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Confronting Safety Gaps across Labor and Delivery Teams

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Abstract

We assessed the occurrence of four safety concerns among labor and delivery teams: dangerous shortcuts, missing competencies, disrespect, and performance problems. 3282 participants completed surveys. 92% of physicians (906/985), 93% of midwives (385/414), and 98% of nurses (1846/1884) observed at least one concern within the preceding year. A majority of respondents said these concerns undermined patient safety, harmed patients, or led them to seriously consider transferring or leaving their positions. Only 9% of physicians, 13% of midwives, and 13% of nurses shared their full concerns with the person involved. Organizational silence is evident within labor and delivery teams. Improvement will require multiple strategies, employed at the personal, social, and structural levels.

Keywords

Communication; organizational silence; patient safety; psychological safety

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Conflict of Interest Statement

Mr. David G Maxfield is employed by and owns stock in VitalSmarts LC. While neither VitalSmarts LC nor its products are mentioned in the manuscript, VitalSmarts LC does create training products that are designed to address the kinds of problems identified in this study.

No Disclaimer is appropriate

Introduction

Communication breakdown remains a leading contributor to adverse events in the United States.¹ Previous studies indicate that clinicians may not always speak up when they have concerns about safety or performance,^{2,3} and that the quality of the work environment is associated with patient outcomes.^{4,5} Human fallibility may be inevitable,⁶ but should be open for discussion, especially within labor and delivery teams. In this study, five organizations, each committed to improving the birth process, have come together to study the kinds of high-stakes, emotional disagreements that are especially likely to be problematic.⁷

Studies in other contexts suggest that when high-stakes conversations go poorly, they fail in two very different, but predictable, ways: silence and violence.⁸ People's emotions kick in, and they move toward flight or fight. Silence, the flight response, includes failing to speak up at all, sidestepping true concerns, and taking concerns to the wrong people. Violence, the fight response, includes verbal and physical attacks—sarcasm, putdowns, and insults—and various ways of controlling, labeling or dismissing the other person.

Silence in organizations is both common and costly.⁹ When people do not voice their concerns, the problems they have observed persist, a norm of silence is bolstered, organizational members become less committed, and the system itself becomes less capable.^{10–12} This problem of organizational silence has been found across many healthcare professions, ranging from chairs of medicine¹³ to residents,^{2,14} midwives,¹⁵ and nurses.^{3,16} When silence takes the form of healthcare workers' inability to address each other's fallibilities, patient safety is put at risk.¹⁷ In contrast, organizations that have made a commitment to programmatic changes that include promoting teamwork and effective communication have demonstrated improvements in patient outcomes.^{18–20}

Various forms of violence, including intimidation, disruptive behavior, and bullying, are also common within organizations and come with a price.²¹ These behaviors produce lower levels of commitment and higher turnover, greater burnout, and even revenge.^{22,23} Furthermore, violence within organizations also leads to silence.²⁴ As professionals or staff with greater formal or informal power inappropriately assert their position, those who experience it are far less likely to speak up about future concerns. The experience of organizational violence can be powerful in silencing witnesses as well as direct recipients because it undermines psychological safety.²⁵ Organizational violence has been found across healthcare professions, including horizontal aggression among nurses,²⁵ intimidation of residents,²⁶ physicians' disruptive behavior,²⁷ and managerial bullying.²⁵ The American College of Obstetricians and Gynecologists (ACOG), The Joint Commission, and others have called for health care organizations to formally manage disruptive behaviors,^{28–31} and build positive partnerships to improve patient outcomes and experience in childbirth.³² Surveys are available to measure unit- and hospital-level safety culture,^{33,34} and several programs are available to help facilities improve communication and teamwork (e.g. TeamSTEPPS³⁵; MoreOB³⁶). However, the scope of concerns regarding safety and performance in US labor & delivery units remains unknown.

