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Healthcare team communication

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Inter-professional interactions

Healthcare team communication

Melinda M. Villagran and Paula K. Baldwin

Introduction

Communication is central to the study of healthcare teams because social interaction creates and sustains team structures and processes. Ideally, members of effective healthcare teams engage in communication to share timely, culturally, and linguistically appropriate health information to achieve team goals. The structure of the healthcare team is typically physician-directed and hierarchical, but optimal patient care requires dynamic and deliberative dialogue among a wide variety of healthcare professionals, patients, and caregivers, using appropriate sociolinguistic practices (Jones and Stubbe 2004). Information dissemination, problem solving, coordination, and affiliation among members of high performing teams are achieved through reflexive, ongoing interaction and shared decision-making (Jones and Stubbe 2004).

Communication also has direct links with patient health outcomes resulting from team-based patient care (Kuziemensky et al. 2009). Interdisciplinary healthcare teams seek to deliver coordinated care through a complex maze of roles, structures, regulations, and contexts with the goal of achieving optimal health outcomes for patients. Recent healthcare reforms place a strong emphasis on use of inter-professional collaboration to achieve cost-effective health outcomes for patients, but all too often health organizations manifest fragmentation and turbulence that limit the capacity for optimal team functioning. Moreover, the complex nature and high demands of health environments require coordination among team members trained in differing aspects of patient care (Kuziemsky et al. 2009), but clinicians do not typically receive formal team communication skills training as part of their medical education.

Contemporary research related to healthcare team communication focuses on two main areas: individual communication skills training for clinicians, and clinician cultural competency. Unfortunately, much of this work fails to tie individual communication skills to the co-creation of team communication, and fails to fully explicate the links between team-based structural and procedural communication processes that improve patients’ health outcomes (Epstein and Street 2007). Research does suggest that ineffective communication among healthcare professionals can result in medical errors, uninformed patients, and missed opportunities to maximize treatment options and health outcomes (Epstein and Street 2007), but specific strategies for effective communication are not particularly generalizable because they rely on contextual issues of each interaction (LWP 2009).

Recent increases in the prevalence of healthcare teams may be related to more and better communication technologies used by health professionals. Face-to-face interpersonal
interactions are now coupled with tools such as electronic medical records, cell phones, and web portals to share information and deliver care. These issues highlight the need to better understand how team communication processes among healthcare providers impact successful healthcare delivery.

This chapter explores historical and current conceptions of healthcare team communication as supported by the sociolinguistic and organizational communication perspectives from the Language in the Workplace Project (LWP 2009). Several critical team communication issues, current contributions and research regarding healthcare teams, applicable research methods for healthcare teams, and recommendations for practice and future directions are discussed. Although the structure and functions of healthcare teams varies greatly, most healthcare teams share the ultimate goals of delivering high quality care to improve health outcomes for patients.

Defining teams

Organizational scholars have long suggested the future of the global workplace will be comprised of interconnected teams (Dodd 2008). Unlike groups that may be comprised of autonomous individuals working concurrently on some task or goal, teams represent a system of interconnected individuals with unique roles, working collaboratively to attain a common goal (Ilgen 1999). Healthcare teams work interdependently to accomplish positive outcomes that are attributed to the team effort, as opposed to any one member’s contribution.

Healthcare teams are distinct from the more general concept of teamwork, which can be used in a broader sense to discuss care provided by more than one member of an organization. Teamwork implies the existence of a functional team, but many studies on teamwork have found remarkably little structure, coordination, or integration among professionals involved in patient care (O’Leary et al. 2010). Specifically, research on the potential for team communication in operating rooms, intensive care units, and general medical units found although physicians were generally positive in their teamwork assessments, nurses felt communication and true collaboration with physicians was suboptimal or nonexistent (Joint Commission 2007; Nicotera and Clinkscales 2010; O’Leary et al. 2010). Some healthcare professionals reported a lack of shared decision-making about team processes among members. Specifically, nurses often served as a liaison between physicians and patients, but generally did not feel empowered to define or perform this role. Since a lack of teamwork among healthcare professionals is associated with more medical errors, and less favorable patient outcomes, a greater emphasis on team training, and the integration of teamwork into more structured healthcare teams could be beneficial (Joint Commission 2007; O’Leary et al. 2010).

