

II—TASKS AND SKILLS IN INTER-PROFESSIONAL COMMUNICATION AND CO-OPERATION

JACK DUNHAM

School of Humanities and Social Science, University of Bath

There are frequent criticisms that the resources which are available to meet the needs of the handicapped are not being used with optimum effectiveness because of poor communications between the professional workers who provide the services. Reports have been published which suggest that the problem is increasing. These are good grounds for examining the possible causes of poor inter-professional communications and for discussing ways of promoting better co-operation.

1. The Problems of Poor Inter-professional Communications

The consequences of communication difficulties in the field of mental health have been reported in detail by a practising psychiatric social worker and psychiatrist (Kenny and Whitehead, 1974):

“Any rapid and effective communication between separate but interdependent branches can expect occasional problems, but the health services in general and the psychiatric services in particular seem to develop more than their fair share of them. These problems affecting the progress and outcome of a mental disorder arise directly from failures of communications between the branches. Some of the more common difficulties for patients and relatives are listed below. In a different field of work they might be called demarcation disputes.”

“(i) The family doctor and some social workers disagree about the nature of the patient’s problem. Each of them pursues his own line of intervention to the bewilderment of the patient. (This situation can apply with any combination of the three professionals involved—family doctor, psychiatrist and social worker.)”

“(ii) The psychiatrist refuses to refer any patient to local authority social workers because he cannot control their activities and uses nurses instead for all follow-up work, whether or not they are appropriate people for the job.

The overall effect of these situations is to make the patient and his family feel that they are being treated like parcels rather than people” (Kenny and Whitehead, 1974).

The headmaster of a hospital school has noted some of the difficulties between GP’s and hospital doctors:

“There are often large areas of mutual ignorance. The family doctor, for instance, rarely encounters certain of the conditions of mental handicap and has such a poor channel of communication with the hospital-based specialist that he seeks to give assurances to the patient which are ill-founded and often dangerous. Moreover, he is often expected to initiate certain activities or treatments which his colleagues assume are his responsibility but which he does not perceive to be part of his role.”

The British Institute of Social Welfare has commented on the problems experienced by social workers concerned with the Social Services. In its (1974) report of the proceedings of a Conference of Professional Organisations the participants’ experience of communication difficulties was shown to be quite general:

“There was a complete unanimity that communication in the Social Services was completely inadequate, and in some cases non-existent. This inadequacy was

universal, and to the detriment of the services, the operating staffs and the ultimate consumers. It applied in relations between administering bodies, between departments of those bodies, between the disciplines in the departments and even between the strata of employment within those disciplines."

A research worker at Newcastle University has noted the effects of these difficulties in the field of child care. He is engaged on "A Study of Inter-professional Relationships in the Services for Children in Difficulty." In the summary of his research he wrote:

"After being personally involved in inter-professional supportive work for a number of years, it has become obvious that there are a great number of frustrations and disfunctions which point to the need for investigation into inter-professional co-operation" (West, 1974).

2. The Causes of Poor Communication

West has identified five causes of poor communications:

(i) Each professional group approaches a client's treatment from the point of view of its own professional perspective.

(ii) Differences exist between the services in the explanation of how clients' difficulties come about. Whether such difficulties stem mainly from individual failure or from social influences is often an area of deep disagreement.

(iii) Semantic difficulties at times can exacerbate these inter-professional differences; for example, the term "judgment" can be used by some supportive professions as a neutral term intended to imply an objective assessment of an individual's situation, while for others the term can involve a moral statement.

(iv) Sheer ignorance of another profession's purposes and procedures are major stumbling-blocks to co-operation.

(v) The question of confidentiality presents a dilemma to close inter-professional co-operation. Social workers have an immense amount of confidential information. They are sometimes reluctant to share it with other professional workers and co-operation is hindered (West, 1974).

An additional cause of poor co-operation has been reported by a psychiatrist with much experience in the development of teamwork with multi-disciplinary teams. He explains the communication difficulties which he has encountered in terms of professional group loyalties:

"Agencies and work organisations seem to resemble families in possessing collusive systems to avoid insight and change to a much greater degree than I had anticipated, not only because of emotional pressures on new members to share the agency's ways of perceiving themselves and others, but even more because of the unconscious mutual selection process, akin to that occurring in or with similar psychopathology" (Skynner, 1974).

