity and how they related to others as they learned about their decision-making approaches. The dietitians in this study were still defining, questioning and refining their professional identity. The findings of my research indicate the importance of supporting early career dietitians to engage in ongoing self and peer reflective dialogues to become aware of expectations, beliefs and preferences that shape professional decision-making approaches and ultimately their professional identity.

My dietitian participants appreciated the series of interviews with me as open reflective dialogues, implying a need for mentors in professional development. Some of these dietitians were working in isolation and appreciated the opportunity to reflect, engage and scrutinise their professional decision making with another dietitian. Early career dietitians who are continuing to develop professional identity and who might be struggling to think about alternative ways to practise and engage with or manage challenges could use the Interpretive Engagement Model of Collaborative Decision Making to understand and advance a collaborative approach to decision making. More experienced dietitians could utilise the model to guide reflection sessions with early career dietitians where the aim is to provoke pre-understandings (after Davey, 2006), and question and challenge accepted practices.
Beyond engaging in and awareness-raising about CDM, adopting critical perspectives on dietetics can foster and complement CDM in action. Critical dietetics recognises and celebrates the agency of the people dietitians work with (Fieldhouse, 2011). Critical dietetics calls for dietitians to rethink and reframe perspectives, to explore and incorporate alternative points of view, challenge the status quo and hegemonic views (Anderson, 2011; Aphramor, 2011; Chapman, 2011; Fox, 2011; Power, 2011) and facilitates a creative, questioning, dialogic approach to developing dietetic practice that responds to the ongoing complexity and changing nature of eating and health (Anderson, 2011; Aphramor, 2011; Power, 2011). These perspectives resonate well with the dialogic, relational, cultural and self-awareness emphases in the Interpretive Engagement Model of CDM and could provide a basis for exploring a variety of approaches to professional decision making, including CDM, and expand perceptions and interpretations of professional roles. Understanding this variety of approaches in professional decision making can also lead towards an understanding of responding appropriately to each given situation in practice.

Practitioners should be encouraged to remain cognisant of the significant complexity of practice situations and to deepen their understanding of situationally appropriate professional decision making in practice. Dietitians could find it helpful to use my model to reflect on the complex range of factors that have shaped pre-understandings as well as current interpretations of practice, including but not limited to professional values, beliefs and viewpoints; educational experiences; their relationships with others; and the sociocultural, organisational, geographical, systemic and political context in which they work. Table 7.1 provides some examples of questions derived from my model that can guide reflection on each capability for enacting CDM in practice. These questions could be used to guide discussion of professional decision making in general, or for specific situations.
<table>
<thead>
<tr>
<th>Table 7.1: Sample questions to guide reflection on capabilities of CDM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Developing self-awareness</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Building caring and trusting interpersonal relationships</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Establishing and maintaining open and transparent dialogues</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Responding to the given situation</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Identifying and exploring common ground</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Finding time to think and talk</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

My research showed that patient viewpoints are often different from those of practitioners and that the incorporation of other voices is essential in CDM. Practitioners need to ask themselves if they can hear these other voices and how they have influenced the development of their identities and professional decision-making approaches. Gao and Riley (2010, p. 327) argued that “identities are activated by situations and suggest that such situations are interpreted through a set of prior assumptions which are, in part, engendered by group affiliations”. These groups in health care could include the profession, the organisation within which practitioners are employed, or the health care team.
Two further key areas with particular implications for professional decision making are the concepts of duty of care and power. A clash of inter- and intra-personal perspectives that was found in my research, and that could be useful for other practitioners to contemplate, was between balancing patients’ rights to autonomy in making decisions about health care with practitioners’ sense of duty of care to ensure patients make what they see as the best decisions. Practitioners need to contemplate more deeply what has influenced their concept of duty of care and what constitutes the best decisions about dietetics for them (in different situations, and potentially in different phases of their careers). Dowding, Ash and Shakespeare-Finch (2011) found that new graduates, including those working in rural and regional environments, struggled with their perceived (often “received”) duty of care and felt distressed when they were unable to fulfil these expectations.

Duty of care as a concept and espoused “norm” of practice can be misused to disguise power and therapist-centred approaches to professional decision making. Tew (2006, pp. 39-40) argued that it is helpful for practitioners to consider power as a social relation, “a relation between people that may take form at various scales, from the systematic patterning of the social whole, through the more local structuring of interpersonal interactions, to the construction and organization of personal identities (the internalization of power relations)” and argued that power can be both damaging and productive. Tew stressed the importance of ensuring that practitioners do not misguidedly use their “protective power”, which he defined as “deploying power in order to safeguard vulnerable people and their possibilities for advancement” (p. 41). Wanting to take control of decision making to ensure that patients make the right decisions is an example of misusing power when sharing decision-making control is more appropriate.

While supportive organisational, professional and health care team and system cultures are important for nurturing CDM, my findings suggest that the first key step is to create a community of early career practitioners who engage in open dialogues about professional decision making. This may begin a cultural shift towards greater acceptance of CDM as an approach to professional decision making. In my research, uncritical dialogues often meant that early career practitioners were not encouraged to
question their professional decision making approaches and consider when different approaches to decision making were appropriate.

7.6 Implications for further research
My findings have implications for future research agendas in both education and practice arenas. These implications include the value of exploring the context of early career practitioners and the capacity of this community or cohort to engage in open dialogues about decision-making approaches and its impact on higher uptake of CDM. Investigation of the use and value of a range of communications and collaboration strategies across communities in the digital age, including e-mentoring through email, Skype or other mobile technologies with rural and regional dietitians in the early stages of their career, would provide new knowledge regarding how to cope with the large geographical distances that exist between dietitians in rural and regional areas (An, 2010). Online discussion forums, such as that described by Stewart and Abidi (2012) where practitioners can share, discuss and learn about practice problems, might be useful as a means for engaging in open dialogues in this population.