Current conceptualization of team communication

Much of the literature on organizational communication struggles to acknowledge differences between organization-as-noun, which conceptualizes the structure of organization as a being or entity in-and-of-itself, and organization-as-verb, which focuses on relevant processes and activities that constitute a team (Putnam and Nicotera 2010). Similarly, despite a growing body of research on teams in the healthcare context much of this research overlooks differences among team-as-noun (an entity or being in which members work together to achieve a shared goal), team-as-adjective (a special type of cognition, attitude, or behavior among persons on a team), and team-as-verb (discursive and regulatory actions performed to achieve a shared goal).
Team-as-noun research generally focuses on outcomes achieved through the efforts of a seemingly monolithic team, and tends to minimize the importance of discursive practices within the team. Team-as-noun research may also examine the juxtaposition of the healthcare team versus an individual healthcare worker, to determine whether teams are more effective than individuals seeking to achieve the same goal. Comparative research on the effectiveness of teams versus individual healthcare professionals is performed with the assumption that team coordination is achieved through interaction, but team interactions may be difficult for healthcare providers who are used to working more independently.

Team-as-adjective research examines components, characteristics, and classifications of teams. This type of study explores the extent to which team characteristics such as team efficacy or team composition affect team interactions and goal achievement. By considering the personal and professional backgrounds of members, health organizations can seek the best configurations to maximize effective communication (Kozlowski and Bell 2003).

Team-as-verb research recognizes the dynamic processes of communication within a team, and seeks to reveal how team processes are enacted in support of collective goals. This type of research places the greatest emphasis on the communicative constructions of roles, relationships, and behaviors among members.

Historical perspectives

In the past, physicians, nurses, technicians, and administrators have often functioned autonomously in healthcare settings, based on the rules of varying hierarchical structures, professional identities, and personal discursive practices (Ledema 2007). In the last decade however, some health delivery systems such as the US Military Health Service and the Veteran’s Healthcare Administration, have shifted away from an individual healthcare provider model toward team-based systems of coordinated care. Not surprisingly, increases in the implementation of team-based approaches to health care have brought about more research conducted to explore issues related to team processes and outcomes (Crabtree et al. 2010). Team researchers have produced volumes of work on various aspects of teams, including team structures, contexts, and overall team functioning (Mathieu et al. 2008).

Some research demonstrates how team-based health care can have significant implications for the type of care provided to patients, as well as the practice infrastructure that supports patients and providers across the continuum of care (Fields et al. 2010). In the healthcare context, team-based approaches to patient-centered care can produce improved health outcomes for patients, and reduced costs for health organizations, but the body of evidence regarding specific team outcomes is still limited (Fields et al. 2010). Newer team models may draw from the research on communication among interdisciplinary healthcare teams (IDT) in palliative care settings, which have proven to improve patient safety, satisfaction, and health outcomes during the last two decades (Hearn and Higginson 1998). The IDT model of care has been successful in health care because it increases the potential for coordinating patient care across medical subspecialties and professional roles. When teams are adopted as part of efforts to improve patient safety however, the focus on communication among team members is often minimized in favor of assessments of issues such as commitment to safety, attitudes toward stress, and knowledge of how to report adverse events (Sexton et al. 2006).
Critical issues and topics

Healthcare team communication often seeks to leverage information and resources for patient care across a variety of subspecialties. From a systems perspective, each team operates as a set of interrelated or interacting components, with ‘formal and informal connections and relationships among its components’ (Cushman and Craig 1976: 41), and shaped by necessity from the particularly specialized discourse of the healthcare profession itself (Candlin and Gotti 2004). Across time, team structures are constituted by regularities, patterns, traits, and values enacted through discourse among the members (Katz and Kahn 1978). Each specialized aspect of team functioning is a necessary element in the delivery of comprehensive patient health care, so team members’ training and professional expertise, medical subspecialties, academic backgrounds, and professional affiliations shape the nature and goals of interactions.