This pessimistic conclusion about like selecting like and thus reinforcing group identities and maintaining differences in inter-group perception is a clear indication of the socialisation process which occurs when a student after training joins his professional group. I was socialised into my psychologists' group by my Senior Psychologist who described in amusing detail the behaviour of the psychiatrists and social workers in the Child Guidance Clinic.

Skynner's conclusion would now be challenged on the grounds that the entrants to psychiatry, social work, psychology and teaching appear to have ideas about their roles which are quite different from the role descriptions of their older

colleagues. These differences between the younger and older members of the teams may create further difficulties of communication and co-operation because of different perceptions of their roles. Young psychologists may refuse to be only "test-bashers," and recently trained social workers may be very critical of the traditional diagnostic "labels" used by their older colleagues.

One important consequence of these changes has been noted by Bland:

"When professional workers are reared under certain paradigms it is possible to identify by means of professional qualifications the person appropriate for the particular task. In the social services the question of qualification and professional expertise is still a hazy area and the clouds are very slow to clear."

In hospitals major changes are required in the perceptions and attitudes of doctors, administrators and social workers because of recent developments in the nursing profession, which have included integration of patients and staff of opposite sexes on the wards; changes in the physical appearance of the wards; increased contact with the community and with community workers as a result of an "open-door" policy.

There has been a significant shift in the self-image of nurses which is leading to strong demands for changes in their working conditions and professional relationships. This development has been fostered by the changes in the administrative structure in the hospitals. One of the most important changes has been a decentralisation of the authority system for nurses with the termination of the Matron's role and its replacement by a more diffuse system of nursing officers. The autocratic management of nurses has slackened at the same time as they have developed a largely unexpected sensitivity to their status and power. Doctors and psychologists who have been used to having the nurses as their handmaidens in hospitals are now required to cope with very different attitudes. The adjustment required of psychiatrists and psychologists so that an effective dialogue can begin with the nurses is considerable. They may find it difficult to adjust to an image of nurses as militant union members. They are experiencing conflict and frustration. One Senior Psychologist told me that he spends most of his time attempting to cope with inter-disciplinary negotiations which are concerned, in the main, with staff relationships. Most of the difficult situations which these negotiations are attempting to solve involve the nurses rather than the psychiatrists or the social workers, who have not changed their perceptions of their roles as quickly as the nurses, though the former are now experiencing considerable uncertainty about their roles. The conflict situations involving nurses include for instance refusing to collect data for the psychologists' behaviour modification programmes and not attending ward meetings.

Recent research suggests that these inter-professional difficulties may be associated with stress within the nursing profession. One study was conducted amongst three groups of nurses at the Westminster Hospital. Those interviewed in the first group were student nurses, who said that the Sisters rarely talked to them and when they did it was to issue orders and criticism. Student friendship groups which had started to develop as a result of shared experiences in the early part of the training courses, were broken up by individual placements on different wards. This resulted in further communication difficulties and feelings of isolation, so that there was only a minimum of support from among the nurses themselves to help each other cope with the difficulties of learning new skills.

The nurses in the middle levels of responsibility and authority within the hospital administrative hierarchy reported that they felt a "heavy sense of responsibility" to patients, doctors and administrative staff. They attempted to bridge the frequent gaps in communication between these groups.

In the third group were the nurses who had risen to the top management positions in the hospital. They were separated from their subordinates by their offices and segregated dining rooms so that they had little contact with the middle and junior grade nurses (Duff, 1974).

This report suggests that the effects of reorganisation on the communication processes amongst nurses may be so severe that they may become preoccupied with them at the expense of their relationships with other professional groups.

