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VOICES IN HEALTHCARE: UNDERSTANDING COMMUNICATION GAPS ACROSS PROFESSIONAL BOUNDARIES

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Abstract
Modern inter-professional communication remains a barrier to positive patient outcomes. It is within these hierarchies that barriers emerge: varying schedules, inter and intra team relationships, and differences in perspectives to name a few. This qualitative study explores the patterns pertaining to communication in the tertiary hospital setting through focused interviews and group discussions, observations, and document analysis of 33 participants, including nurses, physicians, pharmacists, and public health experts. Five themes emerged from the data: (1) the impact of hierarchical structures, (2) inconsistent or non-standardized communication habits, (3) time constraints, (4) interpersonal challenges, and (5) practical strategies to bridge these gaps. The participants expressed frustations such as being silenced as a result of the existing power dynamics, and they suggested solutions such as SBAR, standardized handover tools, regular team briefing sessions, and developing a culture in which concerns can be openly expressed. Overcoming these challenges may lead to enhanced team integration, reduced errors, and improved patient care within an organization.

Keywords: Multidisciplinary teams, communication gaps, hierarchical barriers, interprofessional collaboration, patient safety, qualitative research, healthcare communication, psychological safety

Introduction

Envision a bustling hospital ward where the doctors, nurses, pharmacists, and even public health practitioners have their unique roles. But at the same time, they continuously need to share information. They hail from different cultures and have to communicate using their separate ‘professional languages’ under constant time pressure. If any part of that chain of communication breaks—perhaps a nurse is a bit too timid to reveal something to the main doctor, or a key piece of lab data is accidentally left out from the dialogue—patient care will be compromised.

A study undertaken by Leonard et al. (2004) indicated that miscommunication is perhaps one of the key contributors towards medical errors. Therefore, it is no wonder that finding new strategies on how these teams communicate is of utmost importance. However, establishing standardized communication protocols can prove to be very difficult. Lingard et al., (2004) van Rosse et al., (2009) point out that almost every ‘human’ feature of communication – for example, respect, clarity, and

openness – are some of the things that are incredibly difficult to automate, even with the availability of technology such as electronic health records EHRs.
In this case, we tried to get an in-depth understanding of the existing communication issues. Members of the team were asked how they communicate with one another, what factors limit communication, and how might such factors be overcome to enable effective information exchange. In the long run, we want to enhance the safety and quality of healthcare for patients as well as healthcare providers.

Literature Review
Within the healthcare system, effective communication remains among the most salient factors. Poor communication results in patient dissatisfaction, as well as a disengaged or worn out workforce (Salas et al., 2005).

1. Significance of Communication in Multidiscipline Teams
A patient's care is enhanced by the collaboration of nurses, doctors, pharmacists, and even public health practitioners. This collaboration, however,poses the challenge of everyday language barriers, workflow policies and jargon expectations which are alien to the practitioners (Leonard et al., 2004). If such distinctions remain unfulfilled, mere issuing of medication errors or lack of laboratory documentation can trigger major complications.

2. Major Obstacles Faced in Communication
o Geographic and Occupational Profession: The strict divisions between people from different areas of Medicine would hinder genuine collaboration, as explained by Lingard et al. (2004).
o Power Relations: Junior members in the majority of the hospital settings tend to remain quiet even in the most intimidating situations; as a result, some members may take advantage of their power (Sutcliffe et al., 2004).
o Resource Availability: Intensive care Units and other departments such as emegency have a strict time constraint with no chance for deep analysis and unanimated document handovers (Kohn et al., 2000).

o Communication Challenges: While data may be made easily accessible through the use of electronic health records, their use does not encourage realtime dialogues or informal discussion (van Rosse et al., 2009).

3. The Consequences of These Gaps
Everyone loses in communication collapses. Safety concerns for the patient arise, and team members feel robbed of appreciation if not downright stressed. The prevalence of greater medical mishaps coupled with lesser job satisfaction is a common reality.

