**Health and Social Care Communication**

**Question 5: Communication theories in health care and social work**

This section will provide through analyses of two critical theories whose relevance exists in both social work and healthcare.

**The Social Penetration Theory (SPT)**

The social penetration theory is based on the concept of self-disclosure to evolve the communication process. According to Altman and Taylor (1987), the individual is a lot lie an onion, which is composed of different layers. As such, developing a relationship and an intimate interpersonal communication process requires a gradual and continuous process of wearing down the person’s defensiveness. Self-disclosure refers to the sharing of personal information to varying degrees. In agreement to the SPT, the act of self-disclosure occurs in a hierarchical process starting from simple small talk to intimate personal details. The effectiveness of the communication process and level of self-disclosure is subject to assessment according to the rewards and costs of advancement (Frye & Dornisch, 2010). Therefore, the individual will feel freer to communicate openly and intimately if the rewards exceed the costs significantly. The nature of the theory can be described through its stages.

The first stage of the SPT is orientation. It involves introductions as well as the creation of first impressions by all the participating parties. In many cases, the process includes salutations or greetings as well as brief and necessary information such as names and titles (Barnett, 2011). The second stage is the exploratory affective where the participants disclose information about themselves including opinions, likes, and dislikes. This step represents a small advancement from the introductory phase. However, the third stage, which is the affective, involves sharing of personal information. At this stage, a relationship exists between the individuals characterized by open and honest communication pertaining private matters. After this point, the relationship can continue steadily to the stable stage or lose stability in the depenetration stage (Altman & Taylor, 1987). The stable bond involves a continuation of open and honest communication among the participants driven by high rewards of self-disclosure. However, the depenetration stage includes increases in costs of self-disclosure to outweigh the rewards leading to a regression in the SPT process.

Healthcare and social workers rely significantly on the SPT to enhance their effectiveness as professionals. For example, the physician has a responsibility to initiate the communication process by making an introduction as per the orientation stage (Barnett, 2011). The patient goes further to describe their symptoms and into further disclosure about their condition. The personal information supplied is necessary to improve the doctor’s ability to diagnose and treat the problem. For instance, someone with symptoms of an STD will have to provide information about their sexual activity despite the personal nature of the information. Similarly, social workers have to employ a similar process to gain the trust of their clients and obtain information necessary to help them. For example, a social worker providing services to abused women will require following the steps to build a relationship with the client. The prevalence of the stable stage is especially vital to long-term professional relationships and improved service delivery.

**Theory of Planned Behaviour (TPB)**

The approach of planned behaviour is a vital model in healthcare and social work communication. The model helps to evaluate the way people behave based on the information and cultural norms that they are exposed. The concepts of behavioural intentions and self-control are the core components of this theory. The theory follows the idea of self-control where it only applies to behaviour that one can be in a situation to implement restraint or overindulge (Ajzen, 2011). The planned act arises from preconceived thought in the form of intentions. However, this thought certain aspects of the environment that emphasize on a particular course of action influence process. The theory also creates a link between belief systems and behaviour by claiming that specific belief systems contribute to precise practices. For example, the belief that cigarette smoking is unhealthy will lead to the habit’s cessation. The most relevant aspect of this theory to communication is that interactive, normative, and power beliefs are the result of the transfer of information from one person to another.

This theory is relevant to the communication process in healthcare and social work because it involves the use of information to create behavioural intent or exercise self-control. For example, an oncologist will advise their patient to stop smoking because it places them at risk of cancer. By providing factual details about this threat, the healthcare professional can change the patient’s belief system and motivate changes for health improvement (Grierson, Fowler & Kwan, 2015). Similarly, the social worker has to contend with harmful or damaging belief systems to create positive change. For instance, they will need to educate abused women on their rights and independence as an individual to prevent the prevalence of domestic abuse. The way that healthcare and social work professionals communicate should be geared towards promoting positive behavioural changes among the clients.