The role of expert patients could be explored in nurturing and supporting the professional decision making development of early career dietitians. CDM could be examined with a prime focus on patient perspectives to illuminate patient capabilities for CDM. Future research could focus on the patient voice in CDM in dietetic practice to further deepen understanding of the core capabilities required by early career dietitians to enact CDM in their practice and what is required of patients to participate in CDM.

The gender balance in the dietitian-patient relationship (whether the dietitian-patient is male-female, female-female or male-male) was not a particular issue reported by my research participants, nor was it an intended focus of my research. This matter could have greater relevance to some patients (e.g. vulnerable people with dietary and lifestyle concerns). It would be useful to explore the implications of gender balance for relationship building and dialogue in future research.

My research was situated in an interpretive research paradigm but there are opportunities for future research to operate in the critical paradigm, such as working with dietitians to study their professional decision-making approaches using a
participatory action research approach. Further research could extend the perspective on CDM to consider the impact of the broader social, cultural and political contexts of practice on decision making about food, nutrition and dietetics.

7.7 Final comments
This research in CDM has illuminated the contextual, relational, sociocultural and dialogical aspects of professional decision making. It has highlighted the need for engaging and understanding self and others. The *Interpretive Engagement Model of CDM* is a valuable and complex framework that recognises the importance of many core capabilities of dietitians and the value of supportive contexts. It promises to inform and enhance the dietetic experience for patients and practitioners. Creating supportive environments is imperative, especially in rural and regional contexts where early career dietitians are often sole practitioners. Dialogical relationships rather than more diffuse team-based strategies can play an important role in positive outcomes for patients for whom success requires reflection, agency and life changes, not just instruction and compliance.
REFERENCES

NB: All websites were correct at the time of publication of this thesis.


252


APPENDICES
Appendix 1: Literature search strategy

Databases searched:

- Ebscohost
- Medline
- The Cochrane Library
- INFORMIT
- JBI COnNECT+
- SAGE journals online
- Wiley Online Library

Search terms used:

- A combination of “decision making” [TI], “model” [TI] and/or “health” [ALL], “medicine” [ALL], “nursing” [ALL], “occupational therapy” [ALL], “speech therapy” [ALL], “dietetics” [ALL], “nutrition” [ALL], “physiotherapy” [ALL], “physical therapy” [ALL], “midwifery” [ALL], “podiatry” [ALL], “pharmacy” [ALL] and “social work” [ALL].

Excluded search terms of:

- TI manager*; TI student*; TI team; veterinary

Limits applied:

- Scholarly (peer reviewed) journals
- Language: English
- Time frame: 1995-2012
Appendix 2: Ethics approval

21 September 2007

Ms Marissa Olsen
C/- Professor J Higgs
Director
Education in Practice Institute
Charles Sturt University
18 Masons Drive
NORTH PARRAMATTA NSW 2151

Dear Ms Olsen

Thank you for the additional information forwarded in response to a request from the Ethics in Human Research Committee.

The Committee has now approved your proposal entitled “Sharing decision-making between dietitian and patient in early dietetic practice”. The protocol number issued with respect to the project is 2007/248. Please be sure to quote this number when responding to any request made by the Committee.

You must notify the Committee immediately should your research differ in any way from that proposed.

You are also required to complete a Progress Report form, which can be downloaded from [www.csu.edu.au/research/forms/chre_annrep.doc](http://www.csu.edu.au/research/forms/chre_annrep.doc) and return it on completion of your research or by 2/11/2008 if your research has not been completed by that date.

Please don’t hesitate to contact the Executive Officer telephone (02) 6338 4628 or email ethics@csu.edu.au if you have any enquiries about this matter.

Yours sincerely,

Julie Hucks
Executive Officer
Ethics in Human Research Committee

Cc: Professor J Higgs Dr Fransiska Teuko
05 June 2008

Ms Marissa Olsen
PO Box 5908
Wagga Wagga
NSW
2650

Dear Ms Olsen

HREC reference number: 08/GWAHS/2
SSA reference number: 08/GSAHS/21

Project title: Sharing decision-making between dietitian and patient in early dietetic practice

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place at the following sites:

Sites across GSAHS where dietitians are employed.

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the research governance officer;

2. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project, are to be submitted to the research governance officer.

Yours sincerely,

Sally Josh
Research Governance Officer, GSAHS.
19th February, 2008

Ms Marissa Olsen
PhD Candidate
School of Community Health
Charles Sturt University
PO Box 6908
WAGGA WAGGA NSW 2650

Dear Ms Olsen,

HREC Multi-Centre Project No.: 08/GWAHS/2
Project Title: Sharing Decision-Making Between Dietitian and Patient in Early Dietetic Practice

Thank you for responding to the HREC's clarification request for the above project. The HREC Executive considered your responses on 13th February, 2008. This lead HREC has been accredited by the NSW Department of Health to provide the single ethical and scientific review of proposals to conduct research within the NSW public health system.

This lead HREC is constituted and operates in accordance with the National Health and Medical Research Council's National Statement on Ethical Conduct in Research Involving Humans and the CPMP/ICH Note for Guidance on Good Clinical Practice.

I am pleased to advise that the Committee has granted ethical approval of this research project. The documents reviewed and approved include:


Please note that your project number has changed. The new multi-centre project number is 08/GWAHS/2. Please quote this number in all correspondence.

Please note the following conditions of approval:

1. The co-ordinating investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including any unforeseen events that might affect continued ethical acceptability of the project.

Greater Western Area Health Service
ABN 88018650302

Human Research Ethics Committee
P.O Box 141 "The Lodge"
Gorman's Hill Road
Bathurst NSW 2795

260
2. Proposed changes to the research protocol, conduct of the research, or length of HREC approval will be provided to the HREC for review in the specified format.