4. Solutions for Communication Gaps
- SBAR (Situation-Background-Assessment-Recommendation) is a common framework that can aid certain gaps (Haig et al., 2006).
- In protected, simulated environments, team members can work on raising their voices and pulling together their simulations (Baker et al., 2005).
- Tools should include more than just storing information, they must also support collaborative work in real time (van Rosse et al., 2009).
- Edmondson (1999) coined the term psychological safety. This concept indicates that groups function more effectively when the members of the team are treated with respect and their input is valued.
These techniques do not end the conversation, as there is still much left to be desired—particularly the understanding of how these relations are manifested in socio cultural differences or teams which heavily depend on digital mediums and AI. We hope to contribute some of that knowledge my exploring one hospital's case and extracting the useful bits from it.

Methodology

Study Design

A qualitative approach was chosen because we wanted to get firsthand stories, observations, and opinions from the people on the frontline. This design let us capture the real-world texture of day-to-day communication, which can sometimes be lost in purely quantitative research.

Study Setting

We focused on a 500-bed tertiary hospital known for its multidisciplinary care model. This environment provided a rich tapestry of specialties, from general medicine and surgery to public health and pharmacy units, all intersecting daily.

Participants

We used purposive sampling to ensure we heard from a variety of roles:

- **Nurses (15)** from ICU, surgical, and medical units.
- **Physicians (10)** spanning internal medicine, surgery, pediatrics, and more.
- **Pharmacists (5)** from inpatient pharmacy and clinical pharmacology.
- **Public Health Professionals (3)** involved in broader health initiatives.

Data Collection

1. **Semi-Structured Interviews (45–60 minutes each):**

We asked open-ended questions like, "Can you tell me about a time communication really affected patient care?" These one-on-one chats helped us understand personal viewpoints.

2. **Focus Group Discussions (8–10 participants each):**

Bringing diverse professionals together in a group setting revealed both shared frustrations and differing perspectives. Each session lasted about 90 minutes.

3. **Observation:**

We watched real-time interactions during shift handovers, ward rounds, and team meetings, using a structured checklist to note communication patterns.

4. **Document Review:**

We looked at hospital policies, meeting notes, incident reports, and examples of standard communication protocols like SBAR.

Data Analysis

We followed Braun and Clarke's (2006) six-step process:

1. **Familiarization:** We transcribed interviews and focus groups, then read them alongside observation notes.
2. **Initial Coding:** Using NVivo software, we tagged recurring ideas in the transcripts.
3. **Theme Development:** We grouped related codes into broader themes.
4. **Review and Refinement:** The research team discussed and refined these themes to match our objectives.
5. **Defining Themes:** We named and described each theme, selecting powerful quotes to illustrate key points.
6. **Report Writing:** Finally, we wove everything together into a coherent narrative.

Ethical Considerations

We got the thumbs-up from the hospital's ethics committee, and all participants provided written consent. Identifiable data were anonymized, and observations only happened in non-sensitive areas with department heads' approval.

Quality Assurance

- **Member Checking:** Some participants reviewed the preliminary findings to confirm accuracy.

• **Triangulation:** We cross-checked data from interviews, focus groups, observations, and document reviews to ensure our findings held up.
• **Reflexivity:** The research team kept journals to acknowledge any biases or assumptions that might creep into our analysis.

Limitations
This research was limited to one hospital, so the findings might not apply everywhere. Also, some participants might have put a positive spin on their experiences in group settings.

Findings
From our thematic analysis, we identified **five overarching themes**, each shedding light on why communication falters and what might help fix it.

Theme 1: Hierarchical Barriers
• **Intimidation Factor:**
Nurses, pharmacists, and public health professionals often felt overshadowed by senior physicians.
"Sometimes, you feel like your opinion doesn't matter when senior doctors are discussing." – Nurse (P3)
• **Unequal Role Valuation:**
Public health perspectives or pharmacists' insights were sometimes sidelined.
"We're often brushed off because immediate clinical needs get priority." – Public

