Communication

• A key dimension of IPC/IPE
  - "Openness in communication"
  - "Respectful interprofessional communication"
• Education targets individual skill development
  - "Improved communication skills"
  - "Students practice communicating"
  - "Students learn to talk with colleagues"

Objectives

• To expand our focus beyond individual communication skills
• So that our practice and education efforts can better grapple with the complexities of team communication

Presentation Outline

• Introduce a rhetorical approach to team communication
• Present 4 claims, with reference to research on interprofessional teams
• Discuss what these claims might mean for our efforts in IPC/IPE
Beyond our traditional focus on what communication says

(the descriptive aspects of language)

To consider what communication does

(the constructive aspects of language)

(Burke 1969; Blackman 1985; Lynd 1990, 2009; Schryer 2009)

One of the things communication does is socialize
Rhetoric and IPC/IPE

- Rhetoric helps us see how communication shapes professional identities & values
- It draws attention to the social relations embodied in all communication acts
- It provides tools for excavating communication practices for discussion

Miller 1995; Diao 2002; Schryer 2005; Lingard 2007; Gardezi 2009

4 rhetorical claims about communication

Claim #1

Language is not self-evident ...

And interpretations differ

- OR team members interpret communication events differently
- Ratings of video scenarios differed by profession re:
  - Level of tension
  - Responsibility for creating
  - Responsibility for resolving

(Lingard 2002)
Profession shapes interpretation

- Surgeons perceive team communication quality as higher than nurses do
- OR team members rate communication differently when they're rating a peer or an 'other'

(Flin 2006, Makary 2006)

Implications for IPC/IPE

- Rethink educational focus on 'content & delivery'
- Accurate 'content & clear' delivery are insufficient
- IPE efforts need to include training novices in gauging how their communications are received

New approaches

- An IPE workshop used videos of team tension to provoke debate among team members about different perceptions & their implications for collaborative practice

(Lingard 2002b)

Claim #2

Communication “problems” aren’t just a matter of individual skill

They arise from rhetorical situations
Communication & medical error

- A root cause in >70% of errors
- Individual communication 'skill' rarely the main issue
- Until recently, no systematic study of the nature of communication problems on teams

(ICAHO 2004; Fin 2006; Yue 2008)

Communication failures model

<table>
<thead>
<tr>
<th>Failure Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occasion failure</td>
<td>Problems in the communicative situation</td>
</tr>
<tr>
<td>Content failure</td>
<td>Insufficiency/inaccuracy in the information</td>
</tr>
<tr>
<td>Audience failure</td>
<td>Not all relevant team members present</td>
</tr>
<tr>
<td>Purpose failure</td>
<td>Unclear, or not achieved</td>
</tr>
</tbody>
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(Lingard et al. 2004)

Communication Failures

- In one study, 30% of OR communication exchanges exhibited failures
- Over a series of studies, the model has retained its explanatory power
- One addition: style failures

(Lingard 2003; 2009; Impress)

Implications for 'skill' development

- Our traditional focus is on teaching ‘content & delivery’
  - ‘Be accurate’
  - ‘Be relevant’
  - ‘Be clear’
- This is insufficient to equip trainees to judge and navigate complex social situations

A surgical trainee may have the right information.

She may deliver it to the anesthetist at the right time in the procedure.

Her delivery may be clear and well understood.

BUT

If she doesn’t understand enough about the situation to know that the circulating nurse also needs this information in order to facilitate related actions...

then her communication will fail.
After 5 minutes hunting for the correct pathway to insert a patient diet change in the EPR, the physician forces the system to let him enter what he wants by creating a free-text entry. Afterwards, the physician looks for the patient’s nurse. “I’ve created an order that I think will create confusion so I wanted to explain it to [Nurse B].” Finds the nurse and says, “OK, so I just wrote an order but I want to make sure you understand that we continue with the other and add this to it.”

Fieldnote

Trainee A is struggling with the EPR. Frustrated, she enters a free text morphine order as a ‘workaround’ because she can’t get the field she wants on the screen. Another trainee warns it will look like 2 morphine orders. Not everybody would know what you mean.” Trainee A struggles for another few minutes. Finally, s/he says, “I’ll enter it for the time being and come back and fix it later.” Trainee B is hesitant: “I don’t think it will be clear…”, walks away.

