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.

**Context**

**Physician A’s perspective.** Ms B is a long-time 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 “Hmph” 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.

**Physician.** 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.

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
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 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.3,4 Highly reliable perinatal units that hold patient safety as a central value3,4 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 threats8 and to adapt to dynamic conditions appropriately.8 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 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.15,19

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-
vious when communication occurs bet- 

between attending physicians. However, 

nurses, medical residents, and even at- 

tending physicians do not always voice 

concern at critical times or may struggle 

to do so.\textsuperscript{16,19,22} Multiple helpful strat- 

gies for structuring information transfer 

between colleagues and among teams are 

delineated elsewhere.\textsuperscript{23} Although several 

sites have demonstrated safety improve- 

ments with the use of packages of team-

work interventions,\textsuperscript{24-26} other sites dem- 

onstrate mixed results.\textsuperscript{29} It may not be 

possible to empirically isolate specific 

communication strategies as most effec- 

tive.\textsuperscript{30} One surgical setting found that 

the implementation of a structured 

briefing tool actually resulted in uncon- 

structive, potentially detrimental brief- 

ings, in 15% of the cases that were 

observed.\textsuperscript{31}

The mixed performance of communi-

cation support tools may be due to the 

fact that communication is a social pro- 

cess that constitutes much more than 

simple sending and receiving technical 

information. Each party in the interac-

tion brings his/her history, assumptions, 

and expectations of others, and each per-

son is influenced by organizational cul-

ture.\textsuperscript{32} Because of this, structured tools 

may not be successful if not embedded in 

an infrastructure of respect and attentive-

ness. 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 substi- 

tute for) strategies such as team training; 

SBAR (situation, background, assessment, 

assessment, recommendation); board rounds; hud-

sires, 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.\textsuperscript{7,17,33} Likewise, all clinicians, 

but especially those in authoritative po-

sitions, must attend to their listening 

skills. Team leaders should not view in-

quiry (asking for clarification, request-

ing rationale for decisions) and assertion 

(stating concerns with persistence) as 

challenges to their expertise. Rather they 

should welcome them as protective be-

cause inquiry and assertion promote 

safety by maintaining preoccupation 

with potential failure\textsuperscript{9} and by protecting 

against the tendency for normalization 

of deviance that can lead to catastrophic 

harm.\textsuperscript{8,34} Furthermore, all team mem-

bers must ensure that they have con-

firmed agreement on the actions to take 

and the rationale for planned care. Orga-
nizations must align systems of care to 

to address sleep deprivation and other 

workforce-related interferences to atten-

tive listening.

Even in the setting of excellent com-

munication 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 vs observ-

ing labor, management of induction or 

augmentation of labor, interpretation 

and management of complex fetal heart 

rate patterns, pain management, and 

second-stage management. Thus, clinici-

cal conflicts are a fact of life, and cli-

nicians must learn to deal with them effec-

tively (Table 1).\textsuperscript{35-37} Many people prefer 

to avoid confrontation, and nurses in 

particular traditionally have found ways 

to sidestep it.\textsuperscript{32,36} However, addressing 

conflicts as they arise is more likely to 

build engagement with and trust in team 

members.\textsuperscript{39} Furthermore, addressing po-

tential conflicts early may allow smoother 

communication later should an obstetric 

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 rec-

ognizing the influence of cultural factors 

on differences in perspectives.\textsuperscript{32,39} Each
right away if you are concerned about the uterine activity or fetal heart rate? [Acknowledges perspective, makes more complete rationale for decisions explicit, presents collaborative solution.]

Nurse. Thanks Dr A. It’s funny that we are both worried about her having a section but for different reasons. I will increase the pitocin every half hour and will call you to review the tracing if I have any concerns. [Ratifies agreement with concerns]

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

Physician [having arrived on labor and delivery at 10 AM and finding that the oxytocin had not yet been started]. Why haven’t you started the pitocin yet? [Statement of concern.]

Nurse. I am sorry Dr A; my other patient was having decelerations, so I had to prioritize that. [Explanation; accepting accountability.] But I am glad you are 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 are busy. [Acknowledges colleague.] You are right; she hasn’t had any elevated pressures here, but she did in the office last week. Here is the rest of her prenatal record. I once had a patient who had a stillbirth at term with gestational hypertension, 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 will start the pitocin right after that and will call you if I have any concerns about her progress or the tracing. [Includes the patient; closes the loop.]

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**TABLE**

**Approaches for improving communication**

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

Adapted from Knox et al,3,4 Agency for Healthcare Research and Quality,23 Provonost et al,35 American College of Obstetricians and Gynecologists,36 and Simpson.37

* An obstetric hospitalist; † Tug of war between physicians and nurses over the management of oxytocin.

Comment

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 4 hospitals, everyone acknowledged communication can be a safety problem; however, only 2 caregivers identified themselves as having difficulty communicating effectively (unpublished data). However, behaviors are more important than attitudes, because attitudes follow behavior. Accountability and thoughtful action are essential for creating change.40,41 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 occur only through direct engagement, practice, and refinement of expectations and skills by individuals, units, and organizations.40,41

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 because of sleep deprivation or shift work and different “world views” (eg, 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 is built on an infrastructure of respect, attentiveness, collaboration, and competence. This foundation includes all of the structural supports that are 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 hierarchical. Behavior change is hard. We have a mutual responsibility to get this right.

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