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Effective Physician-Nurse Communication: A Patient Safety Essential for Labor & Delivery

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Abstract

Effective communication is a hallmark of safe patient care. Challenges to effective interprofessional communication in maternity care include differing professional perspectives on clinical management, steep hierarchies, and lack of administrative support for change. In this paper we review principles of high reliability as they apply to communication in clinical care, and discuss principles of effective communication and conflict management in maternity care. Effective clinical communication is respectful, clear, direct, and explicit. We use a clinical scenario to illustrate a historical style of nurse-physician communication, and then demonstrate how communication can be improved to promote trust and patient safety. Consistent execution of successful communications requires excellent listening skills, superb administrative support, and collective commitment to move past traditional hierarchy and professional stereotyping.

Keywords

Interprofessional Communication; Labor & Delivery; Patient Safety

A Not-Unusual Situation

Ms. B, a 38-year-old woman at 39 weeks gestation who desires natural labor and birth is admitted to a community hospital for induction of labor. Her diagnosis is gestational hypertension: three days earlier her blood pressure in the office was 139/89 with negative dip urine protein. Her 24-hour urine was negative, but today her blood pressure is 140/90 and her physician recommends induction. She's been on oxytocin for most of the day and is progressing, but her physician and nurse disagree on how to manage oxytocin and labor pain.

Context

Physician A's perspective: Ms. B is a longtime patient of mine who had several miscarriages. I'm worried this induction may take a while. I don't want to be in

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house tonight, because I only got 6 hours of sleep last night and it's my 6 year-old's birthday. But I've promised Ms. B I'd be there for her.

Nurse C's perspective: Ms. B came in this morning for induction. The indication is gestational hypertension, but her BP was 110/70 and her urine dip was negative. I had a copy of her prenatal records up to 36 weeks, and her BP was normal throughout pregnancy. I'm not sure what's going on here. She is 39 weeks, so she's ok for elective induction at our hospital, but she really wanted a natural labor, so I wasn't excited to get her induction started. I did her intake and started her IV, when my other patient started having lates, so I got tied up in her room, and wasn't able to get the Pit started right away.

Physician When I get to L&D at 10 am, Ms. B's pitocin hasn't been hung yet. The unit is busy, and I can't find her nurse right away to get things going. The fetal heart rate tracing is reactive and her BP is 120/70. I contemplate sending her home, but I once had a patient who had a stillbirth at term in the setting of gestational hypertension, so hypertension always makes me a little nervous, even when it's mild. An hour later, things quiet down in L&D and the pit finally gets started. By late afternoon, she's in a good pattern.

Nurse: When I saw Dr. A this morning he asked me why Ms. B's pit hadn't been started yet. I told him that her induction didn't seem urgent, and that my other patient had a bad tracing. He just said “Hmmpf,” and asked me to get it started. I went up on the pit all afternoon. When she got up to 12mU/min, she started contracting 6 in 10 minutes and had a run of lates, so I backed down on the pit, and the strip was fine after that.

Physician: At 4:00 pm the strip is fine, she's 3 cm, contracting nicely, and wants an epidural. She had an episode of tachysystole with lates a little earlier, but an otherwise reactive tracing. I take the lates as a sign that she may be developing a little placental insufficiency, so I'm glad we decided to induce instead of sending her home. I run to the office to see 2 urgent patients, but plan to be in L&D after that. I'll rupture her membranes after she gets her epidural.

Nurse: At 4:30, Ms. B's on 10 of pit, 3 cm, contracting, and wants an epidural. I tell her that I worry that if she gets an epidural now; she's more likely to end up with a c-section. At the hospital I used to work at, we used fentanyl first when women were this early on in labor, so I tell her that we can discuss that with Dr A, then my charge nurse pulls me out to cover another patient's epidural.