Specialization and classification

A recent comprehensive analysis of team classification research found three underlying constructs impacting healthcare team communication across a myriad of team taxonomies and types: skill differentiation, authority differentiation, and temporal stability (Hollenback et al. 2012). Each team construct offers the opportunity for successful team communication, but also may contribute to miscommunication or conflict among members. Team skill differentiation is ‘the degree to which members have specialized knowledge or functional capacities that make it more or less difficult to substitute members’ (Hollenback et al. 2012: 94). The interdisciplinary composition of healthcare teams creates differentiation among members based on professional and personal training and experiences. Divergent language seeking to stress power based on skill differentiation was evident in data from Nicotera and Clinkscale’s (2010) study of nurses at the nexus of healthcare teams:

The comment is made, ‘I am an RN. Get a tech to do certain things.’ [it] used to be RNs working side-by-side with the techs. They should be helping each other … They do not work as a team. They need to understand that this is not ‘my patient’ or ‘your patient,’ it is ‘our patient.’

Authority differentiation in teams refers to ‘the degree to which decision-making responsibility is vested in individual members, subgroups of the team, or the collective as a whole’ (Hollenback et al. 2012: 94). Authority differentiation is a major factor in healthcare teams because of laws and professional conventions, which mandate physicians’ decision-making authority as leaders in the healthcare process. Like skill differentiation, authority differentiation may be stressed in team discourse aiming to reinforce power structures among team members (Nicotera and Clinkscale 2010). Marin et al.’s (1994) study of conflict among healthcare teams provided illustrations of conflict arising from boundaries for patient interaction based on authority differentiation. Among nurses in this study, patient advocacy communication was:

‘a no win situation because someone would end up a victim, the doctor or the patient’
‘you’re damned if you do, damned if you don’t’
‘you want to make sure the patient knows what is going on, but you’re not the doctor. It’d probably be a real sticky situation’
‘As a patient advocate ... it’s important to tell them [patients] what their rights are’… but ‘it would get me into trouble with the surgeons.’
The temporal stability of a team is defined as, ‘the degree to which team members have a history of working together in the past and an expectation of working together in the future’ (Hollenbeck et al. 2012: 94). Temporal stability is a significant threat to communication effectiveness among healthcare team members because of the multi-organizational, multi-disciplinary, and multi-functional nature of health care. For example, physicians may routinely work with a healthcare team in a hospital for a period of time, but may not be present in the hospital when the physician does not have patients at the facility. Moreover, hospital staff members who work in shifts around the clock may be members of different teams based on their work schedule. Specialists who are members of a team delivering care for a specific disease, or to a specific patient population, would not be included if the same team cares for a variety of patients with a variety of diseases.

**Synergy development**

Researchers have identified five stages of development of a team, each of which impacts the quantity and type of communication among the members (Dodd 2008). In the first phase individuals come together to form a structural group, but members may lack information or confidence in a shared vision for the group’s long-term goals. Team members begin seeking information from other members regarding the roles, expectations, and intended outcomes of their efforts. In the second phase, team members become more familiar with each other, and communicate about past conflicts or concerns that might inhibit the team’s effectiveness. The third phase occurs when team members gain experience working together as a team. In this phase, team members begin to develop their own normative process for healthcare delivery as a team, and also begin to form expectations about individuals’ personal and professional strengths and weaknesses as a team member. Peak performance of the healthcare team occurs in the fourth phase of team development, when an increase in trust among members fosters shared decision-making and open communication to achieve team goals. The final phase of development is characterized by highly productive and innovative team functioning where members with specialized responsibilities work together at peak efficiency. Teams operating at this level have relational and professional knowledge of each member, drawn from experience working as a team. Ad hoc teams working together for short periods may find it difficult to attain peak efficiency because of undefined roles and a lack of trust in the skills of individual members (Dodd 2008).