Aims of the present study

We sought to investigate the occurrence of clinician concerns about safety and performance in labor & delivery units. This study focused on concerns that arise among physicians, midwives, and nurses during labor and birth, and explored whether and how they were voiced. The birth process can create an urgent need for skillful communication. Although birth is usually a normal, physiologic process and most occur without problems, its dynamic nature requires swift, coordinated action when complications do arise. Risks to the mother

and fetus may be known in advance or may develop suddenly. In either case, circumstances can be ambiguous and complex, conditions can change quickly, and caregivers must rely on one another to recognize and resolve evolving problems. Caregivers need to discuss their concerns about their colleague's plans or actions.³⁷ Yet the need to remain at the bedside may inhibit direct engagement in "disagreement" in front of women and their families. Delay in fully open communication can amplify risk or delay needed treatment. And yet, research has shown it can be difficult to speak up across professions, especially when power gradients exist²⁵ as they do within labor and delivery teams.

Our interest was in mapping four kinds of concerns healthcare professionals are likely to have: concerns about dangerous shortcuts, missing competencies, disrespect, and performance problems. Previous studies have found that these concerns are prevalent, but rarely addressed, within populations of critical-care and OR nurses.^{3,37} Our goal was to document how common these concerns are within labor and delivery teams, how costly they are judged by team members, and how discussable they are within the team.

Materials and methods

This study was conducted among members of four professional organizations whose members attend labor and birth: American College of Nurse-Midwives, American Congress of Obstetricians and Gynecologists, Association of Women's Health Obstetric and Neonatal Nurses, and Society for Maternal-Fetal Medicine. From a convenience sample of those with active email addresses on file, we randomly selected half of the members from each organization to receive a multiple-choice survey. The survey was delivered by the associations via an email describing the study that included direct link to a secure survey platform. Our ability to calculate a response rate was limited because the associations did not all have the capacity to track detailed information about survey delivery. The profession of each respondent was tracked by using a unique link for each professional association. No personal identifiers were collected. Western Institutional Review Board determined the study to be exempt.

The survey was adapted from previous studies^{3,37} by an expert panel of physicians, nurses, and midwives who each had experience in the Labor & Delivery setting. A copy of the survey is available as Appendix 1 online. The behaviors of interest were defined as follows:

1. *Dangerous Shortcuts* were defined as "shortcuts that could have been dangerous to a patient (for example, not washing hands, not changing gloves when appropriate, failing to check armbands, forgetting to perform a safety check, or not following an agreed-upon protocol)."
2. *Missing competency* was defined as "not as skilled as he/she should have been (for example, not up-to-date on a procedure, policy, protocol, medication, or practice or was lacking basic skills)."
3. *Disrespect* was defined as "demonstrated disrespect (was condescending, insulting, or rude—or yelled, shouted, used profanity, or name called)."
4. *Performance Problems* were defined as "a performance problem (poor attention to detail, poor initiative, uncooperative, lazy, etc.) that undermined teamwork, productivity, safety, patient experience, or quality of care."

Respondents were asked to rate how common, costly, and discussable each problem is within their labor and birth teams. These terms were defined as follows:

Common—"In the last year how often have you worked with someone on your labor and birth team (nurses, midwives, physicians, etc.) who demonstrated the problem being

described?” Respondents answered on a 5-point Likert-type scale that ranged from *Not at all* to *Daily*.

Costly—“Describe the impacts of the problem being described.” Respondents were given a list of possible impacts tailored to each of the concerns. Respondents selected all of the impacts that applied.

Discussable—“Think of the person whose shortcuts create the most danger for patients. Who have you spoken with about the problem?” Respondents selected from a list of people they might have spoken with, and selected all that applied.

The survey also asked participants to think of times when they hadn’t spoken to the target of their concern and to select from a list of possible reasons for their silence. This question was designed to help delineate the reasons for organizational silence within labor and delivery.