3. The HREC will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.

4. The co-ordinating investigator will provide an annual report to the HREC and at completion of the study in the specified format.

HREC approval is valid for 6 years from the date of this letter.

Should you have any queries about the HREC’s consideration of your project please contact the GWAHS HREC Executive Officer on (02) 6339 5601 or via email ethics.committee@gwahs.health.nsw.gov.au.

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the Chief Executive or delegate of that site has been obtained.

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

The HREC wishes you every success in your research.

Yours sincerely

Ms Suzanne Degiorgio
The Secretary
For
Dr Anthony Brown
Executive Officer
Human Research Ethics Committee
Greater Western Area Health Service
24th April, 2008

Ms Marissa Olsen
PhD Candidate
School of Community Health
Charles Sturt University
PO Box 5908
WAGGA WAGGA NSW 2650

Dear Ms Olsen,

HREC Multi-Centre Project No.: 08/GWAHS/2
Site-Specific Assessment No.: 08/GWAHS/5
Project Title: Sharing Decision-Making Between Dietitian and Patient in Early Dietetic Practice

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place within Greater Western Area Health Service.

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the research governance officer.

2. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project, are to be submitted to the research governance officer.

Should you have any further information regarding your application, please do not hesitate to contact the undersigned on (02) 6841 2275.

Yours sincerely

Dr Anthony Brown
Research Governance Officer
Greater Western Area Health Service
Appendix 3.1: Information statement and consent form (dietitians)

SCHOOL OF COMMUNITY HEALTH
PO Box 799
Albury NSW 2640
Australia
Tel: +61 2 6051 6420
Fax: +61 2 6051 6772
Email: centralth@csu.edu.au
ABN 90 679 709 551

INFORMATION STATEMENT

Sharing decision-making between dietitian and patient in early dietetic practice
Principal Investigator:
Matissa Olsen
PhD student
The Education for Practice Institute
Charles Sturt University
North Parramatta Campus
16 Macarova Drive
North Parramatta NSW 2151
Telephone: 02 8388311
Email: molen@csu.edu.au

Supervisors:
Professor Joy Higgs (principal supervisor)
Dr Pramukh Trivedi (co-supervisor)

The Education for Practice Institute
Charles Sturt University
North Parramatta Campus
16 Macarova Drive
North Parramatta NSW 2151
Telephone: 02 8388311
Email: jhiggs@csu.edu.au
Email: ptrivedi@csu.edu.au

You are invited to participate in this study which aims to explore the way dietitians and patients make decisions about nutrition. We hope to learn from both patients and dietitians about shared decision-making, in particular how dietitians make decisions and to what extent patients feel appropriately involved in the decision making process in order to achieve the best possible health result.

If you agree to participate in this study, you will participate in two to three interviews over a period of 9 months. Each interview will be audio taped and the Principal Investigator will take notes throughout. Interviews will typically be 45 to 60 minutes in duration and conducted at a time and place of your convenience. The interview will focus on questions relating to your experiences about providing dietetic services.

You will also be invited to complete a task of your choice (such as a mini case study, a reflective journal or learning from critical incidents) between each interview to enable further reflection on approaches used when decision-making in practice. The outcomes of these tasks will be used as a stimulus for future interviews. All data generated by interviews and tasks will be collected, drawings and artwork photocopied and texts transcribed, coded and interpreted.

Please turn over...

Dietitian Information Sheet Master Copy
www.csu.edu.au

The Commonwealth Register of Iterest and Courses for Overseas Students (CRICOS) Provider Number is 00038F for Charles Sturt University and the Charles Sturt University Language Centre

263
As part of the study the Principal Investigator will also interview one of your patients once regarding their views on decision-making approaches. You will be asked to give patients a sealed envelope with information about the study inviting them to participate. Patients need to meet the following criteria:

- Over 18 years of age
- Has received at least two occasions of clinical dietetic care
- Cognitively and physically capable of completing an in-depth interview
- Living in a rural/regional setting within New South Wales (NSW)

Please ask patients to contact the Principal Investigator directly. This approach aims to avoid any breaches of confidentiality for patients, or possibly feeling obligated to participate.

It is not expected that significant risk is posed by taking part in this study. However, the option for debriefing and/or counselling will be available at all times throughout the study. In the rare event that you feel you do require counselling services as a result of issues raised in the interview, you will be provided with a list of appropriately qualified persons who can assist you. You will be free to leave the study at any time, by asking for the interview to stop, or by asking for the information collected in your interview to be removed from the study. You can do this at any time, simply by contacting the principal investigator. The outcomes of your participation in the study will not be provided to your employer.

All information collected will be securely stored during the course of the study and destroyed seven years after completion of the study. Only the principal investigator and supervisors will be able to see this information.

As this study is to be conducted as part of a PhD, quotes from interviews may be used in written publications or presentations. Your privacy will be protected at all times during the study by using code names and where possible any details that could identify you will be removed or changed.

If you agree to participate in this study, please contact the researcher directly on (02) 6969332874 or mosien@csu.edu.au. If you choose not to participate, simply discard this information.

Charles Sturt University’s Ethics in Human Research Committee has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer:

The Executive Officer
Ethics in Human Research Committee
Academic Secretariat
Charles Sturt University
Private Mail Bag 29
Bathurst NSW 2795
Tel: (02) 6338 4628
Fax: (02) 6338 4194

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

The ethical aspects of the project have also been approved by the Human Research Ethics Committee (HRREC) of the Greater Western Area Health Service. If you have any concerns or complaints please contact:

The Executive Officer, PO Box 143 Bathurst NSW 2795 or telephone (02) 63395601.
CONSENT FORM

Sharing decision-making between dietitian and patient in early dietetic practice

Principal Investigator: Marissa Olsen
PhD student

Professor Joy Higgs (principal supervisor)
Dr Franziska Trede (co-supervisor)

C/ The Education for Practice Institute
Charles Sturt University
North Parramatta Campus
16 Masons Drive
North Parramatta NSW 2151
Telephone: 02 8838911
Email: molisen@csu.edu.au

The Education for Practice Institute
Charles Sturt University
North Parramatta Campus
16 Masons Drive
North Parramatta NSW 2151
Telephone: 02 8838911
Email: jhiggs@csu.edu.au
Email: ftrede@csu.edu.au

I,....................................................................................voluntarily agree to participate in
the study of decision-making in dietetic practice, being conducted by Professor Joy
Higgs, Dr Franziska Trede and Ms Marissa Olsen.

