Stuck in the middle: the impact of collaborative interprofessional communication on patient expectations

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Abstract

A central aim of modern day healthcare is to deliver a high quality, patient-centred service that addresses the expectations of its service users. However, mounting research evidence highlights a lack of patient satisfaction across a range of healthcare settings, with an overwhelming proportion of complaints relating to interprofessional communication. The link between interprofessional miscommunication and poor patient outcomes has been well documented. All too often, patients are left feeling stuck in the middle between opposing opinions, differing diagnoses and conflicting clinical outlooks. This article aims to highlight the issues surrounding interprofessional communication in healthcare, at the same time as addressing the potential facilitators and barriers for developing improved collaborative links between healthcare providers. Several key questions will be considered: (i) what are the underlying causes of interprofessional miscommunication; (ii) what do patients expect from healthcare professionals; and (iii) how might we reduce the risk of miscommunication and develop interprofessional collaboration?

Keywords

collaboration, communication, interprofessional, patient expectations

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Introduction

A central aim of modern day healthcare is to deliver a high quality, patient-centred service that addresses the expectations of its service users.¹ However, mounting research evidence highlights a lack of patient satisfaction across a range of healthcare settings, with an overwhelming proportion of complaints relating to interprofessional communication.^{2,3} The link between interprofessional miscommunication and poor patient outcomes has been well documented.⁴ All too often, patients are left feeling stuck in the middle between opposing opinions, differing diagnoses and conflicting clinical outlooks.

Following several years of interviewing clinicians, researchers and service users, the healthcare journalist Judy Foreman⁵ discovered an appalling mismatch between what patients need, and what healthcare professionals are equipped to provide. This troubling mismatch is further complicated by a lack of interprofessional healthcare education,⁶ which frequently results in separated pockets of professional protectionism, a lack of knowledge sharing between care providers and

contradictory mixed message miscommunications for patients seeking healthcare solutions.⁷

Anecdotally, clinicians often experience the impact that disjointed links between the healthcare professions can have upon patient expectations. A list of typically frustrated patient complaints might include: 'I feel like I am going around in circles'; 'I am being passed from pillar to post'; and 'It seems like the left arm doesn't know what the right arm is doing!' These characteristic statements act as a reminder of our need to develop more seamless, integrated healthcare services that not only recognize the compromising impact on patient care and patient safety,⁷ but also regard interprofessional communication training as an essential prerequisite for service development.⁸

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Despite repeated calls for improved interprofessional connections across all hierarchical levels in healthcare, the present-day literature continues to point towards an unremitting concern regarding a lack of collaboration between traditionally distinct, and often disconnected groups of healthcare providers.⁹ This problem is further compounded by the multifaceted needs of patients who require an integrated, multidisciplinary approach. The complex nature of many modern-day healthcare problems means that patients frequently seek care from a wide variety of healthcare professionals.¹⁰ Therefore, the lack of effective interprofessional bonds amplifies the risk of ambiguous miscommunication and can compromise patient care and patient safety.⁷ In a recent integrative review of interprofessional communication in healthcare, Foronda et al.³ found that ineffective communication leads to patient dissatisfaction, misdiagnosis, delayed treatment, medication errors and injury or death. Consequently, the development of communication standards across the healthcare professions is urgently needed.¹¹

This article aims to highlight the issues surrounding interprofessional communication in healthcare, at the same time as addressing the potential facilitators and barriers for developing improved collaborative links between healthcare providers. Several key questions will be considered: (i) what are the underlying causes of interprofessional miscommunication; (ii) what do patients expect from healthcare professionals; and (iii) how might we reduce the risk of miscommunication and develop interprofessional collaboration?

The Expectation and Thinking Divide

Managing patient expectations is an essential part of any clinicians' role.¹² When taking into account the expectations of both patients and healthcare professionals, it is worth considering William Shakespeare's quotation, 'Expectation is the root of all heartache'. To minimize the potential heartache and dissatisfaction experienced by both patients and healthcare professionals when their expectations are not met, it is essential to develop a collaborative, shared understanding of each other's requirements.^{13,14} Not only is there a pressing need to bridge the expectation divide that exists between patients and clinicians, but also we must address the interprofessional and intraprofessional partitions that restrict communication and impede patient experiences.³ Without a greater understanding of each other's roles and clinical expectations, patients will likely remain stranded between contrasting clinical viewpoints. They may consequently become confused as to who to trust and who's clinical advice they should implement.