**Question 6: Individual values and cultural factors affecting communication in healthcare and social work**

Communication in the healthcare and social work practices are subject to cultural factors and individual qualities. Individual qualities refer to elements that are subjective and lead to changes in the way that participates in wither industry communicate. Cultural factors are generalized societal qualities that have an impact on the communication process.

**Individual traits**

Subjective factors that influence communication include demographic descriptions such as education levels, economic status, and personal ethics. Education plays a crucial role in designing the communication process. More specifically, it determines the formality of communication. For instance, people with lower educational levels require simple wording of messages to facilitate their understanding of a particular situation (Knapp, Vangelisti & Caughlin, 2014). On the other hand, intra-organizational communication in the workplace will subscribe to a specific discourse characterized by medical jargon. The patient is a non-professional who is not academically equipped to interpret messages relayed by the sender. As such, professionals within the industry have to consider the patient’s level of education before communicating to promote message comprehension.

The economic background of an individual has a profound implication on the quality of the message as well as how people interpret information. Additionally, it is necessary to promote the content of any given dispatch from a social worker or healthcare professional. This disparity in communication occurs due to the difference in content requirement and delivery (Finney Rutten, Augustson & Wanke, 2006). Wealthy individuals accessing medical services will not require information on the cheapest or free offerings. Instead, they may be more concerned about the quality of the healthcare or social work service. On the other hand, the patients from lower-income households will be concerned about the costs of a given procedure relative to its quality. Therefore, the communication process should consider the patient’s expectations of a service based on their economic status.

Personal ethics also have a substantive influence on the communication process. Ethics refer to the rightness or wrongness of a particular actions or behaviour such as the interpersonal communication. The appropriateness of the delivery and content of the message are essential in the continuance of an open channel of communication (Finney Rutten, Augustson & Wanke, 2006). For example, a person who talks using profanities may make the recipient uncomfortable and unwilling to extend the conversation. Such a situation leads to communication breakdown that can impair the formation of trust between the professional and client. Doing so leads to failure in achieving healthcare and social work goals. The consideration of ethics is evidenced by the code of conduct in the workplace that requires professionals to engage in respectful interpersonal or group communication.

**Cultural factors**

Societal norms and beliefs are vital considerations in the communication process in healthcare and social work. The customs and belief systems propagated within the society influence personal attitudes towards healthcare and social work leading to communication breakdowns and failure to achieve professional goals (Nápoles‐Springer, Santoyo, Houston, Pérez‐Stable & Stewart, 2005). For example, a negative perception exists against abused men. Male abuse is a rarely discussed topic since it undermines the societal constructs of masculinity. In such a situation, a patient could feel uncomfortable or embarrassed disclosing their condition to a social worker. They may lie or fail to disclose valuable information relevant to the intervention process.  Similarly, mental health stigma leads to challenges in the way that victims seek help. The societal pressure that surrounds mental illness has the potential to prevent the formation of trust in a clinical setting.

Cultural identity influences the functional aspect of communication through the creation of language barriers. People who subscribe to particular cultural identities are not versed in unfamiliar discourse. As such, their lack of fluency in a language can lead to the distortion of the messages interpretation leading to a different meaning (Paternotte, Dulmen, Lee, Scherpbier & Scheele, 2015). For example, a social worker who uses English to cater to Hispanic immigrant communicates may experience challenges in conveying valuable information to victims or the community. Therefore, healthcare and social work organizations need to consider language barriers and cultural identities to promote effective communication.

**Question 7: Legislation, charters, and codes of practice**

**Legislation**

Various legislations apply directly to the NHS and UK healthcare system. Some of these legislations have a profound impact on the way that professionals and patients communicate in the clinical setting. For instance, the Health and Social Care Act of 2012 imposes significant regulations on the dissemination of information within the UK health and social care system (The NHS, 2012). The act formalizes the communication process by placing a chain of command that is responsible for the sharing of information. Additionally, the law also establishes regulations on the confidentiality of information. In this legislation, the industry professionals and the public have rights in accessing personal information about patients. For example, the healthcare organisation can distribute information to relevant agencies also called the principal body. In doing so, the law provides a safe environment for patients to communicate freely with professionals thereby enhancing self-disclosure. A great example of the way that the legislation influences communication is the filtering of content to avoid identifying specific individuals in published information such as healthcare statistics. Therefore, the Health and Social Care Act includes provisions on the procedures and content in public communication.