The reason for the study has been explained to me, including the (potential) risks or
discomforts that may occur. I have read and understood the written information sheet
given to me. I have had the opportunity to ask questions about the study and I am
happy with the answers given.

I understand that this study involves a series of interviews and that these will be
audiotaped. I am also aware that this study is being undertaken as part of a PhD. I am
also aware that I will be asked to identify patients for inclusion into the study.

I understand that I am free to withdraw my participation in the study at any time, and
that if I do I will not be subjected to any penalty or discriminatory treatment. I am also
aware that I can ask for the information collected about me in the interview to be
removed from the study.

I understand that any information or personal details gathered in the course of this
study about me are confidential and that neither my name nor any other identifying
information will be used or published without my written permission.

Please turn over

Dietitian Consent Form Master Copy

The Commonwealth Register of Institutions and Courses for Overseas Students (CRICOS) Provider Number is 00006F for Charles Sturt University and the Charles Sturt University Language Centre

www.csu.edu.au

265
Charles Sturt University’s Ethics in Human Research Committee has approved this study. I understand that if I have any complaints or concerns about this study I can contact:

**The Executive Officer**  
**Ethics in Human Research Committee**  
**Academic Secretariat**  
**Charles Sturt University**  
**Private Mail Bag 29**  
**Bathurst NSW 2795**  
Phone:  (02) 6338 4628  
Fax:  (02) 6338 4194

The ethical aspects of the project have also been approved by the Human Research Ethics Committee (HREC) of the Greater Western Area Health Service. I understand that if I have any complaints or concerns about this research I can contact:

The Executive Officer, PO Box 143 Bathurst NSW 2795 or telephone (02) 63395601.

Signed by:  .......................................... Date:  .........................................................
Appendix 3.2: Letter, information statement and consent forms (patient participants)

Sharing decision-making between dietitian and patient in early dietetic practice

Dear Patient,

I would like to invite you to participate in a study about your experiences in making decisions about your healthcare with your dietitian. It is hoped that this study will provide a better understanding of how dietitians and their patients can work together to reach the best possible health outcomes. Please find enclosed an information sheet about the study.

The study is being conducted by Marissa Olsen who is a PhD student at Charles Sturt University. Marissa is not employed by NSW Health. Professor Joy Higgs and Dr Franziska Trode are Marissa’s research supervisors. The study is funded by a full time Community Health Research Scholarship from Charles Sturt University.

You have been identified by your dietitian as someone who would be able to provide valuable information on this topic. Please note that the researchers are not aware of your identity at this time.

Participation is completely voluntary and you do not have to tell your dietitian if you choose to participate or not.

Please turn over...
If you are interested in taking part in the study, or would like more information, please contact Marissa Olsen on 02 69332874 or by email at molsen@csu.edu.au. Alternatively, please provide your details below and return this letter in the pre-paid envelope provided to Marissa Olsen, PO Box 5908, Wagga Wagga, NSW, 2650.

Name:

Phone Number:

If you choose not to participate in the study, simply discard this information. As the researchers have no connection with the health service provider, and your dietitian will not know if you have decided not to participate, your future care will not be affected in any way.

Yours sincerely,

Marissa Olsen  Dr Franziska Trede  
Primary Investigator  Senior Lecturer
INFORMATION STATEMENT

Sharing decision-making between dietitian and patient in early dietetic practice

Principal Investigator: Marissa Olsen
PhD student: Dr Franziska Trede
C/ The Education for Practice Institute: Charles Sturt University
North Parramatta Campus: North Parramatta Campus
16 Masons Drive: 16 Masons Drive
North Parramatta NSW 2151: North Parramatta NSW 2151
Telephone: 02 88388911: Telephone: 02 88388911
Email: molsen@csu.edu.au: Email: jhiggs@csu.edu.au: Email: ftrede@csu.edu.au

You are invited to participate in this study which aims to explore patients’ understanding and experiences about making decisions with their dietitians about nutrition. We hope to learn from patients how dietitians can make sure that the way they work with patients meets their expectations and helps them to achieve the best possible health result.

If you agree to take part in this study, you will be interviewed once. The interview will be audio taped and the researcher will take notes throughout. The interview will typically last 30 to 60 minutes and will take place at a time and place of your convenience. The interview will focus on questions relating to your experiences with dietitians.

It is not expected that significant risk is posed by taking part in this study. However, the option for debriefing and/or counselling will be available at all times throughout the study. You will be free to leave the study, by asking for the interview to stop, or by asking for the information collected in your interview to be removed from the study. You can do this at any time, simply by contacting the principal investigator. As your participation in the study is confidential, withdrawal from the study will not impact upon your future use of any healthcare services in any way.

All information collected will be securely stored during the course of the study and destroyed seven years after completion of the study. Only the principal investigator and supervisors will be able to see this information.

Please turn over...

Patient Information Sheet Master Copy


www.csu.edu.au

The Commonwealth Register of Institutions and Courses for Overseas Students (CRICOS) Provider Number is 00005F for Charles Sturt University and the Charles Sturt University Language Centre.

