Partnership or Prejudice

COMMUNICATION BETWEEN DOCTORS AND THOSE IN THE OTHER CARING PROFESSIONS

A collection of essays by members of a Nuffield Working Party on Communication

EDITED BY

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AND

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Introduction

JOHN WALTON AND
GORDON McLACHLAN

Introduction

IN 1972, IN ITS ROCK CARLING MONOGRAPH SERIES, THE NUFFIELD Provincial Hospitals Trust published *Communication in Medicine* by C. M. Fletcher. Subsequently the Trust became increasingly concerned with, and aware of, the practical consequences of failures of communication in the National Health Service and a Working Party was established in 1980 under the Chairmanship of one of us (John Walton) in order to explore this matter.

The Working Party began by holding a series of seminar discussions involving doctors working in many different branches of medicine, both in hospitals and in the community, as well as members of other caring professions. They noted first that communication between doctors and patients was often imperfect and that it could even lead to faulty diagnosis, or at least to misunderstanding. Some patients were dissatisfied about the information they were given and consequently complained about their management, while others often failed to follow the advice they received. Recent research on methods of teaching communication skills was reviewed, as were methods of assessing the acquisition of those skills. The early deliberations of the working party led to the publication of *Talking with Patients: a Teaching Approach* in 1982; this booklet described first the interview, giving reasons for, and evidence of, poor interviewing and methods of improving it; it then discussed the exposition, considering the failures in it, the reasons for them, and methods of producing improvement. We have noted with pleasure that many medical schools are now teaching communication skills and are making copies of the booklet available to clinical medical students.

In the second phase of its work, the Working Party went on to

examine communication between doctors. In 1984 it published *Doctor to Doctor: Writing and Talking about Patients*, a collection of essays which highlighted problems that had been identified in communication between GPs and hospital doctors, communication between doctors in different departments within the hospital, in administration and related spheres, and other relevant issues. It noted that stories about misunderstandings and mistakes caused by careless clinical requests, notes, and letters were often recounted by doctors in casual conversation and were attributed, sometimes with merriment, to curious idiosyncrasies of other doctors from which the discussants felt themselves to be free. The fact that it was sometimes the patient rather than the doctor who might be most inconvenienced or even harmed by these mistakes was often overlooked. In an epilogue Dr Charles Fletcher skilfully deployed, analysed, and annotated the steps which must be taken to improve communication between doctors in all branches of medicine to their mutual benefit and, above all, to the benefit of their patients.

Throughout the deliberations which led to the publication of these two books, evidence continually emerged to indicate that similar problems in communication frequently arise between doctors (in whichever field of medicine they work) and those in the other professions upon whose collaboration and goodwill so much of good medicine depends. Similar problems clearly arise whatever the profession concerned. The list, including, for example, clinical psychologists, dietitians, drug firm representatives, health visitors, hospital and family practitioner committee administrators, medical laboratory scientific officers (as well as those working in electrocardiography and clinical physiology), medical physicists, midwives, nurses, occupational therapists, pharmacists, physiotherapists, radiographers, remedial gymnasts, secretaries, social workers, speech therapists, and many others, is potentially interminable. And it is easy to forget the ambulance drivers and attendants who transport patients to and from hospitals and who welcome (and deserve) praise and thanks, as do the often hard-pressed hospital telephonists who provide a key link in the communication chain and seem at times to experience unforgivable rudeness, even abuse. However, the principles of communicating with any one of these remain fundamentally the same, even though the dangers and

consequences of poor communication plainly vary depending upon the profession concerned. Nevertheless, in greater or lesser degree all represent important components of the health care team and failures of communication between doctors and any one of them may on occasion have serious consequences for patient care. In all such settings, the fundamentals of good communication remain the same, being based upon clarity and brevity of information presented, whether verbally or in writing, and also the avoidance of significant errors of omission or commission. But even these failings are less serious than a failure to communicate at all except through third or fourth parties, when the risk of error or mis-interpretation inevitably rises.

To have produced a third book dealing comprehensively with all of the potential problems which emerge when doctors and the members of 'the greater medical profession' talk to, write to, or bombard request forms or reports upon one another would be an impossible task. In this book we concentrate upon points of principle by highlighting in the essays which follow the defects in communication skills which doctors, and members of a selected few of the other health care professions, have identified in each other and by suggesting some remedies.

We must stress that this third and final book in our series has been written by doctors for doctors, but with the benefit of the advice of members of many other caring professions. Before embarking upon our task, we consulted many individuals known to the members of the Working Party who we thought would be capable of giving us cogent and carefully considered advice. And so it proved. Prior to final publication, we have sought the opinions of our advisers upon each of the individual essays and are grateful to them for the help that they have given, appreciating, as they and we do, that this book might have been very different in form and content if it had been based upon joint essays written with them. The decision that we should concentrate upon the education of the medical profession was ours; nevertheless, we hope that members of the other caring professions may find it useful in demonstrating that doctors are becoming increasingly aware of the needs, abilities, strengths, functions, aspirations, and attitudes of the other caring professions with whom doctors come into contact in the course of

their everyday professional practice, whatever its nature. We therefore wish to acknowledge the help of:

Professor ROSEMARY CROW, Director of the Division of Nursing Studies, University of Surrey.

Miss ELIZABETH DREW, University Hospital of South Manchester.

Dame CATHERINE HALL, former President of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

Dr PETER HUXLEY, Lecturer in Psychiatric Social Work at the University of Manchester.

Dr SUE PEMBREY, District Clinical Practice Development Nurse to Oxfordshire Health Authority.

Mr BRIAN ROYCROFT, Director of Social Services, City of Newcastle upon Tyne.

Miss JOY YOUNG, Regional Nursing Officer, Oxford Regional Health Authority.

The help of many other correspondents is acknowledged in subsequent pages.

In the light of the comments and advice we received, the Working Party decided, as with *Doctor to Doctor,* to apportion the tasks of writing individual essays between its members. Hence in the essays that follow Paul Freeling writes about communication between doctors on the one hand and nurses, midwives, and health visitors on the other; Bill Whimster discusses communication with non-medical scientists and medical laboratory scientific officers in the various laboratory medicine departments of our hospitals; Ian McColl deals with communication between doctors on the one hand and physiotherapists, occupational therapists, and secretaries, on the other; and Neil Kessel considers relationships and communication with social workers, both in the hospital and in the community. John Walton was given the task of dealing in his essay with communication between doctors and a variety of other health care professionals, accepting that his consultations and hence the content of his essay would be selective. The Working Party decided that it would be important to concentrate upon those professions which come into direct contact with patients and hence to

exclude communication with lay administrators not directly involved in patient care. In his essay, therefore, John Walton deals particularly with clinical psychologists, dietitians, medical physicists, and pharmacists, while accepting fully that in confining his discussion to these particular professions there were many notable omissions such as, (to quote but two examples) radiographers and speech therapists. Nevertheless, it was felt that this selective coverage would allow a reasonably comprehensive discussion of the communication problems which arise and that it should be possible to derive from these consultations some general principles of relevance to all of the remaining professions not separately identified.

The reader of the essays which follow will at once recognize that in each of the situations described, problems relating to the attitudes of the various professions to one another continually emerge and that many issues arise which are not directly related to communication as such. Thus there are comments upon what is seen as the somewhat autocratic and dominant role assumed by the medical profession, perhaps based upon the long-standing tradition and general acknowledgement in the past that the doctor was the leader of the health care team, a view now being increasingly challenged by members of the other professions. Thus we were made increasingly aware that assumptions by some doctors of a 'superior-subordinate' relationship between the medical and other professions has caused resentment, often tainted by envy, which is also coloured by the higher earnings of doctors and their (at times) overt and unquestioned view that they belong to a higher social stratum than do some of those with complementary caring roles. Similarly, it is evident that because of increasing demands for greater autonomy and independence in action by the other professions, many doctors have seen their traditional role as being under substantial threat at a time when they continue, reasonably, to require that ultimate clinical responsibility rests with them. To doctors this view is self-evident, but it is being increasingly challenged. To some it might have seemed appropriate to omit all issues relating to attitudes but the Working Party concluded that problems of this nature inevitably colour communication and affect its quality. For this reason and because inter-relationship has so powerful an influence upon morale, discussion of

attitudes has been retained in each of the essays. These issues have also highlighted another relevant factor, namely that staffing levels (for example of physiotherapists, occupational therapists and dietitians) in the Health Service are plainly insufficient for members of such professions to be instantly available for advice (thus it is plainly impossible for all overweight individuals to see a dietitian). Hence a doctor may be compelled to give advice which the other professions regard as potentially infringing the role for which they have been trained.

As mentioned above, the Working Party decided deliberately not to deal specifically with communication between doctors and lay administrators in the Health Service, even though new arrangements being introduced for management in the National Health Service are clearly influencing inter-professional relationships and are particularly affecting doctors and nurses. One hospital secretary has said 'my job is to serve 100 consultants, 96 of whom owe allegiance to God, and four of whom do not accept even that limitation' (1). With this thought in mind we took particular note of the thoughtful comments made by Mr Michael Ruane, District General Manager of the Central Manchester Health Authority, who wrote:

> I suspect that doctors share with other specialist groups in society problems of communicating with those who do not share the same knowledge, experience or outlook. . . . I have observed that doctors communicate differently when, for instance, dealing with social workers than when dealing with psychologists. . . . I also suspect that doctors within each major specialty exhibit different communication patterns and problems than those in other specialties; it also seems at least possible that the age of the doctor may have an effect upon the way in which he communicates with other professionals.
>
> It seems to me that in discussing communication, three components should be isolated, namely the process, the content, and the context. By process I mean how communication takes place, i.e. is it written or oral, formal or informal? Content is self-evident in that it describes the nature of the information being transmitted, i.e. fact or

> opinion, technical or general? The context refers to all the background elements which mould people's attitudes, understandings, and perceptions of those with whom they communicate. I can recollect occasions when a doctor adopted an aggressive posture in seeking information or advice from an administrator based upon his prior view that administrators were there principally to frustrate progress and to apply inflexible rules.
>
> I believe that the attitudes and perceptions which both parties have about each other may influence communication for better or worse and am reminded of a quotation from an author whose name I cannot recollect: 'I cannot understand what you are saying because what you are rings so loudly in my ears'.
>
> There is a danger when selecting a topic like this that we go in search of problems and inevitably find them. Communication is so central and important in any human activity that its significance cannot be over-estimated and it is impossible to achieve perfection. There must therefore be a sense of perspective about the nature and scale of communication problems between health care professionals which are all too easily exaggerated. It is natural to focus on the difficulties and short-comings and to forget the countless occasions when communications have been successful.

The Working Party can do no more than to echo and endorse the wisdom of these words, and hope that this book will help both doctors and the other health care professionals with whom they work. Perhaps it will highlight the problems which they identify in their attitudes towards, and perceptions of, each other and the detrimental effects which these can have upon communication, mutual understanding and support, each of which is so important in the interests of their patients, their clients and of society. We hope that in consequence they will be enabled to understand and to correct or overcome them.

REFERENCE

1. HAMPTON, J. R. (1985). 'Innovation and Inertia in the NIIS', Editorial, *Hospital Update*, 11, 731.

Communication between doctors and nurses

PAUL FREELING

Communication between doctors and nurses

INTRODUCTION

THE NATIONAL HEALTH SERVICE IN ENGLAND EMPLOYS MORE than 60,000 doctors and more than 370,000 nurses. The ratio of nurses to doctors is much higher in the hospital services than in the community and this affects the relationships which exist between the two professions in these two very different environments. Wherever they work, members of both groups try to provide for their patients the highest possible standards of care and all are aware that a patient is likely to suffer when communication between carers is poor. As Dr Susan Pembrey, District Practice Development Nurse to the Oxfordshire Health Authority points out, 'Different health care professionals are deliberately created to bring perspectives, skills, and knowledge to patients.' Communication is the key to understanding, valuing, and using different professional contributions effectively. Differences should be a source of benefit, not conflict.