The regulation of Investigatory Powers Act is concerned with the security organisation in the UK as well as their efforts in deterring and detecting crime. This acts application to the healthcare and social work industry acts in contradiction to the confidentiality laws that have been established in the Health and Social Care Act of 2012 (UK Government, n.d.). The legislation allows security organs to intercept communication in a bid to promote law enforcement efforts. To this effect, the health and social care professionals have the mandate to disclose information that they feel is party to criminal behaviour. For example, a caseworker is required to reveal the perpetrator of the physical abuse to the relevant law enforcement agencies. However, doing so can lead to fear of self-disclosure if the patient or victim was party to the criminal behaviour. For instance, a woman would be afraid of the incarceration of the abusive husband leading to dishonesty when communicating with social workers or healthcare professionals.

**NHS Charter**

The NHS has numerous charters aimed at cementing organizational policies into practice. The Charter of Patient Rights and Responsibilities is valuable to the communication process (The NHS, n.d.). It establishes the regulations that govern the dispensation of organizational responsibility to the patient. For example, the charter encourages communication and participation between the patient and attending professional through the acknowledgement of relevant information and service feedback. In doing so, it creates an environment that fosters open communication between the professional and patient to enhance the quality of all the services offered. Additionally, it also includes clauses on the management of confidential information that constitutes complete access for the patient in question and limited access for the public. Finally, the charter also directs professionals to treat patients with respect and dignity, which includes the communication process.

**Codes of Practice**

The obligation to maintain confidentiality begins after self-disclosure between the patient and the doctor. The same applies to disclosure between the social worker and their client (The NHS, n.d.). Confidentiality is necessary since the interactions between professionals and clients involve sharing confidential information. Such cases require that the professional exercise confidentiality and protect the identity of the patient. As such, the healthcare and social work department of the UK places significance on the necessity to maintain the client’s privacy. Doing so leads to the development of a safe space where the client can provide information that is necessary for the intervention. It also leads to the improvement of the relationship between the participants thereby paving the way for successful interactions.

The industry professionals also have to abide by a code of equality and diversity. Heath and social care work apply to people from diverse backgrounds (The NHS, n.d.). As such, a need exist to provide services to all the members of the population in a uniform manner free of discriminatory processes. As such, professionals in healthcare and social work cannot decline to provide a service to a person due to their distinct and individual characters such as race, religion, and age. This code of practice promotes communication across cultural and social backgrounds by creating a standard for acceptable service. Professional conformance to the system fosters effective communication as well as the building of trust with patients.

**Question 8: Organizational systems and policies in promoting good communication practices**

Systems and procedures are vital in shaping the way that an organisation carries out its operations with the aim of improving communication. The structures and guidelines put in place within the organisation play a crucial role in shaping the organizational culture. Consequently, these values and beliefs lead to the alteration of the behaviours of professionals in the workplace (Willis et al., 2016). The policies and systems provide guidelines for operations that govern the way that health and social workers approach their occupation. Guidelines that focus on the technique that stakeholders communicate are vital in cultivating good practices in the communication process. For instance, an organizational policy requiring constant engagement among stakeholders ensures fast response rates for inquiries from the public or other concerned and authorized agencies. For example, a code of ethics that emphasizes on equality will necessitate all-inclusive service communication. As such, the professionals must promote respectful and dignified dialogue when conversing with a patient or fellow practitioner.

Systems to enforce policies are necessary to ensure compliance from professionals. These safeguards provide a mechanism for reporting as well as punishing practitioners who fail to adhere to organizational policies. One such approach is whistleblowing (Taiwo, 2015). This act involves disclosing unethical or malpractice incidents to the public and relevant authorities. For instance, a racist physician who uses profanities when conversing with people from different minority races should be reported for contravening policies on equality. Declaring such an individual creates a transparent workplace and ensures adherence to the proper practice. Punishment should also occur as a deterrent to inappropriate communication processes. Firing the individual or suspending their license to practice is an efficient way of promoting appropriate communication processes.