269
As this study is to be conducted as part of a PhD, quotes from interviews may be used in written publications or presentations. Your privacy will be protected at all times during the study by using code names and where possible any details that could identify you will be removed or changed.

If you agree to participate in this study, please contact the principal investigator (Marissa Olsen) on (02) 6969332874 or molsen@csu.edu.au. Or, if you prefer, you may provide your contact details to the administrative staff and they will contact the principal investigator. This process ensures that your dietitian will not be aware if you choose to participate or not, and there will be no impact on the future provision of your nutrition care. If you choose not to participate, simply discard this information.

The ethical aspects of the project have been approved by the Human Research Ethics Committee (HREC) of the Greater Western Area Health Service. If you have any concerns or complaints please contact:

The Executive Officer, PO Box 143 Bathurst NSW 2795 or telephone (02) 63395601.

**NOTE:** Charles Sturt University’s Ethics in Human Research Committee has also approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer:

<table>
<thead>
<tr>
<th>The Executive Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethics in Human Research Committee</td>
</tr>
<tr>
<td>Academic Secretariat</td>
</tr>
<tr>
<td>Charles Sturt University</td>
</tr>
<tr>
<td>Private Mail Bag 29</td>
</tr>
<tr>
<td>Bathurst NSW 2795</td>
</tr>
<tr>
<td>Tel: (02) 6338 4628</td>
</tr>
<tr>
<td>Fax: (02) 6338 4194</td>
</tr>
</tbody>
</table>

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.
CONSENT FORM

Sharing decision-making between dietitian and patient in early dietetic practice

Principal Investigator: Marissa Olsen
PhD student
c/ The Education for Practice Institute
Charles Sturt University
North Parramatta Campus
16 Masons Drive
North Parramatta NSW 2151
Telephone: 02 88388911
Email: molsen@csu.edu.au

Supervisors
Professor Joy Higgs (principal supervisor)
Dr Franziska Trede (co-supervisor)
The Education for Practice Institute
Charles Sturt University
North Parramatta Campus
16 Masons Drive
North Parramatta NSW 2151
Telephone: 02 88388911
Email: jhiggs@csu.edu.au
Email: ftrede@csu.edu.au

I, ...........................................................................................................voluntarily agree to participate in the study of decision-making in dietetic practice, being conducted by Professor Joy Higgs, Dr Franziska Trede and Ms Marissa Olsen.

The reason for the study has been explained to me, including the (potential) risks or discomforts that may occur. I have read and understood the written information sheet given to me. I have had the opportunity to ask questions about the study and I am happy with the answers given.

I understand that this study involves an interview and that it will be audiotaped. I am also aware that this study is being undertaken as part of a PhD.

I understand that I am free to leave the study at any time, without my health care being affected. I am also aware that I can ask for the information collected about me in the interview to be removed from the study.

I understand that any information or personal details gathered in the course of this study about me are confidential and that neither my name nor any other information that could identify me will be used or published without my written permission.

Please turn over…


The Commonwealth Register of Institutes and Courses for Overseas Students (CRICOS) Provider Number is 00067F for Charles Sturt University and the Charles Sturt University Language Centre
Charles Sturt University’s Ethics in Human Research Committee has approved this study. I understand that if I have any complaints or concerns about this research I can contact:

**Executive Officer**  
**Ethics in Human Research Committee**  
**Academic Secretariat**  
**Charles Sturt University**  
**Private Mail Bag 29**  
**Bathurst NSW 2795**  
**Phone:** (02) 6338 4628  
**Fax:** (02) 6338 4194

The ethical aspects of the project have also been approved by the Human Research Ethics Committee (HREC) of the Greater Western Area Health Service. I understand that if I have any concerns or complaints about this research I can contact:

The Executive Officer, PO Box 143 Bathurst NSW 2795 or telephone (02) 63395601.

Signed by:  

Date: 

---

Patient Information Sheet Master Copy  
### Appendix 4: Dietitian participant questionnaire

<table>
<thead>
<tr>
<th>Participant Questionnaire</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you from a rural or regional background?</td>
<td>Yes</td>
</tr>
<tr>
<td>Which year did you graduate from university?</td>
<td></td>
</tr>
<tr>
<td>From which university did you receive your dietetics qualification?</td>
<td></td>
</tr>
<tr>
<td>How many months of experience do you have in clinical dietetics?</td>
<td></td>
</tr>
<tr>
<td>Have you worked elsewhere prior to this position?</td>
<td>Yes</td>
</tr>
<tr>
<td>Have you undertaken any formal professional development since graduating?</td>
<td>Yes</td>
</tr>
<tr>
<td>Are you an Accredited Practising Dietitian?</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>In relation to your current position:</strong></td>
<td></td>
</tr>
<tr>
<td>Are you a sole practitioner?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you work part time or full time?</td>
<td></td>
</tr>
<tr>
<td>What service settings do you work in? (For example hospitals, Community Health Centres)</td>
<td></td>
</tr>
<tr>
<td>Do you travel to other centres to provide a service?</td>
<td>Yes</td>
</tr>
<tr>
<td>Which type of patients do you mostly work with? (age, gender, cultural background, presenting complaint)</td>
<td></td>
</tr>
<tr>
<td>Which other health professionals do you work with on a regular basis?</td>
<td></td>
</tr>
<tr>
<td>Do you have roles other than clinical roles?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you have a preferred pseudonym to be used for analysis and in publications about this research?</td>
<td></td>
</tr>
</tbody>
</table>

Are you from a rural or regional background?  

Yes                         ... other roles: 

Do you have a preferred pseudonym to be used for analysis and in publications about this research?

If yes, please list the type of position/s and location/s:

If yes, please list:

If yes, how many hours per week do you spend travelling?

If yes, please indicate the proportion of time per week you would spend on these other roles:
Appendix 5: Interview guides

Dietitians

Interview one

Questions/topic areas
Why did you want to be involved in the research?