A report of Staff Attitudes and Opinions in the London Hospital Group supports these conclusions:

"A striking feature of the survey concerns the desire most nurses have for a large element of participation in the decisions which concern them at work, and an increased amount of consultation by other staff, such as medical staff. Consistent with this, nurses have a number of criticisms concerning communications and co-operation with other groups of staff. The area of consultation and participation and the closely-linked area of co-operation and communications amongst nurses and between nurses and other groups of staff is among the most important uncovered by the survey" (Hughes, 1974).

3. Improvement of Communications

Some of the major tasks in the improvement of inter-professional communication have been set out in the working paper produced by the Brunel Institute of Organisation and Social Studies in 1976:

"How can better working links be established between various practitioners, for example, doctors, nurses and social workers who are concerned in the same cases? How can better communication patterns be established; better co-ordination and continuity; more cross-fertilisation of ideas; more opportunities for explaining and demonstrating the specific and different contributions of the various professions and emerging professions?"

There is a strong belief in the effectiveness of contact between the members of different professional groups in the improvement of communications. Unfortunately some forms of contact, as for instance in case conferences, may not be very helpful. These multi-disciplinary experiences may reinforce the perception of intransigent fellow-professionals who are jealous of their professional boundaries. When I worked in a Child Guidance Clinic I was very aware in the Weekly Case Conferences of the expectations from my colleagues to keep within my psychologist's role and present information about intelligence, attainments, attitudes and personality. If the child I was interviewing talked about his home background I omitted his comments from my report.

Bland has also perceived these sensitive boundaries in case conferences:

"On some occasions when case conferences have taken place with nursing staff it has been obvious that the charge nurse has felt himself to be under assessment and has ignored the value other professionals placed on his contribution. I have found that, however good the relationship being built up, the merest breath of criticism is sufficient to reveal concealed or repressed antagonisms."

Contact as in joint conferences may not be any more helpful in modifying unfavourable stereotypes. In the last two years I have organised joint conferences for teachers and social workers concerned with socially disadvantaged children. Not many social workers attended one of these conferences. Perhaps they were too busy.

Perhaps on the other hand they thought that the teachers' perspectives were too different from their own for effective discussions to take place.

The other conference revealed considerable differences, not only in the perspectives of these groups of professional workers towards disadvantaged children but also towards each other. The teachers thought that the social workers paid too much attention to home and community factors and not enough to what could be done in school. The social workers thought that the teachers largely ignored the significance of factors outside the school. Inter-disciplinary co-operation may not have been fostered by this experience, which may have instead confirmed the stereotypes each group has of the other.

A more optimistic outcome of a multi-disciplinary conference has been reported by Zwerlin (1976). It was carefully planned by a steering committee and was composed of people with experience of working in "mental health teams" in community mental health centres in which there had been a "clash, collision, confrontation and mutual and reciprocal education." Zwerling claims that in this conference, "Much was accomplished in spite of profound differences and conflicts, because there was a bond of mutual trust, however strained at times and however frequently tested."

An intensive attempt to improve inter-professional working relationships has been reported by Skynner (1974). His team from a Child Guidance Clinic—psychiatrist, psychologist, psychiatric social worker and child psychotherapist—visited a comprehensive school every month for two years to discuss with the staff the pupils who were problems in the school. Skynner discusses the contact and interaction between the teachers and the clinic team as the experiment progressed:

"At our first meeting there was a large attendance, perhaps about 30 teachers in all. There may have been a feeling among the teachers that the large group situation was too chaotic because the senior staff altered the arrangements for our second visit without prior agreement or warning. Only four teachers were present and it was explained to us that they were the only ones concerned in the case. The third visit brought a crisis. We arrived on time to find the library, where we held our meetings, locked, while the teachers were still eating and paid little attention to our presence. We were late starting and exactly as the session was due to end, a second case was raised which took us ten minutes over our time. Two of my colleagues arrived ten minutes late to the staff conference which followed at the clinic, saying that they had needed extra time to finish their lunch; but they refused to accept any suggestion on my part that their lateness had any connection with their feelings over events at the school."

This incident caused him to question his own role as team leader: "At this point I perceived that the use of authority within the team was in no way incompatible with the maintenance of adult professional relationships. I had for instance not only a right but a duty, as head of the clinic, to demand proper time-keeping at clinic conferences if everyone was to benefit from them. It was clear that my management of the situation was threatening the project with breakdown and leading individuals to set up their own boundaries because those I was providing were inadequate."