Therefore, organizational systems and policies are valuable tools in promoting good communication practices. Decision makers have the responsibility of designing policies and systems that support professional responsibility and accountability. The intended outcome is to develop a structure that motivates a corporate culture characterized by open and honest communication especially in cases of cultural diversity. It should also protect the privacy of clients. Finally, the structures put in place should motivate adherence by the staff to prevent weak or ineffective communication.

**References**

Ajzen, I. (2011). The theory of planned behaviour: Reactions and reflections.*Psychology & Health, 26*(9), 1113-1127. doi:10.1080/08870446.2011.613995

Altman, I., & Taylor, D. (1987). Communication in interpersonal relationships: Social penetration theory. *Interpersonal processes: New directions in communication research*, *14*, 257-277.

Barnett, J. E. (2011). Psychotherapist self-disclosure: ethical and clinical considerations. *Psychotherapy*, *48*(4), 315.

Care Quality Commission. (2012). *The state of health care and adult social care in England in 2011/12* (Vol. 763). The Stationery Office.

Finney Rutten, L. J., Augustson, E., & Wanke, K. (2006). Factors associated with patients' perceptions of health care providers' communication behaviour.*Journal of Health Communication, 11*(sup001), 135-146. Doi: 10.1080/10810730600639596

Frye, N. E., & Dornisch, M. M. (2010). When is trust not enough? The role of perceived privacy of communication tools in comfort with self-disclosure. *Computers in Human Behaviour*, *26*(5), 1120-1127.

Grierson, L. E. M., Fowler, N., & Kwan, M. Y. W. (2015). Family medicine residents' practice intentions: Theory of planned behaviour evaluation.*Canadian Family Physician Médecin De Famille Canadien, 61*(11), e524.

Knapp, M. L., Vangelisti, A. L., & Caughlin, J. P. (2014). *Interpersonal communication & human relationships*. Pearson Higher Ed.

Nápoles‐Springer, A. M., Santoyo, J., Houston, K., Pérez‐Stable, E. J., & Stewart, A. L. (2005). Patients’ perceptions of cultural factors affecting the quality of their medical encounters.*Health Expectations, 8*(1), 4-17. doi:10.1111/j.1369-7625.2004.00298.x

National Health Service. (n.d.). *NHS Information Governance - Guidance on Legal and Professional Obligations*. *Digital.nhs.uk*. Retrieved 16 January 2018, from <https://digital.nhs.uk/article/1203/NHS-Information-Governance-Guidance-on-Legal-and-Professional-Obligations->

Paternotte, E., Dulmen, S. v., Lee, N. v. d., Scherpbier, A. J., & Scheele, F. (2015). Factors influencing intercultural doctor-patient communication: A realist review.*Patient Education and Counselling, 98*(4), 420-445. doi:10.1016/j.pec.2014.11.018

Taiwo, S. F. (2015). Effects of whistle blowing practices on organizational performance in the Nigerian public sector: Empirical facts from selected local government in Lagos & Ogun state. *Journal of Marketing and Management, 6*(1), 41.

The National Health Service. (n.d.). The Charter of Patients Rights and Responsibilities. *Nhsinform.scot*. Retrieved 16 January 2018, from <https://www.nhsinform.scot/care-support-and-rights/health-rights/patients-charter/the-charter-of-patient-rights-and-responsibilities>

United Kingdom Government. (2012). *Health and Social Care Act 2012*. *Legislation.gov.uk*. Retrieved 16 January 2018, from <https://www.legislation.gov.uk/ukpga/2012/7/contents>

Willis, C. D., Saul, J., Bevan, H., Scheirer, M. A., Best, A., Greenhalgh, T., . . . Bitz, J. (2016). Sustaining organizational culture change in health systems.*Journal of Health Organisationand Management, 30*(1), 2-30. Doi: 10.1108/JHOM-07-2014-0117