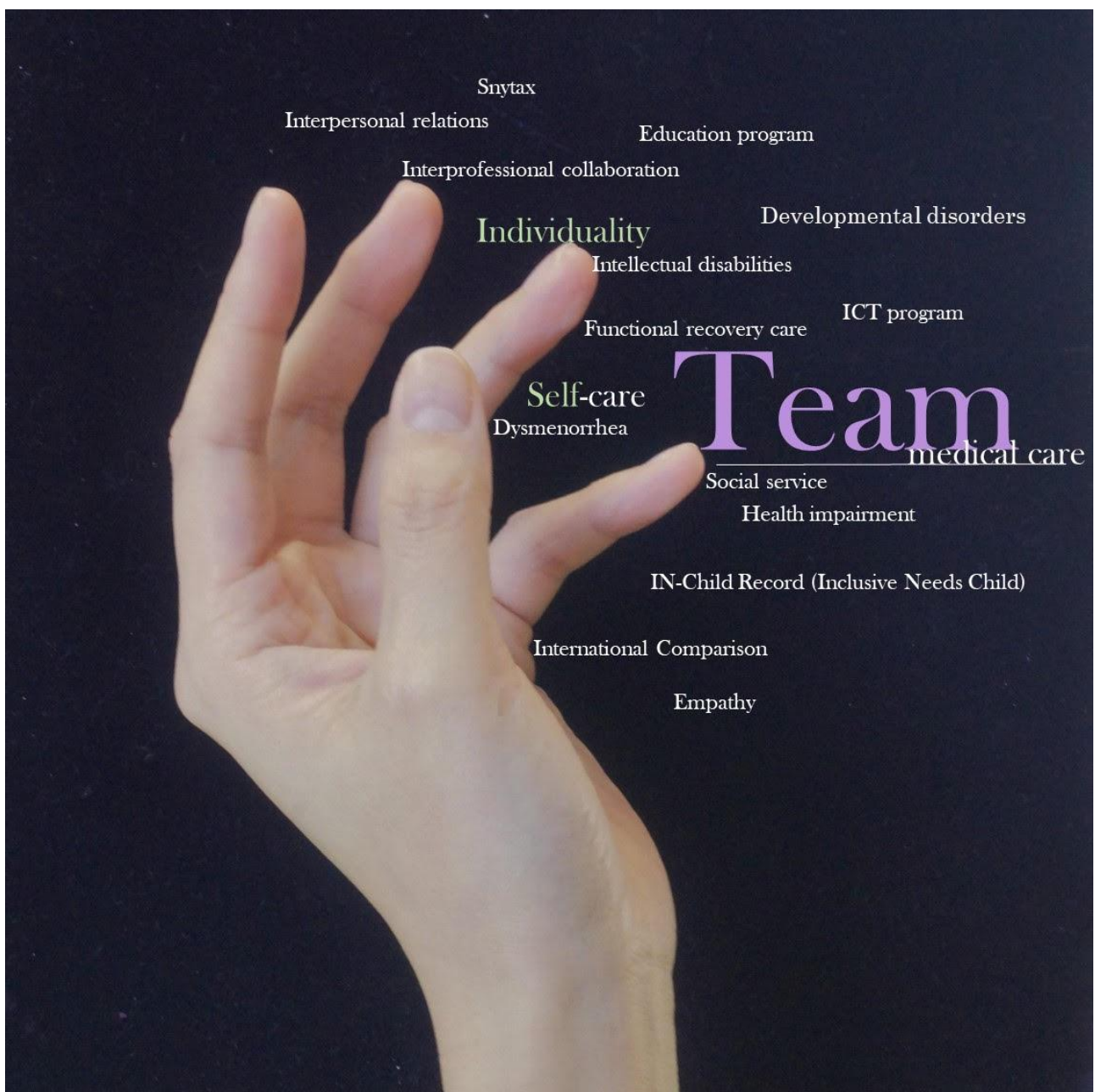


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ORIGINAL ARTICLE

The Characteristics of Communication in Interprofessional Collaboration in Multidisciplinary Team

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ABSTRACT

The purpose of this study is to identify the characteristics of communication in interprofessional collaboration for team medical care. Analysis of interview data from 18 doctors, nurses, medical social workers, care managers, and visiting nurses revealed [[Speaking/Conveying]] characteristics such as [Speaking freely, speaking unilaterally] and [Overbearing and superior attitude and manner of speaking], [[Listening/Not Understanding]] characteristics such as [Does not listen to people] and [Not understood due to technical terms and lack of information], and [[Awareness in Interprofessional Collaboration]] characteristics such as [Assumptions and Misinterpretations] and [There is a hierarchy depending on profession], as well as [[Consultation & Information Sharing]] characteristics such as [Discussion, Consultation & Adjustments] and [[Information Sharing]]. There are also [[Negative Feelings in Interprofessional Collaboration]] such as [Feeling intimidated] and [Hurtful manner of speaking/interaction]. Perceptions of [[Interprofessional Collaboration]] include [Collaboration means each professional doing what he/she should do] and [Collaboration means making adjustments and providing support among professionals], perceptions of [[Professional Role]] include [Professional roles and division of roles is not clear] and [Respective professional roles are not understood], perceptions of [[Patients]] includes [Understanding of the patient differs because of different points of view] and [Patient attitudes differ between home and hospital], and perceptions of [[Discharge]] include [Interprofessional Discrepancy in Opinion] and [Objectives for discharge are different].

