CHAPTER 6

Communication within the organisation

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LEARNING OBJECTIVES

After reading this chapter and completing the activities, you will be able to:

- Review basic models of interpersonal communication
- Examine the flows and dynamics of organisational communication
- Discern the barriers to effective communication in multicultural healthcare organisations
- Describe ways of communicating more proficiently in healthcare organisations.

KEY TERMS

Emotional intelligence | Open communication | Communication style

Introduction

Effective and efficient healthcare not only depends on good interpersonal communication but also on the ability of organisations to communicate successfully and professionally. Yet organisations can become entrenched in rules, regulations and expected behaviours that stifle creative responses to work situations. Deep-seated bureaucracy can alienate the personal, and is made even more challenging if the organisation has multi-sites. This chapter will examine the many varied structures of organisation, and how communication flow within organisations can limit or expand inclusion of staff members within its boundaries. This chapter offers several barriers to good organisational communication and suggests ways these hurdles can be overcome. The ethics of healthcare practice is discussed in relation to the effect on the individual and the organisation, highlighting how both parties could respond to avoid conflict, clash and threats to professionalism. Above all, this chapter emphasises how open and honest person-centred communication in an organisation can lead to healthy outcomes for staff and patients alike.

Straightforward communication?

One of the chief axioms of communication is that you cannot *not* communicate (De Vito 2013). Communication occurs even when it is unintended, or when there is silence. We tend to convey more non-verbally, which encompasses anything that is unspoken (Alder & Elmhorst 2005), such as appearance, gesture, proximity, posture, punctuality, scent, touch, intonation, facial expression, and even a certain look (Remland 2009). Not only are most of us in the habit of communicating incessantly, in one way or another, but also few of us would claim not to know how to communicate effectively, or deny that we are adept at 'straight talk.' After all, in the ~~linear process of~~ transmission model of communication described ~~by~~

FOCUS BOX **Straightforward models of communication**

In the simplest of communication models, messages are communicated directly from sender to receiver. Information is sent using a common code, which for many is English, and channelled through audio-visual media. Transmission will be successful provided noise is minimised. While providing a starting point for understanding the process of communication, the linear model (Shannon & Weaver 1949) has been superseded by the interactional model, first described by Weiner (1948), and subsequently, the transactional model originally put forward by Berlo (1960). These subsequent models retain the basic elements of the simple transmission model, while broadening our understanding of the dynamics, rather than the mechanics, of the communication process. The interactional model highlights the role of feedback in establishing relationships. Information is not simply transmitted; it is processed and fed back. It also introduces the notion of noise to include psychological and semantic (meaning) as well as auditory distortion.

the seminal work of Shannon and Weaver (1949), communication appears to be pretty straightforward. This concept is explored further in the Focus panel 'Straightforward models of communication'.

But do we, in fact, possess the knowhow of communication? Consider the following well-known snippet:

> *There are known knowns; there are things we know we know. We also know there are known unknowns; that is to say we know there are some things we do not know. But there are also unknown unknowns - the ones we don't know we don't know.*

The statement was uttered by Donald Rumsfeld while serving as US Secretary of Defence in the Bush administration, in response to a question about the weapons capability of the Iraqi army, and more pointedly, whether Saddam Hussein's arsenal contained weapons of mass destruction (WMD). The question was posed at a press briefing Rumsfeld gave before the beginning of the Iraqi War (Steyn 2003). Rumsfeld's response invoked merciless reaction from all quarters. It was roundly condemned as utter nonsense. Not only was Rumsfeld thoroughly lampooned, but the credibility of the Bush Presidency and indeed, the entire war, was also called into question. Despite the international fallout and ensuing blowback, careful examination of the statement reveals that the utterance does make sense. Indeed, talk of the known unknown existed long before Rumsfeld gave it a new audience. The Johari window (Luft & Ingham 1955; Hase et al. 1999), made famous in many communication texts, is a tool for reflection on and of self. This process embraces what the person knows about themselves, what is shown to others, what is shown to others but not known by the person and is solicited in feedback and what is unknown to self and unknown to others. This window, set up in four quadrants, has movable lines so that each pane can be moved to reveal how 'open' or 'closed' a person presents. Also, much scientific progress, including medical progress, is based on discussions about known unknowns. (See Weblinks for the Rumsfeld press briefing.)

Both interactional and transactional communication models reveal as much about the persons communicating as the messages sent and received. They make it clear that in whatever form it takes or channel it uses, the process of communication involves two important variables: content and relationship. Neither occurs in a vacuum or in isolation. Context determines the connection between content and relationship.