To bridge the expectation divide, it is essential to first understand the inherent distinctions in how

people think. Schon¹⁵ argues that all professional thinking exists on a continuum between a technical rationale viewpoint at one end, and a professional artistry viewpoint at the other. These two opposing perspectives underpin how we communicate, and how we transfer our knowledge to patients and other healthcare professionals.¹⁶ Table 1 highlights the characteristic differences between technical rationale thinking and a professional artistry perspective of clinical practice.

Table 1. The professional thinking continuum.

The technical-rationale viewpoint	The professional artistry viewpoint
Follows rules, laws, schedules	Starts where rules fade
Uses routines, prescriptions	Sees patterns, frameworks
Uses diagnosis, analysis to think about professional practice	Uses interpretation and appreciation to think about professional practice
Technical expertise is all	Wants creativity and room to be wrong
Sees knowledge as graspable, permanent	Sees knowledge as temporary, dynamic, problematic
Sees professional activities as masterable	Sees mystery at the heart of professional activities
Emphasizes the known	Embraces uncertainty
Standards must be fixed, measurable and controlled	Emphasizes investigation, reflection, deliberation
Quality is really about quantity of that which is easily measurable	Quality comes from deep insight into one's values, priorities, actions
This is training	This is education
Visible performance is central	There is more to it than surface features
Wants efficient systems	Professional judgement counts
Theory is applied to practice	Theory emerges from practice

Adapted from Fish and Twinn¹⁶ and Schon.¹⁵

Using Schon's¹⁵ professional thinking continuum as a basis for improving interprofessional communication, we may begin to better understand the process by which patient expectations get lost amid differing interprofessional ideologies. The mismatch between what patients want and what patients get from healthcare services has been well documented.^{17,18} Yelland¹² found that patient expectations frequently contain a range of meaningful, practical desires. These include symptom relief, functional improvement (return to work), acquired knowledge, social legitimization (believed/listened to), an accurate diagnosis (clearly and confidently explained) and a positive shift in attitude. However, research continues to show that many of these patient expectations are not met with repeated accounts of frustration and dissatisfaction noted throughout the literature.^{19–21}

As with most health-related problems, people seeking advice for musculoskeletal shoulder and elbow pain may encounter multiple opinions from a variety of sources. The advice patients receive from each clinician will vary depending upon their beliefs, and their philosophical position on Schon's¹⁵ professional thinking continuum. Equally, the people experiencing pain will also bring their own predetermined philosophical viewpoint to the consultation. This poses an intrinsic dilemma for the development of collaborative, interprofessional communication as a thinking match or mismatch may exist within both clinician-patient relationships and within interprofessional interactions.²²

Figure 1 highlights the potential cognitive match or mismatch that underpins frequent miscommunications and misunderstandings in healthcare interactions. If the patient in Fig. 1 views her problem with a high degree

Figure 1. The gap between patient expectations and contrasting interprofessional advice.

of technical rationality, she will likely perceive an inevitable technical solution,²³ and is therefore more likely to agree with those clinicians who think similarly (i.e. the Family Doctor, Surgeon 1, the Sports Therapist and Physiotherapist 2). Equally, she is also more likely to refute advice provided by clinicians who embrace the uncertainty of clinical practice from a professional artistry perspective (i.e. Physiotherapist 1 and Surgeon 2).

Gawande²⁴ argues that healthcare communication consists of 'Constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line. The gap between what we know and what we aim for persists. And this gap complicates everything we do'. Of course, it is only natural that the six clinicians shown in Fig. 1 may provide different, contradictory information. Just as we would expect six different accountants to each provide a range of differing financial advice, so too should we expect six different healthcare professionals, even from within the same profession, to offer guidance that is based upon a combination of their clinical experience, their interpretation of scientific evidence and their individual beliefs. Although an acceptance of each other's professional thinking differences is essential for the development of interprofessional communication, we must also seek to enhance collaboration if we are to improve patient care.²⁵

The Interprofessional, Cultural Divide

Over the past couple of decades, healthcare education at both undergraduate and postgraduate levels has undergone an interprofessional revolution.²² A more collaborative and integrated approach to learning means that many healthcare students are now more comfortable with each other's clinical duties. Equally, they are also more aware of the differences that exist between the healthcare professions.³ However, despite the move towards a more unified model of healthcare training, the literature continues to highlight examples of miscommunication, and numerous cultural barriers to improving interprofessional communication remain.^{26,27}

Quintero²⁸ argues that many obstacles facing the development of interprofessional communication stem from distinct cultural differences within undergraduate healthcare education. For example, Rodgers²⁹ found that nurses are trained to be highly descriptive and physicians are trained to be succinct when communicating with patients, carers and colleagues. This cultural difference underpins the communication divide between healthcare professionals from an undergraduate level and is reinforced throughout clinical practice.²⁵ Clark⁹ found that different healthcare professionals communicate information about patients within a narrative framework that fits their own discipline.

