PATIENT SAFETY SERIES

Effective physician-nurse communication: a patient safety essential for labor and delivery

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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: 3 days earlier her blood pressure in the office was 139/89 mm Hg with negative dip urine protein. Her 24-hour urine was negative, but today her blood pressure is 140/90 mm Hg, and her physician recommends induction. She has been receiving oxytocin therapy for most of the day and is progressing, but her physician and nurse disagree on how to manage the oxytocin and labor pain.

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. 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 an historic style of nurse-physician communication and demonstrate how communication can be improved to promote trust and patient safety. Consistent execution of successful communication requires excellent listening skills, superb administrative support, and collective commitment to move past traditional hierarchy and professional stereotyping.

Key words: interprofessional communication, labor and delivery, patient safety

Context

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

Nurse C's perspective. Ms B came in this morning for induction. The indication is gestational hypertension, but her blood pressure was 110/70 mm Hg, and her urine dip was negative. I had a copy of her prenatal records up to 36 weeks gestation, and her blood pressure was normal throughout pregnancy. I'm not sure what is going on here. She is 39 weeks, so she is 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 was not able to get the pitocin started right away.

Physician. When I get to labor and delivery at 10 AM, Ms B's pitocin has not 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 blood pressure is 120/70 mm Hg. 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 is mild. An hour later, things quiet down in labor and delivery, and the pitocin finally gets started. By late afternoon, she is in a good pattern.

Nurse. When I saw Dr A this morning, he asked me why Ms B's pitocin 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 pitocin all afternoon. When she got up to 12 milliunits, she started contracting 6 times in 10 minutes and had a run of lates. I backed down on the pitocin, and the tracing was fine after that.

Physician. At 4:00 PM the fetal heart rate tracing is fine; she is 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 experiencing a little placental insufficiency, so I am 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 labor and delivery after that. I will rupture her membranes after she gets her epidural.

Nurse. At 4:30, Ms B is on 10 milliunits of pitocin, 3 cm, and contracting and wants an epidural. I tell her that I worry that if she gets an epidural now, she is 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 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.

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Physician. When I come back to labor and delivery, Ms B looks like she is getting active, but she is 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 is not in the room. I just check her and write the examination on the strip (4/90/-1). I plan to rupture her membranes after she gets her epidural. I am really frustrated that things just do not seem to be getting done. And I can never find Nurse C.

Nurse. At 5:00 PM, I am 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 bradycardia. Just to the 100s, but I am frustrated because I know she really wants a vaginal birth. Here she is getting an epidural because she is getting oxytocin, because she is getting induced for what? I wonder if she really ever did have any high blood pressure 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 has spontaneously ruptured. She is comfortable with the epidural, and her pitocin level is still at 10. Gosh, it seems like Nurse C is really dragging her heels! Ms B really wants a vaginal birth, but if I keep running into this "pitocin dystocia," she will have a ridiculously long labor, get chorio with dysfunctional contractions, and end up with a cesarean. (And I am probably going to miss my daughter's birthday while we are fooling around here.) I tell Nurse C that we need to get Ms B into a better labor pattern, so could she please keep increasing the pitocin. Let's have a baby here!

Resulting communication

Nurse. Dr A, I am not really comfortable increasing the pitocin. 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 am 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 pitocin as I ordered. *[Acknowledgement, but tone of frustration is intimidating and mention of orders invokes hierarchy, which discourages 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 pitocin, 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 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 constantly to 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 a well-known challenge to patient safety in labor and delivery units.[8-11] It is often tempting to point fingers across professional boundaries (ie, 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 by demonstrating a foundational characteristic of high reliability, which is 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 do not see eye-to-eye. Thus, the problem of ineffective communication is not a problem of any 1 profession, but a communal problem for which physicians, nurses, midwives, and institutions must be accountable.

Research indicates that physicians, nurses, and midwives have differing views on optimal labor management,[12,13] which suggests 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 and delivery units highlights chronic communication breakdowns that result from differing "world views" (on the benefit and risks of oxytocin, especially; unpublished data) and relationship strains between providers who may have worked 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 ob-