CONFLICT AND ATTITUDES

That conflict can and does exist between doctors and nurses in the community was emphasized by Dame Catherine Hall, former Chairman of the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting. Dame Catherine writes that problems in communication between doctors and nurses 'militate against the best interests of patients/clients' and

takes the view that 'the type and tone of communications between professionals are influenced by attitudes and relationships'. She points out that there are notable exceptions which 'are normally the result of full understanding of respective roles, mutual respect, and an appreciation of the contribution which each professional makes to the total care of patients and clients'.

WORKING IN A TEAM

The theme of attitudes and the way in which they 'colour the nature of any relationship' is taken up by Professor Rosemary Crow, Head of the Division of Nursing Studies, University of Surrey, who adds an outline of the problems of working as a member of a team. She writes,

'So often teams are formed and doctors then think of themselves as the 'Leader', without being able to use the contributions of others. Partly this is a problem of lack of social skills, but again influenced by their attitudes to others. What needs to be learned is the ability to listen to the contribution of other'members and value what is being offered.'

It is understandable that doctors who, as a group, have been shown to need to improve their communications with patients and with each other should also need to learn how best to communicate with nurses. What is surprising is that nurses working with doctors in the intimacy of the ward and operating theatre still find communication unsatisfactory. In discussion, ward sisters confirm this: one wrote,

'The days of the Consultant—Godlike and austere—arriving on the ward to hear the scurry of feet as nurses ran to hide from him have gone, but successful communication between nurses and doctors still often depends on the position in the hierarchy of each one and their attitudes to one another. Different personality traits can affect communication and be instrumental in its breakdown. This can lead to doctors seeing patients, informing them of changes in treatment, but not telling nursing staff. Frustrating and dangerous.'

In operating theatres and intensive care units, on the other hand, communication seems to be very effective and its tone

generally more acceptable. The contrast between ward, operating theatre, and intensive care unit, may arise from the clear-cut nature of the roles and tasks in the latter two situations which have been modified gradually as changes in tasks have been identified. On wards, however, changes in roles seem to many doctors (1) to have been imposed in the hope that task performance will alter and that needs identified by outsiders will be met. Much of the debate about changes taking place in nursing has been described by a senior nurse (2) as ill-informed with confusion arising from the use of the phrase 'the nursing process' without full understanding. If doctors were to understand the two main themes embodied within the term there might be less confusion. They are: 'the introduction of a systematic approach to the planning and execution of nursing'; and, 'the promotion of self-care as being the purpose of nursing' and are unexceptionable.

It seems clear that on hospital wards more attention should be given by both doctors and nurses to lines of communication in order that medical staff at all levels should be quite clear as to which nurse is the one to whom they should pass on instructions about treatment and they should also be more willing to discuss with senior ward nurses issues such as when to discharge individual patients. And the important role played by the ward sister or staff nurse in contributing to the training of young and inexperienced house officers should not be overlooked.

COMMUNICATING ABOUT COMMUNICATIONS

Problems with communicating about communications were emphasized by Miss Joy Young, Regional Nursing Officer to the Oxford Regional Health Authority,

> One particular area that causes much anxiety and concern is the understanding or lack of understanding between doctors and nurses on communication to patients and their relatives about the patient's condition. . . . I am sure there are some other areas but this particular one has so often been the subject of discontent that perhaps your Working Party could explore the topic.

Miss Young's concern is hardly surprising when a nurse working with GPs can say,

> Very few meetings or discussions occur between doctors and nurses in my experience, although it is agreed by everyone that they would be a very good idea. Unfortunately there is very little time to chin-wag with the doctors—only very brief chats; remarks can be made when whisking the old paper sheet off the couch or re-stocking the examination trolley.

This particular nurse had only recently made the transition from hospital ward to Health-Centre-based group general practice and it might be thought she was hankering after the arrangements of the hospital ward with its multiple opportunities, formal and informal, for communication. Yet even there a sour note can sometimes be heard.

> Often during handover sessions medical staff are still asleep (nursing staff tend to start work one to two hours before the doctors) or just waking up and thus pay little attention to what is being said.

A SENSE OF DISSATISFACTION

What comes through from the letters we have received and the interviews I have conducted is a sense of dissatisfaction with some aspects of doctor/nurse communication even though things are recognized to have improved and to be improving. If this dissatisfaction is the result only of a search for perfection, then all is very well but one suspects that it is not. Certainly, there is little formal teaching of medical students concerning the range of skills generic to nurses and only very little more concerning the function and skills of nurses with special training. Equally, all doctors train on wards staffed with nurses at all levels of their hospital training but not all nurses train on wards on which medical students work and learn.

IMPROVING NURSE/DOCTOR COMMUNICATION

What, then, can doctors do to improve their communication with and understanding of nurses? One answer, it appears from

much of our correspondence, is to change their attitudes. As a start doctors should realize that it may be only myth that extensive co-operation always existed between nurses and doctors in the past. Sarah Gamp midwifery only utilized the help of doctors as a last resort: ever since hospital wards first existed nurses have provided a mixture of hotel facilities and the services which would otherwise have been provided by a family. Until relatively recently the relationship between nurses and doctors may have involved relatively little overlap when medicines were to be given to patients or dressings to be applied. Nurses touched patients, doctors palpated them. Nevertheless, most doctors would accept that without the guidance and help of ward-sisters their transition from medical graduate to practising doctor would have been difficult to make or might have been, at times, dangerous for patients. In general practice, however, most nursing care is given by relatives or friends and often domiciliary nurses are involved only when these lay carers are absent or feeble so that the special skills of domiciliary nurses may remain unrecognized, understated and undervalued.

THE EFFECTS OF CHANGE

Changes in the techniques of medical care, with more people receiving care for chronic conditions, and changes in the emphasis of care towards a preventive approach, have all affected the need for and nature of co-operation between nurses and doctors. What might be called chamber-maid and parlour-maid duties in hospital have been devolved to new groups of ancillaries and much more of a ward-nurse's time is spent in both psychosocial and technical care than it used to be. In medicine the differentiation of doctors by specialty has increased without some doctors realizing that the same has happened to nurses. It is the increased complexity of treatments and increased differentiation of skills which has made a team approach to care essential if patients are to benefit from advances in the management of disease. The very changes which have made effective co-operation and communication between doctors and nurses increasingly important may have made more difficult effective communication between nurses, just as it has

between doctors. Effective communication is difficult to establish between any two large groups, and doctors and nurses are no exception, although some of their problems are unique to their particular responsibilities.

APPROACHES TO IMPROVE COMMUNICATION

The sources of difficulty can be described: solutions lie within the remit of the communicators. The principles of effective communication can be applied as readily to doctors and nurses as to other situations, and awareness of them should help each of us to recognize difficulties and find ways of resolving them for ourselves. A 'good' form of communication is one which achieves its purpose. If it has no definable purpose then there is no criterion against which the quality of communication can be judged. The purposes of communication may be to convey advice or instructions or sometimes to change beliefs, attitudes, and/or behaviour. To achieve such changes it is usually helpful if the message sender has some idea of the attitudes and beliefs of the recipient, at least in regard to the content of the message. This means that message senders must be good listeners and observers. Where messages are written and sent to strangers then the emphasis has to be on the clarity of content of the message. However, in the context of doctor/nurse communication it is reasonable to assume that both sender and recipient know something about each other and that even written messages can be couched in personally acceptable terms.

THE EFFECTS OF COMMUNICATION

Any communication may have three types of effect: informative (conveying information); promotive (producing observable behaviour); and evocative (arousing feelings) (3). Effects may be intended or incidental. Even if only one effect is intended the others will often be produced. A doctor saying to a nurse 'Please get me Mrs X's case notes' will evoke feelings or convey information as well as promoting the nurse's behaviour. Luckily one of these feelings seems to be tolerance. A nurse working with GPs in the treatment room of a health centre wrote to us,

> Instructions are often verbal, usually with a great deal of gesticulation. They will point from wrist to elbow, they will wrap their hands around their heads, but terminology is always loose— "clean this with— well you know". "Tell her to come back in a few days and we'll look at it again when I'm on".

The balance of effects produced by a particular communication will depend not only on its purposes, but upon its mode, the environment in which it takes place, and the perceptions of the recipient.

MODES AND MEANS OF DOCTOR/NURSE COMMUNICATION

Modes of communication are of varying degrees of formality ranging from pre-printed forms to an accidental meeting in the corridor. Formality will be related to individual means which range from written notes, through telephone conversations, or face-to-face discussion. The mode chosen by the sender will affect the value placed on a message by its recipient. A note in a patient's medical or nursing record may be seen as more important and certainly more permanent than a casual statement made over coffee. Doctors and nurses are busy people and may be irritated when the mode of a communication seems more formal than is justified by the importance of its purpose. They will be more irritated still if written notes are illegible or mis-placed. This essay is not the place to enlarge on legibility. We made the point in *Doctor to Doctor* (4) that records are a form of communication, not merely an *aide-memoire* to the writer nor a kind of legal insurance policy. It seems good sense for doctors always to try to discuss with the nurse any notes in medical records which convey specific instructions rather than always relying upon the nurse to check them. The notion of joint records has always seemed a sensible one and will be essential if computerization of narrative notes ever takes effect. At present it seems that formal requirements to communicate within the hierarchy of each profession takes precedence over the need to communicate between the individual professional groups.

ENVIRONMEKTS AND THEIR COMPONENTS

The quality of any relationship between people who are communicating forms part of their environment and has aspects related to the ways in which tasks are to be carried out as well as formal social connotations. These two factors obviously interact and sometimes conflict.

Task-based relationships can be delegated, substituting or collaborative. The act of delegation leaves responsibility for the decision firmly with the person giving instructions whilst the person receiving instructions is accountable only to the extent of the degree of skill exhibited whilst implementing the decision. Where substitution has occurred, decision and skill are both the responsibility of one person: during collaborative work decisions and skills are shared as seems appropriate at the time.

Evidently, collaborative work involves a dynamic relationship which will usually ignore formal boundaries. Nevertheless, such formal boundaries do exist. They reflect the structures which exist for relationships between and within the institutions to which the nurse and doctor belong: they outline the characteristics of the roles which the individuals play.

All working relationships have a more personal flavour which results from the personal characteristics and attitudes of the participants and which interact with the roles they fill and the ways in which tasks are allocated or accepted. The flavours result in different kinds of working relationships: co-active, inter-active, or competitive. Co-action seems suitable for delegation in that it recognizes that different people possess different skills, the sum of which may be necessary for the care of an individual patient. Interaction seems suitable for collaboration because, like collaboration, it is dynamic. Substitution tends to arouse competition, the outcome of which is unpredictable, although it can certainly benefit patients, given that the result is not reduced interaction. Flavours need not be discreet but produce a need for careful monitoring of the quality of relationships by both participants; in particular, this applies to the initiator of any specific encounter.

INITIATIOK AND CONTROL

Initiation is related to control, a key feature in relationships between members of different groups. Szasz and Hollander (5) have used a control-based classification for interaction between doctors and patients. They suggested that there were three broad divisions into which such interactions fall: active/passive; guidance/co-operation; and mutual participation. These categories seem relevant to many doctor/nurse relationships. Indeed, Dame Catherine Hall commented in particular that:

> . . . the type and tone of communication between professionals are influenced by attitudes and relationships, i.e. whether the relationship is seen as a 'colleague' one or a 'superior/subordinate' one. There is a general feeling in the nursing profession that the majority of doctors still retain a stereotyped image of the nurse as one who is to do their bidding and fail to take account of the fact that nursing has developed considerably over the years and is distinct from but complementary to medicine; that the nursing *profession* is therefore not subordinate to, but complementary to the medical profession. Where the stereotyped image of nursing is still held problems in communication are inevitable.

If a doctor's behaviour is seen to be dominant or, even worse, domineering in this sense then free exchange of communication is likely to be limited and patients are likely to suffer.