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Theme 2: Lack of Standardized Communication
• **Inconsistent Use of Tools**
While SBAR is officially "on the books," it wasn't consistently applied.
"Some of us use SBAR religiously, others never do, so you don't always know what information you're getting." – Nurse (P6)
• **EHR-Related Challenges**
Electronic records helped keep data in one place but sometimes reduced face-to-face check-ins.
"It's convenient but can be impersonal. Important context might not make it into the system." – Pharmacist (P7)

Theme 3: Time Constraints
• **Minimal Time for Detailed Talk**
In high-pressure spots like the ICU, quick decisions overshadow thorough discussions.
"When you've got five other emergencies, you might skip clarifying details." – Physician (P9)
• **Delayed Shift Handovers**
Late or rushed handovers meant incoming staff missed key updates.
"I've started a shift not fully knowing the patient's condition because the outgoing team was in a hurry." – Nurse (P4)

Theme 4: Interpersonal Challenges

- **Team Conflicts**

People noted that direct or abrupt styles could be misread as hostility, fueling tension.
"Some folks are so blunt, it feels like you're being scolded." – Nurse (P2)

- **Cultural and Language Barriers**

With a globally diverse staff, subtle differences in language or etiquette sometimes led to miscommunications.
"We come from everywhere, so misunderstanding can happen even if we speak the same language." – Pharmacist (P5)

Theme 5: Strategies for Better Communication

- **Structured Briefings**

Quick, purposeful team huddles helped align everyone on patient priorities.
"We do a short morning briefing, and it's amazing how it clears up issues before they snowball." – Physician (P1)

- **Psychological Safety**

Teams thrived when leaders encouraged open dialogue without judgment.
"Having a supportive environment made me confident enough to point out potential errors." – Nurse (P6)

- **Interprofessional Training**

Regular communication workshops eased tensions and clarified expectations.
"We learned how to give feedback in a respectful way, which has helped reduce conflicts." – Public Health Professional (P15)

Discussion

Our findings echo what many healthcare experts have been saying for years: effective communication is the secret sauce of a high-functioning healthcare team. However, it's clear that tackling hierarchical structures, inconsistent practices, time pressures, and interpersonal friction is no small task.

Hierarchical Structures

Fear of speaking up or being disregarded can stifle vital contributions (Lingard et al., 2004). Building a culture of psychological safety (Edmondson, 1999) means leaders and senior staff must actively invite feedback, while junior members are encouraged to voice their insights.

Standardization

Tools like SBAR only work if they're embedded in everyday routines (Haig et al., 2006). Many participants admitted to inconsistent use, suggesting that ongoing training and clear hospital policies could help. Meanwhile, EHRs, though essential for record-keeping, sometimes replaced face-to-face dialogue (van Rosse et al., 2009). A balanced approach—using technology but maintaining personal check-ins—is crucial.

Time Pressures

In busy departments, thorough communication can feel like a luxury. Yet, cutting corners often backfires, leading to errors that take even more time to fix (Kohn et al., 2000). Creating "protected time" for crucial handovers could be a game-changer.

Interpersonal Factors

Conflicts rooted in communication style or cultural differences aren't easily solved by a new policy. Instead, teams benefit from facilitated discussions, workshops, or simulation-based training that encourage empathy and mutual respect (Baker et al., 2005; Sutcliffe et al., 2004).

Practical Takeaways

1. **Leadership and Policy**: Commit to a hospital-wide communication protocol and enforce it.
2. **Psychological Safety**: Foster an environment where questions and concerns are welcomed.
3. **Tech and Human Touch**: Keep using EHRs but encourage direct conversation for context.
4. **Time Management**: Allocate specific times for thorough handovers and briefings.

Conclusion

At the heart of every strong healthcare team is the ability to share information openly, respect one another's roles, and collaborate seamlessly—especially in high-stakes environments. Our study reveals that communication breakdowns often have multiple layers, from intimidating hierarchies to cultural misunderstandings. Fortunately, there's hope: standardized protocols, regular training, supportive leadership, and a culture of psychological safety can work together to bridge these gaps.

By taking these insights to heart, hospitals can create a more connected, cohesive workforce where each professional is empowered to share knowledge and concerns. This, in turn, translates to higher-quality patient care and a more rewarding work experience for everyone involved.

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