<Key-words>

team medical care, interprofessional collaboration, communication, communication gaps

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I. Introduction

The Ministry of Health, Labour and Welfare (2016) is promoting the establishment by 2025 of comprehensive systems to provide support and services that aid in the protection of dignity and independent living among the elderly (community comprehensive care system), and therefore, the practice of team medical care and nursing care by health, medical and welfare practitioners is becoming ever more important. Team medical care requires sharing common goals and collaborating and cooperating through respective areas of expertise to achieve certain tasks; the outcomes benefit not only patients and their families, but also the health, medical and welfare practitioners who experience a sense of satisfaction and self-efficacy from achievement and who are motivated to learn and perform even better at their work (Takase, Nakagawa, Sakaguchi, et al., 2009).

Yet nurses, pharmacists, radiologists and others who participated in team medical care training have expressed views on how it is “difficult to interact and collaborate with people in other fields” and how “communication is fundamental to multidisciplinary collaboration and cooperation, yet is the greatest challenge”. Previous studies have outlined how role stress is experienced in collaborative work with care managers or nurses at elderly homes (Kanehara, Okada & Shirasawa, 2012), and how interprofessional collaboration can be challenging due to diffidence in the face of other professions and an inability to share information between team members (Harada & Yamane, 2013). Despite the need for interprofessional communication in team medical care, the level of achievement is still far from sufficient in practice. In another study by Higuchi, Harada & Oki (2009), one of the difficulties experienced during collaborative work between various home care and medical service providers was “interpersonal relationships within the team” specifically in relation to consultation across professions: “finding it difficult to consult with doctors” and “not being able to communicate well between medical and nursing care staff”. Subjects thus understood both the indispensability and difficulty of communication in interprofessional collaboration for team medical care.

Sano (2014) discusses how confrontations, discord, disputes and other friction are encountered across professions and departments, and Shinoda (2010) explains how interprofessional conflicts often arise from differences in educational background, training method, and value systems. These conflicts include irreconcilable differences in beliefs, values, or objectives, or conscious conflicts surrounding different desires related to control, status, affection, etc. between two or more individuals in a mutually dependent relationship (Northouse & Northouse, 2010).

Conflicts and difficulties with communication in interprofessional collaboration are due in part to communication gaps. Such communication gaps refer to discrepancies stemming from different understandings or values, or a lack of information (Matsumura, 2012). They can be “information gaps” arising from failure to receive necessary

information, or “understanding gaps” arising from differences in the cultural backgrounds, values, experiences or perceptions of the speaker and the receiver (Japan Contact Center Education and Certification Association, 2014). To even slightly alleviate difficulties communicating in interprofessional collaboration, these communication gaps need to be filled as much as possible.

II. Research Purpose

This study aims to identify the characteristics of communication in interprofessional collaboration for team medical care.

Team medical care is “the provision of precise, patient-suited medical care by various types of medical care staff who share objectives and information and collaborate to divide up work while complementing their respective fields of expertise” (Ministry of Health, Labour and Welfare, 2010).

III. Methodology

1. Research design

Content analysis of semi-structured interviews.

2. Participants

Total of 25 subjects: 5 hospital doctors, 5 discharge support nurses (nurses), 5 medical social workers (MSW), 5 care managers, and 5 visiting nurses with five or more years of experience. Selection was conducted through snowball sampling.

3. Research period

December 2016 to March 2017

4. Content

Topics were 1) manner of communication attempted in interprofessional collaboration, 2) nature of difficulties experienced with communication in interprofessional collaboration, and 3) awareness of interprofessional collaboration.

5. Data collection

Semi-structured interviews were conducted based on an interview guide. Research requests were submitted to facility directors. Participants were those people who agreed to cooperate in this study. Participants were interviewed for approximately 60 minutes upon agreeing to a written and oral explanation of the research. Each participant introduced the next participant until there were no more people to introduce.

6. Analysis

Verbatim transcripts were created based on IC recordings and analyzed for content. Transcripts included only data consented to by participants. Data was chunked while preserving meaning and then coded, divided into similar themes and then categorized per advice of the research director. Division of data was spread out over time to maintain validity and reliability and repeated until categories became fixed.

7. Ethical considerations

A letter of request was distributed to facility directors and study participants. The letter of request stated the purpose of research with a summary and explained that interview data would be used only for purposes of this study and destroyed after the later of 5 years following the conclusion of the study or 3 years from final presentation of research, and that, although results might be presented at symposiums or in academic journals, no individual information would be unidentifiable. The letter further explained that participation was voluntary, that there were no unfavorable consequences to not responding, and that participants were free to withdraw from interviews at any time even after granting consent. There are no conflicts of interest associated with this research, and this study has been approved by the International University of Health and Welfare IRB (Approval Number: 16-Ig-84).

IV. Results

1. Participants

There were a total of 18 participants: 3 doctors, 3 nurses, 4 MSWs, 5 care managers, and 3 visiting nurses (Table 1).