The tendency for doctors to see themselves as initiators may be encouraged by the structure within which they relate to nurses. In part, this may be because structures are difficult to alter and, therefore, are often outmoded. Certainly, some structures seem likely to lead to interactions between nurses and doctors which result in a social mood perhaps best thought of as one of mutual non-participation. The pros and cons of a geographical distribution of health visitors were balanced originally in favour of such a distribution which later became institutionalized. The administrative structure was not changed when some health visitors became attached to group general practices. This has left some health visitors with conflicting

objectives and, for some, a consequential reluctance to be attached to general practices. Unfortunately, structures cannot be designed only with communication in mind, and doctors should look out for occasions when they seem to have adverse effects on the tasks involved. The best opportunity to correct such effects is whilst care is taking place. In these more intimate environments trust and mutual respect are likely to develop, differences in perceptions between doctor and nurse to be identified, and compromises negotiated or consensus established.

PERCEPTIONS OF DOCTORS AND NURSES

The perceptions doctors and nurses have of each other will have origins additional to those already discussed. Medical Schools now produce, in theory at least, a basic medical graduate capable of being trained further in any specialty including that of general practice. Much greater emphasis is placed, during medical education, on human development and human behaviour, and there is general acceptance of the proposition that the 'whole person' must always be considered. The result in terms of doctors learning to communicate with patients is still open to criticism: nevertheless, a deficiency was identified and steps taken to correct it. Modern nurse training emphasizes much the same points in order, presumably, to correct the same deficiency. The result of these changes may unfortunately have been to produce competition rather than collaboration between doctors and nurses, so that, for instance, some general practitioners see themselves threatened by the suggestion that nurse-practitioners might be trained to undertake certain tasks which they at present perform.

For an increasing proportion of nurses their discipline is now an academic one with entry by degree rather than simple in-service training. Changes in nurse education have been paralleled by a rapid increase in the proportion of female medical students, which itself reflects secular changes in society at large. Professor Margot Jeffreys and her colleague Hessie Sachs (6) have summarized well these secular changes when discussing factors affecting mutual perceptions of doctors and nurse-trained professionals in modern group general practice.

First, changes are occurring generally between socio-economic strata. The members of the middle stratum, to which nurses have traditionally belonged, are in all walks of life challenging the authority of the upper stratum which traditionally has included doctors. Second, in primary health care at least, the upper stratum has until recently been predominantly male and the middle and lower strata predominantly female. Changes in balance between genders are now taking place and reflect changes in perceptions which are causing tensions in a wider context, methods for resolving which have yet to be agreed. These tensions are most acute when the definition of a task made by the formerly dominant group is challenged. Such challenges are most likely to occur when the personal attributes of the carer, doctor or nurse, form a main component of patient management. Examples are mental illness and emotional stress, and given the emphasis in nurse and doctor education on consideration of the 'whole person' it is hardly surprising that competition sometimes affects collaboration.

Relationships between caring occupations are influenced by patients' views about whom it is most appropriate to approach for help and from whom it is proper to receive it. There are therefore a wide range of scenarios within which communication can take place and it would be stupid to say that any one of them is better than the other in principle.

ORGANIZING COMMUNICATION

One other effect of increasing specialization and differentiation must be considered, namely the need for organizing communication more effectively or at least to create the opportunities for it to take place. In hospitals responsibility for this will usually fall on senior practising nurses such as the ward 'sister', while in group general practice it will involve practice managers who may have a secretarial rather than a nursing background. Doctors may resent having their lines of communication organized for them because this might seem to imply some loss of control on their part. If this occurs the task becomes impossible and patients will suffer.

CONCLUSION

Good communication depends upon mutual trust and respect. These may be bred by propinquity but are unlikely to develop fully between disciplines unless effective communication is recognized as something which needs to be worked at by all, and not least by the doctors involved.

The task is not a simple one. Recognition of the need to improve communication carries with it recognition of existing faults and failures. All too often devoted professionals busily involved in patient care will blame first the circumstances in which they work, then nameless others, 'them', for making things difficult. It seems unfortunate that many enthusiasts believe that 'cotnmunication' means agreeing with them. Perhaps all of us would communicate more effectively if we remembered that a prime purpose of an eloquent speech may be to prevent others from speaking. It is a useful rule of thumb to realize that the art of communication includes the ability to listen and skill in using what one has heard when responding.

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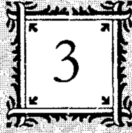

Communication between doctors and hospital laboratory staff

W. F. WHIMSTER

Communication between doctors and hospital laboratory staff

INTRODUCTION

THERE HAVE BEEN SO SCIENTIFIC STUDIES INTO COMMUNICATION between doctors and laboratory staff, but it is safe to assume that all doctors and all members of hospital laboratories have strong feelings and opinions about the relationships and communications between each other. The question for this paper is: can these feelings and opinions be encapsulated so that they can be dissected and examined within a single paper, or are they so varied that they call for a proper research project?

In most British hospital pathology laboratories, and in those run on similar lines elsewhere, I think the former is probably true, and that there are several obvious problem areas in communication between medical, scientific, and technical staff in pathology laboratories. These areas were highlighted in a discussion between myself and certain co-operative staff from the histopathology and haematology departments at King's College Hospital, London, in the spring of 1985, and I am indebted to them for permission to quote what they said.

There are, of course, many other types of hospital laboratory, and of scientific and technical staff in hospitals, dealing, for example, with tests of cardiac, respiratory, and neurological function, various types of imaging and the application of physics, chemistry, pharmacology, and engineering to the problems of patients. In common with those working in pathology laboratories they are all there to try to answer in

various ways the requests made to them by the doctors involved in patient care. Conversation with these staff suggests that their communication problems fall into the same categories as those experienced in the pathology laboratories, but I expect there are also other ones that I have not heard about.

ATTITUDES

Communication between laboratory staff and doctors is bound up with and cannot be separated from their attitudes to each other, which are determined by many factors including their diverse backgrounds and training.

> 'There are snobbish members of our profession (Medical Laboratory Scientific Officers) who sometimes have a chip on the shoulder because other people (doctors) are more qualified.'
>
> 'They earn more and there is an instinct for class warfare in human nature which is difficult to overcome. I think it is human nature to feel antagonism to people who are different and not to understand them, perhaps because you don't want to.'
>
> 'There are two levels of rank which are not reconcilable—the doctors and the senior technicians. Ultimately, on District Management Teams and so on, the consultants have sway and that causes friction and envy and all sorts of problems. There is class rivalry.'
>
> 'The physicians should understand that we have a lot of knowledge that we can help them with. If they tell us what they are trying to find out or what the disease is, we can often help them decide which are the best tests to do. Unfortunately there are still some doctors who have the attitude that they're doctors and we're technicians and that we are there to do their tests whether they are useful or not.'

LEVELS OF COMMUNICATION

The work is initiated by the clinical consultants and trainees whose medical and personnel management skills and experience

vary from the most senior consultant down to the newly qualified house officer. The work is done by medical laboratory scientific officers in collaboration with scientifically qualified staff and medically qualified consultant and trainee pathologists. Thus communications go on at various levels, but for the day to day work:

> 'A lot of our communications are with housemen. In their first jobs they do not know how we do things. They just send the specimen down and when they don't get the result back they start wondering what is happening. That causes quite a few problems initially. They may ask for a range of tests when we could give them the answer on one or two tests.'

> 'In the blood bank the housemen are always coming to talk to us so we can get a chance to educate them. But they are only there for six months.'

> 'No one talks to the clinical consultant so the problems of his houseman never get back to him.'

> 'It seems that there is no communication with the clinical consultants at all. We can't get them to change any of their policies. It is impossible to persuade them to change the times of their clinics so we could give a better service.'

> 'Communications are better with the specialties like paediatrics which work more on a team basis and when we may be part of the team. The doctors meet more with our paediatric haematologist (who is also in charge of the blood bank). We worked out a system for doing the sickle tests before the children are admitted, but it was done at consultant level.'

> 'In the routine laboratory you are buffered by your own consultants because the clinicians tend to go to them. Our consultants do as much diplomacy as we ask them to do. If we have trouble with a clinician we fire one of our doctors at them. We do it at the right level—if it's a registrar, we'd ask our registrar to deal with it. If we introduce a new technique our consultant probably explains it to some of the clinical consultants at lunch and it gets round that way.'

'There is a level of communication there which does help us even if we are not involved in it.'

TYPES OF COMMUNICATION

These are written (often illegibly or in incomprehensible abbreviations), telephonic, face to face, or, possibly in the future, by computer and visual display units. Requests to carry out tests come to the laboratories mainly on request forms designed to include all the information needed to carry out the tests intelligently and helpfully. The request form may be accompanied by a specimen or by a patient (from whom missing information may sometimes be elicited). Clinicians may sometimes request tests in person or over the telephone. The test results are generally conveyed to the requesting clinician on paper for inclusion in the case notes, but may also be conveyed in person or over the telephone. More communication is needed if the requester does not have the results to hand when he needs them or if he wants to query them or their interpretation. In laboratories that provide a 24 hour service, much communication takes place outside normal working hours.

'At any time communications are better face to face than on the phone. You can have a real argument on the phone, but as soon as they come down you can see that you are both busy and tired and then everything is all right again.'

'We only deal with the anaesthetists when they are on the phone in a panic, asking for things that make no sense, and saying things like 'if this patient dies, it's Blood Bank's fault'. When the panic is over or one of our registrars goes up to theatre, it all settles down.'

'It's easier if you can make it personal — if they come up and talk to you, you find that you are friends rather than doctor and technician, and you both respect each other's work. People are much more courteous and polite on-call. They seem to be on first name terms. You also have your worst arguments on-call because everyone is frantic and ratty. So you tend to blow up with each other, especially on the phone. But then they send down the next form with a couple of biscuits taped to the back. So I think everybody understands how everybody feels on-call.'

'General practitioners send in quite a lot of haematological and microbiological specimens. Mostly they send the patient with the request forms rather than bleed them themselves, but then we can get more information from the patient than is on the form.'

Comment
Sending the patient to hospital to have a blood sample taken is inefficient. It is more efficient for the hospital to collect specimens taken by the GP although the laboratory cannot then obtain supplementary information from the patient.

'If the doctors have a criticism of us it is probably to do with getting the results back to them. There seems to be no money to install electronic systems of getting the results back to the wards and clinics. The Regional Health Authority is paying for computerized systems for the laboratories but I don't think they'll be right for getting the results to the bedside or clinic when they are needed. Region hasn't come down to the grass roots to see what we really need, which might be a lot cheaper than what they will supply.'

Comment
This illustrates a common form of malcommunication — making decisions about a programme of work without consulting those who actually do the work.

'We put a lot of effort into getting the reports out on time but they don't get back to where they're needed. And that is regarded as a reflection on the laboratory. This area accounts for 90 per cent of the communication problems.'

'In histopathology we also have specimens not getting to us. In fact one of our staff has to go out and find and collect the specimens. In chemical pathology, with all their

computerized multichannel analysers, the time taken for the specimens to reach them is the rate-limiting factor.'

'If the results don't get back we just get another specimen to repeat the tests on. Even if we do get the results back the same tests are likely to be requested first from Casualty, again from the Ward, and again from Outpatients—nobody looks to see if they have been done before. Mind you, I don't know how the houseman would look back through some of the piles of notes, it may well be quicker for him to repeat the test.'

'The case notes are undoubtedly a communications disaster area but fortunately laboratory staff don't deal with them much, although in haematology there is an increasing tendency for the pathologists to see patients in the department with their notes.'

Comment

Case notes present a communication problem which affects the entire NHS and in our recommendations we suggest that this problem could best be tackled nationally.

UNDERSTANDING OF EACH OTHER'S WORKING PRACTICES

It is naturally much easier to communicate effectively if the communicator knows how the recipient works. In laboratories this means knowing what information the laboratory needs on the request form to provide a meaningful report, what happens to the request forms and specimens after they leave the requester, how they are received in the laboratory, whether any of the tests are batched (and how often the batches are tested), roughly how long the tests requested take, and how the results are transmitted back to him. The laboratory staff need to know how the results will help the requester, and when he needs them. Irritations include badgering the laboratory with demands for results before it is possible for them to be available, and results not reaching their destination and having to be phoned for. Lack of understanding of working practices accounts for many of the failures of communication.

There are lots of patients and a houseman may not have time to get to know all of his patients. We get a lot of specimens—and they are simply specimens. The houseman brings or sends them down and gets the results, but beyond that we usually don't have any insight into what's going on at all.