How would you describe your role as a dietitian when it comes to medical nutrition therapy for individual patients?

Can you talk me through how you would go about making decisions about medical nutrition therapy with your patients?

Prompt questions:
  - When you first meet someone, how do you work out what the issues are that you are going to address in medical nutrition therapy?
  - Tell me how you would go about setting the goals of treatment or management for a patient…
  - Tell me how you decide what types of dietary interventions to use with your patients… Does this vary depending on the type of patient? How?
  - How do you monitor/evaluate care?
  - What sort of information do they use to make decisions, how do they decide on what is useful and what is not?
  - Do they seek information from the patient? If so what information, how do they seek it?
  - How do they know the patient’s preference for information, how much to provide?
  - What do you think the patient’s role is in making decisions about nutrition care?
  - If they do involve the patient, how do they do so?
  - Do they establish the patient’s preference for participating?

I’m interested in collaboration as a decision-making model. Can you give me an example of where you collaborated with a patient in your practice? Or alternatively, where you just did not click with a patient?

Probing Questions

- Can you give me an example?
- Can you describe the situation in more detail?
- What were your thoughts at that time?
- What isn’t your role? What are your boundaries? When would you not do that?
- If theorising, ask for an example in their practice and talk me through it
- How did you feel about that?
- Why do you think… is important?
- It seems to me you are saying… am I on the right track? Would you like to elaborate/clarify?
- If I could just summarise what you are saying… am I on the right track? Would you like to elaborate/clarify?
Interview two
If the participant has completed the reflective/transformational activity

- Can you describe what happened during the completion of the task?
  - Is there anything you did differently this time?
  - Why are you doing it differently to before?
- What do you think this tells you?
- How were you feeling/what were you thinking? What happened around you/context?
- What went well? What didn’t?
- Why do you think you took this approach with this patient?
- Could you have done it differently?
- Would you change anything if you had the chance? Tell me more…
  - How would you like your practice to be?
  - What is stopping you doing the things you would like to do?

Interview 3
If the participant has completed the reflective/transformational activity

- Can you describe what happened during the completion of the task?
  - Is there anything you did differently this time?
  - Why are you doing it differently to before?
- What do you think this tells you?
- How were you feeling/what were you thinking? What happened around you/context?
- What went well? What didn’t?
- Why do you think you took this approach with this patient?
- Could you have done it differently?
- Would you change anything if you had the chance? Tell me more…
  - How would you like your practice to be?
  - What is stopping you doing the things you would like to do?

Do you think sharing decision making with the patient is useful in dietetic practice?

When do you think shared decision-making with patients is the best approach to use?

When do you think its best not to share decision-making with patients?

What difficulties do you think patients might have in participating in decision-making?

How do you think experts make decisions about dietary interventions?

Frame questions

1. What are you doing?
2. What would you like to do?
3. What is stopping you?
4. Why did you do it?
5. Is there anything you did differently this time?
6. Why are you doing it differently to before?
Patients

1. Can you tell me about what your expectations were when you went to see the dietitian?
   o How did you think the dietitian could help you meet those expectations?

2. Can you tell me about how your dietitian helped you meet those expectations?
   o What actually happened during the session with your dietitian? Were your expectations met?

3. One of my aims of my research is to help students learn about working well with their patients
   o Is there any advice you could give to the students about what they should and shouldn’t do when working with dietitians
   o What do you think the most important role of a dietitian is?
   o Can you give me any ideas about what wouldn’t be a good way to work with people? Anything that would put you off seeing a health professional?
   o What sort of skills do you think they need to work well with people?

Target questions

Outcomes
   o What would be a really good outcome of seeing the dietitian?
   o Is there potential to keep working with your dietitian in the long term?

Information sharing
   o Did you already know a lot about diet before you saw the dietitian?
   o What sort of information do you think is important to share about yourself with a dietitian?

Decision-making
   o Who do you think should make the decisions about what dietary changes you make? Do you think the dietitian should be the one to give you ideas or can you contribute to these ideas? When should the dietitian make the decisions? When should they make the decisions? When should decision-making be shared?

How did you feel about that approach? Did it work well or not? What does that mean for you as a patient?
### Appendix 6: Decision making models from the health care literature

<table>
<thead>
<tr>
<th>Author (publication date)</th>
<th>Journal</th>
<th>Context</th>
<th>Decision-Making Model</th>
<th>Key Focus</th>
<th>Methodological or Analytical Weakness</th>
</tr>
</thead>
</table>
| Baker et al. (2007)       | *Biology of Blood and Marrow Transplantation* | Medicine | Shared | Process: outlining steps of the model  
Relationships: Emphasis on empathic and compassionate communication in establishing the therapeutic relationship | No methodology declared. |
| Betan (1997)              | *Ethics & Behavior* | Psychotherapy | Collaborative | Ways of knowing: coming to a shared understanding by exploring pre-understandings of both decision-making partners; taking into account situational, contextual nature of ethical dilemmas and the partners’ subjective understandings of ethical dilemmas in decision making | No methodology declared. |
Nature of the decision: impact of the decision on patients, the degree of expert agreement about patient options and the seriousness of the outcome of the treatment influence how decision | No methodology declared. |
<table>
<thead>
<tr>
<th>Authors</th>
<th>Journal</th>
<th>Field</th>
<th>Type</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charles et al. (1997, 1999)</td>
<td><em>Social Science &amp; Medicine</em></td>
<td>Medicine</td>
<td>Shared</td>
<td>Identification and discussion of the elements and processes of decision making and the ways of knowing that are exchanged. Relationships: brief discussion of the need for flexibility in decision making due to individual nature of relationships between patients and practitioners as well as consideration needed of power imbalances and creation of a safe environment for communication between patients and practitioners. Nature of decision to be made: multiple perspectives to be taken into account.</td>
</tr>
<tr>
<td>Chewning &amp; Sleath (1996)</td>
<td><em>Social Science &amp; Medicine</em></td>
<td>Pharmacy</td>
<td>Shared</td>
<td>Identification and discussion of the processes within the model and ways of knowing exchanged. Relationships: briefly identify the challenge of sharing power between patients and practitioners.</td>
</tr>
<tr>
<td>Colella &amp; DeLuca (2004)</td>
<td><em>Urologic Nursing</em></td>
<td>Nursing</td>
<td>Shared</td>
<td>Identification and discussion of the processes within the model and the ways of knowing exchanged.</td>
</tr>
</tbody>
</table>

