Abstract:
Communication breakdowns in high-risk areas such as emergency medicine and pediatrics impede care and threaten patient safety. A pervasive problem is the failure of clinicians to speak up with ideas, questions, or concerns. Honest lapses in communication occur with the distractions and interruptions of the emergency department despite the best intentions; in contrast, failures to speak up represent conscious choices to remain silent over giving voice to concerns. The complex socialization process in health care, authority gradients, and past experiences with disruptive and rude behavior influence clinicians from all professions when they weigh the risks and benefits of speaking up. Culture change at the organizational level and within clinical units will enhance the psychological safety that enables speaking up and promotes listening. Direct supervisors who engage in specific leadership behaviors foster a supportive workplace climate. Targeted communication strategies can help clinicians find their voice in the service of patient safety.

Keywords:
speaking up; patient safety; communication breakdown; learning; team

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Disclosures: None.

1522-8401

"Speaking Up" for Patient Safety in the Pediatric Emergency Department

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The emergency department (ED) is a busy place. Patients are coming and going. Some are so unwell that they need our best efforts to achieve a good outcome; others can be released again for ongoing outpatient management after assessment and any needed interventions. In addition to patients, the ED is a hub for emergency physicians, nurses, and other staff as well as specialists and care providers from a broad spectrum of other disciplines and departments who come to the ED to provide patient care. These may include providers from the intensive care unit, surgery, and radiology, to name a few. Communication within ED teams and across disciplinary and professional boundaries is a critical mechanism[1] that enables health care professionals to enact their knowledge in everyday clinical practice and forms the foundation for the teamwork[2] and interprofessional collaboration[3] that is required for safe patient care.[4] Unfortunately, communication breakdowns contribute to more than 70% of medical errors in the United States, according to the 2000 Institute of Medicine Report, *To Err is Human*.[5] Furthermore, medical errors from all causes led to as many as 400 000 deaths per year in 2013,[6] making effective communication all the more important, especially in high-risk areas such as emergency medicine [7] and pediatrics.[5] Communication breakdowns are a significant issue in clinical practice across health care professions;[8] they threaten patient safety due to failure to exchange information and may involve verbal, nonverbal, and written communication during patient handoffs, communication with patients, and failures to speak up with questions or concerns.[8,9]

FAILURE TO "SPEAK UP"

As a particular form of communication breakdown, the failure to "speak up" is an insidious and pervasive problem. "Speaking up" can be narrowly defined as "the raising of concerns by health care professionals for the benefit of patient safety and care quality upon recognizing or becoming aware of the risky or deficient actions of others within health care teams in a hospital environment."[9] Speaking up should not be confused with "whistleblowing,"[10] a distinct entity, which is related to reporting major incidents. Of course, beyond speaking up with concerns in the interest of patient safety, speaking up can also be viewed more broadly as "voice,"[11] as in giving voice to ideas, information, and opinions[12] in the service of solving problems clinical practice, and forms the basis for collaborative learning.[13] With this broader view, a trainee or clinician who does not share potentially important information or input out of fear of being wrong—or even worse, ridiculed—is germane to this discussion. In contrast to slips in communication that represent honest mistakes that can be viewed as inevitable[14] due to distractions, interruptions, competing tasks, and others, which occur frequently in the ED, the failure to speak up and give voice to questions or concerns represents a different category of communication breakdown because it occurs in full awareness of the person who remains silent,[15] raising ethical issues[16] and hindering learning through a number of mechanisms, such as impacting crucial feedback-seeking behavior.[17]

The prevalence of difficulties with speaking up is remarkable. Although more than two thirds of physicians or nurses report observing incompetent behaviors, less than 10% are willing to share their concern with their colleague.[18] Maxfield et al[18] have articulated 7 categories of "crucial conversations" that health care providers find particularly challenging to tackle:

1. Broken rules
2. Mistakes
3. Lack of support
4. Incompetence
5. Poor teamwork
6. Disrespect
7. Micromanagement

For practicing clinicians, these examples of crucial conversations such as observing a colleague break a rule of some kind or commit an error but then remaining silent are everyday occurrences in most clinical settings. Most if not all clinicians may recognize this behavior in themselves at one point or another. They also have clear notions about what instances would provoke them to speak up, no matter the consequences.

FACTORS THAT IMPEDE SPEAKING UP

Authority gradients[19,20] within professions but also across professional and disciplinary boundaries or "tribes"[21,22] play a role in speaking up behavior as well. Several factors contribute to authority gradients, including social status, educational level, professional role, and perceived expertise; the impact is that someone with less authority is less likely to challenge someone with more authority as well as someone with more authority being willing to "hear and heed" concerns.[20] As an example, a junior resident may find daunting the prospect of questioning an attending physician or asking for justification for management decisions[23] by someone who is above them in the health care hierarchy. This is not to say that leadership and authority have no place in health care; on the contrary, they both play an essential role, but blind obedience does not.[20] Hierarchies can also be expressions of power that can hinder teaching as well as learning.[24] Communication difficulties occur both vertically and horizontally within health care hierarchical structures. For example, a convenience sample more than 4000 nurses and nurse managers from the American Association of Critical Care Nurses and the Association of Perioperative Registered Nurses in the United States participated in the 2010 Silent Treatment study, which explored speaking up behaviors.[15] The authors found that 84% of nurses surveyed reported witnessing their colleagues taking dangerous shortcuts, such as not changing gloves or failing to check armbands, and 26% say that shortcuts have harmed patients; however, less than a third of nurses spoke up to the person taking dangerous shortcuts to share their concerns.

Developing a professional identity[25] during formative educational periods and socialization within a profession[26] contribute to the "tribalism"[21,22] and professional cultures that serve as barriers to communication.[27] For example, physicians and nurses are trained to communicate differently: nurses are encouraged to be broad and narrative when describing clinical situations, whereas physicians favor concise communication that highlights main points.[4] This gap in preferred communication approaches is also mirrored in discrepant attitudes in perceived effectiveness of teamworking, with physicians rating teamwork quality higher than their nurse peers.[23,28-30] So if our socialization[20] within our professional group (physician vs nurses)