< Table 1 > Basic attributes

| Basic license | Age | Sex | Duty place | Length of service (years) | |
|-----------------------|-------|--------|---------------------------------|---------------------------|-----|
| Doctor | A 40s | Male | University hospital | Physician | 21 |
| | B 60s | Male | hospital | Surgeon | 41 |
| | C 40s | Male | General hospital | Physician | 21 |
| Nurse | A 60s | Female | hospital | Discharge support room | 30< |
| | B 40s | Female | hospital | Discharge support room | 8 |
| | C 40s | Female | hospital | Discharge adjustment | 17 |
| Medical social worker | A 40s | Female | hospital | | 15 |
| | B 40s | Female | hospital | | 16 |
| | C 40s | Female | hospital | | 17 |
| | D 30s | Female | hospital | | 7 |
| Care manager | A 40s | Female | Home care support establishment | Care job | 9 |
| | B 50s | Female | Visit care support | Counselor | 17 |
| | C 40s | Female | Home care support establishment | Medical social worker | 5 |
| | D 50s | Female | Home care support establishment | Welfare job | 5< |
| | E 50s | Female | Home care support establishment | Care job | 11 |
| Health visitor | A 50s | Female | Home nursing station | | 18 |
| | B 40s | Female | Home nursing station | | 20 |
| | C 40s | Female | Home nursing station | | 5< |

2. Communication in interprofessional collaboration

Extractions for communication in interprofessional collaboration consisted of 824 codes, 78 sub-categories, 25 categories, and the 5 core categories of [[Speaking/Conveying]], [[Listening/Not Understanding]], [[Consultation & Information Sharing]], [[Awareness in Interprofessional Collaboration]] and [[Negative Feelings in Interprofessional Collaboration]]. The number of codes and number of codes by profession are shown in Tables 2-1 and 2-2. Within this text, core categories are indicated with [[]] brackets, categories are indicated with [], and sub-categories are indicated with { } brackets. The number of sub-categories is indicated in () parentheses after [] brackets.

1) [[Speaking/Conveying]]

[[Speaking/Conveying]] consists of six categories: [Speaking freely, speaking unilaterally] (5), [Overbearing and superior attitude and manner of speaking] (2), [Inquiries depending on profession] (2), [Creating an easy-to-work atmosphere and minding manner of speech] (3), [Being unable/unwilling to say certain things] (6), and [Being scolded or yelled at] (2). [Speaking freely, speaking unilaterally] and [Being unable/unwilling to say certain things] were extracted mainly from MSWs, care managers and visiting nurses.

2) [[Listening/Not Understanding]]

[[Listening/Not Understanding]] consists of three categories: [Does not listen to people] (2), [Not understood due to technical terms and lack of information] (5), and [Not understood or comprehended] (3). [Not understood due to technical terms and lack of information] was extracted from all professions.

3) [[Consultation & Information Sharing]]

[[Consultation & Information Sharing]] consists of four categories: [Discussion, Consultation & Adjustments] (5), [[Information Sharing]] (3), [Choosing trustworthy people] (2), and [Doctors and nurses lend a helping hand] (2). [Discussion, Consultation & Adjustments] was extracted frequently from all professions.

4) [[Awareness in Interprofessional Collaboration]]

[[Awareness in Interprofessional Collaboration]] consists of seven categories: [Assumptions and Misinterpretations] (3), [Easier to implement collaboration] (3), [Awareness for communication] (3), [Hierarchy depending on profession] (5), [Cannot oppose doctors] (2), [Desire to learn] (3), and [Confidence/Complexes] (2). Both {I have no issues with communication} and {I cannot oppose doctors because they have authority over treatment and employ me} were extracted from all professions.

5) [[Negative Feelings in Interprofessional Collaboration]]

[[Negative Feelings in Interprofessional Collaboration]] consists of five categories: [Feeling intimidated] (5), [Hurtful manner of speaking/interaction] (3), [Stress] (2), [Aversion due to fear of failure] (3), and [Sharing Feelings] (2). This core category was extracted mainly from MSWs, care managers, and visiting nurses.