No methodology declared.
<table>
<thead>
<tr>
<th>Study</th>
<th>Journal</th>
<th>Field</th>
<th>Approach</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collins &amp; Street (2009)</td>
<td>Social Science &amp; Medicine</td>
<td>Medicine</td>
<td>Shared</td>
<td>Relationships: brief mention of the role of practitioners in establishing positive communication to enhance the development of an effective relationship</td>
</tr>
<tr>
<td>Cottone (2001)</td>
<td>Journal of Counseling &amp; Development</td>
<td>Counselling</td>
<td>Shared</td>
<td>Identification and discussion of the processes within the model and the ways of knowing exchanged&lt;br&gt;Dialogue: coming to a shared understanding of each other in decision making</td>
</tr>
<tr>
<td>Coulter &amp; Collins (2011)</td>
<td>N/A (published report)</td>
<td>Medicine</td>
<td>Shared</td>
<td>Identification and discussion of the processes within the model and the ways of knowing exchanged&lt;br&gt;Ways of knowing: bringing clinical and patient expertise</td>
</tr>
<tr>
<td>Cribb &amp; Entwistle (2011)</td>
<td><em>Health Expectations</em></td>
<td>Multidisciplinary</td>
<td>Shared</td>
<td>Relationships: developing a supportive patient-practitioner relationship where practitioners can support patients to explore and question their preferences while still respecting patient autonomy</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------</td>
<td>------------------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Deber (1994a, 1994b)</td>
<td><em>Canadian Medical Association Journal</em></td>
<td>Medicine</td>
<td>Shared</td>
<td>Ways of knowing: developing an understanding of patients’ preferences for participation is important in ensuring that shared decision making is utilised appropriately for each occasion of care</td>
</tr>
<tr>
<td>Elwyn, Edwards, Kinnersley, &amp; Grol</td>
<td><em>British Journal of General Practice</em> (general)</td>
<td>Medicine</td>
<td>Shared</td>
<td>Identification and discussion of the processes and valued ways of knowing within the model</td>
</tr>
<tr>
<td>Reference</td>
<td>Journal/Book</td>
<td>Field</td>
<td>Relationship</td>
<td>Ways of knowing</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>-------</td>
<td>--------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Entwistle &amp; Watt (2006)</td>
<td><em>Patient Education &amp; Counseling</em></td>
<td>Medicine</td>
<td>Shared</td>
<td>knowing within the model&lt;br&gt;Ways of knowing: understanding patients’ preferences for involvement and information&lt;br&gt;Relationships: discussion of ways to ensure patients’ voices are heard and incorporated into decision making in light of practitioners’ greater power in the relationship</td>
</tr>
<tr>
<td>Faith, Pinhas, Schmelefske, &amp; Bryden (2003)</td>
<td><em>Eating Disorders</em></td>
<td>Multidisciplinary: psychiatrists, child and youth workers, dietitians, physicians, therapists, family workers, and teachers</td>
<td>Collaborative</td>
<td>Relationship: important to take into account how patients and practitioners view the relationship, their roles and contributions to decision making in an ongoing fashion to ensure optimal decisions are made</td>
</tr>
<tr>
<td>Authors</td>
<td>Journal名称</td>
<td>Field</td>
<td>Collaboration</td>
<td>Nature of decision to be made</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------</td>
<td>------------------------</td>
<td>---------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Garcia et al (2003)</td>
<td><em>Journal of Counseling &amp; Development</em></td>
<td>Counselling</td>
<td>Shared</td>
<td>eating; knowledge derived from reflecting together within the health care team; importance of ensuring multiple perspectives are taken into account</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Nature of decision to be made: patients’ socio-cultural background and how it influences beliefs, values and preferences, as well as those of the many individuals participating in care, the many treatment options available for care, the uncertainty of outcomes of various treatment options and the number of settings in which care takes place</td>
</tr>
<tr>
<td>Goodwin, Kiehl, &amp; Peterson (2002)</td>
<td><em>Nursing Science Quarterly</em></td>
<td>Nursing</td>
<td>Shared</td>
<td>Identification and discussion of the processes and valued ways of knowing within the model</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ways of knowing: importance of taking into account multiple perspectives on the ethical issue as well as potential internal and external influences on the development of pre-understandings</td>
</tr>
<tr>
<td>Source</td>
<td>Type</td>
<td>Medicine</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>----------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Hope (1996)</td>
<td>N/A (published report)</td>
<td>Shared</td>
<td>Identification and discussion of the processes and valued ways of knowing within the model. Ways of knowing: emphasis on and discussion of how evidence-based practice can be blended with patient preferences, context and values. No methodology declared.</td>
<td></td>
</tr>
<tr>
<td>Kasper, Légaré, Scheibler, &amp; Geiger (2011)</td>
<td><em>Health Expectations</em></td>
<td>Collaborative</td>
<td>Relationships: relationships are dynamically constructed and reconstructed through dialogue. Dialogue: emphasis on practitioners to facilitate a dialogue with patients and coming to a shared understanding through social interaction. No methodology declared.</td>
<td></td>
</tr>
<tr>
<td>Authors</td>
<td>Journal</td>
<td>Field</td>
<td>Method</td>
<td>Description</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------------------------</td>
<td>----------------------</td>
<td>-----------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Moats &amp; Dobel</td>
<td><em>Canadian Journal of Occupational Therapy</em></td>
<td>Occupational therapy</td>
<td>Shared</td>
<td>Ways of knowing: focus on multiple perspectives informing decision making, coming to an understanding of how patients give meaning to their lives, creative problem solving as part of making a decision</td>
</tr>
<tr>
<td>Politi &amp; Street</td>
<td><em>Journal of Evaluation in Clinical Practice</em></td>
<td>Medicine</td>
<td>Collaborative</td>
<td>Ways of knowing: coming to a shared understanding by sharing evidence, experience, context, values, preferences and perspectives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Relationships: importance of both patient and practitioner working together, openness to each others point of view, trust and commitment</td>
</tr>
<tr>
<td>Authors</td>
<td>Journal/Book Title</td>
<td>Field</td>
<td>Approach</td>
<td>Methodology Declared</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------------</td>
<td>-------------</td>
<td>---------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Relationships: open acknowledgement of power imbalances, careful use of practitioners’ power to share their values and preferences about treatment options in facilitating decision making about care</td>
<td>declared.</td>
</tr>
<tr>
<td></td>
<td>Dialogue: importance of openly sharing values and preferences of practitioners to come to a shared and deeper understanding of the issue at hand</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nature of decision to be made: explores the complexity of how decisions are made, including the temporal, relational and organisational aspects that affect decision making</td>
<td>but not further discussed: ethnomethodology.</td>
</tr>
<tr>
<td>Sandman &amp; Munthe (2010)</td>
<td><em>Health Care Analysis</em></td>
<td>Medicine</td>
<td>A range of patient driven, practitioner driven, shared and collaborative models are</td>
<td>No methodology</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Identification and discussion of the processes and valued ways of knowing within a range of models</td>
<td>declared.</td>
</tr>
<tr>
<td></td>
<td>Dialogue: emphasise the importance of engaging in a discussion prior to making</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author(s) &amp; Year</td>
<td>Journal/Book Title</td>
<td>Field</td>
<td>Model Type</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------------------</td>
<td>----------</td>
<td>--------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Siminoff &amp; Step (2005)</td>
<td><em>Health Psychology</em></td>
<td>Medicine</td>
<td>Shared</td>
<td>Identification and discussion of the processes and valued ways of knowing within the model&lt;br&gt;Relationship: strong emphasis on what patients and physicians bring to the decision-making process with respect to their preferences for the way they communicate with each other as well as the impact of the communication climate on decision making</td>
</tr>
<tr>
<td>Slingsby (2004)</td>
<td><em>Social Science &amp; Medicine</em></td>
<td>Psychiatry</td>
<td>Practitioner driven and shared both presented</td>
<td>Identification and discussion of the processes and valued ways of knowing within a range of models</td>
</tr>
</tbody>
</table>
Relationships: give attention to the concept of partnership and what this implies in decision making as well as identifying competencies for patients (specifically being aware of their own preferences for relationships they would like with practitioners as well as participating in the management of their relationship with practitioners)