Physician: When I come back to L&D Ms. B looks like she's getting active, but she's crying and tells me that Nurse C told her she couldn't get an epidural yet. I want to check her, maybe rupture her membranes, but her nurse isn't in the room, so I just check her and write the exam on the strip (4/90/-1). I plan to rupture her after she gets her epidural. I'm really frustrated that things just don't seem to be getting done. And I can never find Nurse C.

Nurse: At 5:00 pm, I'm getting Ms. B ready for the anesthesiologist and her membranes rupture spontaneously. When she gets the epidural, her blood pressure drops, and the fetus has a brady. Just to the 100s, but I'm frustrated because I know she really wants a vaginal birth, and here she is getting an epidural because she's getting oxytocin, because she's getting induced for what? I wonder if she really ever did have any high blood pressures in the office. Some of the doctors where I used to work would send people in for induction with no reason.

Physician: When I get back I see she's spontaneously ruptured. She's comfortable with the epidural, and her pitocin is still at 10. Gosh, it seems like Nurse C is really

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dragging her heels! Ms. B really wants a vaginal birth, but if I keep running into this "pit dystocia," she'll have a ridiculously long labor, get chorio with dysfunctional contractions, and she'll end up with a cesarean. (And I'm probably going to miss my daughter's birthday while we are fooling around here.) I tell nurse C we need to get Ms. B into a better labor pattern, so could she please keep increasing the pit – let's have a baby here!

Their Resulting Communication

Nurse: "Dr. A, I'm not really comfortable increasing the pit. Ms. B had tachysystole with late decelerations when she was at 12 milliunits before." *[Expression of concern about the plan.]*

Physician: *[nonverbal clues indicating frustration]* "Nurse C, Thank you for reminding me of the tachysystole. We haven't seen any more decelerations, so I'm not worried about it. We need to have this baby; I don't want her having protracted labor and getting chorio. Please go up on the pit as I ordered." [Acknowledgement, but tone of frustration is intimidating and mention of orders invokes hierarchy, discouraging further discussion and collaboration. Does not give true attention to the nurse's concern.]

Nurse: [grumbling] "*Okay*" [Thinking, "They never listen. Well, I'm the one managing the pit and I'm not going to put her back into tachysystole." Does not resolve concern collaboratively.]

Discussion

Effective communication between team members and with patients is one of the hallmarks of safe and highly reliable patient care.[1, 2] Highly reliable perinatal units, ones that hold patient safety as a central value,[3, 4] have an infrastructure of respect, attentiveness, communication, and competence.[5] System structure alone does not produce high reliability. True high reliability requires individuals and teams to constantly scan for, detect, and correct evolving safety threats,[6] and to adapt to dynamic conditions appropriately.[6] Every team member is accountable for "speaking up and stating concerns with persistence until there is a clear resolution."[7] Additionally, team leaders must be clear about the reasoning for specific courses of action, and demonstrate openness to input from all team members by soliciting and reflecting on team member perspectives.

Problems with communication and teamwork are well-known challenge to patient safety in labor and delivery units.[8–11] It is often tempting to point fingers across professional boundaries -- i.e. to view our communication breakdowns as a "nursing problem" or a "physician problem." However, the sources of communication breakdowns in labor and delivery are complex. Physicians, nurses and midwives are equally capable of engaging in both excellent and suboptimal habits and styles of communication. They are equally capable of practicing collegially, demonstrating a foundational characteristic of high reliability: open communication that is respectful, attentive and collaborative. Likewise, nurses, physicians and midwives are all equally capable of disrespectful styles of communication, being distracted by personal issues or system problems, or being self-centered. The misunderstandings illustrated in our scenario could have occurred between a midwife and a nurse, between a physician and a midwife, or between members of the same profession who don't see eye to eye. Thus the problem of ineffective communication is not a problem of any one profession, but a communal problem for which physicians, nurses, midwives, and institutions need to be accountable.