The doctors don't realise that we also need clinical information. Our clerk is always phoning up to find out why they are asking for a test so that we can see if the request is reasonable.

In histopathology the gynaecologists frequently send us curettings without the patient's age or the date of the last menstrual cycle, so the microscopical appearances cannot be interpreted helpfully.

The trouble with many requests is that the nurses fill out the forms rather than the doctors. The doctors are cut out, which would cut out your book altogether!

Comment

Nurses in operating theatres may fill in request forms to accompany specimens removed by surgeons who are 'scrubbed up'. Sometimes surgeons sign the forms before operating and leave a nurse to fill in the details. In wards and outpatient departments forms requesting investigations may also be signed in advance leaving their completion to nurses who have little awareness of what information the laboratory is likely to require. Whenever possible doctors should complete these forms; and house officers need more training about what laboratories need.

'The doctors just will not understand that it is very inefficient to do one-off tests and that a single one on its own may take hours. They also persist in wanting the answer before they operate in half an hour's time.

The doctors don't understand the working of the laboratory—just think of all the late samples that come down day after day. It is so difficult to organise our daily programme.'

'Some housemen send specimens for 'blood group and save serum (for cross matching if required later)' from the same patients every day although we keep each patient's serum for about four weeks. It doesn't matter how often we tell them not to waste their time, they have so much to do they just cannot take in the workings of the blood bank.'

Comment

The lesson to be drawn from these comments is that doctors are not careful enough in framing their routine requests. Most know what information laboratory staff require and it is foolish and wasteful to repeat requests without thought or reason. This issue involves more than communication but depends upon the psychology of performing routine tasks (for housemen) and of supervising them (for registrars and consultants). I believe that the medical profession has paid insufficient attention to this problem.

COST

We considered whether communications would be different if the cost of everything had to be considered as it must be in private hospitals.

It would give us fewer tests because they wouldn't repeat tests.

No one has found any other way of reducing that sort of waste.

THE DOCTORS' VIEWS

The views of the clinicians have not been specifically sought but, while depending considerably on the grade and personality of the doctor, are believed to mirror those of the laboratory staff. It is very easy to leave important information off the request forms when the information is not immediately to hand. The doctor only knows when the request is sent and when the result is received— and is not greatly concerned about what happens in

between unless the result is not back when he needs it. He may well resent attempts by persons he regards as less well qualified than himself to tell him what investigations he needs. Nevertheless most doctors try to make friends with the laboratory staff they deal with most, so that in a crisis communications can be swift and effective. With some exceptions the pathologists of all grades seem to be generally aware of the problems and try to improve communications between the front line specialties and the laboratories.

CONCLUSIONS

There is no doubt that in many hospitals, especially big ones, poor arrangements, too much to do, thoughtlessness, lack of consideration, and personality clashes impair communications. Poor communications hit the patients, the communicators, and the budget, causing harm, irritation, and waste. When communications are impaired the roots may lie in the participants' attitudes and backgrounds, service grades and personalities, in the type of communication, in mutual lack of understanding of work practices, or in the work practices themselves. It is as important for the scientific and medical heads of hospital laboratories to spot impaired communications, to analyse them, and to put them right as it is to produce accurate results.

Fostering good communication between doctors and—secretaries, physiotherapists, occupational therapists, and ward receptionists

IAN McCOLL

Fostering good communication between doctors and — secretaries, physiotherapists, occupational therapists, and ward receptionists

INTRODUCTION

IN FOSTERING GOOD COMMUNICATION BETWEEN DOCTORS AND others engaged in patient care, the. essential ingredients are consideration, courtesy, and consultation. The doctor who endorses these principles is much more likely to have a team which gives a first class service to his patients. If the doctor believes that he is a cut above those who help him, it is bound to show, and arguably, demonstrates his intrinsic inferiority.

A recent survey of secretaries in general (not specifically medical) carried out by Gallup (1985) (2) showed that 'Charm goes further than champagne with secretaries. And they'd rather have politeness than posies.' The vast majority think the most important words the boss can say are 'please' and 'thank-you'. Fewer than ten per cent consider being taken out to lunch, being given champagne or the occasional bunch of flowers as important. Much higher come pleasant surroundings, with a 52 per cent vote. Most important of all is common civility, with an 89 per cent response from the women who often wonder if their employer would be 'happier with a robot'.

A clinician from another hospital was visiting her husband in his Professorial Department. As the secretary had to leave the office to collect the mail, the 45 year-old lady sat at the secretary's desk and answered the phone for about 20 minutes.

During this time, a young doctor, half her age, came into the office, and assuming that she was the secretary began talking to her in a rather cocky, rude fashion, as he thought appropriate for her rank, giving instructions about what he wanted doing, etc. When he realized that she was a doctor and not a secretary his attitude immediately changed, which made the lady even more critical of his inappropriate behaviour. In the close-knit confines of a health care team, the right-hand cannot afford to treat the left-hand as inferior. 'The rank is but the guinea's stamp' (Burns, R., 1795) (1).

The doctor's duty is to make the environment of his secretary as pleasant as possible. It does not cost much to quieten the office with carpets and replace telephone bells with lights; it all makes for a happy ship. He ought to plan ahead as this is simply part of good management and consideration. Of course, there will be emergencies and papers need to be typed without much warning, but usually this can be forecast weeks or months ahead. The more the doctor consults with his secretary and staff the better. To consult, not to dictate should be the order of the day.

It is also important to remember that a medical secretary serves a number of doctors and hence it is not always possible for her to drop work to undertake a task which another doctor regards as urgent.

BELIEVING ONE'S SECRETARY

What the patient says may not necessarily be true. One irate patient said 'I tried to phone you doctor, all yesterday, but your secretary wasn't there'. The reasons for this are many, the patient may feel guilty, angry, confused, and want everything done immediately. Nothing is more irritating for the secretary than not to be believed by her boss under these circumstances. Of course secretaries make mistakes, but loyalty is an essential ingredient of good working relationships. She must be given the benefit of the doubt. Some patients ring up and say 'I am only available for two days, and I want everything sorted out today'. The poor secretary has to rush around arranging everything at short notice. Good quality of life for the secretary is essential and this type of hassle is on the whole, unnecessary. We must be properly organized and do things in a civilized way. Except in an

emergency, patients cannot have everything done at once. It often transpires that the patient is available for longer than he says, and in the case of patients from abroad, they can readily stay for several weeks or months; the patient is simply making the point that he wants matters sorted out immediately and he is trying to obtain the best deal he can in the market place. Often the patient will have telephoned the secretary and asked for an appointment at once, to be told that it is not possible. The patient then rings the doctor at home and the doctor replies, 'Yes of course, I will see you, ring my secretary tomorrow and tell her that I will see you tomorrow'. This is bad management, poor loyalty and makes for poor morale. Believe your secretary, be loyal to her and do not undermine her authority and management. There are patients who undoubtedly cause secretaries unnecessary hassle for a variety of reasons. Of course, if the patient is very ill in mind or body, the secretary will cope and understand. If his behaviour cannot be explained on this basis but is due to innate aggression and rudeness, this can exasperate a secretary beyond endurance.

'LET ME SHOW YOU HOW EASILY I CAN DO IT' SYNDROME

The doctor comes into the office to find his secretary distraught; she has been trying in vain for two hours to get another department to do something, on a particular time scale. The doctor says 'I will fix it for you immediately'. He says this not necessarily in any superior way, not trying to demonstrate his prowess, not trying to humiliate his secretary, but only trying to be his usual helpful self. Then in her presence, he picks up the telephone and in ten seconds, achieves the desired result. The secretary is naturally furious at yet another example of male chauvinism. The solution is probably quite simple. The doctor should retire to his office, only to emerge after an hour or two with the problem solved. It reminds me of a prolonged industrial dispute which was solved in a two-minute amicable meeting, between a TUC leader and the leader of the employers. In order to avoid the 'let me show you how easy I can do it' syndrome, they spent the next three hours enjoying themselves over a whisky or two and emerged with their hair ruffled and

their ties out of place in order to address the assembled strikers downstairs. The TUC leader told them that he had had the biggest battle of his life but had managed in the end to achieve an honourable solution!

The same lesson is relevant in clinical medicine. It is important to be careful in dealing with a patient who has been a puzzle to many clinicians for a long time. Even if the doctor recognizes the rare condition immediately, it is wise not to tell the patient right away, but to appear to ponder the problem for 5 or 10 minutes. Instant revelation may be good for the clinician's ego, but often upsets the patient if the diagnosis is so obvious. He then directs his anger to those who have failed him.

'VENT YOUR SPLEEN ON A DRAFT LETTER'

Inevitably doctors will receive rude and aggressive letters and it is not unnatural to reply in kind. The wise secretary will faithfully type out her boss's angry reply on a flimsy pink paper and then hide it for a few days. On a propitious day she casually presents it to him for signature. As he screws it up and throws it in the rubbish bin he thanks her for giving him insight in a gentle way. We need our insight in small doses when the weather is fine!

HOW TO HELP OCCUPATIONAL THERAPISTS PHYSIOTHERAPISTS, AND RECEPTIONISTS

Good communication between doctors and physiotherapists, occupational therapists, and ward receptionists is best fostered by frequent consultation on the wards. The disadvantage of all meeting together on ward rounds as a large crowd around the patient's bed is the intimidation felt not only by the patient, but by many others in the team. The difficulty in hearing on these large whispering ward rounds is shared by all including the patient whose only advantage is that he does not have sore feet at the end of a long shuffle about. A better solution is a weekly meeting in a side room near the ward over a light lunch discussing all the patients with the physiotherapists, occupational therapists, social workers, nurses, pharmacists, doctors, and students. These are profitable and happy occasions where everyone can readily take part.

A sense of humour is indispensable in running a happy unit, but not all humour is helpful. Physiotherapists do not appreciate receiving a request for post-operative physiotherapy specifying 'slap and tickle please' any more than the occupational therapist likes being referred to as a basket-maker. Doctors should be aware of what these jobs entail as, for example, in the case of a handicapped child. The doctor may see the child for 20–30 minutes every six months whereas the physiotherapist sees the child daily in school, devises a programme of treatment, discusses management with the school, and knows the parents well. The occupational therapist visits the home, discusses practical problems of daily living, and helps the parents with advice and by supplying equipment, aids, and appliances. The best communication achieved is by the doctor consulting the physiotherapist about the most appropriate management of the patient. Often physiotherapists and occupational therapists know very much more about the subject in question than the doctor. A good example of this is in the provision of wheelchairs or other aids for the disabled. The doctor must sign the prescription, but often knows very little about wheelchairs and appliances. He therefore asks the physiotherapists or occupational therapists to fill in the form which he duly signs himself. Not unnaturally this gives rise to irritation in the long term. The matter can easily be put right by having the person who fills in the form signing it as well as the doctor. This seems a trivial matter, but over the years it can fester. Many doctors still remain ignorant of the expertise of occupational therapists in giving advice and assistance upon all aspects of daily living to those permanently or temporarily handicapped. Giving credit where credit is due costs nothing, but improves relations no end.

The ward receptionist is in a key position to facilitate the smooth running of the ward. It goes without saying that she should be treated with courtesy and consideration and consulted frequently where appropriate. The students and housemen have much to learn from her. In some places she is correctly described as the 'smoother', keeping the ward generally happy and an invaluable right-hand for the sister. Her charm and ability to defuse explosive telephone conversations are invaluable. Some doctors are like Jekyll and Hyde. Face to face they are charming, but on the telephone they become aggressive and rude. It is

rather like someone changing their character when they get behind the wheel of a car. In some private hospitals checks are made by telephone. An administrator telephones a ward pretending to be a patient and if he gets a flea in his ear the producer of the flea may be cautioned. If the offence is repeated dismissal may follow.

CONCLUSION

In summary, consideration, courtesy and consultation are the watchwords for good communication between doctors and all those who are involved with them in working toward the mutually important goal of excellent patient care.