Benefits from team-based care may come from the synergistic nature of systems. All systems have synergy, which means the components interact in such a way that team interactions produce care that could not be produced by any one component of the system. Thus far, healthcare team researchers have not definitively identified the best way to maximize synergy through a particular team structure. Instead, the structure and management of individual teams seem to be contingent on the nature of the organizational and regulatory environment, and the specific goals of the team for patient care.

**Interconnected interpersonal interactions**

Interconnected interpersonal interactions are the central mechanism through which teams are constituted, but few interventions directly evaluate interactions among team members (Epstein and Street 2007; Jones and Stubbe 2004). Despite a 2008 call from the Institute of Medicine to, ‘train residents in how to hand over their patients using effective communications,’ few medical education programs place a strong emphasis on team communication skills as
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part of resident education (Institute of Medicine 2008). Despite the lack of team communication training, Kuziemsky et al. (2009) found healthcare team structures are constituted through interactions among members who work together to achieve two core communication goals: internal interactions among team members and external interactions on behalf of the team. Internal communication shaped and reinforced the team’s identity, climate, and cultural norms regarding practices for implementation of policies and procedures. The extent to which individual team members felt empowered in their team roles was contingent upon internal interactions that bolstered mutual respect and shared decision-making among members. External interactions were more likely to focus on issues of workflow and interagency agreement regarding team decisions. Team climate was created by task and relational communication among internal and external parties, and climate was positively associated with team members’ perceptions of their teams’ quality, and patients’ perceptions of the quality of care provided by the team (Mohr et al 2011). Although task climate may be relevant in considering the quality of team functioning, patients’ perceptions of the team’s relational climate may have a greater impact on quality of care measures (Mohr et al. 2011).

**Boundaries**

Teams coexist to achieve shared goals for their patients and membership is informally shaped by boundaries between internal and external forces. There are four general types of team boundaries, each of which has implications for communication between and among members. **Physical team boundaries** include the physical location of teams, the physical technology or equipment used to support team interaction, and any other physical tool or structure used to create secure team interactions. Teams may be co-located in a hallway or wing of a building, or they may use specific software to gain access to team-related tasks and discussions. Some technological channels of communication create impenetrable boundaries that connect team members, and separate the team from the external environment. Computer programs with password protection, for example, are useful only to the extent that all team members have access and knowledge of the program. Members may use face-to-face communication more often for interactions, or may coordinate care using an electronic medical record system. Virtual teams are not bound by any formal or geographical boundaries, but rather work together using technology such as videoconferencing systems or Internet-based communication portals.

Problematic physical boundaries for interdisciplinary healthcare teams may include a lack of access to the same paging system or records system to share information and coordinate care (O’Leary et al. 2010). **Linguistic team barriers** refer to specialized language used among members of the team in interactions with each other. **Systemic boundaries** dictate the rules that regulate interaction among members. Systems are often tied to the professional titles and levels of experience of each team member. The system of medical education, for example, dictates the nature of communication among medical residents, attending physicians, and other hospital staff. Ineffective team system boundaries are a source of consistent miscommunication. Examples of ineffective systems boundaries are teams with unclear role specialization, overlap of responsibilities among members who do not communicate, and a lack of a common communication channel to share information. **Psychological boundaries** restrict communication among team members due to stereotypes or prejudices held by individual members (Ledema 2007). For in-patient teams, research suggests regularly scheduled interdisciplinary rounds can be an effective way to overcome communication barriers that lead to miscommunication among teams (O’Mahony et al. 2007). Increased
collegiality and information sharing during interdisciplinary rounds also contributed to reduced lengths of stay for patients.

Current contributions and research

Member communication creates healthcare team structures that vary based on the team’s goal and the resources available to contribute to the formation and maintenance of the team. For example, many teams draw on individual expertise of members and extend across formal medical professional roles, medical specialties, and types of care. Diverse roles and dispersed boundaries among members increase the importance of streamlined and timely communication among all members.