(Fieldnote)

In a study of how team members communicated using the EPR on a pediatric ward, savvy communicators demonstrated their insight into the social environments their ‘communication messages’ were delivered into...

(Schryer 2005; Dian 2002)

Savvy communicators understood

- That communication shaped the work of other team members
- That EPR entries were not static messages – they had audiences whose situations required them to interpret
- However, less savvy communicators did not exhibit this strong sense of the social context of their messages

Implications for IPC/IPE

- Train novices to judge how the social situation influences their communication
- Look beyond individual incompetence to understand why communication breaks down

(Fieldnote)
The circulating nurse and scrub nurse are doing their count near the end of the case. Surgical resident requests "4-0 Vicryl please" from the scrub nurse. The scrub nurse's back is to him; she doesn't immediately respond. Resident requests again with a slightly louder voice: "Can I get a 4-0 Vicryl please?" Nurse still doesn't respond. The surgical resident raises his eyebrow at the junior resident across the table. A few moments later, the count is done. The nurse repeats "4-0 Vicryl", handing the suture. The resident takes it, appears irritated, sighing loudly and shaking his head.

What does the silence mean?
- Nurse didn't hear request
- Nurse did hear request, but prioritizes the count
- Nurse seeks to delay closure until count is complete, using silence to avoid overt conflict

It depends... and it matters
- Silence is not the absence of meaning; it can be purposeful and meaningful, functional or dysfunctional

(Glenn 2004)
• We might see the suture request responded to immediately (no silence)

• However, this very responsiveness may be problematic, as it interrupts the counting protocol

• Sometimes communication progresses smoothly towards dangerous outcomes

Implications for IPC/IPE
• Teach novices to listen to silence

• Reflect on the functional and dysfunctional uses of silence on teams

• Critically evaluate our assessment tools – do they focus exclusively on spoken discourse, or do they account also for how silence is used?
Claim #4

Changing team communication habits

Is an intrinsically relational activity

Improving team communication

- Wave of improvement efforts
  - SBAR
  - Handover protocols
  - Surgical pause, briefing
- Pre-operative briefing is designed to ensure info transfer & invite cross-checking


Increasingly good evidence

- Teams can change their communication habits
- Improved communication leads to improved collaborative care


Simple?

- In fact, the evidence is so strong that interventions such as the "OR team briefing" are increasingly assumed to be standard, not innovative.

(WHO Safer Surgery, 2008)
Not simple

- Communication interventions are social phenomena
- They may be tacitly resisted or taken up in adaptive ways
- Many waver after early apparent success
- Rarely do we recount details of uptake processes or failures


Excavating the challenges

- Failure is as good as success for teaching us about uptake
- In one analysis, we studied unintended consequences, or ‘what goes wrong’ in briefings
- 13% contained ‘paradoxical effects’

(Aythe 2008)

Team briefings are intended to diminish professional divisions

but some uptake practices reinforce professional divisions

Implications for IPC/IPE

- New communication routines are a common emphasis in IPC and IPE initiatives
- Uptake of these routines is a social and relational activity
- Uptake is rarely straightforward – subtle adaptations can produce radically different results

This briefing covered significant details about the patient’s history and the operative plan. However, SS gave something of a monologue and didn’t invite contributions from others. CN and AS each interjected at points in the briefing, but SN (a novice nurse) stood at the scrub table and kept her back to the group as she listened. After the briefing, she told (observer) that SS “hadn’t really included” her, so she didn’t want to [appear to be eavesdropping].

(Briefing 94)
Communication is invariably a focus in efforts to promote IPC/IPE
- These 4 claims are intended to push us beyond the descriptive aspects of communication
- To the constructive aspects of communication

Rhetoric can help us shift the way we teach interprofessional communication

Away from our traditional focus on _individual communication ‘skills’_

And towards curricular efforts that acknowledge _what communication does in complex social situations_

Language is not self-evident:
interpretation is (almost) everything.
Communication failures aren’t just a matter of individual ‘skill’:
they arise from rhetorical situations.

Meaning emerges not only from speech but also from silence.

Changing team communication habits is an intrinsically relational activity.

Questions for teams & trainees
- What do we hear when colleagues speak?
- What recurrent situations produce communication ‘problems’?
- How does silence work on our teams?
- What subtle & surprising features of uptake occur when we introduce new communication initiatives?

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