

The Importance Of Interdisciplinary Communication In Patient Care

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Introduction

Patient care increasingly involves people from multiple professions: physicians, nurses, pharmacists, therapists, social workers, dietitians, laboratory staff, interpreters, case managers, and others. Their expertise becomes valuable only when information and responsibility are coordinated.

Interdisciplinary communication is therefore not an optional courtesy. It is a clinical safety mechanism. (World Health Organization, n.d.)

The original reflection correctly described a committee in which caregivers developed a shared care plan. It also used “multidisciplinary” and “interdisciplinary” as if they meant the same thing. A multidisciplinary team may work in parallel, with each profession contributing separately. An interdisciplinary or interprofessional team actively integrates perspectives, negotiates priorities, and creates a shared plan with the patient.

Why Communication Affects Outcomes

A patient’s condition does not fit neatly into professional boundaries. A physician may diagnose, a nurse may notice deterioration, a pharmacist may identify an interaction, and a social worker may discover that the patient cannot afford the medicine. If these observations remain separate, the plan can fail.

Effective communication reduces duplication, conflicting instructions, omitted treatment, and delayed response. It can also improve experience by preventing the patient from repeating the same story to multiple people who appear unaware of one another.

Team Structure and Shared Goals

Teams need clear membership, leadership, roles, and escalation routes. Membership changes across the patient journey. An emergency team forms rapidly, while a rehabilitation team may work together for weeks. The patient and family caregiver should be recognized as team members when appropriate.

A shared goal should be specific and meaningful. “Improve the patient” is too vague. A team might

agree to control pain enough for safe mobility, complete medication teaching, arrange home oxygen, and confirm follow-up before discharge.

Structured Communication Tools

SBAR

Situation-Background-Assessment-Recommendation helps a speaker organize urgent information. It is especially useful when hierarchy or time pressure makes communication difficult. The tool should not replace clinical detail when a complex discussion is needed. (Agency for Healthcare Research and Quality, n.d.)

Check-Back and Read-Back

Closed-loop communication confirms that a message was heard and understood. The receiver repeats the instruction, and the sender confirms or corrects it. Read-back is particularly valuable for verbal orders and critical results.

Handoffs

A handoff transfers information and responsibility. Standard templates can include illness severity, active problems, pending tests, contingency plans, and what the receiving clinician should watch. Interruptions and unclear ownership are common hazards.

Briefs, Huddles, and Debriefs

A brief establishes the plan and roles before work begins. A huddle reassesses when conditions change. A debrief examines what happened and how the team can improve. These conversations are short but require psychological safety.

The Nurse's Role

Nurses often maintain continuous contact with the patient and observe response to treatment, functional status, pain, understanding, and family concerns. They connect orders with actual bedside conditions. Their input is essential during rounds and discharge planning.

Communication should not depend on personal courage alone. Organizations must create channels in which nurses can question a plan, request review, and escalate deterioration without retaliation. Tools such as CUS—Concerned, Uncomfortable, Safety issue—give language for escalation.

Pharmacists and Medication Safety

Pharmacists contribute knowledge of dosing, interactions, organ function, duplication, monitoring, and affordability. Medication reconciliation at admission and discharge benefits from direct pharmacist participation for high-risk patients.

The team must also communicate with the patient. A technically correct list is unsafe if the person cannot explain which medicine to stop, start, or change.

Therapy, Rehabilitation, and Function

Physical, occupational, and speech therapists assess mobility, daily activities, swallowing, cognition, and communication. Their recommendations can affect discharge destination, equipment, diet, and caregiver training.

Conflicts may arise when medical stability is defined differently from functional readiness. Interdisciplinary discussion helps the team understand that discharge is not safe merely because acute treatment is complete.

Social Work and Care Coordination

Social workers and case managers identify insurance, housing, family support, transportation, legal, and safeguarding issues. These conditions can determine whether the clinical plan is realistic.

Communication should avoid treating social needs as last-minute discharge barriers. They should be assessed early, and the patient should be involved in choosing among feasible options.

Interpreters and Language Access

Patients with limited English proficiency face additional safety risk when teams rely on family members or untrained staff. Qualified medical interpreters should participate from the beginning of relevant encounters, not only when consent is signed.

AHRQ's TeamSTEPPS materials emphasize identifying language needs, involving interpreters as team members, and using teach-back. Communication with the interpreter should be direct and respectful; clinicians should speak to the patient, not about the patient. (Agency for Healthcare Research and Quality, n.d.)

Hierarchy and Psychological Safety

Healthcare hierarchies can prevent people from speaking. A junior clinician may notice an error but fear embarrassment or punishment. Leaders must explicitly invite concerns and respond constructively.