Implementation of interdisciplinary teams

Some teams function as a unit within a larger organization, such as a hospital or clinic. This type of team may be comprised of individuals who work for the same organization, but whose functional role in the organization is shared among team members. An example of this is the approach of the patient-centered medical home (PCMH) or patient-aligned care team, which has recently been implemented by the US Military Health Service and Veteran’s Administration. The PCMH has been implemented to care for diverse patient populations including those in primary care, mental health clinics, and among the homeless veteran population. The PCMH moves from a model of one physician caring for one ill patient, to a team-based model where a consistent group of providers care for patients by providing healthcare information, promoting prevention, and treating patients. Similar to the nursing model utilized for decades in the US, a PCMH is built by combining aspects of teamwork and patient-centered communication, and includes patients and family members as co-equal partners in their healthcare team and care. The team-based infrastructure of the PCMH means practice patterns across patients can be assessed because the same team serves a whole practice. A key aspect of the PCMH team is that each member plays a specialized role in the total care infrastructure. By shifting responsibility for certain tasks away from the physician to other team members, patients receive more care from more team members, but this shift requires coordinated and regular communication among team members.

Kuziemsky et al.’s (2009) study on interdisciplinary team communication found six core team processes: care planning, information exchange, teaching, decision-making, negotiation, and leadership. Of primary concern was the extent to which external information was shared among team members, and whether members felt empowered to negotiate and advocate for a particular decision or care plan. When teams engaged in shared decision-making and negotiation based on equal access to information, leaders were more likely to emerge in particular instances based on expertise and formal role expectations. Some evidence suggests the synergistic nature of teamwork can help healthcare professionals to make better decisions and reach more accurate conclusions than would be made by any one team member (Hearn and Higginson 1998). External communication processes are highly important to gain information and services from care partners including nursing homes, home health agencies, and medical specialists.

Multi-team systems

Successful healthcare delivery often requires multi-team systems where individuals communicate with members of their own team, and collectively communicate with members
of other teams to achieve a collective goal (Zaccaro et al. 2011). A hospital multi-team system might be comprised of teams of nurses, physicians, technicians, and hospital administrators that are both independent from other teams, and interdependent upon other teams within the larger healthcare structure. Gray defines inter-organizational collaboration such as that required by multi-team systems as ‘the process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible’ (1989: 5). Teams who work together typically require some level of deliberate negotiation and adjustment among members to create mutual goals, make decisions, and gain consensus on the teams’ goals and plan of action. All team members must develop shared meanings by using a common language that reflects the diversity of contributing disciplines and organizational types to achieve a common goal of patient well-being.

**Team research trends**

Research examining all types of healthcare processes often takes place in the academic medicine context. Traditionally, the culture of health care places a greater value on technical proficiency among individuals over interpersonal skills competence. Medical education systems in the US teach and reward individual excellence and individual mastery of medical knowledge and skills, whereas group skills are rarely rewarded. Students receive grades, choose medical specialties, and ascend through their medical education based on individual achievement, and receive little or no training on team-based approaches to health care. Recently, however, renewed interest in practice-based research has spurred an increase in team-building activities during medical residency. Training and education meant to support the conduct of practice-based research may also provide new opportunities to conduct research on aspects of team communication and team functioning in the healthcare context.

Programs with successful research cultures among medical residents report a few common elements that mirror essential components of healthcare teams. First, scholarly activity must be viewed as valuable based on mentoring and modeling from other residents and program leaders. Like healthcare delivery teams, resident scholarship teams must be empowered to define team roles, and to engage in shared decision-making. Formal curricular activities also must include training and experience in the conduct of research, and there must be a team-like support system in place to mentor and assist residents in the research process (Seehusen and Weaver 2009).