Context is featured in the transactional model. It refers to time and place. Yet there is more to context than its spatial or temporal dimensions. The cultural and historical context in which communication occurs is of equal importance. It is possible to see this by returning once again to Rumsfeld's briefing. Taken out of context, Rumsfeld's statement could hardly be construed as anything more than doubletalk. But it is possible to make sense of Rumsfeld's talk of 'known unknowns,' when considered in the context in which it was communicated. At the

time the conference was held, there were indications that the Bush administration was anticipating problems in garnering popular support for the planned liberation/invasion of Iraq—especially given America's controversial record of military intervention dating from the Vietnam war—and the government was preparing a range of alternative justifications. Rumsfeld's pronouncement contrived to offer a pretext for war while leaving sufficient room for withdrawal should the invasion go ahead and WMDs were found to be non-existent. There were, however, increasing signs of a culture of deceit, and Rumsfeld was eventually removed from office.

Reflect and apply

Consider the process of communication between patients, peers and doctors in the context of a large public hospital. What are the apparent limitations of the linear process model of communication in this instance?

Communication in the organisational context

A highly important context is the organisation. Organisations are as varied as they are pervasive. Indeed, it would be rare to find anyone who is untouched by them. People are born in organisations, most notably hospitals, and many of them spend their lives working for them so that they can eat, drink, learn, play, pray and reside in them. Organisations are often thought of in physical or symbolic terms, most notably buildings and logos. What springs to mind, for instance, when Coca Cola or McDonalds are mentioned? However, buildings and brand names are not organisations, they merely accommodate and represent them. Organisations are composed of people, and they are living rather than inanimate systems. Indeed, a corporation has the legal identity and status of a person.

The lifeblood of organisations is communication, whether channelled directly (face-to-face), electronically (email, tele-conferencing, video-conferencing), and digitally (blogs, Facebook, Instagram, Twitter, wikis). Communication exerts a profound influence on individual and collective thinking, feeling, and behaviour within organisations. The vigour of an organisation depends on its members' willingness and ability to communicate. While a high level of proficiency will optimise the performance of an organisation, poor communication renders it dysfunctional; this is of particular concern to healthcare organisations where matters of life and death are at stake.

Organisational communication is usually examined in terms of flow. Communication in organisations flows in at least three directions: up, down, and across. The structure of most conventional organisations tends to be more or less hierarchical. The larger an organisation, the more likely it is to adopt a hierarchical or bureaucratic structure, and the greater the tendency for communication cascading or escalating within it to be filtered, and even impeded. While extolling

its many virtues, the earliest proponent of bureaucracy, Max Weber (1978), warned of the propensity for it to become an 'iron cage' (p. 975). For Weber (1978), 'bureaucracy develops the more perfectly it dehumanises' (p. 975). Moreover, the more complex an organisation grows, the more internal divisions it creates which, in turn, intensifies the strain on lateral communication. Organisations operating in more than one location (multiple suburbs, states or nations) make the flow of communication even more precarious. Some organisations have attempted to make communication flow more freely by becoming 'flatter' and reducing the number of administrative layers, particularly at middle management level. However, while levelling organisational structures may improve the flow of communication between those at the top and bottom of the hierarchy, horizontal divisions remain, and may actually multiply. Most organisations use electronic communication networks as a means of integrating units (Heini et al. 2014). But communication remains fraught, right down to its most common form: the email (Shilpey & Scewalbe 2007). Even the most sophisticated electronic media do not replace communicators, from which distorted messages originate. It seems that whatever structure is adopted, any top to bottom and centre to periphery configuration will invariably affect the course of communication in an organisation.

Most medium and large healthcare organisations are bureaucratic. Bureaucracies are typically regarded as the least conducive to the free flow of organisational communication (Anderson & Brown 2010). Indeed, the rank and file of the corporate world, particularly the 'googlites' and 'dot.comers,' consider bureaucracy an anathema. In order to succeed in an external environment characterised by unbridled competition and extreme uncertainty, contemporary organisations require the agility, flexibility, inventiveness and enterprise that bureaucracies simply do not have. Indeed, judging by some accounts, 'bureaucracy,' appears to have caused a good deal more harm than good. Not only are bureaucracies charged with procrastination, obfuscation, circumlocution and endless red tape, they are also indicted for such heinous crimes as despotism and genocide.

Ironically, maladministration and mismanagement are precisely what bureaucracies were designed to eliminate. The bureau sought to supplant arbitrary and corrupt rule caused by patronage and privilege with legal authority and meritocracy. Thus, despite the bad press it receives, a properly functioning bureaucracy represents the epitome of rational organisation. Indeed, even a highly anti-bureaucratic organisation such as Google is unable to avoid the practical and legal necessity of adopting bureaucratic processes, practices and structures as it becomes larger and more diversified. In fact, Google follows a standard functional structure with management positions specialised by value-chain activity. As a multinational corporation, these positions are further divided and grouped into regions of interest that aid the company in managing the breadth of its operations. Within each top-level activity, there is a multidivisional structure where small business units are divided on the basis of geography or product markets.