This clarification by Skynner of his role *vis à vis* the clinic team and the teachers appeared to lead to a lessening of their uncertainties about their professional relationships. Their confidence to offer contributions increased. Their capacity to tolerate open disagreement grew.

These developments were not continuous: "A marked advance would often be followed by a partial regression, a well-attended and lively session by lateness, absence and seemingly unrewarding interchange. In one session we found ourselves

once again locked out, the teachers eating; almost everyone was late, with no excuses made; and the discussion of cases seemed inconclusive and marked by indifference and fragmentation, people often talking together in twos or threes."

A follow-up visit to the school made by Skynner and the psychologist enabled him to report that:

"Staff spoke of the ability they now had to share problems and communicate about them, as well as the confidence they now possessed that they would cope. It was, however, impossible to decide how much our meetings had contributed to this improvement."

The contributions of the Educational Psychologist to the maintenance of good communications appears to have been very important. Skynner reports that "He frequently played a vital role in linking us, perceiving where difficulties of communication might be and clarifying the difficulties of each side to the other."

This is an excellent definition not only of the role of a psychologist in a school staff-clinic team experiment but of the role of a negotiator in a whole range of inter-group situations. The analysis of the significant differences in perception and understanding which doctors, administrative teachers, social workers have of each other for communication barriers which may lead to frustration and anger is an important contribution to the reduction of these barriers to the level at which messages can pass between the members of the professional groups. A negotiator may not be able to remove all conflict and misunderstanding. But he can help to reduce them to functional levels.

Skynner's investigation also indicates another important factor in the reduction of inter-group conflict and establishment of good professional relationships. There is evidence that conflict in organisations can be reduced by shared experiences in groups if the members accept the necessity of working together because their tasks cannot be accomplished by departments or teams working separately. These common tasks have been called "superordinate goals" by Sherif (1967) because they override the limited perspective of any one section of an organisation. Shared social activities, for instance skittles challenge matches, are usually inadequate for this purpose.

One of the most effective superordinate goals, as Skynner found in his investigation, is to work together on common problems. When I worked for the Bristol Aeroplane Company I organised residential courses for managers from many different departments of a wide range of organisations. In their groups they attempted to resolve the communications problems which they experienced at work. Details of their difficulties were given to me before a course started so that I could prepare the group work materials. For one course I received three reports:

(i) Administration Officer—Financial Accounts

I find difficulty in adjudicating between opposing views of different factions of my staff. While adopting one view I do not wish to reject the opposing view in such a way that animosity is caused, thus resulting perhaps in a degree of insularity between such factions. I feel that this could result in a reduction in the efficiency of the Department for which I am responsible.

(ii) Contracts Administrator

I found difficulty in motivating people to accept changes in works procedures and systems.

(iii) Experimental Chief Planning Engineer

I am experiencing difficulty with staff who are ill two or three days a week on a regular basis, thus affecting the efficient running of the department.

These courses also revealed the marked bias which the managers had developed in the course of their work. Two shortened evaluation reports which were written at the end of one course suggest a possible modification of attitudes:

(a) A Manager in a purchasing department wrote: "For me the greatest value of the course lies in the intangibles, the result of group discussions and informal writing and talking. It has swept away my typical office attitude of those obstructive, unintelligent buggers down in the shops!"

(b) A Manager in a production department commented: "Technicians, who appeared to me to be 'Johnnie-Head-in-Clouds,' living in a world of their own, now appear more closely defined as individuals with problems more closely akin to my own. This has partially broken down, in my mind, that vague barrier separating the technical bods from the, dare I say it, the peasants" (Dunham, 1972).