Recent research examines the relationship between knowledge and skills gained from practice-based research teams during the medical residency, and attitudes toward participation in healthcare teams for patient care. These findings reveal similarities between the uncertainty experienced among residents regarding practice-based scholarship, and uncertainty among residents regarding shared patient care in healthcare teams. In the context of medical education, both types of teams provide opportunities for research on team-based care planning, information exchange, teaching, decision-making, negotiation, and leadership. In addition, research that assesses team processes and outcomes resulting from team training could provide valuable clues about attitudes and skills among clinicians who participate in team education programs. For example, a recent study examined the extent to which medical students trained in shared decision-making among teams successfully integrated their own communication of medical information and data with the preferences and values of patients and other clinicians on the healthcare team.
Many US health delivery organizations, such as the Joint Commission, the Institute for Healthcare Improvement, the National Quality Forum, and the Accreditation Council for Graduate Medical Education, have cited the importance of teamwork in health care (Baker et al. 2008). The National Defense Authorization Act of 2001 requires the Department of Defense to deliver team training through the Health Care Team Coordination Program, and the Joint Commission recommends all hospitals establish team training programs. These programs offer several new opportunities for research on team processes. For example, the US Department of Defense (DoD), in conjunction with the Agency for Healthcare Research and Quality (AHRQ), developed a comprehensive research protocol to assess healthcare team processes among DoD medical professionals. TeamSTEPPS, which stands for Team Strategies and Tools to Enhance Performance and Patient Safety, is the result of a multi-year research and development project by DoD and the AHRQ. The TeamSTEPPS curriculum is accompanied by a set of measures that tap into team members’ attitudes toward team structure, leadership, mutual support, situation monitoring, and communication (Baker et al. 2008).

A recent analysis of team processes after TeamSTEPPS training examined communication in three high stress labor and delivery units. A combination of didactic training and simulated team activities were used to help participants learn, practice, improve, discuss, and receive feedback on necessary communication skills among team members. In labor and delivery teams, the combination of didactic training with in-situ communication-based simulation exercises led to a 37 percent improvement in perinatal morbidity (Riley et al. 2011). Studies involving didactic and simulation activities could provide formative research for expanded studies of teams engaged in other areas of patient care.

Recommendations for practice

Communication processes among team members serve different functions with a variety of impacts. For instance, research has demonstrated that well-organized patient-centered medical teams had a positive impact on racial and ethnic health disparities through enhanced access to the range of health providers (Beal et al. 2007). Research suggests in some instances minority patients are just as likely as Caucasians to have care when needed, receive preventive screening, and have chronic conditions managed appropriately when they receive care through a patient-centered team model.

Contexts

Communication is contextually bound, so the context of healthcare team communication often dictates the nature of team discourse in a given setting. Recent research examined multiple types of information sharing among team members within the context of an Emergency Room (Thomas et al. 2010). An example of this may be observed in the communication processes that occur with an Emergency Room team in the instance of an infant emergency resuscitation. Information about the event is shared as well as current status of the infant. The communication interaction as to the most likely cause of the distress and probable best course of action is manifested through observations, impressions, opinions, and questions. The team process work using verbal and nonverbal cues and these communication channels result in a team-coordinated intervention for the infant. However, differentiation of communication process is distinguished by the quality of the communication interactions of the team and the eventual outcomes of these processes in the context within which it occurs.
Processes

Team processes are rooted in collaboration among members (LaFasto and Larson 2001), so healthcare teams must be mindful of the process of their interactions. Communication in collaborative teams involves team building, respectful negotiation, conflict management, containment of negative behaviors, and workplace design to facilitate collaboration (Larson and LaFasto 1989). Additional attributes associated with successful team collaboration include willing participation of members, shared planning and decision-making, shared responsibilities and shared power based on knowledge or expertise (Henneman et al. 1995). For healthcare team collaboration to be effective, members must feel safe to communicate with team members to manage conflict and solve problems (LaFasto and Larson 2001).