< Tabl 2-1 > Communication in interprofessional collaboration

| Core Category | Category | Sub-Category | Number Coded | | | | | | |
|---|---|---|---|---------|--------|-----|--------------------------------|----|---|
| | | | Total | Doctors | Nurses | MSW | Care Manager Visiting Nurse | | |
| Speaking freely, speaking unilaterally | Overbearing and superior attitude and manner of speaking | I can say what I want to say | 5 | 0 | 1 | 0 | 3 | 1 | |
| | | It is easy to talk in face-to-face relationships | 21 | 2 | 0 | 4 | 6 | 9 | |
| | | Harsh expressions | 7 | 0 | 1 | 1 | 2 | 3 | |
| | | Opinions are unilaterally forced on people | 37 | 1 | 4 | 0 | 18 | 14 | |
| | | With multiple professions, there are conflicting opinions or the same opinions are repeated | 10 | 1 | 0 | 8 | 0 | 1 | |
| | Inquiries depending on profession | Superior manner of speaking and acting | 18 | 1 | 0 | 5 | 3 | 9 | |
| | | Overbearing attitude and language | 14 | 4 | 0 | 4 | 3 | 3 | |
| | Speaking / Conveying | Creating an easy-to-work atmosphere and minding manner of speech | I select the content of my inquiries depending on the profession | 5 | 2 | 0 | 0 | 2 | 1 |
| | | | I change the way I speak to match the other person | 10 | 0 | 0 | 6 | 4 | 0 |
| | | Being unable/unwilling to say certain things | I hold back or refrain from saying things so as not to upset people | 13 | 1 | 0 | 2 | 6 | 4 |
| It is important to respect and try to understand the other person | | | 12 | 0 | 1 | 0 | 10 | 1 | |
| I try to create an easy-to-speak atmosphere and ways of talking | | | 17 | 1 | 2 | 5 | 2 | 7 | |
| Being scolded or yelled at | | Difficult to say things depending on profession | 22 | 2 | 3 | 5 | 5 | 7 | |
| | | I cannot express my opinion to or disagree with the hospital | 9 | 1 | 0 | 2 | 1 | 5 | |
| | | I cannot say things because of atmosphere or overbearing attitude | 39 | 0 | 6 | 17 | 7 | 9 | |
| | | I cannot say things because I do not want to be hurt by the other person's response or comment | 28 | 0 | 1 | 9 | 15 | 3 | |
| | | I do not know how to interact, and so it is difficult to talk | 10 | 3 | 2 | 2 | 3 | 0 | |
| Does not listen to people | Does not speak so that other people can understand | 10 | 2 | 0 | 0 | 1 | 7 | | |
| | I was yelled at or scolded by the doctor | 7 | 0 | 1 | 1 | 1 | 4 | | |
| Listening / Not Understanding | Does not listen to people | Get angry when busy and asked about complex matters or things that can be answered by people other than doctors | 8 | 6 | 2 | 0 | 0 | 0 | |
| | | Does not accept the opinions of other people, does not listen | 5 | 1 | 0 | 1 | 3 | 0 | |
| | Not understood due to technical terms and lack of information | Does not accept other opinions | 2 | 0 | 0 | 2 | 0 | 0 | |
| | | Summaries do not contain the information I need, therefore, not communicated | 31 | 2 | 6 | 11 | 0 | 12 | |
| | | Plans are not assessed, so no change whatsoever | 11 | 1 | 0 | 5 | 1 | 4 | |
| | Not understood or comprehended | Information Sharing | Not understood because it is only results without any explanation | 8 | 0 | 0 | 0 | 1 | 7 |
| | | | The same words are not accurately conveyed when the people hearing them have different values and experiences | 9 | 1 | 1 | 2 | 2 | 3 |
| | | Choosing trustworthy people | Not understood in terms of content, or because of abbreviations and technical terms | 22 | 1 | 2 | 7 | 5 | 7 |
| | | | Not conveyed even if speaker thinks it is | 15 | 7 | 0 | 4 | 0 | 4 |
| | Consultation & Information Sharing | Discussion, Consultation & Adjustments | Not conveyed unless conveyed | 7 | 0 | 0 | 2 | 3 | 2 |
| Hard to get the point through | | | 9 | 0 | 2 | 0 | 0 | 7 | |
| I participate in discharge conferences and engage in discussion | | | 21 | 3 | 5 | 2 | 4 | 7 | |
| Cannot discuss sufficiently | | | 23 | 1 | 2 | 3 | 6 | 11 | |
| Doctors and nurses lend a helping hand | | Information Sharing | Able to mutually confer | 28 | 1 | 4 | 13 | 2 | 8 |
| | | | I made adjustments with other professions and families | 4 | 1 | 0 | 1 | 1 | 1 |
| | | Mutually able to verify | Information is shared and there is a shared understanding of how to resolve issues | 7 | 1 | 2 | 2 | 1 | 1 |
| Need tools for sharing information | | | 12 | 7 | 0 | 0 | 0 | 5 | |
| Doctors and nurses lend a helping hand | | Choosing trustworthy people | Misunderstandings may arise depending on how information is shared | 21 | 3 | 4 | 5 | 0 | 9 |
| | | | Choose responsive people who are easy to assist | 5 | 0 | 0 | 1 | 0 | 4 |
| Doctors and nurses lend a helping hand | Doctors and nurses lend a helping hand | Choose people who have mutual knowledge of each other and are trustworthy | 8 | 0 | 1 | 1 | 4 | 2 | |
| | | Some doctors are kind and helpful | 2 | 0 | 0 | 0 | 1 | 1 | |
| Doctors and nurses lend a helping hand | Doctors and nurses lend a helping hand | Doctors and nurses tell patients that they are collaborating with care managers | 2 | 0 | 0 | 0 | 2 | 0 | |