There is a possibility that these changes may not survive the Manager's return to his own department for there is clear evidence that the effects of joint courses on inter-departmental (or inter-professional) attitudes depend to a great extent on the attitudes and expectations of the Manager's departmental colleagues. If these are unfavourable to improved communications with other departments there will be pressure to conform and forget the favourable experiences on the recent course (Katz and Kahn, 1966). On the other hand if two members of the department attend the joint course at the same time they may be able to resist these conformity pressures to a much greater extent. Continuing links between the course organisers and the people who have shared these joint experiences are also helpful in maintaining the impetus for improved communications with an organisation (Sherif, 1967).

A major goal of joint courses should be the opportunity of learning a common professional language. The importance of this development has been argued by a number of writers:

"The various professions concerned with children; doctors, psychiatrists, social workers and teachers should have the ability to understand each other's language. The education welfare officers could play a lay part in bridging gaps of understanding between the shades or language used by members of different professions" (Dennett, 1974).

Milson (1974) has suggested that the tutors responsible for joint courses for teachers and social workers, "should be bilingual, able to understand and speak each other's language without forgetting their own."

Hoghugh (1966) has noted that psychologists and psychiatrists often use such terms as "impulsive," "immature," "unstable," "psychopathic," etc., in their professional reports as if there was general agreement about their meaning. He argues that, "The ultimate justification for such usage is that we cannot at present do without these terms and that in any case other professionals understand what is meant by the terms used. Professional training imparts a conceptual framework which is shared by people trained in the same disciplines."

Language can also be used as an indication of group membership and a passport to acceptance. Entrance to the group is restricted to those who know the language. Terms such as "defence mechanisms," "rationalisation," "interpretations" and "introjection" may be used as an indication of special training and knowledge.

Each professional group has its own private language which is dismissed as jargon by the members of other groups. One hospital chaplain expressed his distaste for hospital language very succinctly:

"I had been informed by telephone that the stomach wound delivered the night before had died at five-thirty a.m. I had looked in on him late at night, but he had still been only semi-conscious, as he had been since his arrival by ambulance. (I feel that I should apologise at this point for using the hospital jargon by which wounded men are referred to as 'the femur' or the 'lung wound,' so that one hears phrases such as 'The ulcer in 26 is being put on a special diet.' It is a frightful way of talking and I shall do my best to avoid it") (Goes, 1951).

Brewer, a psychiatrist, has reported on his efforts to make his professional communication skills as a psychiatrist more effective:

"In practice, I find that a great deal of psycho-jargon can be dispensed with to the benefit of patient and practitioner alike. The majority of psychiatric work involves eminently understandable misery and there is no need to use terms like 'depression,' 'neurotic' and 'psychopathy' when homelier words like 'unhappiness,' 'anxiety' and 'undesirable personality traits' will often—though not always—do as well" (Brewer, 1975).

Kushlik (1975) has strongly argued for the importance of organisational skills in inter-professional co-operation. He claims that the satisfaction of each handicapped person's needs can only be achieved by the analysis of sub-goals and the recognition that each worker has important tasks to perform. The identification and achievement of these tasks may best be accomplished in inter-professional teams.

The development of the skills to complete these tasks effectively and to the satisfaction of the workers concerned is an essential aim of initial and in-service training. The skills of inter-professional communication and co-operation which have important linguistic, negotiating and job analysis aspects, should have top priority.

Summary

There are major problems of communication and co-operation between the professional workers who are concerned with the care of the handicapped. These problems are caused by differences in priorities and language and by ignorance of the aims and procedures amongst those people who should be working together to provide an integrated service. There are barriers to the necessary flow of information between the workers because of caution over confidentiality and on account of strong professional group loyalties. Major changes have taken place in the nursing profession which have resulted in a critical re-appraisal of roles and status within the profession and in the relationships with colleagues, and which has led to difficulties in inter-professional communication and co-operation.

Better links between doctors, nurses, social workers, teachers, non-professionals (volunteers), administrators, landladies, probation officers and psychologists can be developed but not necessarily in case conferences or joint training courses at the in-service level. There is evidence that communication barriers can be reduced if the workers acknowledge the necessity of working together to identify and to achieve common tasks. The skills of working in an integrated rather than a divisive manner include the development of a shared language, the analysis of "caring" into sub-tasks, and understanding how to conduct the process of negotiating. These skills can be learned.

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