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Research indicates physicians, nurses, and midwives have differing views on optimal labor management,[12, 13] suggesting a continual need for communication and negotiation among team members during labor and birth. Yet clinicians persistently express diverse perspectives on the quality of teamwork, communication, and collaboration in their inpatient clinical units.[14, 15] Common reasons for breakdowns in understanding include clinicians' failure to communicate their plan and rationale, their failure to communicate concern effectively, their inattention to expressed concerns, and their efforts to protect patients, themselves, or colleagues from negative consequences of open disagreement. Research suggests that all clinicians - both in labor and delivery and elsewhere - at times minimize communications, do not voice concerns about patient care, or actively avoid clinical conflict. This occurs for a variety of reasons that may include lack of confidence, saving face, preserving relationships, deference to hierarchy, and fear of repercussions.[12, 16–21] Our work on interprofessional communication in Labor & Delivery units highlights chronic communication breakdowns that result from differing “world views” (on the benefit and risks of oxytocin, especially; unpublished data), as well as relationship strains between providers who may work in the same unit for years or decades.[13, 19]

Ideally, all clinicians would speak up with confidence, stating what they see, what they think is happening, and why they think certain actions should or should not be taken in any patient care situation. This approach may seem obvious when communication occurs between attending physicians. However, nurses, medical residents, and even attending physicians do not always voice concern at critical times or may struggle to do so.[16, 19, 22] Multiple helpful strategies for structuring information transfer between colleagues and among teams are delineated elsewhere.[23] While several sites have demonstrated safety improvements using packages of teamwork interventions,[24–28] other sites demonstrate mixed results[29] and it may not be possible to empirically isolate specific communication strategies as most effective.[30] One surgical setting found that implementation of a structured briefing tool actually resulted in unconstructive, potentially detrimental briefings in 15% of cases observed.[31]

The mixed performance of communication support tools may be due to the fact that communication is a social process constituting much more than simple sending and receiving technical information. Each party in the interaction brings their history, assumptions, and expectations of others with them, and each is influenced by organizational culture.[32] Because of this, structured tools may not be successful if not embedded in an infrastructure of respect and attentiveness. To this end, we outline here some principles of communication and conflict management that are likely to be helpful across settings to augment, (but not substitute for) strategies such as team training, SBAR (Situation, Background, Assessment, Recommendation), board rounds, huddles, debriefings and the like.[23]

Effective clinical communication is clear, direct, explicit and respectful. It conveys the level of urgency in the situation, the rationale underlying the requested action, and openness to alternatives so that team members can quickly develop a shared understanding of the situation and present differing interpretations as needed. Excellent listening skills, superb administrative support, and collective commitment to move past traditional hierarchy and professional stereotyping are necessary to execute such communication practices consistently. Nurses, residents, attending physicians and midwives must all accept the necessity of persistently pursuing their concerns about patient care until the team determines a clear resolution to the problem.[7, 17, 33] Likewise, all clinicians, but especially those in authoritative positions, must attend to their listening skills. Team leaders should not view inquiry (asking for clarification, requesting rationale for decisions) and assertion (stating concerns with persistence) as challenges to their expertise. Rather they should welcome them as protective: inquiry and assertion promote safety by maintaining preoccupation with

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potential failure[5] and protecting against the tendency for normalization of deviance that can lead to catastrophic harm.[4, 34] Furthermore, all team members need to ensure they have confirmed agreement on the actions to take and the rationale for planned care. Organizations need to align systems of care to address sleep-deprivation and other work-force related interferences to attentive listening.

Even in the setting of excellent communication skills, nurses, physicians, and midwives may have substantially differing views on what constitutes the best or safest care in common obstetric situations such as hastening versus observing labor, management of induction or augmentation of labor, interpretation and management of complex fetal heart rate patterns, pain management, and second stage management. Thus clinical conflicts are fact of life and clinicians must learn to deal with them effectively. (Table 1)[35, 36] Many people prefer to avoid confrontation, and nurses in particular have traditionally found ways to sidestep it.[32, 37] However, addressing conflicts as they arise is more likely to build engagement with and trust in team members.[38] Furthermore, addressing potential conflicts early may allow smoother communication later should an obstetrical emergency arise.