Outcomes

Kuziemsky et al. (2009) outlined several patient outcomes resulting from team communication processes including reintegration to the family and home environment, adherence to treatment recommendations, communication satisfaction, and achievement of optimal health goals. Team communication processes were also linked to family caregivers’ satisfaction with patient care, and caregivers’ facilitation of discharge planning.

Future directions

Several innovations for improved team communication in healthcare settings are currently changing the nature of how healthcare teams organize, and interact on behalf of patients. Current trends include increased use of interdisciplinary teams (IDT); reflexive practice; situation, background, assessment, recommendation (SBAR); and e-health communication technology to facilitate team interactions. First, use of an interdisciplinary team in hospice end-of-life care is mandated by Federal law (Health Care Financing Administration 1983), and the utility of IDT is increasingly apparent. Medicare requirements dictate regular IDT meetings in order to develop holistic plans of care (Baldwin et al. 2011). In this setting, scholars have applied another model for interdisciplinary collaboration (Bronstein 2003) which demonstrates five main components similar to Dodd’s (2008) model: interdependence between the team members, professional activities created by the team inception, flexibility, collective goal ownership, and reflection on the team processes to address patient and family care.

Second, use of ‘reflective practice,’ where discourse is contextualized (Schon 1983), can create an environment where the experiences and knowledge of the healthcare team members dictate the analysis, problem-solving, and therefore, solutions for the interdisciplinary communication strategies. Reflective practice provides the opportunity for internal and external feedback (Jones and Stubbe 2004), giving scholars a window into the contextual factors of the dynamic team interactions. The use of reflective practices can also serve to overcome the limitations of the communication audit process of diagnosis and prescription (Downs 1988) by allowing input by the practitioners themselves, in this case, healthcare team members. Implementing reflective practices to improve healthcare team communication strategies can serve to reduce the distance between theory and application (Jones and Stubbe 2004).

Third, the SBAR mental model framework is an increasingly popular communication tool in the US and Great Britain to improve patient safety and healthcare team communication.
SBAR – situation, background, assessment, and recommendation – was originally developed for use by flight crews in the US Navy. It was later imported into the healthcare field by employees of Kaiser Permanente to provide a routine structure for patient handoffs between shifts at hospitals (Haig et al. 2006). The goal is to limit extraneous and repetitive information during team interactions, and focus on four key issues that highlight necessary actions by team members. The following example comes from the Institute for Healthcare Improvement, and emphasizes the basic content and structure of SBAR:

- **Situation**: ‘Dr. Jones, I have a 55 Y/O Man who looks pale, sweaty and is complaining of chest pressure’
- **Background**: ‘He has a history of HTN, admitted for GI Bleed received 2 units, last crit two hours ago was 31 his vital signs are: BP 90/50, Pulse 120’
- **Assessment**: ‘I think he’s got an active bleed and we can’t rule out an MI but we don’t have a troponin or a recent H&H’
- **Recommendation**: ‘I’d like to get an EKG and labs and I need for you to evaluate him in right away.’

SBAR offers several potential benefits to improve team communication. First, SBAR may help reduce medical errors caused by ineffective team communication by providing a routine and expected structure for team interactions. Second, the cognitive load of team members delivering information in a patient handoff or meeting may be reduced as use of SBAR becomes a routine practice over time. Routinization means using the framework diminishes uncertainty regarding which information needs to be conveyed to a team member caring for the same patient.

Fourth, and finally, team members are increasingly connected through virtual channels intended to improve interaction among team members, but certain mediated communication channels may actually serve to limit the need for interpersonal contact to achieve group goals. For example, providers now share information about patients using asynchronous communication such as electronic medical records (EMR) to coordinate care and medical decision-making. The proliferation of EMR facilitates virtual teamwork by allowing each team member to contribute to the record based on their individual task roles, and their individual experience with the patient. The running record can then be shared virtually among team members as a way to update each team member on the patient’s progress and current health status. Research suggests virtual teams may experience less conflict and a higher level of performance than teams who communicate via face-to-face communication.

**Related topics**
Healthcare teams; organizational culture; interdisciplinary health care.

**Further reading**


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References