Some barriers to communicating effectively in the organisational context

Communication in organisations is prone to a number of common barriers that are particularly evident in highly bureaucratic organisations—and are characteristic of most healthcare centres. Among the most significant barriers are the inherent complexity of interpersonal communication, the difficulty of establishing and maintaining open lines of communication, protecting privacy, deterring censorship, verbal aggression, the repression of emotion in communication, and having time to communicate.

The complexity of interpersonal communication

Organisations are composed of people and, as such, are full of talk; indeed, some organisational theorists consider organisations to be 'discursive constructions' (Fairhurst & Putnam 2004, p. 5), that are created in and through the process of communication (Vásquez & Cooren 2013). Organisations are not just talk, however. Communication both prompts and inhibits action. Yet, when considering the range of variability possible at each stage in even the most basic interpersonal communication process, it is surprising that there can be any successful discourse between people. Linear models have severe limitations, as they tend to view communication as a clearly defined, step-by-step process, rather than an indefinite simultaneous process and, as a consequence, largely ignore the intrinsic interpersonal dynamics. To be sure, linear models have been augmented by sensitivity to the intersubjective nature of communication (interactional model) as well as the overall context (transactional model) in which it takes place. However, common understanding remains difficult to achieve in multicultural healthcare organisations. Indeed, most interactions in these organisations are intercultural, as patients seldom share the terminology, assumptions and norms embedded in the culture of the health profession (O'Toole 2012). Moreover, both patients and professionals are encoders and decoders of messages packed with meanings, motives, and agenda that may be misconstrued, distorted or undisclosed, but that still shape the process and outcome of communication.

Establishing and maintaining open lines of communication

Candour and familiarity have the potential to amplify otherwise distant or obscured voices (Bennis et al. 2008). These redemptive strategies can make communication less inhibited. However, although transparency appears to be highly valued, it rarely occurs in organisations (Bennis et al. 2008). Indeed, unfettered openness and informality may generate conflict. There are also occasions when the availability of information is restricted or withheld, even from patients. For instance, discretion can be invoked in instances where disclosure is judged seriously harmful to a patient. The license to do so in these circumstances is granted under what is known

as 'therapeutic privilege' (Hodkinson 2013, p. 106). Bennis et al. (2008) point out that candid communication may not be appreciated or well received, especially by those in positions of power and authority, even if they claim they have an 'open door policy.'

FOCUS BOX **An honest answer to a simple question**

How differently would US Secretary of Defense Donald Rumsfeld have acted early in 2003 in the face of informed intelligence, that is, 'known knowns,' if he had listened to General Shineski. When asked by a member of the Senate Armed Services Committee how large a force would be needed in post-war Iraq, General Eric Shineski spoke frankly and said, 'Something on the order of several hundred thousand soldiers are probably … a figure that would be required' (quoted in Reingold 2004). Not only was this the wrong answer, in Rumsfeld's view and others in the Bush administration who claimed, incorrectly, that peace could be maintained in Iraq with a minimum of ground forces, but Shineski had, according to some, committed 'candourside' (Bennis et al. 2008). Shineski, who chose a military career despite being seriously wounded in the Vietnam War, had served with distinction for more than 35 years, including a stint as U.S. Army Chief of Staff. As a result, he was publicly criticised by Defense Department officials, and Rumsfeld and other luminaries boycotted his retirement ceremony. Shineski was simply doing his duty in speaking up, and unlike Edward Snowdon and others like him, was not blowing the whistle on the nefarious activities of a government intelligence agency like the National Security Service. Little wonder that Rumsfeld was removed from office.

Censorship

Where formal, hierarchical communication permeates the healthcare context, there will be censorship, curtailing opportunities to express new ideas, advance alternative viewpoints, have robust discussions, and even report malpractice. The latter is highly consequential. There has been growing public recognition in many countries that healthcare facilities are often dangerous places (WHO 2012). Reports published in the US, UK, Australia, New Zealand and Canada have focused public and policy attention on the safety of patients, and have highlighted the alarmingly high incidence of errors and adverse events that lead to some kind of harm or injury (WHO 2012). See the Focus panel 'Incidence of adverse events'.

Most treatment errors are caused by flaws in increasingly complex and overextended healthcare systems, rather than by incompetent individuals (Grube et al. 2010). The greatest impediment to improving patient safety in all healthcare organisations is a lack of awareness of the extent that errors occur on a daily basis (Walshe & Shortell 2004). This ignorance is attributed to misconceptions about what constitutes a medical error (Valiee et al. 2014), and, more disturbingly,

a general reluctance among healthcare professionals to report errors when observed. Substantial under-reporting (estimated to be between 50 per cent and 96 per cent) occurs in almost all healthcare reporting programs (Naveh et al. 2006).

FOCUS BOX Incidence of adverse events

The WHO (2005) defines an adverse event (AE) as:

> 'An injury related to medical management, in contrast to complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be preventable or non-preventable' (p. 8).