<Tabl 2-2> Communication in interprofessional collaboration

| Core Category | Category | Sub-Category | Number Coded | | | | | |
|--|---|---|--------------|--------|-------|-----|--------------|---------|
| | | | Total | Doctor | Nurse | MSW | Care Manager | Visitor |
| Awareness in Interprofessional Collaboration | Assumptions and Misinterpretations | Disconnect because of discussion based on assumptions and biased interpretation of information | 29 | 2 | 3 | 12 | 6 | 6 |
| | | Patients/families and medical practitioners have different opinions, but the medical opinion prevails | 6 | 1 | 0 | 3 | 2 | 0 |
| | | Not understanding the other person's position | 3 | 0 | 1 | 2 | 0 | 0 |
| | Easier to implement collaboration | I am notified earlier now | 12 | 3 | 1 | 1 | 4 | 3 |
| | | Systemization contributed to a awareness, and it is clear now where to go with questions | 15 | 0 | 1 | 8 | 3 | 3 |
| | | Changes in awareness, manner of speaking and attitudes about collaboration | 25 | 3 | 0 | 6 | 10 | 6 |
| | Awareness for communication | I have no issues with communication | 18 | 6 | 5 | 1 | 5 | 1 |
| | | Easy to speak because of no aversions or seniority relationships | 4 | 1 | 1 | 0 | 2 | 0 |
| | | It is more difficult to communicate within the same profession | 3 | 0 | 2 | 1 | 0 | 0 |
| | Hierarchy depending on profession | I believe medical care and doctors at the hospital are the best | 11 | 7 | 0 | 0 | 3 | 1 |
| | | I was ranked by my professions | 9 | 2 | 0 | 0 | 2 | 5 |
| | | They have their position and freely rank people | 8 | 2 | 0 | 0 | 4 | 2 |
| | | Easy to work with no seniority relationships | 7 | 2 | 1 | 0 | 3 | 1 |
| | | Some professions are to be revered and are difficult to approach | 10 | 4 | 1 | 1 | 4 | 0 |
| | | Hospitals are places for treatment, so by default doctors must take the initiative | 4 | 4 | 0 | 0 | 0 | 0 |
| | Cannot oppose doctors | I cannot oppose doctors because they have authority over treatment and employ me | 3 | 0 | 0 | 1 | 0 | 2 |
| | | Study to increase knowledge or mutually learn about others | 12 | 2 | 0 | 0 | 9 | 1 |
| | Desire to learn | Depends on differences in desire to learn | 8 | 1 | 1 | 4 | 2 | 0 |
| | | I do not know what to study | 6 | 6 | 0 | 0 | 0 | 0 |
| | Confidence / Complexes | I am proud or confident | 5 | 0 | 0 | 1 | 4 | 0 |
| | | I have flaws or complexes | 6 | 0 | 0 | 2 | 1 | 3 |
| | Feeling Intimidated | I feel intimidated depending on profession | 5 | 0 | 0 | 2 | 1 | 2 |
| | | I am intimidated by yelling or scolding | 3 | 1 | 0 | 0 | 0 | 2 |
| | | Atmosphere and manner of speaking is intimidating | 3 | 0 | 0 | 1 | 2 | 0 |
| | | I feel intimidated not having met before or not knowing the person | 2 | 1 | 0 | 1 | 0 | 0 |
| | | I have less fear or stress related to doctors | 3 | 1 | 0 | 1 | 0 | 1 |
| | | I was hurt by callous manner of speaking or response | 4 | 0 | 1 | 3 | 0 | 0 |
| Hurtful manner of speaking/ interaction | I was hurt when someone took out their anger on me when things did not go as planned | 2 | 0 | 0 | 2 | 0 | 0 | |
| | I feel a lack of respect and consideration of others | 3 | 1 | 0 | 1 | 1 | 0 | |
| | I feel stress over things I cannot say | 3 | 0 | 0 | 0 | 1 | 2 | |
| Stress | Stress is being alleviated | 6 | 0 | 2 | 2 | 1 | 1 | |
| | I am afraid of failure and find it difficult to speak with others | 5 | 2 | 1 | 0 | 2 | 0 | |
| Aversion due to fear of failure | People who are not good at communication think that other people will not be cooperative | 7 | 1 | 0 | 0 | 6 | 0 | |
| | I am increasing opportunities to improve communication and taking steps not to be nervous | 7 | 0 | 0 | 1 | 5 | 1 | |
| | I can share when I am uncertain about things or feeling hurt | 5 | 0 | 0 | 4 | 1 | 0 | |
| Sharing Feelings | People do not understand me because they are in the same profession | 1 | 0 | 0 | 0 | 1 | 0 | |

2. Understanding of interprofessional collaboration by profession

Extractions for understanding of interprofessional collaboration consisted of 279 codes, 33 sub-categories, 14 categories, and the 4 core categories of [[Interprofessional Collaboration]], [[Professional Role]], [[Patients]], and [[Discharge]]. The number of codes and number of codes by profession are shown in Table 3. Within this text, core categories are indicated with [[]] brackets, categories are indicated with [], and sub-categories are indicated with { } brackets. The number of sub-categories is indicated in () parentheses after [] brackets.

1) **[[Interprofessional Collaboration]]**

[[Interprofessional Collaboration]] consists of four categories: [Collaboration means each professional doing what he/she should do] (2), [Collaboration means making adjustments and providing support among professionals] (3), [Collaboration is not effectively implemented due to different understandings] (2), and [The need for collaboration and the meaning of collaboration is not understood] (2).

{Collaboration means connecting with other specialists}, etc. was extracted from doctors, nurses, and MSWs and {Collaboration means making adjustments and providing support where professions overlap} etc. was extracted from MSWs, care managers, and visiting nurses.

2) **[[Professional Role]]**

[[Professional Role]] consists of four categories: [Professional roles and division of roles is clear] (2), [Respective professional roles are not understood] (2), [Professional roles and division of roles is not clear] (2), and [Professional role and nature of work is not understood] (3).

{Professional roles and division of roles are defined} was extracted from MSWs, care managers, and visiting nurses. {Professional roles and division of roles is not clear} was extracted from nurses, MSWs, and care managers.

3) **[[Patients]]**

[[Patients]] consists of two categories: [Understanding of the patient differs because of different points of view] (2), and [Patient attitudes differ between home and hospital] (2).

{Patient attitudes differ between familiar home and hospital} was extracted from all professions, {Interprofessional viewpoints differ} was extracted from all professions other than doctors, and {I do not know the patient's actual condition beyond the scope of what I see myself} was extracted from MSWs, care managers, and visiting nurses.

4) **[[Discharge]]**

[[Discharge]] consists of four categories: [Interprofessional Discrepancy in Opinion] (3), [Hospital rules and systems are not understood] (2), [Preparation of environment for discharge without anxiety] (3), and [Objectives for discharge are different] (3).