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Communication between doctors and social workers

NEIL KESSEL

Communication between doctors and social workers

INTRODUCTION

THIS PAPER DISCUSSES PROBLEMS OF COMMUNICATION BETWEEN doctors and social workers, how they arise and ways of overcoming them. Much of it is concerned with the attitudes towards each other of the practitioners of the two professions. Attitudes inevitably influence communication; to a great degree they facilitate or impede it. Hostile or defensive attitudes promote misunderstanding; and misunderstandings make for bad coinmunication. Another factor is ignorance, of the other profession's knowledge, of its professional philosophy, even of its language on the one hand and of its techniques, skills, procedures, competencies and limits on the other. Such ignorance can lead to expecting too much or too little.

ATTITUDES

Wrong attitudes breed intolerance. Unfounded criticisms stem from ignorance. Indeed, so striking are the difficulties and barriers arising from the different viewpoints, objectives and backgrounds of the two professions that I started to wonder how any satisfactory *modus vivendi* between us is ever achieved. Similarly, in 1981 Huntington (1), addressing these very problems, has expressed the view that the starting points of the two professions are so far distanced from each other that there may be no bridging of the gap. Some have said that so disparate

are the two professions that it is not worth while attempting a conjunction. They claim that even when the social worker and doctor deal with the same individual, they do not work together but each attacks a different problem. I demur. Mrs Morris's tiredness may be helped both by a home help and iron tablets. William's difficulties with his mother and with school may be treated by individual psychotherapy and by social work with the family and a school visit. My conviction that answers can be found arises from witnessing so many instances where doctors and social workers communicate well and fruitfully. Warmth of personality and agreeableness can set up the necessary willingness to work well together and a common determination to do what is best for our common charges leads to wanting to help each other. Those who work well together soon develop mutual respect.

Where there's a will there's a way. Shared purpose provides the will. Mutual respect and liking makes the way easier to find. Please remember this while I describe the peculiarities of the vehicle of communication and the route it has to traverse. The vehicle may be lop-sided, with different sized wheels which can only be manoeuvred into parallel positions with determination. The two engines are of different power and on any particular journey one will have started before the other. The steering mechanism is not fully understood by either of the co-drivers, one of whom may well be a learner while the other has long ago passed the advanced test, conducted by a different examining board, for they have had different instructors. This vehicle has to negotiate a bumpy road over rough ground, sometimes with impossible gradients. The exact destination is not clear and the two drivers are using different maps, employing different scales; not all the possible routes are marked on both. Much ingenuity is required by all parties, therefore, to arrive at an agreed finishing position, since the passenger, also, is unsure how he got on or where he gets off.

HOW, WHERE, AND WHY DOCTORS AND SOCIAL WORKERS MEET PROFESSIONALLY

Most social workers work mainly in a community setting with a relatively infrequent contact with the medical services, princi-

pally, for them, the primary health care system—general practice. Indeed they may well turn first for advice about how to handle those of their clients' problems that have medical relevance to more senior and specialist social workers. Some social workers, however, including those specialists just mentioned, spend most of their time working in a medical setting and are attached to hospitals for this work. A special and important group of these medical social workers is that of the psychiatric social workers who will always have received intensive training in that field.

Before the 1974 Social Services Act (which followed the Seebohm Report) community social workers, who came from a great variety of backgrounds, lacked a common training and carried out very disparate tasks. Today the local authority Social Services Department employs nearly all social workers and there are common stems of training, resulting in a greater interchangeability of roles. Because of pressure on curricular time the training contains little about disease processes or about the effects of illness and the particular social needs of patients. Paradoxically, medical students now receive much more education, than once they did, about social aspects of disease.

A basic course in social work is designed to produce the generically trained Jill-of-all-social work who, when working as a member of a medical team, preserves an independent status and is there on secondment from the Social Services Department which remains her employer. By contrast to the position before the Social Services Act, therefore, medical social workers will not have been specially trained for such work and few will have worked exclusively in hospitals where they once took their place, often a handmaidenly place, in a hospital structure dominated by doctors.

These changes have altered powerfully the whole relationship between social workers and doctors. Social workers know this and are glad; doctors know this but sometimes appear not to want to acknowledge it. They do recognize, however, that even among medical social workers there is less knowledge than formerly about illnesses and less awareness of medical ways of thinking about patients.

No hard and fast line can be drawn between medical social workers and those working in the community. Medical social

workers have, after all, to deal with the social predicaments of patients even when these are not directly related to their medical problems, and community social workers must often come to grips with features of their clients' cases that are illness related. Nevertheless, the distinction can serve us in the present context because each setting has its particular problems of communication. Difficulties will be discussed of liaison between general practitioners and social workers in the community, whilst between medical social workers and the doctors and nurses whom they join in hospital-based teams there need to be especially close and effective relationships.

Although the battle has been won, the struggle to establish themselves as a profession and to exercise professionalism is still very present in the minds of social workers and accounts for a certain prickliness, pride, and sometimes prejudice when they face the assuredness of their professional strength that doctors display. Social workers often come from different social backgrounds and upbringings from doctors and often, though without good warrant, believe themselves to have more sympathy with minority groups and disadvantaged people. The growth of social work as a profession has coincided with a rise generally in the fashion of doctor-knocking. The two are perhaps unconnected but it is unfortunate that social workers are frequently perceived by the medical profession as lining up against doctors on that platform. Social workers tend to see doctors as symbols of authority (why should they not indeed?). A flavour of feminism may also be an ingredient in their developing a covertly hostile attitude towards doctors. Doctors, it goes without saying, besides being autocratic, are male and sexist; that so many of them are young and women does not, it seems, change that stereotype.

'THE MEDICAL MODEL'

Doctors are in such an entrenched position that they do not care a straw about all this. They are, however, concerned whenever they can appreciate what is at issue, with the attack on what has come to be called *the medical model*. The canons of their nosology and therapeutics rest upon considering patients' complaints in terms of pathological process and directing treatment towards

reversal of, or palliation of that process. They know that people who come to them have to be regarded as ill and hence to be approached in terms of pathology. That is the mutually acceptable essence of being a patient. 'Here I am, make me better' is the contractual cry uttered in the consulting room. Doctors (I speak of the generality; it is perhaps less true of those recently qualified) do not adequately consider social issues in illness, or domestic or other stressful matters which may determine symptoms or lead to the complaining. Even psychiatrists regard behaviours, if they cause suffering or disability, within a framework of their being pathologically determined. Social workers on the other hand conceive much behaviour as socially caused. They have not studied psychopathology but will have absorbed sociological theories. Doctors are rightly not prepared to depart from thinking within a medical model. Almost all the advances in medicine have sprung from its adoption and while they cleave to it they are acting as scientists. Social workers largely reject the medical model. But then they are not scientists. This is the great divide. The professional stand of social workers is different. It is society oriented, family oriented. Thus Snow (5) can write 'we would see anorexia nervosa and reactive depression as family problems rather than individual dysfunction.'

DIFFERENCES IN PROFESSIONAL ETHICS

One fundamental issue of divergence between doctor and social worker is a matter of professional ethics and therefore not compromisable. Fortunately it rarely provokes an issue over treatment but when it does there is no getting round it. For the doctor, attention to his patient's welfare is his sole duty. For social workers, although this is currently under debate by them, the unit is often the family, if not, indeed, the community. The doctor must make all his decisions in his patient's interest whatever the hurt to others. The social worker has to consider the patient's spouse and the patient's children. If the medical programme might harm them, of course this has to be brought to both parties' awareness, but the doctor must then set it aside. The social worker cannot.

Doctors are aware that social workers lack a knowledge base

of medicine; they also believe that a scant knowledge base exists for the social recommendations of social workers. Both the literature and the research of sociology are not usually relevant, and numerate research findings are few. So deductive reasoning does not seem to inform a social worker's opinions in an individual instance. Such opinions may be based on practical experience but the doctor often feels that his own experience in dealing with similar problems is no less extensive. Thus one dogmatic statement clashes with another. Resentment follows. Social workers for their part disparage many aspects of doctors' activities; this will be discussed later.

I have endeavoured to expose and explain some of the tensions between social workers and doctors. They spring from their different roles, positions and stances. They are professional jealousies and envies. They are unavoidable but not irreconcilable. They must be faced. The professions are different.

COMMUNICATION PROBLEMS IN THE PRIMARY HEALTH CARE SETTING

Communication difficulties between community social workers and general practitioners begin with the difficulty of establishing any communication at all. General practitioners have a reputation for unavailability—not always deserved, but they are not absolutely undeserving of it—and social workers are out doing social work. An agreed time of accessibility each week might help. One thing is clear from all discussions of the problem. There has to be two-way communication; matters cannot be dealt with merely by passing messages. As there is no shared geographical patch, each general practitioner and each social worker has to deal with a number of counterparts. The temptation to rely on messages is great.

When, however, direct contact is established formidable difficulties still remain. Bruce (2) has pointed out that even in those rare instances where the parties work in the same building they do not necessarily communicate unless there is the motivation to do so. There is no sufficient background of understanding of what the other can do. Snow (3) writes that, 'we social workers are unclear what our role should be in a

medical setting' to which one is tempted to reply that they ought to make themselves clear without delay. A bigger block to effective communication is that many social workers have not the necessary medical knowledge to know what doctors can or cannot do and what information it is pertinent to provide. Let me give an example. The social worker trying to help Mrs Robinson cope with a job, an unfeeling husband and three difficult children finds that she seems constantly tired. Unsure as to whether this may be due to a medical cause, he may pluck up the courage to ask the general practitioner about it. The doctor, who knows his patient may realize that there is nothing he can do and be vexed that someone supposes he is neglecting some medical step. He may think, in effect, 'Nothing can be done. What do you expect me to do?' but if that is the response he utters he is being unfeeling and unhelpful. Now reverse the position. If it is Mrs Robinson's doctor who discovers she is tired he might turn to the social worker and ask, 'Can you do something about her. She's getting tired out?' The social worker, knowing the overtaxed home-help situation and the intractable home circumstances may, in effect, dispiritedly respond: 'I can do nothing. What do you expect me to do?' Unless good communications exist either party may precipitate such a stand-off position. Community social workers see doctors as a potential source of help that, somehow, they cannot quite tap. General practitioners see social workers as a source of potential help that all too often fails to materialise. If they communicated they would better understand what help was needed. If they combined they might, together, be better able to achieve it.

COMMUNICATION PROBLEMS IN THE HOSPITAL SETTING

At the hospital level great tension is caused by the way health moneys and social services moneys are disbursed. Doctors and social workers can only suppose that the DH does not talk to the SS, and that the Minister of Health does not walk the same corridors as the Minister for the Social Services. The separation of Health Service budgets from Social Service budgets, though both largely come from the same great Department of State, makes it difficult for doctors and social workers to combine in their patients' interests, or for that matter, in the interests of

economy. It costs more to keep a patient in hospital than for him to be in residential care in the community; yet to retain a patient in hospital longer than is beneficial for him, and at greater expense than if he were properly sheltered in the community, may have to be done to save the Social Services budget. The other side of the coin is that hospital doctors, although they may want to get more patients out of hospital, are reluctant to see any hospital moneys being transferred outside the walls, for example to provide more community nurses. Today, when resources for both health and social services are under considerable pressure, the strains inevitably surface in the form of conflict between the two professions that share responsibility for the patient.

The separateness of the two organizations raises other difficulties. Whereas the doctor in administrative charge of medical services, the community physician, has virtually no say over the activities of any clinician, his counterpart, the Director of Social Services, Jill- or Jack-in office, is very much the director of the field social workers. It may be that they escaped from the loose-reined tyranny of medical direction into the tighter harness of a strict hierarchical departmental organization with, at all levels, bosses who constrain their activities. The doctor, not unreasonably, expects his partners in the team to be responsible to no-one outwith the team. He will not tolerate interference from others who are not team members. The problem becomes actual and stark when the team social worker has to discuss details of an individual case, and what he should do, with a senior social worker who is not party to the team's thinking. The doctor rightly holds that all decisions must be taken within the confines of the team. The unfortunate social worker cannot feel comfortable when he is torn two ways. If he openly avows the' conflict, then the doctor will ask him to execute the team's plan and the social work supervisor (odious term) will point out in no uncertain terms his duties within the social service organization. I wish this were mere exaggeration, but regrettably piper-paying still goes with tune-calling.