Most current knowledge of AEs is based on reviews of hospital medical records, incident reports by health staff or analysis of administrative databases. The findings obtained from investigations using these approaches are telling, but conservative, as many AEs go unreported and unrecorded (Adams et al. 2009). Moreover, comparatively little is known about AEs outside hospitals.

A Canadian study published in 2004 revealed the incidence of AEs to be 7.4 per 100 hospital admissions. Among these, 36.9 per cent were considered preventable and 20.8 per cent resulted in death (Baker et al. 2004). In an earlier New Zealand study, the AE rate was 12.9 per cent of hospital admissions (Davis et al. 2002). A review of the medical records of over 14 000 admissions to 28 hospitals in New South Wales and South Australia revealed that 16.6 per cent of these admissions were associated with an AE caused by healthcare management, which resulted in disability or a longer hospital stay for the patient; 51 per cent of the AEs were considered preventable. In 77.1 per cent of cases, the disability ended within 12 months, but in 13.7 per cent the disability was permanent, and in 4.9 per cent the patient died (Wilson et al. 1995). The AIHW reported that in 2011–12, 5.3 per cent of patients admitted to public and private hospitals (486 310 patients) incurred an AE. The rate was higher for sub-acute and non-acute patients than acute care patients. The Institute of Medicine reported that between 44 000 and 98 000 people in the United States die annually from AEs, making this the seventh leading cause of death in the country, with an associated cost of US$3.5 billion per year (Kohn et al. 2000).

These landmark investigations were centred on hospital-based specialist care provision. Further studies have been able to estimate the prevalence of harm due to all episodes of secondary care ranging from 3.2 per cent to 16.6 per cent (WHO 2012).

Reflect and apply

- Would you report any medical error you observed, no matter how minor it was? If not, which errors would you not report, and why?
- How would you go about speaking up against malpractice you personally experienced?

Fear of negative professional and personal repercussions is a major factor in maintaining workplace silence (Kish-Gephart et al. 2009), who point to research demonstrating that employees frequently remain silent at times that call for speaking out, and speaking upwards about matters relating to employee mistreatment, managerial misbehaviour, organisational dysfunction, the outbreak and spread of organisational scandal and cases of withholding relevant knowledge that affects patient care decisions.

Silence also gives free reign to corruption and allows it to become embedded in organisational structures and processes, accepted by organisational members and passed on to new employees (Ashforth & Anand 2003). The enculturation of corruption is highly destructive. Reticence has caused the downfall of such corporate giants as Enron (McLean & Elkind 2004), forced others like Merrill Lynch to make hefty out-of-court settlements in order to avoid public scandal (Gasparino &Smith 2002) and precipitated the global financial crisis that began in 2008 (Sorokin 2010).

Privacy

While censorship and silence in the workplace have the potential to wreak havoc, some matters must be kept private. Information conveyed to and about patients is often highly personal and needs to be treated delicately. As Brann and Mattson (2004) make clear, confidentiality is a basic right of all patients, but it is one that is often breached by healthcare practitioners. For instance, while visiting an ailing relative at his bedside in a major public hospital, a radio announcer named Islander reported hearing that:

> *The patient in the next bed had been hospitalized after passing out from unregulated diabetes. His daughter couldn't bring him home with her, and was attempting to have him transferred to a VA hospital, since he did not have private health insurance.*
>
> *In the room across the hall was an elderly man with an inoperable brain aneurysm. He was unconscious, and the doctors said he needed to be put on life support. The man's wife didn't want to, but his son was insisting that everything possible be done.*
>
> *Down the hall, a middle age woman was told that her breast cancer had spread to other organs. The doctor was recommending more surgery and a major course of radiation and chemotherapy (Islander 1999).*

Everything Islander heard during the hospital visit was from hallway conversations between medical personnel and, as it transpires, was subsequently publicly broadcasted.

This example shows that breaches of confidentiality occur when restricted information is intentionally or inadvertently communicated to others who are not privy to it (Brann & Mattson 2004). Communicating confidential information

without authorisation continues today and it is a serious ethical and legal violation of the integrity of the patient–provider relationship. Patients are left betrayed, vulnerable and distrustful, while providers do irreparable damage to their professional credibility and reputation—and ultimately to their duty of care.

Reflect and apply

- Would you stay silent about breaches of patient confidentiality? If so, why?

Verbal aggression

While some staff fear voicing their views, especially dissent, others verbalise their aggression (Swain & Gale 2014). Non-physical violence ranges from insensitive and rude remarks to serious verbal abuse. It can be overt, as in bullying, which is 'a repeated pattern of physical and/or psychological violence over time that can be directed at one or more individuals' (Spector et al. 2014, p. 73), or covert, as in backstabbing, which involves intentionally spreading rumours, failing to transmit information, belittling opinions or disparaging a person behind his or her back (Malone & Hayes 2012).