Some key principles in addressing conflict effectively include setting aside assumptions about what happened and underlying intentions, listening to the other person's story and goals, and recognizing the influence of cultural factors on differences in perspectives.[32, 38] Each party in a conflict holds a different story about what is "really going on here." Listening carefully to these stories and understanding what each person is contributing to the problem and its potential solutions are critical to conflict resolution that builds transparency and trust rather than damaging interpersonal relationships and teamwork.[38] While this approach may take more effort and certainly takes practice; it does not necessarily have to take more time. Taking such an approach might have resolved our opening scenario differently:

> Nurse: Dr. A, I'm not really comfortable increasing the pit. Ms. B had tachystole with late decelerations when she was at 12 milliunits/minute before. What's the urgency? *[Statement of concern, request for rationale]*
>
> Physician: Nurse C, I'm worried about tachysystole, too. But there haven't been anymore decelerations, so I think we're ok. We need to have this baby; I don't want her getting chorio. Please go up on the pit. *[Acknowledgement, but no change in plan]*
>
> Nurse: Can I have an IUPC then? *[Different tactic subtly restating concern]*
>
> Physician: Hmm. You seem more worried about the oxytocin dose than I am. Is there something else going on? [Recognition of request as re-statement of concern, probing for information, opening dialogue]
>
> Nurse: Honestly Dr A., I'm wondering about why we induced her in the first place - I haven't seen a single elevated pressure - and I'm frustrated that we've committed the patient and now more pit is going to land her a cesarean when she really wants a vaginal birth. [Presents underlying rationale for concern and commitment to protect patient's preferences]
>
> Physician: Ok, I see. You're right, she hasn't had any elevated pressures here. But she did in the office and I had a patient who had a stillbirth at term with gestational hypertension once, so I don't want to take any chances. I'm worried that if we don't increase the pit she'll get infected and need a section. I'm going to be in house, so how about you increase the pit regularly but call me right away if you're concerned about the uterine activity or FHR? [Acknowledges perspective, makes more complete rationale for decisions explicit, presents collaborative solution]

Nurse: Thanks Dr. A. It's funny we're both worried about her having a section but for different reasons. I'll increase the pit every half hour and I'll call you to review the tracing if I have any concerns. *[Ratifies agreement with collaborative solution.]*

Even better, team members could set a different tone for the day by having a proactive conversation early:

Physician [having arrived on L&D at 10am and finding the oxytocin not yet started]: Why haven't you started the pit yet? *[Statement of concern]*

Nurse: I'm sorry Dr. A - my other patient was having decelerations so I had to prioritize that. *[Explanation; accepting accountability]* But I'm glad you're here, because I have some questions about this case. Can you tell me more about the plan to induce Ms. B? I haven't seen any elevated pressures in house and she didn't seem to have any on her prenatal record. *[Inquiry, opening dialogue]*

Physician: Sure. I understand you're busy. *[Acknowledges colleague]* You're right, she hasn't had any elevated pressures here, but she did in the office last week. Here's the rest of her prenatal record. I had a patient who had a stillbirth at term with gestational hypertension once, so I don't want to take any chances. I plan to be in house, so I hope you feel comfortable with actively managing the pitocin. [Acknowledges question, makes more complete rationale for decisions explicit]

Nurse: That sounds fine. Could we both go in to talk with her together now to make sure we are all on the same page about the induction and pain management plans? I'll start the pitocin right after that, and I'll call you if I have any concerns about her progress or the tracing. *[Includes the patient; closes the loop]*

A challenge to improvement is that most clinicians and many organizations seem to see communication breakdowns as a problem of "others," believing themselves proficient. For example, in 45 in-depth interviews with nurses, physicians, and midwives at four hospitals, everyone acknowledged communication can be a safety problem, but only two identified themselves as having difficulty communicating effectively (unpublished data). However, behaviors are more important than attitudes, as attitudes follow behavior. Accountability and thoughtful action are essential for creating change.[39, 40] In other words, whether or not individuals accept the need for self improvement, holding everyone accountable for communication standards and openly practicing and role-modeling the desired behaviors are essential. Sustained progress will only occur through direct engagement, practice, and refinement of expectations and skills by individuals, units, and organizations.[39, 40]

