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RESEARCH

Contributions of Clinical Disconnections and Unresolved Conflict to Failures in Intrapartum Safety

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ABSTRACT

Objective: To explore clinician perspectives on whether they experience difficulty resolving patient-related concerns or observe problems with the performance or behavior of colleagues involved in intrapartum care.

Design: Qualitative descriptive study of physician, nursing, and midwifery professional association members.

Participants and Setting: Participants ($N = 1932$) were drawn from the membership lists of the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN), American College of Obstetricians and Gynecologists (ACOG), American College of Nurse Midwives (ACNM), and Society for Maternal-Fetal Medicine (SMFM).

Methods: Email survey with multiple choice and free text responses. Descriptive statistics and inductive thematic analysis were used to characterize the data.

Results: Forty-seven percent of participants reported experiencing situations in which patients were put at risk due to failure of team members to listen or respond to a concern. Thirty-seven percent reported unresolved concerns regarding another clinician's performance. The overarching theme was clinical disconnection, which included disconnections between clinicians about patient needs and plans of care and disconnections between clinicians and administration about the support required to provide safe and appropriate clinical care. Lack of responsiveness to concerns by colleagues and administration contributed to resignation and defeatism among participants who had experienced such situations.

Conclusion: Despite encouraging progress in developing cultures of safety in individual centers and systems, significant work is needed to improve collaboration and reverse historic normalization of both systemic disrespect and overt disruptive behaviors in intrapartum care.

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Clear communication is important in intrapartum care. Miscommunication is a common and significant cause of safety issues (Grobman et al., 2011; Kennedy & Lyndon, 2008; Lyndon et al., 2012; Maxfield, Grenny, Lavandero, & Groah, 2011; Maxfield, Grenny, McMillan, Patterson, & Switzer, 2005; Simpson, James, & Knox, 2006). Several groups have demonstrated improvement in the culture of safety and presumably communication and teamwork in perinatal settings (Pettker et al., 2011; Simpson, Knox, Martin, George, & Watson, 2011; Thanh, Jacobs, Wanke, Hense, & Sauve, 2010). Yet implementation of teamwork training has had variable results depending largely on organizational factors (Farley, Sorbero, Lovejoy, & Salisbury, 2010; Jones, Skinner, High, & Reiter-Palmon, 2013), and implementation of comprehensive safety strategies has not yet reached all corners of intrapartum care. Furthermore, reports of disruptive behavior, problems with clinician performance, and breakdowns in communication continue to surface in the literature (Maxfield et al., 2005; Rosenstein & Naylor, 2012).

Researchers of these issues in intrapartum care have tended to use small samples from single sites or from within specific hospital networks or geographic regions. In this study we sought to explore in a broader sample clinicians' perspectives on whether they experience difficulty resolving patient-related concerns or observe problems with the performance of colleagues involved in intrapartum care. We report findings from a large sample of obstetricians, nurses, and midwives regarding the occurrence of

communication and performance problems in intrapartum care.

We sought to determine whether clinicians providing intrapartum care experience issues with unresolved safety concerns similar to those previously found in other settings.

Methods

We conducted a qualitative descriptive study using a sample of members from four professional associations representing clinicians who attend labor and birth including, Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), American College of Obstetricians and Gynecologists (ACOG), American College of Nurse-Midwives (ACNM), and Society for Maternal-Fetal Medicine (SMFM). An overview of the design is presented in Table 1.

We randomly selected one half of all members with valid e-mail addresses on file from each association to receive an invitation to respond to a story collector survey adapted from two previous surveys (Maxfield et al., 2011; Maxfield et al., 2005). The other one half of association members received an invitation to respond to a multiple choice survey described elsewhere (Maxfield, Lyndon, Kennedy, O'Keeffe, & Zlatnik, 2013). The story collector questions shown in Table 1 were adapted from the previous studies by an expert panel of physicians, nurses, and midwives who each had experience providing intrapartum care. Association membership was tracked by using a unique link for each professional association. No personal identifiers were collected. The study was deemed to be exempt from Institutional Review Board review.

Approximately 3% of respondents submitting narratives reported they did not experience problems in the area being queried. Another 3% of responses were not coded because they were either left blank or the response was so truncated it could not be interpreted. Thematic analysis was conducted on the remaining 94% of the narratives. We coded the data iteratively, explicitly working to identify the ways in which our personal and clinical experiences influenced our interpretations of the data (Whittemore, Chase, & Mandle, 2001). Table 1 outlines the steps of the qualitative analysis. We maintained a questioning stance toward the narratives because they gave only one perspective on the situation described by the participant. Moreover, we did not have outcome data so could not judge the accuracy of the participants' interpretations of events. Inclusion of both clinicians and nonclinicians on the research team strengthened rigor, and comparing interpretations from different positions helped expose interpretive assumptions. Similarly, the inclusion of a physician, registered nurse (RN), and certified nurse-midwife on the research team contributed to rigor by providing analytic triangulation (Whittemore et al., 2001).

Results

The distribution of participants' years of experience in intrapartum care and type of primary work setting are displayed in Table 2. We received 1932 *yes* or *no* responses to Question 1 and 1557 *yes* or *no* responses to Question 2 (Table 3). We received 1,493 narratives: 942 narratives for Question 1 and 527 narratives for Question 2. Participants reported a range of experience with failure to listen or respond to concern and with unresolved concerns about another clinician's performance within the past 2 years. Despite the one-sided nature of the data, in many stories about clinical disagreement the analysts could easily see how the other party might have interpreted the situation differently. For example, RNs reported having clinical judgments that seemed correct to the analysts but were ignored by one or more physicians. In other stories, RNs reported what they believed to be inappropriate decisions by physicians and/or failure to listen to the RN, but the physician seemed correct to the analysts given the information provided. Finally, in some cases where physicians complained that nurses refused to follow their orders, our interpretation was that the nurses' decisions were appropriate. These kinds of issues also occurred between physicians and between physicians and midwives.

The overarching theme was clinical disconnection, which included disconnections between clinicians about patient needs and disconnections between clinicians and administration about the support required to provide safe and appropriate clinical care. We identified four subthemes: (a) common ground-different road signs, (b) perceived imperviousness, (c) inaction or misguided action, and (d) resignation. These themes were situated in practice settings shaped by the dynamic nature of intrapartum care, women's needs and desires, clinicians' philosophies about birth, infrastructure and resource constraints, cultural characteristics of specific hospitals, regulatory and litigation

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