Herschcovis and Barling (2010) revealed that the expression of non-physical aggression has a strong negative impact on employees' workplace attitudes towards job satisfaction, commitment and behaviours; for example, lower job performance and higher interpersonal and organisational deviance, which raises general levels of stress, illness and depression. As work standards decline, morale and productivity drop, the intention to quit becomes more prevalent and staff turnover increases. One person targeted by aggression recounted the experience as follows:

> *I admit that, before I was bullied, I couldn't understand why employees would shy-away from doing anything about it. When it happened to me, I felt trapped. I felt like either no one believed me or no one cared. This bully was my direct boss and went out of his way to make me look and feel incompetent … I dreaded going to work and cried myself to sleep every night. I was afraid of losing my job because I started to question my abilities and didn't think I'd find work elsewhere (Post on a New York Times blog, 2008, quoted in Herschcovis and Barling, 2010, p. 24).*

In a landmark study, deviant employee behaviour and absenteeism were estimated to produce organisational losses of up to $200 billion each year in the US alone (Murphy 1993). These figures do not take cyberbullying and trolling into account, so estimates could be considerably higher.

Verbal aggression is a major cause of interpersonal conflict in healthcare organisations. It can occur horizontally among healthcare workers (Brinkert 2010), or vertically between workers and ~~even to~~ management (Birks et al. 2014). Not only

does such communication invite conflict, reacting to it is liable to exacerbate it (Wilmot & Hocker 2007). Although it is common for nurses to be physically attacked by patients, nurses ~~have been~~ found to be more concerned about verbal aggression from peers (Spector et al. 2014). Spector et al. (2014) point out that persistent conflict among nursing co-workers is a serious issue, and is, according to Croft and Cash (2012), one that continues unabated. Indeed, Australian nurses reportedly experience workplace violence, which includes verbal abuse, at a rate four times greater than the average employee, resulting in more workers' compensation claims than either correctional or police officers (Opie et al. 2010, p. 18).

Heartless communication

Bureaucratic rationalisation also diminishes the expression of emotion, which is one of the most important distinguishing features of caring professions such as nursing, and essential for fostering a climate of trust, loyalty, passion and commitment in the workplace. Yet, thinking and feeling are typically thought of as polarised in organisations (Goleman & Cherniss 2001). Not only are they considered to be at odds with each other, but conveying emotion at work is generally deemed irrational and counterproductive (Goleman 2004). However, as Daniel Goleman (2004) argues, reason and emotion overlap:

> *The notion that there is 'pure thought,' rationality devoid of feeling, is a fiction, an illusion, based on inattention to the subtle moods that follow us through the day. We have feelings about everything we do, think about, imagine, and remember. (p. 52).*

It is important to recognise, therefore, that communication encompasses a thinking and feeling dimension, even in discourses about arcane medical matters. In Chapter 2, we introduced the concept of Emotional intelligence (EI). In the organisational context, EI is as necessary as technical rationality, based on logic and objectivity, in conversations about how patients will be managed and cared for. Indeed, Dougherty and Drumheller (2006) contend that emotional ineptitude is a serious liability. They note that:

> *organizational members would be far more successful at producing rational outcomes if they spent less time and effort trying to shove their emotions into rational norms—this can only happen if the duality is closed and organizations are recognized as both emotional and rational locations (p. 235).*

Emotional intelligence
The ability to monitor one's own and others' feelings and emotions, to discriminate among them and use this knowledge to guide one's thinking and behaviour.

Emotional intelligence (EI) is not the same as the intelligence quotient (IQ). However, EI does not oppose IQ. Rather, IQ and EI are simply separate and potentially harmonious forms of intelligence. However, unlike IQ, EI is not a static faculty and can, through learning, be improved. Furthermore, EI does not entail leaving unpleasant feelings aside. There will be times when 'awful truths,' have to be talked about. Nor does it licence being cavalier with emotions, and letting

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them run wild. Of course, this does not necessitate becoming a stoic or attaining inner equanimity. Rather, it entails learning to become more adept at managing and expressing emotions appropriately and effectively.

Too little time to talk

There can be little doubt that the environment in which healthcare is practised is continually stressful and everchanging. As Jones and Cheek (2003) observe, no two days are alike. Workload demands seem insatiably high and time diminishingly short, both of which serve to encourage cursory communication. Hemsley et al. (2011) report that the lack of time is an even greater barrier in caring for patients with complex communication needs and developmental disabilities. Nurses were found either to limit conversations or, worse still, walk away out of frustration with these patients. Similarly, despite the documented benefits of conversing with sedated and unconscious patients convalescing in intensive and post-operative care, studies have shown that communication with them has tended to be short, and more directive and informative than sensitive and caring (Geraghty 2005). Communication with patients who identify as lesbian, gay, bisexual and transgender, or for whom English is a second language, also tends to be avoided or dismissive. 'Othering,'—or what is more commonly referred to as racial discrimination—accounts for the lack of communication with these patients no less than time constraints (Chance 2013; Johnson et al. 2004). As one observer noted:

> *I find that sometimes … the attitude of the professionals in the health-care system tends to have a tone of racial discrimination. It doesn't come out very verbally so it's hard to pinpoint it and say, 'such and such a person is treating me that way.' But it is just a gut feeling that you have. Especially in a waiting area you will find the nurse will come and be very cordial and polite to a white person when they call them in for a test or to see the specialist. And when they come out and as soon as they realise it's an ethnic person they tend to speak slower to you, they tend to speak loudly to you, and they probably assume that you don't understand the language (quoted in Johnson et al. 2004, p. 263).*

Communicating more proficiently in the organisational context

Few healthcare organisations enable staff and patrons to communicate freely and easily. However, while the organisational barriers to communication are formidable, there are measures that can be taken to counteract them. But it takes a good deal of assertiveness to put the specific competencies needed to make practitioner–other (patient, peer, physician, etc.) communication more effective.

A matter of style

It has long been acknowledged that a helping relationship gives rise to a specific kind of communication on the part of helpers, which early theorists termed the 'therapeutic communication style' (Arnold & Boggs 2011). Communication style refers to the way that messages are communicated and is thought to represent a relatively enduring aspect of an individual's discursive behaviour. This is not to say, however, that styles do not change. Given differences in context, individuals may adapt their communication style to meet the demands of the personal or professional situation.

Communication style
The way that messages are communicated; represents a relatively enduring aspect of an individual's discursive behaviour.

Reflect and apply

Would you expect your style to change in communicating with a patient, colleague, senior nurse and doctor in a general ward, operating theatre and intensive care unit? If so, note the main differences in the style of communication you would adopt in each instance.

Practice person-centred communication

One particular model of interpersonal communication deemed effective for healthcare professionals is the 'therapeutic perspective' (O'Toole 2012). It is based on principles of communication advanced in the client-centred approach to psychotherapeutic counselling pioneered by Carl Rogers (1951) and his successors (Tudor 2011). This is not to say that healthcare professionals ought to communicate as therapists or counsellors. Rather, the model advocates that they engage in communication that is patient-centred (Ammentorp et al. 2010), or 'person-centred' (Buetow 2014): congruent, empathic and accepting.

Congruence

Congruence or genuineness means dropping all pretences and allowing ourselves to be who we are. This does not imply offloading everything we hold private, or blurting out anything that comes to mind, especially to those with whom we have a professional relationship. It does mean, however, resisting the impulse to hide behind the mask of professionalism and role of expert. A level of authenticity such as this requires vigilance and self-assurance, since being congruent necessitates admitting who we are to ourselves and owning our self concepts, without the need to deny parts of ourselves which we would rather disown or exaggerate in the hope of being more personally appealing to others. Anything less would be incongruent.

Empathy

Empathy is the attempt to come to as full and accurate an understanding of others' view of themselves and their world as possible. O'Toole (2012) proposes a description of empathy based on the thinking of Rogers (1975). It requires health professionals to 'enter the world of the person in their care' (p. 108). It further shows the complex nature of expressing empathy, not only understanding the emotions of the person in their care but also insisting that health professionals divorce themselves from their own personal biases and feel at one with the person in a non-judgemental manner. By the use of introspection, which creates personal insight and the potential for greater self-understanding, empathy enables individuals to see themselves in and through others.

Acceptance

Acceptance fulfils a basic, and possibly universal, human need. According to Rogers (1959), acceptance means having unconditional positive regard for others. It requires taking people at their word. However, credulity does not imply gullibility. Rather, it acknowledges that personal acceptability is largely conditional. People convey or conceal things about themselves in order to gain others' approval. Having unconditional positive regard for others means accepting them on their own terms, the bad with the good. Validation comes from having the self-confidence to be able to speak freely, though respectfully, and being genuinely heard. Through acceptance, patients become persons, rather than others.

Healthcare practitioners who adopt the therapeutic style and person-centred approach to communicating with others have not only found it easier to establish rapport and elicit cooperation, but derive greater enjoyment from the encounter (Bush 2014). In addition, there is a high degree of reciprocation. Haskard et al. (2009) found that 'pleasantness and involvement from a patient correlates substantially with nursing staff behaviour that is caring or sensitive, professional, and less hurried. These findings reflect the co-occurrence of cooperation and attentiveness, and characteristics of rapport and non-verbal synchrony between patients and nursing staff' (p. 29). Healthcare practitioners using the therapeutic, person-centred approach model reinforce effective communicative behaviours for others.

Listen for and to the emotional tenor and tone of communication

It is essential for healthcare workers to become attuned to the emotional (dis) harmony in communication (Wassenaar et al. 2014). Nursing staff are frequently the first significant, and most recurrent, point of contact for patients, their partners, family and friends (Haskard et al. 2009). All have the ability to judge each other in the first 30 seconds of their first meeting (Haskard et al. 2009). Establishing rapport early is critical for the precedent it sets and because patients report placing greater trust in nurses than physicians (O'Toole 2012).