However, the structure of each professions narrative framework differs according to their training. Hence, interprofessional miscommunications and misunderstandings arise from different disciplines, speaking differently. With this in mind, what might be the solution? Clark⁹ suggests, 'The embracing of true multivocality by a healthcare team is the key to its achieving the kind of integrated communication required for effective collaboration'.

Cross et al.²² propose that collaboration involves a genuine desire and active interest in identifying and solving problems jointly. Inherent in this approach is commitment to assisting interprofessional colleagues, as far as possible, to achieve their own goals, as well as goals shared across the healthcare professions. However, the literature highlights a number of barriers to achieving more effective interprofessional communication. The most commonly discussed barrier relates to the continuation of traditional, hierarchical structures within healthcare.³

If we are to accomplish a truly meaningful, collaborative relationship between different clinical groups, a cultural shift towards a more horizontal professional framework is required. Rice et al.²⁵ discuss the need for a flattening of the hierarchy across the healthcare professions. They found that significant, detrimental effects on both interprofessional communication and collaboration originated from a conventional, hierarchical structure that produced a lack of trust amongst healthcare providers. The physicians within their study stated that they expected their orders to be implemented without the need for negotiation or discussion. One participant noted, 'The fast paced, interruptive environment reduced opportunities or incentive to enhance restrictive interprofessional relationships'. The inherently distracting nature of many healthcare settings acts as a barrier to the development of interprofessional communication.^{26,30}

Yet, the cultural communication divide remains between many healthcare professionals, despite repeated calls for a flattening of the healthcare hierarchy, and an increasing awareness of the negative impact that this framework has upon interprofessional collaboration and patient care. A variety of reasons may explain why these traditional frameworks are resistant to change. Timmons and East³¹ suggest that longstanding mistrust between different healthcare providers is rooted in professional protectionism. Moreover, healthcare practitioners worry that a blurring of professional boundaries may lead to a weakening of professional status.³² Both factors continue to hinder patient care and patient safety by blocking the development of interprofessional communication.³

Smith and Roberts³² analyzed collaborative working between physiotherapists and occupational therapists.

They found that professional tribalism increased as the participants were asked to share more of their core clinical skills. Hunter³³ suggests that professional tribalism forms an implicit and pervasive threat to the development of interprofessional communication and collaboration: 'All of these tribes have slightly different goals and perceptions of what constitutes effective care and are pulling in somewhat different directions'. In an attempt to create a more unified, interprofessional healthcare service, Timmons and East³¹ used focus groups to explore the impact of all clinicians within a hospital (except doctors) wearing the same uniform. They found that the use of generic uniforms did little to reduce professional tribalism, with most participants expressing concerns about a loss of their professional identity.

Although occupational boundaries have somewhat shifted from the conventional view where medicine was perceived to be the predominant profession, Timmons and Tanner³⁴ argue that conflicts continue to block progression towards enhanced interprofessional communication. If we are to aspire towards the development of healthcare services that deliver patient centered care, we need to recognize the well-established, cultural separations that remain between healthcare providers. Until this time, many patients with complex care needs will likely remain stuck between entrenched interprofessional communication divides.

Overcoming Obstacles and Building Interprofessional Bridges

In addition to the complex and thorny issues surrounding professional tribalism, and the ongoing protection of professional identity, a range of other barriers continue to limit interprofessional communication. More optimistically, however, a variety of counteractive measures to facilitate dialogue across the healthcare professions have also been explored throughout the literature. Table 2 shows some of the barriers and facilitators for developing interprofessional communication.

To develop more effective interprofessional communication skills, it is essential for all professions to firstly acknowledge the multitude of barriers that are present within healthcare settings. The hectic, distracting nature of practice must be accounted for when implementing a culture of collaborative, communication skills training. Although there are many variables and human factors to consider, a better understanding of each other's roles stems from an inclusive, multifaceted approach with a strong emphasis on collaboration and teamwork.³⁵

Several studies have found positive effects on interprofessional collaboration, with significant increases in self-reported communication skills when using a variety

Table 2. Barriers and facilitators for the development of interprofessional communication.