{The hospital side has certain rules and systems that do not allow for changes} was extracted from all professions, {Patients are discharged when treatment is completed, without consideration of the family's ability to provide care or other daily life issues} was extracted from MSWs, care managers, and visiting nurses, {Objectives different across fields because the objective is what determines the treatment program} and {interprofessional opinions are divided due to vague indices for discharge} were extracted from nurses and MSWs, and {support is delayed due to unclear treatment program} was extracted from nurses.

< Table 3 > Understanding of interprofessional collaboration by profession

| Core Category | Category | Sub-Category | Number Coded | | | | | |
|--|--|---|--|---------|--------|-----|---------------|------------|
| | | | Total | Doctors | Nurses | MSW | Care Managers | Physicians |
| Interprofessional Collaboration | Collaboration means each professional doing what he/she should do | Collaboration means sharing information and then doing what should be done | 6 | 0 | 0 | 4 | 1 | 1 |
| | | Collaboration mean connecting with other specialists | 11 | 3 | 3 | 5 | 0 | 0 |
| | Collaboration means making adjustments and providing support among professionals | Collaboration means making adjustments and providing support where professions overlap | 8 | 0 | 0 | 4 | 2 | 2 |
| | | Collaboration means mutually exchanging information and being able to discuss and confer with each other | 12 | 1 | 1 | 4 | 2 | 4 |
| | | Collaboration is working with mutual respect without seniority relationships | 5 | 4 | 0 | 0 | 1 | 0 |
| | Collaboration is not effectively implemented due to different understandings | I want to collaborate efficiently | 6 | 2 | 0 | 0 | 1 | 2 |
| | | I want to be able to collaborate, but I am unable to | 12 | 2 | 0 | 1 | 3 | 6 |
| | The need for collaboration and the meaning of collaboration is not understood | I do not see the need for collaboration, or I think it is unnessecary | 9 | 1 | 0 | 5 | 0 | 3 |
| | | I say collaboration but we do not really understand it | 4 | 0 | 0 | 2 | 2 | 0 |
| | Professional Role | Professional roles and division of roles is clear | Professional roles and division of roles are defined | 21 | 3 | 0 | 8 | 3 |
| I only do what I am assigned | | | 6 | 1 | 0 | 3 | 2 | 0 |
| Respective professional roles are not understood | | There are differences in understanding of the nature and effect of professional work | 10 | 1 | 0 | 1 | 4 | 4 |
| | | Patient families and medical practitioners have different opinions, but the medical opinion prevails | 8 | 0 | 0 | 0 | 1 | 7 |
| Professional roles and division of roles is unclear | | Acting beyond the role of one's profession | 17 | 2 | 1 | 6 | 8 | 0 |
| | | Vague roles and division of roles | 17 | 0 | 1 | 2 | 14 | 0 |
| Professional role and nature of work is not understood | | Different perceptions of profession and nature of work | 10 | 0 | 0 | 6 | 4 | 0 |
| | | No knowledge of place of work or daily schedule | 6 | 2 | 0 | 3 | 1 | 0 |
| Patients | Understanding of the patient differs because of different points of view | Interprofessional viewpoints differ | 8 | 0 | 2 | 2 | 1 | 3 |
| | | I do not know the patient's actual condition beyond the scope of what I see myself | 8 | 0 | 0 | 1 | 3 | 4 |
| | Patient attitudes differ between home and hospital | Patient attitudes differ between familar home and hosnital | 11 | 2 | 1 | 4 | 1 | 2 |
| | | Different impressions of patients who live at home | 8 | 1 | 0 | 1 | 2 | 4 |
| | Interprofessional Discrepancy in Opinion | Patients are discharged when treatment is completed, without consideration of the family's ability to provide care or other daily life issues | 9 | 0 | 0 | 3 | 2 | 4 |
| | | Difference in opinion due to specialty | 7 | 4 | 0 | 2 | 1 | 0 |
| Different ways of thinking and approaches to work | | 6 | 0 | 2 | 1 | 2 | 1 | |
| Discharge | Hospital rules and systems are not understood | The hospital side has certain rules and systems that do not allow for changes | 13 | 3 | 2 | 3 | 1 | 4 |
| | | Hospital functions and characteristics are not understood | 3 | 1 | 0 | 2 | 0 | 0 |
| | Preparation of environment for discharge without anxiety | Hospitals are shifting towards support for at-home care | 3 | 0 | 0 | 0 | 0 | 1 |
| | | I want patients to be discharged after symptoms are under control and material preparations are made | 5 | 1 | 0 | 0 | 2 | 2 |
| | Objectives for discharge are different | I value whether the patient and family feel they can comfortably cope with the illness | 9 | 0 | 5 | 0 | 3 | 1 |
| | | Objectives are different across fields because the objective is what determines the treatment program | 7 | 0 | 4 | 3 | 0 | 0 |
| | interprofessional opinions are divided due to vague indices for discharge | 7 | 0 | 1 | 6 | 0 | 0 | |
| | support is delayed due to unclear treatment program | 4 | 0 | 4 | 0 | 0 | 0 | |

V. Discussion

1. Characteristics of communication in interprofessional collaboration

1) How information is conveyed and received

[Speaking freely, speaking unilaterally] and [Overbearing and superior attitude and manner of speaking] were two characteristics of communication in interprofessional collaboration. As Arita & Mizumoto (2011) note, psychological power relationships tend to

be formed between patients and medical practitioners as non-professionals and professionals, healee and healer. This results in a tendency toward one-way communication in which the practitioner instructs and guides the patient. This tendency is not limited to patient and practitioner; it also occurs in interprofessional collaboration when communication flows in one direction from specialist to non-specialist and from the person giving orders to the person receiving them. Efforts were made in communicating: [Being unable/unwilling to say certain things], [Inquiries depending on profession], and [Creating an easy-to-work atmosphere and minding manner of speech]. This may reflect a desire to preserve teamwork and not disrupt relationships; as Higuchi (2015) argues, Japanese people tend to avoid confrontation in interpersonal relationships and strive to keep things smooth on the surface despite their actual feelings.