Focus on the cathartic effect of communication

Communication can have a cathartic effect. An important part of the health practitioner's role involves engaging in caring communication (Scott 2014). While professional knowledge and clinical competence are important, the humanising, attentive elements of nursing communication are of equal value to patients. According to Scott (2014), the former tend to be taken as givens. Patients often consider interpersonal skills to be the best measure of quality care. Caring communication acknowledges and responds to patients' vulnerabilities and sensibilities. It seeks to preserve their dignity and individuality. Patients' compliance with their healthcare plans also depends on the quality of communication with healthcare professionals.

Time is not the enemy, poor communication is

Time will always be important in fast-paced healthcare contexts. However, it need not be an enemy of timely communication. Quality is as important a measure of effective communication as quantity (O'Hagan et al. 2013). While it may not be possible to find or create more time—even if it could be managed with greater efficiency through more careful prioritisation and thorough routinisation of workloads—it is possible to use the limited time available to communicate effectively and productively with colleagues, and caringly with patients. In taking the therapeutic perspective described earlier, attention is directed towards what is communicated and how, rather than how much and how long, particularly since more is conveyed non-verbally and para-linguistically than through words alone. Indeed, minimalism was fundamental to Rogers' person-centred approach to communication. This is not meant to endorse the expediency so valued by contemporary healthcare organisations (Scott et al. 2014). ~~Nor does it suggest that anything comes close to genuine professional care.~~ Rather, what counts is perspicacity, receptivity and responsiveness, not verbosity.

Communicate as openly as possible

Workplace silence is completely indefensible from a moral and legal standpoint. It poses a grave threat to the life of the organisation (Perlow & Repenning 2009), ~~the basis of which, as noted earlier, is people~~. Not only is candour ethical in the context of healthcare, it is also potentially life saving. Open communication is vital for maintaining the free flow of news and information, and the exchanges of views, ideas, engagement and advocacy necessary for improving organisational performance, productivity, and staff and patient wellbeing. However, there is a risk in committing 'candourside'. Indeed, healthcare practitioners who cared less about either their professional or organisational affiliation were found to be the first to voice their concerns (Grube et al. 2010). Sussman (1991) suggests that using discretion may be best for communicating with those in positions of power and

Open communication
Communication that is transparent and accessible; includes the concept of freedom of expression.

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authority, especially defensive superiors. He recommends resorting to guarded communication in instances where:

- one party has been distrustful in the past
- the encounter is adversarial in nature
- the encounter is with someone of higher power
- both parties are committed to the relationship
- the organisational culture punishes candour and risk-taking
- the issue under discussion is consequential and potentially self-incriminating (p. 86).

It is also possible to communicate anonymously where there is an unmitigated risk in being open.

Open communication is equally necessary in stemming conflict, whether it be intraprofessional (among peers, such as aides and nurses), interdisciplinary (between professional groups such as nurses and doctors) or interpersonal (with patients and their families). Conflict and conflict resolution is discussed at length in Chapter 11 and shows how compromise can be effectively reached with a win-win outcome. Although ~~relationship~~ conflict is generally viewed as negative, it can be used positively (Brinkert 2010). At the very least, conflict can let vexatious issues and problems surface by getting individuals to acknowledge, clarify and address disparate interests, areas of responsibilities and cross-purposes that impede mutual gains and, ultimately, larger organisational dividends (Wilmot & Hocker 2007).

While verbal aggression and silence are commonplace in healthcare organisations, most communication usually occurs without force, threat or corruption (Reichertz 2011). Words have no intrinsic power. As the old saying goes, 'sticks and stones may break bones, but words will not' (Lutgen-Sandvik 2007). Any power words have comes directly from relationships between communicators or, more precisely, their relative significance and strength. Reliability is a major factor in developing and maintaining strong, enduring relationships (Reichertz 2011). The parties to a relationship are able to foster reliability by ensuring that their words and deeds match ('congruent' in Rogerian terms) and mutual commitments are honoured (O'Toole 2012). Reichertz (2011) suggests that communication with unreliable people cannot be sustained. These people lose their 'linguistic ability to act' (Kuch & Herrmann 2007, p. 193), and may eventually become *personae non grata*.

Be vocal without speaking for others

Healthcare organisations have always been diverse. However, there is now greater demand for recognition and appreciation of and respect for the cultural diversity that exists within them. In order to be successful, intercultural communication requires even greater competence and sensitivity on the part of healthcare

practitioners. This does not necessitate learning another language. Rather, it entails respecting the values, beliefs and attitudes of others, and becoming attuned to communication cues that signal and transmit important cultural differences. It also means being alert to the fact that heterogeneity exists within each culture, and not all members identify with their cultural heritage (Johnson et al. 2004). Where patients and their families are concerned, effective communication involves acquiring cultural knowledge, and using it during discussions about—and recommendations for—treatment.