Ways of knowing: giving multiple ways of knowing value in decision making and placing patients’ contexts and needs at the centre of making decisions helps to reduce power imbalances; reflecting on and increasing practitioners’ awareness of interests driving practice as well as identifying and challenging potential constraints on practice and on patients’ abilities to make

Methodology declared and discussed: critical social science. Analytical lenses to derive model mentioned and discussed: “critical self-reflection, questioning taken-for-granted practice and transforming current practice” (p.66). |
<table>
<thead>
<tr>
<th>Authors</th>
<th>Title</th>
<th>Domain</th>
<th>Type</th>
<th>Description</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Nature of decision to be made: “1) the health issue, 2) patients’ preferences, 3) practitioners’ recommendations and responsibilities, 4) clinical evidence (including such factors as personal characteristics, socioeconomic factors and stage of disease) and 5) research evidence” (p. 267); each influence the way decisions are made.</td>
<td>No methodology declared.</td>
</tr>
<tr>
<td>Whitney (2003)</td>
<td><em>Medical Decision Making</em></td>
<td>Medicine</td>
<td>A range of patient driven, practitioner driven and shared models presented</td>
<td>Discusses the nature of decisions as having varied certainty and importance</td>
<td>No methodology declared.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Identification and discussion of the elements and valued ways of knowing within the model.</td>
<td>No methodology declared.</td>
</tr>
<tr>
<td>Wiggins Frame &amp;</td>
<td><em>Counseling and Counselling</em></td>
<td>Counselling</td>
<td>Shared</td>
<td>Identification and discussion of</td>
<td>No methodology declared.</td>
</tr>
<tr>
<td>Braun Williams (2005)</td>
<td><em>Values</em></td>
<td>the processes and valued ways of knowing within the model</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------</td>
<td>----------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ways of knowing: importance of the pre-understandings and the cultural influences on pre-understandings of key players in decision making to inform decision making; feelings and intuition of practitioners also important way of knowing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relationships: explicit step of decision making is to consider the influence of the cultural position of key players in decision making on power in the relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Zoffmann, Harder, &amp; Kirkevold (2008)</th>
<th><em>Qualitative Health Research</em></th>
<th>Nursing</th>
<th>Shared</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ways of knowing:</strong> mutual construction of knowledge about individual patients’ experiences via reflection together as patients and practitioners as well as patients reflecting on their own attitudes and experiences of illness on their own</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus on how practitioners might go about facilitating this approach to decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methodology declared and discussed: “grounded theory method comprising a symbolic interactionist perspective” (p.671). Analytical lenses to derive model mentioned and discussed: included foregrounding of researcher assumptions, constant comparative analysis and construction of illustrations.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>