CONFIDENTIALITY

The confidentiality of a patient's medical records, and indeed of all medical information concerning him which is obtained in the

medical setting, is sacrosanct. The doctor's professional ethics forbid any improper disclosures although relevant information, including access to the records, may be shared with others who are working professionally on the patient's behalf. The doctor has to secure that those people do not themselves disclose any medical information. Social workers keep their own case notes, and problems arise if they contain medical information gleaned from the doctors or from the medical records. Social service case-notes may be seen by the social worker's supervisor, but that person himself is then involved in a professional relationship with the patient. Over and above this, some social service directors insist on their own right to see notes made by their staff. Here is potential for a breach of medical ethics. As a matter of principle it can form a significant restraint on communication between doctors and social workers, and in practice it does so. Worse, in some places the elected lay members of the overseeing Social Services Committee of the local authority have accorded themselves 'the right to have access to any of the material produced by social work staff'. Huxley (4) goes on to say that this right may be waived by the Committee members but adds what must be seen by doctors as a great deal worse: 'most social services departments are now giving thought to the creation of a record-keeping system to which clients can have access'. Unless doctors can be assured that the information they share with social workers can be protected, in their patients' interests, so that nobody, unless authorized by the doctor, can see them, then doctors will be forced to withhold information from social workers. This will not serve the patient's best interests. Various devices, such as the social worker maintaining two separate sets of notes, or lay persons waiving their rights of access, are a partial solution but the real solution has to be for members of Social Service Departments to respect the inviolable privacy of case notes which contain medical information. Leaks are especially likely to occur when the Social Service Department is at the same time caring for other members of the family besides the patient, and concerning whom the patient's medical information would be relevant.

THE VALUE OF TEAM WORK

Much medical work can go on in the cosy, other-excluding relationship of the consulting room. A lot of social work needs nobody else than social worker and client. Nevertheless there is considerable scope for doctor and social worker to work together in a team that includes nurses and other health professionals. Difficulties and doubts that militate against easy team work are described in this section. Remedies are given later.

Social workers are happy, indeed often feel privileged (as are doctors themselves) to be members of a medical team. They are understandably less enthusiastic about belonging to *somebody's* team when that somebody is always the doctor. 'The best that one can sometimes expect' writes Roycroft (5), 'is a benign consultant with a very paternalistic attitude which again creates problems for social workers who feel they are being patronised'. Constant use of the phrase 'my social worker' to patients and others is injudicious. 'My social work colleague' is correct. Doctors tend to assume that, if there is a team of which they are a member, they will be in charge. Their training teaches them to take charge, and to accept the attendant responsibilities. It must remain so in the field of medicine, and if other health professionals do not like it they must lump it. Doctors alone have the necessary knowledge of pathology and therapeutics. In return they owe it to the other members of the team to understand each others' understandings, skills, and problems.

Social workers observe that the doctor, as soon as the hospitalized patient's medical state has improved sufficiently, wants imperatively to get the patient out, so that the bed may be filled by someone else requiring attention. The social worker, needing time to make arrangements so that the patient can be adequately looked after, feels himself put under unnecessary pressure. Too often a social worker perceives that the hospital doctor only prizes his ability as a place-finder: in a home, a hostel, in Part III accommodation, it matters little where, or how suitable, so long as the patient leaves hospital. Too often, as Roycroft (5) puts it, social workers 'see doctors as going for quick options'. Social workers are right to question and to resist such uncaring pressures. Moreover, economic factors prevent

speedy compliance. So the social worker is made aware, ward round after ward round, of medical displeasure about a blocked bed. Whatever has been communicated, it has not been good morale.

Social workers believe, not without good cause, that doctors do not appreciate the training they have received, the experience they have gained, the knowledge they can bring to bear, and the skills they deploy. They consider that doctors do not properly value their opinions. Social workers feel that doctors have not fully come to accept the independence of the profession of social work. Social workers are aware that doctors, when making their decisions, do not take enough account of patients' social, and in particular, domestic circumstances.

It seems to social workers and not only to them, that the doctor is arrogant who constantly instructs members of other professions what to do. We have seen that the doctor arrogates to himself the duty of taking charge. He may do this by cracking a joke rather than a whip; nevertheless, arrogance it remains, seemingly the arrogance of despised authority. Too often the social worker perceives that the general practitioner only prizes his ability as a home help or meals-on-wheels provider. The social worker senses, all too often, the same authoritarian approach being applied to patients and may take their side in standing up to the doctor, demanding that 'they' be given explanations and the right to make their own choices. Here lies another source of tension.

If the social worker appears too uppity, or too unprepared to carry out with docility all that the doctor desires, the latter may respond by asking others, health visitors, district nurses, or community nurses, to act in the social worker's stead. He considers that these nurses, because of their background of hospital training, will be more pliant to his bidding. Although there may be some overlap of roles, this manœuvre is inefficient and undesirable, the result of bad communication and bad personal interaction. In any case, the profession of nursing will ensure that it does not succeed.

STATUTORY RESPONSIBILITIES

There are a number of statutory duties, such as certification under the Mental Health Act, where doctors and social workers must act in concert. Clashes here are most unfortunate but may occur if the social worker regards himself as the upholder of the patient's rights against an autocratic medical authority not genuinely acting in the patient's best interests. They certainly will occur if the social worker tactlessly proclaims his adoption of such a position or if the doctor tries to lay down what the social worker has to do. Doctors find it hard to accept, but they must do so, that the social worker is charged by law with giving an independent opinion. In the delicate situation that arises where their opinions do not concur, the doctor has to explain to the social worker exactly why he recommends compulsory detention, for the law makes the social worker the guardian of the patient's rights. It is intensely counter-productive for an irritated doctor to threaten: 'be it on your own head, then, if he commits suicide' but I have heard it said. This is an area where medical opinion and social work opinion may genuinely differ. No matter how long it takes, the two professions need to present all their arguments to one another. However bitter for the doctor it may be, the law gives to social workers the final say. The bitterness should not be worked out in scorn and the doctor, while maintaining his differing viewpoint, need not altogether withdraw his support. A number of social workers and Social Services Departments have been severely castigated by coroners, and in the media, for their decisions, particularly in the field of child care. No doctor should want to increase their jeopardy.

Top doctors and directors of social services sometimes engage in head-to-head confrontation in which neither party wants to show weakness and give way. Happily, relationships are usually much better at the level of clinical involvement. Some things, however, unnecessarily jar.

Social workers often sense that doctors are talking down to them. I hope it is not so, but consider the poor doctor's position. If he does not explain what chronic bronchitis is, and its consequences, and the social worker does not know, the patient's disabilities may not be properly appreciated. If he does explain, the social worker who already knows will feel that he is

being treated as an ignoramus. (Of the two faults, that of inadequately informing is much greater than over-informing and the social worker should accept this with middling grace). Unfortunately, the current training of social workers leaves them ignorant about many common diseases, sufferers from which they must regularly meet.

Doctors, especially hospital doctors who tend to have strong views about such things, may feel that social workers' dress is not responsible enough for the medical arena. A jacket and tie, a dress or blouse and skirt are still accepted professional attirements. Social workers, for their part, often feel that casual (not sloppy) dress, cardigan over open necked shirt, or T-shirt and jump suit is appropriate for themselves to face clients. To each his own. A difference in mode of dress can be present even when the doctor and the social worker are of an age with one another. It reflects differences of a larger significance. The doctor needs to distance himself from his patients in order to perform his professional role. The social worker sees himself, *vis-a-vis* his client, as altogether more alike, more pally, more companionable. More to be regretted are those who choose their clothing not for the relationship it helps to form with the client but deliberately to proclaim a separation from medical counterparts. Well, doctors need not repine. If patients observe a difference between the two, it can only stand to the doctor's credit. The social worker, oddly enough, may think it is to *his* credit. Such is a measure of the divisiveness in our society. For his (or especially her) part the doctor should not tactlessly dress so as to make apparent the disparity of earnings that exists between the professions.

Doctors are right to notice and to deplore that, even in medical settings, many social workers smoke. Does health education mean so little to them? Sadly, doctors must accept this anti-authoritarian demonstration that social workers do not see themselves as in the health business.

SOME SUGGESTED REMEDIES

Remedies are not always needed. The difficulties so far identified should not obscure that so much goes on so harmoniously, usefully, successfully, between doctors and social

workers. We are, both professions, so mutually involved that we need to communicate well and combine well. Outside the field of service, in the tiltyard of discussion, we may disagree, tease and taunt, grow heated and swell with self-righteous indignation. Inside the clinical-cum-social work arena of service we dare not. Therefore, difficulties that arise when the scope of that arena is ill-defined, or when there is disagreement over the 'unit of care', patient or family, should be aired, and the virtues, strengths, and weaknesses of each profession's position understood. Each profession has a different ethic but that gives no warrant to regard either as less ethical. It is not justifiable for the doctor to consider social workers as less dedicated because they do not to the same extent provide round the clock care nor for social workers to impugn the dedication to their NHS patients of doctors who do private practice. Such views are symptomatic of bad communication. In every instance of disagreement, there needs to be agreement to listen fully to what the other has to say, to accept the irreconcilables in approach, and to work within the limits of possible action inherent in the situation. Where there is no perfect solution available there has to be a combinative compromise to achieve the optimum. Where we are at cross-purposes concerning confidentiality a solution must be forged at a high level. We might try the DHSS, except that it would surely respond with pusillanimity. We might try the British Medical Association and the British Association of Social Workers, though each has dug its trenches. We cannot give up trying because solutions forged only locally will sooner or later come unstuck and lead to damaging recriminations.

At hospital team level it is advantageous not to harness together a chief and a chick, an experienced practitioner and a tyro. Directors of Social Service Departments and their deputies are not alert enough to the dangers of this. A youngster of twenty-five working with a fifty year-old consultant who is apt to 'my dear' her can have difficulty maintaining a professionally equal status, while to a sixty year-old consultant, social workers, like senior registrars, are still youngsters when in their late thirties yet even less appreciative of being 'my deared'. There is much to be said for continuity in a working relationship. It leads to mutual acceptance. Social work career structure and the need for experienced workers to move to senior, more administrative,

posts make no easy solution of this age trap possible. However, repeated switching around of staff should be avoided if at all possible.

Each profession must make explicit to the other the relevant facts about a patient. Mishaps occur when this is not done. As they work together, doctor and social worker soon learn the degree of detail of explanation that the other needs. Working together also founds a knowledge of each other's skills and soon produces a happy congruence of opinion as each other's ideas come to be absorbed. Mutual respect develops and leads to trust and hence to communication by consultation rather than by assertion and instruction.

Some communications need to be in writing, those for statutory purposes, and specially agreed letters to be sent to housing authorities or to ward off insistent but untimely demands for payment of debts. These apart, doctors and social workers communicate better by talking to each other. Proper time needs to be found for this. Social workers should not be asked to attend long ward rounds when their contributions and what they need to learn about patients need take no more than a few minutes. That is inconsiderate and unheeding of their efficiency. On the other hand essential exchanges of information should not depend on chance encounters in the ward, the clinic, or even the corridor. As with everything else in clinical care, the necessary discussions should be properly and economically scheduled. The convenience that must be suited is everybody's, and not just the doctor's.

It has been suggested that some joint training of medical students and social workers might make each more aware of the professional strengths of the other. I doubt it. It might even be counter-productive. However, each needs to be taught something of the ethos of the other profession. Those doctors granted lecturing time on social work courses should teach about how doctors approach the problems of diagnosis and treatment. Those who lecture medical students in the behavioural sciences need to be clear thinking about the differences between sociology and social work and not ignore the latter. Each profession should become familiar with the vocabulary of the other and, above all, become used to the presence of the other.

A doctor does not need to possess the knowledge and skills of

a social worker, but he needs to know something of what these are. To succeed in communicating well on a personal basis with his social work colleagues he must acquire a sensitivity to their needs, to what they are trying to do, to the constraints and pressures, both organizational and emotional that they are under and to their needs for tolerance, support and esteem. These needs may be no less than his own!