Johnson et al. (2004) also advise carefully monitoring the language (code) used to communicate with 'others,' since it may inadvertently harbour and reproduce divisions between age, class, faith, gender, sexuality, race and ethnicity. To take a simple example, while 'we' seems an innocuous and thoroughly inclusive term, it can suggest alignments, such as 'us', and demarcations, such as 'them.' By the same token, although dialogue is important, it is not always possible to speak with one voice. However, this need not be problematic. Indeed, monologues, speaking for oneself, may be necessary at times, if only to vent. What is important is for all voices to be heard without fear or favour. This means listening to what people say, ~~not just hearing~~.

Speak from the heart, not just the head

As stated earlier, it is impossible to divorce the emotional from the rational dimension of communication. Even if this were possible, doing so would be undesirable, as both are indispensible to effective, meaningful communication. Emotional intelligence is not a contradiction in terms. Rather, it involves developing competence in the following.

- Knowing your own emotions; being aware of and capable of recognising specific feelings as each is being experienced.
- Managing or regulating your emotions so that they facilitate rather than interfere with self and mutual understanding.
- Self-motivation to pursue desires, strive for improvement, and remain resilient following setbacks and frustrations by tapping into emotional reserves.
- Recognising emotions in others by empathising with them.
- Handling relationships by being able to read and influence social situations, particularly those involving testy individuals (adapted from Goleman 2004, p. 318).

The point of learning to become more emotionally intelligent is to facilitate genuine civility and service, not to manipulate communication to serve the ~~rational~~ ends of the organisation with, for example, command and control (Dougherty & Drumheller 2006).

SUMMARY POINTS

- Communication, both verbal and non-verbal, occurs as inadvertently as it does consciously, and virtually incessantly.
- Though most people communicate on a daily basis, communicating is much less straightforward than it might ~~appear~~. Even people at the top can be inarticulate.
- Models of interpersonal communication, ranging from the transmission through interactive to transactional, invariably fail to capture the full complexity of the communication process.
- Context exerts a profound effect on, and is equally affected by, communication. Organisations are one such context.
- Organisations are built by and for people; the lifeblood of embodied organisations is communication.
- The vitality of an organisation relies on its members' willingness and ability to communicate.
- The larger and more complex a healthcare organisation becomes, the more likely it is to adopt a bureaucratic structure.
- Although properly functioning bureaucracies are considered the epitome of rational organisation, they have the potential to dehumanise and become 'iron cages'.
- Authority and power are distributed hierarchically, and communication tends to flow down more readily than up or across them.
- Common barriers to effective communication within bureaucratic ~~heath care~~ organisations are censorship, conflict, expediency, fear, incivility, prejudice, silence, and technocracy. The prevalence of these communication barriers within healthcare organisations is life threatening as they enable corruption to become institutionalised and malpractice to flourish.
- It is possible to counteract barriers to communication by adopting a person-centred approach to communication that emphasises acceptance, congruence and empathy, practising emotional intelligence, and promoting a culture of candour and collaboration that enables all voices to be heard. This requires healthcare practitioners to be committed and assertive.
- Communication is relatively useless if nobody is prepared to listen.

Critical thinking question

1. If you were a sedated or unconscious patient, what would the first words you would want to hear from the person assigned to your care?
2. If a doctor shouted abuse at you, would you:
   a. Shout back at the doctor?
   b. Ignore the doctor?

c. Report the doctor?
d. How else would you respond?

3. Complete the Blake and Mouton self-assessment questionnaire and plot your score on the managerial grid at: http://fspac.ubbcluj.ro/comunicare/wp-content/uploads/2014/04/Leadership-Matrix-Self-Assessment-Questionnaire.pdf
   a. Was your score indicative of your usual behaviour?
   b. If not, why not?
   c. If so, would you change your behaviour?
   d. If not, why not?
   e. If so, why?
4. Take the emotional intelligence test at: http://www.queendom.com/tests/access_page/index.htm?idRegTest=3037
   a. Was your score an accurate reflection of your current level of EI?
   b. How might you improve your EI?
5. Recall an occasion when you experienced negative discrimination.
   a. What was the basis of discrimination?
   b. How did you feel about being discriminated against?
   c. What did you do in response? What was the result?
6. What do you consider to be the main challenges for you in becoming more accepting of, congruent with and empathic towards others in the work context? What might you do to overcome these challenges?
7. Explore more on Google's organisational structure by reviewing the following report: http://investor.google.com/pdf/2013_google_annual_report.pdf

WEBLINKS

http://www.crnhq.org/
Conflict Resolution Network provides information on strategies and techniques.

https://www.youtube.com/watch?v=GiPe1OiKQuk
The Rumsfeld press briefing.

http://www.who.int/en/
WHO offers a catalogue of publications on health, including the reports cited in this chapter.

www.carlrogers.info/
More about Carl Rogers' client-centred approach.

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