Summary

Effective communication between physicians and nurses is vital to patient safety in obstetrics. The dynamic environment of labor and delivery adds further challenge to effective communication, which may also be thwarted by inattention due to sleep deprivation or shift work and different "world views" (e.g., on the benefit and risks of oxytocin). Despite their mutual commitment to providing the best possible care for childbearing women, nurses and physicians in labor and delivery may minimize communications, not voice concerns about patient care, or actively avoid clinical conflict. Reasons for this may include lack of confidence, saving face, preserving relationships, deference to hierarchy, conflict avoidance, and fear of repercussions. Improving communication thus is built on an infrastructure of respect, attentiveness, collaboration, and competence. This foundation includes all of the structural supports outlined by others as necessary for perinatal high reliability, but ultimately requires the individual and collective commitment of bedside clinicians to transcend professional stereotyping and flatten

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traditional hierarchies. Behavior change is hard. We have a mutual responsibility to get this right.

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Successful interprofessional communication requires excellent listening skills, superb administrative support, and collective commitment to move past traditional hierarchy and professional stereotyping.

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Table 1

Approaches for Improving Communication

Sources of Conflict	Approach
Differing expectations for information needs, communication content and style	Team Training
	Structured communication tools (e.g., SBAR[a]; structured handoffs)
	Board rounds
	Huddles
	Attentive listening
Failure to communicate rationale	Routinely ask for plan and reasoning
Inattention to concern	Persistently restate concerns until resolved
	Consider instituting laborist[b] in-house if provider fatigue frequent concern or service is large with many primary providers
Concerns remain unresolved	Ensure adequate staffing and break relief
	Ratify plan before concluding conversation
Differing “world views, ” e.g., “Oxytocin Wars”[c]	Standardize oxytocin protocol
Fetal monitoring methods, interpretation, and management of complex tracings	Standardize fetal monitoring language and application
	Provide regular interprofessional case reviews to discuss management; role model expression of concern and positive resolution of differences
	Standardize expectations for notification of complications
	Articulate and plan for potential problems early in care
	Individuals take responsibility for collaboratively discussing differing views
	Avoid professional stereotyping as an explanation for behavior
	Consider instituting laborist in-house (especially at night)
Disruptive Behavior	“Good Citizen” policy consistently enforced
	Individuals and peers stand up to unprofessional behaviors
	Administrative commitment to addressing any chronic issues
	Availability of anonymous incident reporting system

Sources: ACOG. Committee Opinion No. 459: The Obstetric-Gynecologic Hospitalist. *Obstet. Gynecol.* July, 2010 2010;116(1):237–239; Knox GE, Simpson KR. Perinatal high reliability. *Am J Obstet Gynecol*. In Press, Corrected Proof; Knox GE, Simpson KR, Garite TJ. High reliability perinatal units: an approach to the prevention of patient injury and medical malpractice claims. *J Healthc Risk Manag.* Spring 1999;19(2):24–32; Simpson KR. Failure to rescue: Implications for evaluating quality of care during labor and birth. *J Perinat Neonatal Nurs.* 2005;19(1):24–34; AHRQ. TeamSTEPPS®: Strategies and Tools to Enhance Performance and Patient Safety; Pronovost PJ, Holzmueller CG, Ennen CS, Fox HE. Overview of progress in patient safety. *Am J Obstet Gynecol.* Jan 2011;204(1):5–10.

[a]SBAR: Situation, Background, Assessment, Recommendation

[b]Laborist: An obstetric hospitalist

[c]“Oxytocin Wars”: Tug of war between physicians and nurses over management of oxytocin