CONCLUSION

Writing this essay has been salutary for me as well as educational. I have become uncomfortably conscious of my own communication faults. Throughout I have written from the standpoint of the doctor, not being able to do otherwise. That is why I have preferred the word 'patient' to the social workers' 'client'. I see their difficulty over 'patient', but I wonder why they should have chosen a word derived from *cliens*, which means someone dependent upon a *patronus*, when dependency is what, wrongly as often as rightly, they seem so anxious to forestall. I believe that when doctors and social workers work together within the *medical setting* upon issues of clinical judgment, the medical standpoint is the more important. The doctor should have no qualms about his being the principal partner but should never forget the mutuality of respect due in any partnership. Although he should not fail to be in charge of the team if he is wise he might adopt the maxim: be direct but don't direct. I hope that in any clash with social workers, I take the side of the patient, against both of us.

ACKNOWLEDGEMENTS

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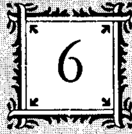

Communication between doctors and members of other selected caring professions

JOHN WALTON

Communication between doctors and members of other selected caring professions

THIS ESSAY COULD BE EXCEPTIONALLY BRIEF OR IMMENSELY long; brief if it were to concentrate simply upon points of principle which have emerged from discussions and written consultation with dietitians, clinical psychologists, pharmacists, and medical physicists; immensely long if it were to attempt to delve into all the minutia: relating to attitudes and communication problems which have been identified in relation to these or in relation to many other professions with whom doctors come into regular contact and who are not separately identified. It has been on the one hand chastening and on the other encouraging to recognize that each of my correspondents has recognized that in many, if not most, instances communication between those whom they represent and doctors has been satisfactory and even sometimes outstandingly good; chastening in that all of those concerned have recognized the attitudes which on occasions impair this process of communication and the problems sometimes arising from these attitudes which compound the difficulties they have experienced.

DOCTORS AND DIETITIANS

Perhaps it would be appropriate to quote selected passages from the very helpful letters I received. Mrs Greta Walton, former Honorary Chairman of the British Dietetic Association, comments that dietetics is a small profession with fewer than 1000 qualified dietitians working in the NHS; some doctors are

unaware that they exist and many have never spoken to one. She points out that dietitians cannot prescribe individual therapeutic diets, as pharmacists cannot prescribe drugs; this is the responsibility of the doctor. Dietitians may, however, speak to groups from any section of the population about normal nutrition or about principles relating to dietary modification in disease. She and her colleagues have identified the following problems arising from lack of understanding by, or poor communication with, doctors:

1. Non-referral of patients with a genuine need for skilled dietetic advice.

2. Late (i.e. pointless) referral, as of women in the 34th week of pregnancy.

3. Referral without adequate information, e.g. 'Diabetic—please advise', 'Low protein diet' (no reasons given). Adequate dietary counselling requires (a) a diagnosis or probable diagnosis; (b) information about investigations that have been or are being undertaken; (c) relevant biochemical details; (d) relevant drugs prescribed; and (e) 'warnings' about social problems. Ideally, the dietitian should have access to the medical notes.

4. Lack of realization that as medical treatment is changed or discontinued the dietitian should be informed. Many patients are left languishing on 'low fat', 'low protein', or other unpleasant regimes long after they need to be.

5. Failure to inform, or to ask the biochemist to inform, the dietitian of biochemical monitoring. For example, changes in the level of phenylalanine are critical in the diet of a child with phenylketonuria.

6. Insistence on the prescription of potentially harmful dietary regimes, e.g. huge amounts of fibre. This can present the dietitian, as a professional in her own right, with an ethical dilemma.

7. Unrealistic expectations of the results of dietary modification. A surgeon, for example, might tell a patient to 'lose three stones before I see you again in two months' before sending him or her to see the dietitian. The hapless dietitian is then faced with the problem of undermining the doctor's authority or losing her

own credibility. Dietetic treatment for allergies or intolerance requires understanding and patience and should not be discontinued or changed by the doctor without consultation with the dietitian. In cases of mild, maturity onset diabetes, oral hypoglycaemic agents should, if possible, be withheld until changes in diet are established and evaluated. Nearly all dietary regimes or changes in dietary patterns produce slow results (compared to some drugs).

8. Diet sheets are, at the best, merely aides memoires. Dietitians do not just hand out diet sheets; they counsel the patient after assessing his total nutritional requirements, his social and economic status and the relationship between the patient and his family.

9. Consultants should invite dietitians to participate in ward rounds, especially teaching rounds, where patients are on therapeutic diets.

10. When patients require parenteral or enteral tube feeds, the dietitian as well as the pharmacist should be involved to ensure that total nutritional adequacy is provided in the most economical or appropriate form.

11. In hospitals, special diets should be ordered by a doctor, not a nurse or a ward orderly.

12. Family and community doctors could use the nutritional and dietetic expertise of dietitians to a far greater extent. They should be used to inform and instruct doctors, nurses, health visitors and client groups 'at risk'. In fairness, they are increasingly doing so.

It is admitted first, that the number of qualified dietitians working in the health service is still insufficient for every patient who could benefit to receive dietetic advice, so that doctors may have to act alone; and there are many problems created by dietitians. Thus dietitians, and especially young ones, expect the doctor to be right in his assessment of patients' dietary needs and, if he is not, they are sometimes too intimidated to argue the case. Some dietitians also fail to keep up to date with changes in medicine or nutrition and dietetic practice. Dietetic departments, too, have traditionally been reactive in trying to cope

with everything that is asked of them without taking an initiative in consultation with doctors. It is also true that dietitians do not always take time to write in case notes or send informative letters to doctors who consult them.

While these notes have identified certain examples of bad practice, communication is often excellent, particularly in teams in special renal, paediatric, metabolic or other units where the role of each profession is clearly understood and defined and where the senior members of each profession have developed good and informal lines of communication. Some dietitians are undoubtedly undervalued, just as some doctors are arrogant, but most dietitians have found that once the initial effort has been made and mutual understanding has been established, there are few communication problems.

DOCTORS AND CLINICAL PSYCHOLOGISTS

Turning to clinical psychology, Susan Saltmore of the Manchester Royal Infirmary thinks that, in general, communication with the doctors with whom she has worked has been positive. Young doctors, particularly, have been psychologically ~educated, are prepared to participate in facilitative communication and have been accessible to consultation. She considers it important that medical colleagues have some knowledge of the various therapeutic and assessment skills used by psychologists and their areas of applicability. Her own experience is that most psychiatrists, but fewer general practitioners and perhaps even fewer rheumatologists, have an adequate working knowledge of the range of skills which clinical psychologists can offer. This can lead to inappropriate referral (referral of patients with problems which could more appropriately be managed by others) and referrals that are narrow and restricted in scope (where absence of knowledge prevents referral of a whole range of problems that may be amenable to psychological intervention). This she regards as a matter which could be improved by education.

Examining the facilitative aspects of communication, she points out that doctors are often unclear as to how to refer to clinical psychologists and takes the view that many suggestions made in 'Doctor to Doctor' have equal applicability to written

communication between doctors and psychologists. She believes that it is important to avoid unnecessarily complex medical terminology, as she herself has spent some time immersed in medical dictionaries or besieging medical colleagues for translations of referral letters, only to discover often that the information, once translated, had no relevance to her involvement with the patient. Referral letters should include a brief statement as to the problem upon which a psychological opinion is requested. In relation to accessibility, she believes that each profession must be accessible to the other, so that doctors and psychologists can find time for joint discussion and research. In the case of an urgent problem, a telephone discussion is desirable whenever possible; there are, of course, practical difficulties when a doctor and psychologist are each providing services in several hospitals. However, in common with members of other professions, she feels that there are settings where doctors, psychologists and other professionals should meet together in social contact to create mutually supportive relationships which she regards as being important in promoting good communication and good clinical practice.

In amplification of these comments, many of which are fully supported by Mr Clive Skilbeck and Mr John Welch of the District Psychological Service at the Newcastle General Hospital, each of my correspondents also stress the importance of the method of referral and the content of the referral letter, as well as the importance of discussion with the referring doctor in cases of difficulty. Many psychologists feel that they are only referred the 'hopeless cases' who have not been helped by a range of medical and other non-medical agencies prior to referral. Examples have included intractable neurotic patients and those with diffuse and severe organic degeneration where the probability of inducing significant behavioural change is very small. Skilbeck and Welch point out that Nichols (1) showed that of 24 clinical consultants (other than psychiatrists) in district general hospitals contacted in 1977/78 with the offer of access to psychological service, only 3 used that service in the first 3 years, and 13 were negative about the value of psychology, while the remainder reserved judgement. In another study (2) one-third of general practitioners felt that they could not use psychologists in their practice, even if they had funding and

accommodation. These correspondents also stress the importance of the treatment role performed by clinical psychologists and point to the importance of preparing patients before being referred for psychological assessment so that they can have some understanding of what is proposed and its purpose. Finally, they also comment upon communication from the psychologist to the doctor and have noted that some doctors have regarded the more casual dress and approach of psychologists as being less professional. Nevertheless, they believe that the traditional stereotypes of doctor and psychologist have been weakened and that many more doctors are becoming sensitive to problems of communication with patients and that, in consequence, psychologists are more secure in their role identity.

They conclude that although there has been little relevant work on communication between doctors and psychologists, and that further research would be useful, the position is improving as more doctors are encountering psychologists in their clinical practice and are becoming increasingly aware of the valuable contribution they can make to patient care.

DOCTORS AND PHARMACISTS

In commenting upon communication between doctors and pharmacists, Mr J. P. Kerr, FPS, a former member of the Council of the Pharmaceutical Society, points out that written communication is by means of a prescription so that it is, by its very nature, one way. Only if the pharmacist is unclear or unhappy about what is written does a dialogue take place. Every pharmacist is reluctant, in the interests of maintaining the confidence of the patient in his doctor, to disclose to the patient that there is a need to consult the prescriber before the prescription can be dispensed; this, however, does create difficulties, particularly in these days where it is less common than it was for the patient to take a prescription routinely to the pharmacist working closest to the surgery where the doctor has been consulted. Pharmacists find it very frustrating that doctors are often difficult to contact (this is a very common complaint). There is also evidence that prescription writing has deteriorated, sometimes with no doses being given, or given in such an abbreviated manner as to make no sense to the pharmacist. It

can be argued that it matters little what the doctor writes, because when the pharmacist transcribes the instructions to the label on the bottle it may be unreadable or misunderstood by the patient. However, nowadays typed or printed labels are the norm and it is therefore increasingly important that doctors should be clear in their instructions with regard to dosage. Difficulties are compounded when receptionists work from doctors' notes or patients' record cards and leave the doctor to sign the prescription, which it is thought he may sometimes do without checking its contents. Since prescriptions coming to a pharmacist may originate from many different areas of a town or city or its environs, the result mainly of posting of repeat prescriptions and of changes in the shopping habits of patients, there may be an increasing need for the pharmacist to be able to contact the doctor but considerable difficulty in doing so. Such contact is now almost entirely by telephone. There are advantages in having a pharmacy next door to, or even attached to, a health centre so that pharmacists can discuss problems face-to-face with doctors and even attend their seminars. In this way, pharmacists may contribute to vocational training in primary medical care. There is also a case to be made out, he feels, for the suggestion that when a doctor is not on duty, a colleague standing in for him, even from an emergency service, may be given authority to amend a colleague's prescription, while accepting that no pharmacist wishes to betray the unwritten rule that one must not undermine the patient's confidence in the doctor (and it is fair to say that many doctors would have reservations about this proposal, feeling that it could be potentially dangerous in some cases). In noting that communication in future may be by means of computer-generated scripts, Mr Kerr feels that it is increasingly important that doctors should pay particular attention to the clarity and content of their prescriptions so that communication between pharmacists and doctors can be maintained and improved in the interests of the patient.