Past experience with [Overbearing and superior attitude and manner of speaking] or [Being scolded or yelled at] may influence [Feeling intimidated] [Hurtful manner of speaking/interaction]. Perceptions such as [Hierarchy depending on profession], [Cannot oppose doctors], and [Confidence/Complexes] may also tie into [Being unable/unwilling to say certain things]. As Shinoda (2011) explains, this may be related to a hierarchy in the medical and health and welfare fields in which doctors stand at the top of the pyramid and monopolize work; certain acts are clearly to be performed only by doctors, and comedicals cannot engage in anything except under the instruction of a doctor. Lack of confidence and complexes may also be due to differences by profession in difficulty levels and time spent on training, as well as basic education systems and certifications required. [Aversion due to fear of failure] may also be tied to [Being unable/unwilling to say certain things].

Regarding [Not understood or comprehended], although we use words and letters to communicate with others, these words and letters can convey only abstract, condensed information. Likewise, Drucker (2000) argues how no matter how well we explain something, it will not be understood if we speak only in one direction. [Assumptions and Misinterpretations] may also be a factor. Fukuda (1998) writes that the receiver relies on various personal factors such as past experience, knowledge, ability, desire, and emotion, and that the same word can be interpreted in a myriad of ways depending on the receiver. Images associated with certain words will also vary by individual and by occupation, and this leads to assumptions and misinterpretations that then tie into [Not understood or comprehended].

[Not understood due to technical terms and lack of information] is another factor to consider. In the medical setting, highly specialized professions co-exist, each with a unique language of technical terms and jargon (Fukuda, 1998). Arita & Mizumoto (2011) point out that because medical practitioners prioritize speed and urgency, dialogues between practitioners tend to contain subjective instructions that lack a clear subject, and the receiver's interpretation may be different from what the speaker intended. Knowledge may not be fully comprehended even when the speaker believes that

something has been communicated, and vague expressions and vague understandings may contribute to [Not understood or comprehended].

2) Discussion and adjustments in interprofessional collaboration

Under [Discussion, Consultation & Adjustments], participants indicated {Able to mutually confer} and {Cannot discuss sufficiently}. As Hotaka, Uchida & Takahashi (2017) explain, nurses are extremely busy providing daily support and constantly responding to patient needs. It is difficult to secure blocks of time to participate in conferences or rounds without adjusting schedules and work content. Of course, it can be presumed that it is difficult for other professions as well to make time for conferences and discussions.

{Cannot discuss sufficiently} includes cases in which the opinions of others are not accepted, as well as cases in which people do not express their own opinions. Shinoda (2011) remarks how teams can freeze up particularly when specialists over-assert their own specialty. Conceptually, Shinoda explains how specialists are like the wheels on a car and are capable of collaborating together. That said, Japanese tend to misunderstand team harmony or “*wa*” and, to avoid conflicts of opinion, simply comply with organizational decisions and refrain from expressing their opinions. In this sense, the greater issue may be how specialists express themselves and conduct conferences and meetings rather than the “place” itself.

Under [[Information Sharing]], there is a perception that {Information is shared and there is a shared understanding of how to resolve issues} and at the same time that {Misunderstandings may arise depending on how information is shared}. Thus the means for [[Information Sharing]] are affected not only by place, but also method.

Despite increasing centralization of information through digital media, Arita & Mizumoto (2011) comment that modes of information sharing still largely rely on medical charts, image films, test reports, documents and other analog media in addition to audio media such as telephones and PHS, as well as written media such as email and facsimiles. Paper media makes it difficult to share information in real time, and it is both costly and difficult to manage across professions.

2. Perceptions of each profession in interprofessional collaboration

[[Interprofessional collaboration]] was viewed as “cooperation”, as in [Collaboration means each professional doing what he/she should do], and as “collaboration”, as in [Collaboration means making adjustments and providing support among professionals]. This difference in understanding of interprofessional collaboration may be a reflection of the medical system in Japan. According to Hosoda (2012), there were no professional medical titles defined by law other than doctor, nurse, and pharmacist prior to World War II. Following post-war Occupation reforms, the establishment of “hospitals” caused the role of medicine to shift from simple treatment by a doctor to recuperation and overall

care of the patient. As the duties of medical practitioners expanded to include diagnosis and treatment, nursing, preparation of meals and beds, tests and training, as well as hospital management, it became necessary to create full-time positions to cover specific tasks. Perceptions of “collaboration” and “cooperation” may be informed by this historical streamlining and specialization in the medical field.

Another perception of [[Interprofessional collaboration]] was: [Collaboration is not effectively implemented due to different understandings]. This may be affected by [The need for collaboration and the meaning of collaboration is not understood].

Perceptions of [[Professional Role]] were: [There are differences in understanding of the nature and effect of professional work] and [Professional roles and division of roles are defined]. In the case of medical care teams, Shinoda (2011) notes that each individual member is highly specialized, and there is a division of labor among respective departments such that nothing is self-contained. When attempting to provide comprehensive care, overlap in services will inevitably occur. On the other hand, a strict division of roles may lead to vertically split services that cause important matters to be lost between specialties. Thus, it is important not to limit each profession to certain roles or tasks, and to instead mutually recognize that work involves multiple overlapping fields and respond flexibly to patient conditions and the situation at hand.