Interprofessional communication barriers	Interprofessional communication facilitators
Professional preconceptions	Clinical companionship
Scheduling and time restrictions	Professional mentoring
Facilities	Online learning modules
Professional attitudes	Virtual simulation training
Hierarchical structure	Expert patient programmes
Lack of confidence/fear of humiliation	Shared decision-making
Undervalued opinions	Cultural humility training
Lack of experience	Interprofessional case studies and simulations
Distracting nature of healthcare settings	Conflict resolution training
Lack of structure and standardization of care	Social media

Adapted from Foronda et al.³, Wagner et al.⁶, Liaw et al.²⁶ and Pfaff et al.²⁷

of integrated training methods. These include interprofessional workshops, online learning modules and case studies.³ Barnsteiner et al.⁸ suggest that, by introducing shared clinical learning experiences, such as simulations and case studies across the healthcare professions, we may begin to break down established barriers and improve interprofessional communication. Sargeant et al.¹⁰ used professional actors to simulate complex clinical situations with 518 healthcare professionals. They found considerable increases in interprofessional collaboration, and an enhanced sense of clinical companionship amongst the participants. A challenge for any interprofessional simulation training experience is to address universal learning objectives, such as communication skills and team interactions, at the same time as paying attention to the development of clinical skills that are specific to each discipline.

Foronda et al.³ argue that the implementation of a cultural shift towards interprofessional communication training must begin in academic institutions and continue to extend into clinical settings. However, although it is commonplace for many undergraduate courses to include interprofessional training experiences, most appear to be delivered sporadically with only

Figure 2. Types of decision-making communication styles.

occasional opportunities for multidisciplinary learning.⁶ With this in mind, Foronda et al.³ suggest that, to improve interprofessional communication, future healthcare training must consider embedding integrated learning experiences across all curricular activities.

Crucially, if we are to meet the patient expectations as outlined by Yelland,¹² we must not only address the communication divides that are present between the healthcare professions, but also first be prepared to place the patient's needs at the centre of our collective, interprofessional decisions. Much has been written about the importance of shared decision-making (SDM) across the healthcare disciplines. Coulter and Collins³⁶ describe SDM as 'A process in which clinicians and patients work together to clarify treatment, management or self-management support goals, sharing information about options and preferred outcomes with the aim of reaching mutual agreement on the best course of action'.

However, despite the emerging importance of SDM, and the assurances of the inclusive, patient-centred slogan, 'no decision about me, without me',³⁶ communication throughout healthcare has been found to be predominately clinician led and paternalistic with patients left feeling disengaged and frustrated.³⁷ A central prerequisite of SDM involves the willingness of all healthcare providers to respect the importance of individual patient decisions. Without a widespread and integrated understanding of SDM across the healthcare professions, many patients will likely continue to experience three distinctly different and opposing approaches to communication and clinical decision-making (Fig. 2). Therefore, to develop interprofessional communication and to empower patients, all clinicians need to be prepared to lose some power and control, regardless of their status and professional background.²

Conclusions

There is a clear need for improved interprofessional communication and collaboration in healthcare. Although

this much-needed process has become well established in many academic settings, there is a lack of evidence to show that this has had a positive pipeline effect into everyday clinical practice. The reasons for this are complex and numerous barriers continue to hinder progression towards a more unified and integrated approach to healthcare communication. However, the literature reveals a drive towards improved interprofessional collaboration, and a variety of training methods to help achieve this have shown positive results. Some suggested that more cultural humility training is necessary to flatten the traditional hierarchical frameworks that exist within healthcare.²⁵ Moreover, care providers may benefit from a greater understanding of the professional thinking differences that exist on both interprofessional and intraprofessional levels, and which form the basis of continuing miscommunications.

Bullington et al.³⁸ suggest that, each time we encounter another human being, we are encountering another world filled with different beliefs and attributions. When seeking to develop interprofessional communication, it is vital to acknowledge and comprehend the idiosyncratic nature of human interactions. This understanding must act as a foundation for the development of any patient-centred healthcare service. Furthermore, when planning collaborative training programmes to develop interprofessional communication within clinical practice, consideration must be given to the diverse styles, expectations and educational needs of each healthcare profession. Finally, amid the complexities and challenges of interprofessional communication, we must not lose sight of our desire to deliver a patient-centred service that aims to meet patient expectations.

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Ethical Review and Patient Consent

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