Results

A total of 3,282 survey responses were collected. The breakdown of respondents included 985 physicians, 414 midwives, and 1884 nurses. The nurses included 895 staff nurses, 419 charge nurses, 368 manager/director nurses, and 195 other nurses.

Table 1 shows how common, costly, and discussable the four problems were for each of the three professions. These four concerns were common across professions: 92% of physicians, 93% of midwives, and 98% of nurses observed one or more of these four concerns within the last year. As seen in Table 2, these concerns were also judged to be costly: 66% of physicians, 59% of midwives, and 77% of nurses said these concerns undermined patient safety, harmed patients, or led them to seriously consider transferring or leaving. And yet, these concerns were largely not discussed: only 9% of physicians, 13% of midwives, and 13% of nurses who had one or more of the four concerns spoke to the person on each occasion, and shared their full concern. Although the majority of healthcare providers did not speak to the person they deemed most responsible, many did speak to someone, as shown in Table 1. Physicians, midwives, and staff nurses were at least as likely to discuss their concerns with co-workers and managers as with the person involved.

We examined this phenomenon more closely within the group of nurse respondents, because we could compare staff nurses to charge nurses and to nurse managers/directors. Staff nurses were more likely to discuss these problems with their manager than with the person who was involved in the problem. They worked through the hierarchy, rather than addressing the problem on their own. We found that nurses in more powerful roles reported speaking up more often than staff nurses; 63% of nurse managers/directors and 30% of charge nurses indicated they spoke to the person and shared their full concern.

Across professions, caregivers cited two primary reasons for not speaking up to the target of their concerns: a) They worried that the person will become harder to work with (47%); and b) They did not want conflict in front of a patient (38%). Additionally, staff and charge nurses cited two other reasons: c) They feared the person would retaliate against them (38%); and d) They had seen the person get angry at someone else who had confronted them (27%).

Comments

The intent of this survey was to determine whether healthcare professionals working within labor and delivery teams observe problems with performance that could affect safety, and whether they speak up and resolve the concerns they have with one another. The results

indicate a clear problem: participants in our study had concerns—concerns they believed could impact patient safety and staff morale—and yet, they were often unwilling or unable to enter into dialogue with the person at the center of their concerns. They feared speaking up would make the person harder to work with, result in a conflict played out in front of a patient, and frequently considered the way the person has acted in the past and worried about possible retaliation. While many discussed their concerns with co-workers and managers, the data from managers showed that only 63% voiced their concerns to the target, suggesting a lack of organizational accountability for creating an environment where concerns are openly discussed and addressed.

Study limitations include the use of a convenience sample from the professional associations. This method of sampling does not ensure access to the entire population of professionals working in Labor & Delivery settings, and may not be generalizable to all settings. It is possible that non-response bias has skewed our results if professionals who do not perceive problems with communication and competence in Labor & Delivery did not respond to the survey. Furthermore, our survey delivery method hampered our ability to calculate a response rate. In the future, researchers will need to carefully consider the trade-offs between focused data collection in contained settings that can achieve a higher response rate, versus the wide reach but lower response rates of typical of electronic survey delivery. Another concern is that the data reflects individual experience. While it is unlikely, we could not determine whether some hospitals are more represented in our sample than others. If some hospitals are more represented, then it could happen that several respondents were thinking of the same incident. This is an issue that might be addressed in future studies by considering how unit- and hospital level data from safety culture surveys may be related to the type of individual-level data collected in our study. Despite these limitations, the number of responses from across professional associations and the consistency of our findings with other literature suggest significant cause for concern.