On this point, Northouse and Northouse (2010) draw attention to the fact that medical practitioners are still confused about the specializations of their colleagues, despite some progress in understanding. The main cause of this is that professional education is substantially divided by field of speciality. Furthermore, there is extremely little interaction in general between practitioners. Although interprofessional collaboration is becoming more common, uncertain understandings of professional roles may cause some practitioners to be called upon to take on roles they would not normally play or to have their normal roles taken over by other practitioners, ultimately tying into [Professional roles and division of roles are defined].

Arita & Mizumoto (2011) further posit that because medical professions are so highly specialized, interest in and understanding of the work of other practitioners tends to wane. A poor understanding of professional roles and the historical context of medical specialization thus contribute to differences extracted under [[Professional Role]].

Perceptions of [[Patient]] were [Patient attitudes differ between familiar home and hospital] and [I do not know the patient’s actual condition beyond the scope of what I see myself]. As Arita & Mizumoto (2011) note, in most hospitals, for any one patient, there are multiple directly and indirectly involved personnel who hail from multiple specialties and multiple positions. Interactions with the patient differ for each profession, and acquired information is limited and changes over time. Differences in perceptions for [[Patient]] may be related to differences in the quality and quantity of information that can be obtained by each profession depending on the patient’s condition and response.

Additional perceptions were [Interprofessional viewpoints differ] and [Different

impressions of patients who live at home]. Hosoda (2012) points out how one factor contributing to the difficulty of collaboration is how separate training produces differing values and philosophies among specialties. As opposed to the medical profession's medical (pathological) model, which focuses on the individual facing challenges, health and welfare relies on an ecological model, which approaches problems by emphasizing transactions between people and their environment. By intervening in the interface between people and the environment, the aim is to improve the individual's ability to adapt, tolerate, and respond and to enhance the quality of transactions with his or her environment (Japanese Association of Schools of Certified Social Worker, 2015). Further, where the medical profession's approach is to uncover what problems a person has and what the causes might be, health and welfare looks less at the client's weaknesses or disadvantages and more at the client's (individuals as well as groups and communities) abilities and motivation, tastes, accessible social resources, and other strengths (Japanese Association of Schools of Certified Social Worker, 2015). These differences in approach to assessment may tie in to perceptions for [[Patient]] as well.

Perceptions for [[Discharge]] were: [Patients are discharged when treatment is completed, without consideration of the family's ability to provide care or other daily life issues], [Difference in opinion due to specialty], [Objectives for discharge are different], and [interprofessional opinions are divided due to vague indices for discharge]. Varying professional values, experiences and approaches to problems are reflected in these different perceptions for [[Discharge]]. Although a medical model is employed in the initial phase of hospitalization with the aim being to recover as soon as possible, it becomes insufficient as the patient begins to recover, rehabilitation is begun in earnest, and life after discharge enters the picture. There is a need to shift from a medical model to biological, psychological and social models (Shinoda, 2011), and consequently a need to change perceptions of [[Patient]] and [[Discharge]] when individuals are prepared to move from hospital back to home.

Communication in interprofessional collaboration for team medical care is characterized by [Speaking freely, speaking unilaterally] and other elements of verbal / non-verbal communication, perceptions such as [Hierarchy depending on profession], and negative emotions such as [Feeling intimidated]. There are also clear differences by profession in perceptions of [[Interprofessional Collaboration]], [[Professional Role]], [[Patients]] and [[Discharge]]. Communication in interprofessional collaboration is further characterized by "information gaps", in which information is not communicated well, and "understanding gaps", in which there are differences between the speaker and receiver in cultural background, values, experience, and approaches to problem-solving. The negative emotions extracted from interviews also suggest that there are also "emotional gaps" involved in communication in interprofessional collaboration.

That said, this study was limited by a small number of interviewees, and coding may have been biased due to a semi-structured interview format. In considering how to fill in

communication gaps in interprofessional collaboration, future studies will need to make a wider survey of the specific nature of communication gaps, specifically, information gaps and understanding gaps, and their particular characteristics by profession.

VI. Conclusion

Communication in interprofessional collaboration had the following characteristics.

1. [[Speaking/Conveying]]: [Speaking freely, speaking unilaterally] and [Overbearing and superior attitude and manner of speaking]; [[Listening/Not Understanding]]: [Does not listen to people] and [Not understood due to technical terms and lack of information]; and [[Awareness in Interprofessional Collaboration]]: [Assumptions and Misinterpretations] and [There is a hierarchy depending on profession]; [[Consultation & Information Sharing]]: [Discussion, Consultation & Adjustments] and [Information Sharing]; [[Negative Feelings in Interprofessional Collaboration]]: [Feeling intimidated] and [Hurtful manner of speaking/interaction].
2. [[Interprofessional Collaboration]]: [Collaboration means each professional doing what he/she should do] and [Collaboration means making adjustments and providing support among professionals]; [[Professional Role]]: [Professional roles and division of roles is not clear][Respective professional roles are not understood]; [[Patients]]: [Understanding of the patient differs because of different points of view] and [Patient attitudes differ between home and hospital], [[Discharge]]: [Interprofessional Discrepancy in Opinion] and [Objectives for discharge are different].

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