DOCTORS AND MEDICAL PHYSICISTS

Turning finally to communication between doctors and physicists, Dr E. D. Williams of the Sunderland Regional Medical

Physics Department and Mr J. W. Haggith of the Regional Medical Physics Department at the Newcastle General Hospital have given their views. Dr Williams comments that doctors tend to make assumptions about the knowledge of medicine held by scientists, assuming either that they know very little or that they are, alternatively, expert in every branch of medicine. The truth is that physicists are often knowledgeable in some areas and very ignorant in others. Conversely, physicists can often assume that a doctor will understand their jargon, and this too can lead to misunderstandings because some doctors are often unwilling to admit their ignorance of any subject to anyone. Dr Williams further comments that doctors should be encouraged to take a greater interest in the work of scientists, noting that when scientists organize meetings of interest to clinicians, these are more poorly attended than when a doctor is speaking; in other words, physicists tend to be more interested in attending meetings on medical subjects than doctors are in attending those dealing with medical physics given by physicists. (It is, of course, possible that sometimes the physicists do not manage to excite the doctors' interest.) Both parties must therefore recognize the benefits of collaboration. Social contact out of hours can be very helpful in establishing relaxed relationships and it is often on such occasions that shared interests are discovered and the advantages of closer collaboration are first appreciated. Mr Haggith confirms that maximum co-operation between colleagues (whether of the same or different professions) arises from mutual understanding of the lack of knowledge of each other's fields, respect for each other's expertise, willingness on the part of both to learn sufficient of the other's subject, and the patience to explain one's own. What can happen in practice is:

1. A physicist, thinking he has grasped the problem, does a lot of hard work and then finds that it is not exactly what was wanted by the doctor.

2. A doctor wrongly interprets or over-interprets the result of the physicist's test (i.e. he may read more into the result than is justified by the scope of the test).

3. Conflict:

(a) is the result of inadequate communication—friendly talk is not necessarily full communication and usually a written

protocol in addition to discussion is the most effective way of ensuring that both doctor and physicist understand the problem and the way it is proposed to tackle it.

(b) most often happens because the doctor, having to make a decision on the management of his patient, has already made up and closed his mind to the result of the test—he is less able than the physicist to enjoy the luxury of uncertainty!

(c) is fortunately rare, it is usually due to a clash of personalities or occasionally to a failure to understand the other's jargon. It may spasmodically be due to political posturing by one or both—in modern life this problem is universal.

Finally, Mr Haggith comments that we all need to be aware of the professional pride that we acquire as a result of our training. Neither the medical profession nor that of medical physics is free from the image of pomposity, arrogance, and self-interest. Neither has a monopoly on intellect, leadership qualities, dedication, industry, or compassion. Communication with each other and other health care professions should be based on mutual esteem and on a spirit of true collaboration. In his experience, doctors and physicists who communicate along these lines invariably collaborate successfully.

CONCLUSIONS

So what may we conclude from these disparate observations provided by members of some of the other caring professions? In my view, certain common themes emerge.

1. When there is mutual understanding of the professional role of individuals in the other caring professions, those doctors who are prepared to acknowledge fully the contributions which colleagues in these fields can make to patient care encounter no serious problems in communication. All such communication should be concise but nevertheless comprehensive and explicit in defining problems which the patient may manifest and in indicating precisely what questions the other health care professional is being invited to answer, and what the doctor hopes to derive from the consultation (for indeed such it is).

2. When doubt arises or in an emergency setting, discussion face to face to clarify any outstanding difficulties about the reference is useful, but where this is impracticable a telephone conversation may resolve any misunderstandings or difficulties.

3. Clarity in presentation of referral notes, letters or prescriptions, with precise information or instructions, is vital.

4. There is a need for further education of doctors about the services which may be offered by their colleagues in the other caring professions and about the roles which they can fulfil, just as the other professions need to know more about medicine. Common seminars, discussion groups, and scientific meetings are to be commended.

5. Contact at a social level can be invaluable in improving communication between the various professions, in breaking down stereotyped images and in promoting mutual trust, understanding and support.

6. Much more effort is needed on the part of all the professions concerned in learning to understand, interpret, and appreciate the reasons for each other's technical and professional language.

7. Colleagues who come to know each other well, whatever their respective professions, commonly achieve mutual trust and understanding which helps greatly to remove or repair communication problems.

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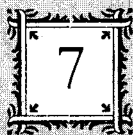

Conclusions and recommendations

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Conclusions and recommendations

COSCLUSIONS

1. IN INTERPROFESSIONAL COMMUNICATION, SUCH AS THOSE between doctors and members of the other health care professions as analysed in the preceding chapters, lack of understanding of professional hierarchies, ideologies, philosophies, and work practices, as well as interprofessional rivalry, arrogance, and prejudice are added to the problems of intraprofessional communication which we identified previously (in *Doctor to Doctor*).

2. Between the professions the problem of responsibility without the power to discharge that responsibility worries individuals to whom responsibility for care may be delegated by a senior member of their own or another profession without adequate control or authority. On the other hand such individuals resent arrogant resumption of responsibility by the senior member when problems arise. Communications between senior and junior members of different professions are even more fraught with problems than those between senior and junior members of the same profession. While the senior members of the different professions appear to be able to communicate reasonably satisfactorily and the junior members commiserate with each other and get on with it, the middle ranks may indulge in the manifestations of rivalry, arrogance and prejudice mentioned above.

3. The fact that many doctors still behave as though the other health professionals are inferior (the assured superior-subordinate relationship) is a thorny point. It is generally accepted that the doctor is responsible for medical decisions concerning the diagnosis, investigation, and treatment of the individual patient, but it is no longer acceptable for the doctor to ignore the advice of other health professionals in reaching these decisions. And he must not give the impression that implementing the agreed decisions necessarily involves an inferior role; certainly carrying out many of them requires professional knowledge and skill that the doctor does not have. It is also no longer generally accepted that the doctor is solely responsible for making the decisions about social, environmental, occupational, and community aspects of an individual's departure from normality. In this climate the doctor has to be careful about how he communicates any advice. Attitudinal differences as between professions and (implied) assumptions about differential social status as well as (real) differences in earning power can have serious effects upon morale and can be detrimental to collaboration. And yet no-one can seriously doubt that ultimate clinical responsibility must rest with the doctor.

4. While doctors are sometimes criticized, especially with the advent of new emphases on management in the NHS, for being too much concerned with individual patients and too little concerned with management of the overall workload and of resources, it is clear that social workers may find it difficult to assess the needs of their individual clients in the light of the wider social and medical context. On the other hand the contribution of the social worker to easing the lot of the individual is often underestimated and misunderstood by the doctor. Such attitudes impair communication.

5. It has been a surprise to the working party that communications between general practitioners on the one hand, and nurses, health visitors, and social workers working in and from the same premises with the same local people can be so difficult.

RECOMMENDATIONS

1. Doctors and members of the other caring professions should each re-examine and re-appraise their perceived stereotypes of the other professions to see whether these accord with current skills, knowledge, and activity. Perhaps a joint working party to examine these problems would have a useful role. Certainly doctors could usefully re-examine the principles which govern communication with their patients (*Talking with* Patients), with each other (Doctor to Doctor), and with members of other caring professions (this volume) now and at intervals in the future since health care and public expectations are changing so rapidly.

2. Each profession has a different, but important role to play in patient management. Where an overlap of responsibility becomes apparent or where the achievement of accurate diagnosis, prognosis, and counselling involves complementary tasks, there should be clear guidelines laid down of methods of proceeding with periodic re-evaluation where necessary.

3. The isolation of each professional role within the overall sphere of medical care should be avoided. This point should be emphasized throughout the training of all those involved in the various professions. Thus joint examination by doctors, nurses, and social workers of various aspects of inter-professional communication seems to be desirable. And senior doctors should pay particular attention to systems of monitoring 'routine' communications such as investigation requests, appointment letters, and discharge letters, as incompleteness or late despatch can greatly inconvenience the recipients but above all the patients to whom they refer.

4. Different methods of communication should be assessed (e.g. the spoken word, prepared written material, standard channels identified within the Health Service, and special cases) with especial reference to problems which have been identified by the different professions. While certain principles plainly emerge as being important (clarity, brevity where possible and appropriate, with feedback to avoid misunderstanding), generalization relating to methods involving all of the professions may not be justified.

We suggest the following checklist for doctors to use in examining their own communication with members of the other professions.

- am I clear why I am communicating?
- am I clear with whom I wish to communicate?
- to what professional group do the recipient(s) belong?
- is my message expressed in such a way that it will be understood by such recipient(s)?
- is it clear whether I expect a response? If so, what type of response do I expect?
- have I provided all the information the recipient needs to make the response I require?
- do I understand the recipient's likely reaction to my request and how it will fit into his own work practice? If not, should I find out?
- have I chosen the best form of communication (written, telephone, face-to-face) both for efficiency and record? Should I use more than one form (e.g. telephone and confirm in writing)?
- if written, is the communication legible?
- have I delegated the communication to someone else (secretary, houseman)? If so, is he/she clear about the answers to the questions above?
- is the communication courteous? If not, is this deliberate or accidental? (being discourteous by mistake is surely totally unacceptable)
- is the communication coloured by emotion (anger, scorn, friendship, sympathy); if so, is it appropriate? Is this likely to interfere with the content of the message?

5. Problems which have .emerged relating to the sharing of information and the effects that this may have upon accepted medical principles of confidentiality are important and must be recognized by all parties. More research in this field is probably required, but both doctors and the members of the other professions should take careful note of revised advice given by the General Medical Council to the effect that those who share

confidential medical information should be willing and able to preserve confidentiality.

6. Where there appears to be unsatisfactory communication between members of the different professions (especially when highlighted by poor outcome for the patient as a consequence of inadequate communication), the method of referral should be examined with a view to creating a more efficient method.

7. It is important that the referrals from doctors to medical laboratory scientific officers and scientists working in the laboratory service should be carefully monitored, especially in relation to their style and content (both in terms of volume and type, and also in the form of referral). Similar principles apply in relation to references to clinical psychologists, medical physicists and dietitians, among others.

8. All of those involved should be clear as to the difference between the prime and the secondary communicator. In each clinical setting, it is important that the prime communicator responsible for informing the patient of recommendations made about his or her care must be identified and will normally be the doctor. Secondary communicators giving supplementary advice on points of detail or on related issues which are not strictly medical (nurses, health visitors, social workers, and others) should always be aware of the limits defining what they should or should not tell the patient and must clearly, therefore, understand what the doctor has said or is intending to say, so that there should be no disagreement or conflict of advice between the parties. Guidelines as to confidentiality, as mentioned above, should be agreed and reasonable consensus achieved as to the main clinical aspects of the case along with appropriate lines of management and counselling. And everyone must recognize that introducing new procedures or administrative innovations should only be done after consulting those whose working practices may be affected thereby.

9. Constraints imposed by patient load and by restrictions on time are, of course, admitted; where face-to-face discussion between the various health care professionals is impracticable, telephone communication is clearly important. Where even this is impossible, in the last resort it may be necessary for the doctor

(and, where appropriate other professionals) to record the relevant information and advice in case notes (which should be available, where possible and where confidentiality can be protected, to members of the other professions involved in managing the patient's problems), or alternatively a letter explaining the doctor's views and intentions should be made available. Yet another possibility is that the form of reference to another health care professional, where appropriate, should indicate what the doctor's proposals for management will be. We are deeply concerned over the inadequacy of patient records both in hospital and in general practice with frequent loss and misfiling of records and believe that this question demands urgent re-examination.

10. Doctors must recognize, in relation to the other caring professions:

(a) the extent to which, on the basis of their specific training and expertise they may be expected to express an independent view upon a patient and his problems;

(b) the extent to which different professions expect to receive suggestions or even instructions as to what should be done as an alternative to inviting them to solve or clarify a specific problem and to communicate their solution to the health care team;

(c) the extent to which a particular aspect of patient management can *only* be handled properly by a member of another profession in contrast to situations in which it could equally well be provided by the doctor but it ought to represent a less efficient deployment of resources for him to do so.

11. Opportunities for social contact across the disciplines should be improved. Joint dining and social facilities in hospitals and health centres are invaluable. The provision of such social amenities contributes to good understanding and to a satisfactory working environment. Staff in all professions will be more inclined to frequent leisure facilities if these allow inter-professional communication of the type recommended above. Such inter-professional discussions at a social level may have what appear to be intangible benefits, but in respect of patient

care they can amount to very much more in improved efficiency and understanding.

12. As the title of this volume implies, good communication, mutual understanding, and support are vital components of satisfactory health care.