Organizational silence undermines a team's ability to course correct, learn as a team, and maintain quality and safety.^{9–12,17} Despite important progress in interdisciplinary collaboration in obstetrics,³² our findings suggest that there is room for improvement regarding organizational silence across all the professions involved in Labor and Delivery, including physicians, midwives, and nurses. Our findings are consistent with studies in Labor and Delivery units and other settings indicating that hierarchy, disruptive behavior, and lack of perceived support from management for expressing concerns undermine patient safety, and that these problems cut across professional boundaries.^{2,3,13–16,26,37} Speaking up to just anyone is not enough. In order to make a difference in patient care, quality, and morale, labor and delivery professionals need to acquire the skills to voice their concerns directly to the involved clinicians in a timely and respectful fashion, and be supported by their health care organizations when they do so. Clear accountability and commitment from all parties at this critical intersection of individual and organizational responsibility will lead to a safer and more satisfying environment for both patients and health care professionals.

The optimal strategy for improving dialogue is not known, and would likely vary from unit to unit. Table 3 contains several suggestions for improving dialogue within labor and delivery teams. These suggestions draw on research from a wide variety of disciplines. Our data show that communication regarding safety concerns in labor and delivery settings is clearly an area in need of further study.

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Table 1

		Reported Observing Problem within the Last Year n (%)						Reported they Spoke with Person Involved and Shared Full Concern n (%)				
		Physicians 985	Midwives 414	Staff Nurses 898	Charge Nurses 420	Nurse Managers/Directors 386	Physicians 985	Midwives 414	Staff Nurses 898	Charge Nurses 420	Nurse Managers/Directors 386	
		594 (61)	290 (71)	757 (85)	375 (90)	338 (88)	280 (47)	106 (37)	201 (27)	146 (39)	240 (71)	
Physicians		702 (73)	288 (73)	686 (78)	345 (83)	291 (77)	240 (34)	94 (33)	114 (17)	94 (27)	175 (60)	
		580 (61)	282 (70)	762 (86)	381 (91)	333 (88)	162 (28)	74 (26)	125 (16)	104 (27)	197 (59)	
Managers		685 (72)	300 (76)	770 (87)	383 (92)	326 (87)	200 (29)	67 (22)	112 (15)	105 (27)	204 (63)	

Table 2

Cost of Concern by Type and Profession

Type of Concern	Physicians n (%)	Midwives n (%)	Staff Nurses n (%)	Charge Nurses n (%)	Nurses Managers/Directors n (%)
Professionals Reporting a Patient was Seriously Harmed ^a					
Shortcuts	78 (8)	38 (9)	86 (10)	25 (6)	48 (12)
Missing competencies	139 (14)	49 (12)	128 (14)	58 (14)	58 (15)
Professionals Reporting Seriously Considering Transferring or Leaving Position					
Disrespect	74 (8)	52 (13)	153 (17)	56 (13)	40 (10)
Professionals Reporting Situation(s) Undermined Patient Safety					
Performance Problems	492 (50)	227 (55)	549 (61)	284 (68)	263 (68)

^aSerious harm defined as any harm listed requiring medication or treatment, up to and including patient death.

Table 3

Strategies for improving dialogue within labor and delivery teams.

- 1 **Implement a formal safety program that includes assessment of safety culture, addresses teamwork training, and provides a structure for setting, tracking, and achieving measurable improvement goals.** It is well-established practice to measure change-management success with baseline evaluation of outcomes and regular post-treatment assessment.³⁸ However, outcomes do not capture buy-in and optimism, invaluable in creating lasting improvement, and teamwork training alone is typically not successful without clinician and administrative buy-in.^{39,40} Establish the infrastructure for cultural change with a program that provides local control of improvement targets within a broader context of safety learning and evaluation.⁴¹ Evaluate cultural norms and change over time by administering a safety culture survey in addition to traditional outcomes-monitoring. This evaluation should include opportunities for regular feedback and learning, through near-miss and adverse event review.^{20,41–44}
- 2 **Set clear behavioral standards.** Specify both the prompt to act and the form the action should take. When people are told what to look for and how to respond when they see it, they are far more likely to follow through.⁴⁵ Below is an example of a standard you might use:
 - Whenever I have a concern about another caregiver's behavior (for example, shortcuts, incompetence, disrespect, or performance problems), I discuss my concerns with the person in a way that is frank, honest, and respectful."