Psychological safety does not mean absence of accountability. It means that raising a reasonable concern is protected. Reckless disregard can still be addressed through a just-culture approach.

Electronic Health Records

Electronic records can make information available across professions, but they do not guarantee communication. Important findings may be buried in notes, copied text may persist after it is outdated, and alerts may be ignored.

Teams should define which information requires direct communication rather than passive documentation. A critical laboratory result or urgent change should not depend on someone eventually reading the chart.

Interdisciplinary Rounds

Bedside or team rounds create a regular opportunity to align the plan. Effective rounds use a consistent agenda, include the patient where appropriate, and identify goals for the day, barriers, risks, and expected discharge needs.

Rounds can fail if one profession dominates or if discussion becomes a performance for hierarchy. Facilitators should invite each perspective and summarize decisions with named owners.

Transitions of Care

Admission, transfer, and discharge are high-risk transitions. Medication lists, pending results, follow-up, warning signs, equipment, and responsibility must be communicated to the next team and the patient.

Closed-loop referral systems confirm that appointments occur and results return. Sending a referral is not the same as completing care.

Conflict Resolution

Professional disagreement can improve care when it exposes assumptions. Conflict becomes harmful when it is personalized or avoided. Teams should return to evidence, patient goals, role boundaries, and the consequences of each option.

Ethics consultation or leadership support may be needed when values conflict. The patient's informed preferences remain central unless immediate safety or legal duties require otherwise.

Measuring Communication

Organizations can examine handoff compliance, communication-related incidents, delayed results, staff teamwork surveys, patient understanding, readmissions, and follow-up completion. Observation often reveals more than documentation audits.

Training should be evaluated through behavior and outcomes, not attendance alone. Simulation can test escalation, handoffs, and response to uncertainty.

Implementation

A practical improvement project can select one high-risk process, map current communication, identify failure points, introduce a small set of tools, and measure change. Leadership must provide time and staffing for teams to communicate.

Standardization should preserve flexibility. A structured tool organizes information, but clinicians must still adapt to the patient and speak in ordinary language.

Telehealth and Distributed Teams

Interdisciplinary communication increasingly occurs across locations. A primary-care clinician, specialist, home-health nurse, pharmacist, and patient may join through different systems. Telehealth can expand access, but it can also fragment responsibility when no one knows who will act on a recommendation.

Virtual teams need the same clarity as bedside teams: agenda, identity, consent, documentation, follow-up, and emergency plan. Technical failure should have an alternative workflow, and patients should not be excluded because of limited broadband or digital literacy.

Communication During Emergencies

During rapid deterioration, lengthy discussion is impossible. Teams need concise calls for help, role assignment, closed-loop orders, and periodic summaries. Simulation can help clinicians practice speaking clearly while under pressure.

After the emergency, a debrief can identify equipment problems, unclear roles, or communication breakdowns. The purpose is learning, not assigning blame in the emotional period immediately after an event.

Ethics, Privacy, and Information Sharing

Interdisciplinary care requires information sharing, but access should remain related to the person's role and the purpose of care. Sensitive behavioral, reproductive, or social information should not be discussed casually merely because many professionals are involved.

Teams should explain to patients who is participating and why. Privacy and collaboration are not opposites; thoughtful sharing gives the right information to the right people while protecting dignity.

Leadership and Sustainability

Communication initiatives often fade after training. Leaders must reinforce tools through orientation, observation, coaching, performance review, and redesign of workflows. Staff need protected time for rounds and handoffs. A rushed system cannot be repaired by posters about teamwork.

Local champions can model behavior, but sustainability should not depend on one enthusiastic person. Policies, staffing, technology, and leadership expectations must support the same practices.

Conclusion

Interdisciplinary communication combines professional knowledge into a coherent plan. It improves safety when team members share goals, clarify responsibility, use structured tools, escalate concerns, and involve patients and families. (Agency for Healthcare Research and Quality, n.d.)

Communication problems are not solved by telling individuals to "communicate better." Organizations must address hierarchy, workflow, technology, language access, staffing, and feedback. When these conditions are present, interdisciplinary care becomes more than multiple professionals in the same building; it becomes coordinated responsibility for one patient.

References

Agency for Healthcare Research and Quality. [TeamSTEPPS 3.0](#).

Agency for Healthcare Research and Quality. [Communication concepts and tools](#).

Agency for Healthcare Research and Quality. [Team communication for patients with limited English proficiency](#).

World Health Organization. *Framework for action on interprofessional education and collaborative practice*.