Example methods of classifying and addressing behavior have also been set forth in the literature:

 - Hickson, et al. outlined methods to identify and confront unprofessional behavior. They suggest moving through tiers of intervention based on patterns of behavior and the offender's response to feedback.⁴⁶
 - The Joint Commission requires a Code of Conduct detailing acceptable and unacceptable behaviors.²⁹ The ACOG Committee on Patient Safety and Quality Improvement recommends that staff members be required to acknowledge their acceptance of the Code and consequences for noncompliance.²⁸
- 3 **Build Personal Motivation.** The personal desire to speak up and resolve these difficult situations must be powerful enough to overcome any reluctance or fear.
 - Speaking up needs to become a moral imperative—an element of professional and self-respect. The mistake we make when trying to motivate others is to rely on verbal persuasion: lectures, sermons, data dumps, and rants. These are the least powerful ways to motivate.
 - The most powerful way to build personal motivation is through direct and vicarious experience.⁴⁷ Caregivers who have spoken up and seen their actions save lives don't need lectures or data to convince them further. You probably have a few of these people on your labor and delivery teams. Encourage them to share their stories with others. They can be your strongest advocates and agents of change.
- 4 **Build Personal Ability.** People need to improve their skills for speaking up in these challenging situations. Currently, they fear that speaking up will undermine their working relationships and create conflicts in front of patients. They need to know how to bring up their concerns in ways that are respectful, minimize defensiveness, and don't provoke conflicts.
 - Many skill-building resources exist, ranging from formal training programs to coaches, books, and websites. Comprehensive training programs with demonstrated use in labor and delivery include the Comprehensive Unit-based Safety Program (CUSP),^{20,41–43} the MORE program,³⁶ and TeamSTEPPS.^{35,40}
 - The two evaluation criteria to consider are relevance and practice. The skill building should show how to address the tough concerns identified in this paper and include role-plays, simulations, or other forms of deliberate practice.^{48,49}
- 5 **Build Social Motivation & Ability.** The right people need to lead this change or the old norms will reassert themselves.
 - Two groups are essential: formal and informal leaders.⁵⁰ Formal leaders include anyone with a management role, especially facility and unit managers. Every formal leader needs to endorse, discuss, and lead this change. Informal leaders are opinion-leaders among midwives, physicians, and nurses. These are respected professionals others look to as they consider their own actions.
 - Identify these leaders and involve them. Ask them to lead out on the tracking measures, behavioral standards, sharing of personal experiences, and training. In addition, ask these leaders to step in and help when others are having trouble resolving their concerns.
- 6 **Build Structural Motivation.** Make sure people don't feel punished when they speak up in frank, honest, and respectful ways.⁵¹
 - Make sure people understand that holding each other accountable is a requirement of their job. Healthcare is a team endeavor where doing one's own job without attending to how others are doing theirs is no longer acceptable.
- 7 **Build Structural Ability.** Create opportunities for people to speak up and discuss their concerns.⁵¹ These discussions have to occur, but need a safe time and safe space." They cannot interrupt or derail the labor and delivery process itself.
 - Research indicates that the type of adverse events, or potential adverse events, reported is influenced by the method of collection.⁵² To give staff the best opportunity to speak up about concerns in every area, a range of times, places, and formats should be set for labor and delivery team members to share and discuss concerns. Some of these occasions should be private while others should involve the whole team. These may take the form of executive walk rounds, scheduled team huddles, required paperwork following adverse events, systems of anonymous spontaneous report, etc.

- 8 Combine Multiple Sources of Influence.** Organizational silence doesn't have a single root cause, so no single solution will be effective.
- Strategies that combine multiple strategies to build motivation and ability at the personal, social, and structural levels are far more successful. AACN Standards For Establishing And Sustaining Healthy Work Environments,⁵³ is one example of an excellent resource outlining a multi-source approach for improving work environments and resolving problems of organizational silence.
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