

BACKGROUND

In the United States, clinician-centered definitions of safety have historically reflected broader policy positions on the (racially disparate) value of women's experiences. While approaches to engineering safety has changed over time, definitions and standards for safety in healthcare for birthing people in the U.S. are still largely established by clinicians, rather than birthing people and communities. The resulting gap between patient *experience* and patient *safety* research limits our capacity for making meaningful improvements to patient safety, documenting disparities in patient treatment and experiences, and building trust with birthing people from diverse backgrounds.

Although the World Health Organization's Declaration of the Universal Rights of Childbearing Women establishes the right to "safe motherhood as a positive right that explicitly includes rights to informed consent and refusal, respect for preferences, confidentiality and privacy, dignity and respect, equitable care, freedom from discrimination, autonomy, self-determination, and freedom from coercion, safety is frequently flattened to a negative right to avoid long-term or permanent injury or harm.

STUDY DESIGN

This (qualitative) inductive thematic analysis was part of a larger study focused on understanding patient experiences in the clinical and home contexts during birth and in the postpartum period.

The research project was reviewed by the University of North Carolina at Chapel Hill IRB (#18-2811) and determined to be exempt. A human-centered design approach guided the study design and analysis. After IRB exemption, potential participants were identified through the Electronic Health Record or by a study researcher involved in their clinical care. Inclusion criteria for all participants included being at least 18 years of age, English or Spanish-speaking, and having singleton or twin infant(s) discharged to home with birthing parent. A total of 46 participants completed a questionnaire and semi-structured telephone interview during May through September 2020. Interview and questionnaire topics included items addressing the context of labor and delivery and the postpartum unit, infant feeding, types of information provided by the healthcare team, health care team members involved in information exchange, discharge and transition home, and knowledge of mother and infant health symptoms. In-depth semi-structured interviews used prompts from an interview guide which inquired about the experiences shared by each of the birthing parents. Questions allowed for open-ended responses to elicit depth of participants perspectives and experiences.

What does "safe" mean to patients? Birthing parent definitions of safety in childbirth and postpartum care.

Safety as a positive right: the right to fulfillment of desired experiences or expectations; birth and postpartum experience in alignment with birthing person's values

Safety as information & knowledge

Information seeking and sharing, patient education, and knowledge about birthing parent and baby needs, health, & whereabouts. **Informed** consent. Access to adequate translation services.

"**knowing** who is coming in and out of your room and not really having concern that your baby will go missing"

Safety as a state of being

Being safe"- focused on physical or verifiable, long-lasting psychological or emotional outcomes.

"I would say making sure the baby is healthy and you're healthy as well mentally, physically, and everything" (M059).

"Whatever that problem was, however it started, they were there to make sure that I made it through it. And I'm grateful and I'm thankful because they did their job, they did what was needed for me to still be sitting here today to talk to you"

Safety as actions & protocols

Formal and ad-hoc safety practices: e.g., routine infection control processes (e.g., hand washing), kidnapping prevention, monitoring and attending to mothers' and babies' physical and emotional needs in the hospital, watching for possible complications

Safety as power & control

Birthing parents' power to control their environments, information, and clinical experiences. Bodily autonomy, control over personal information, and the power to consent to and refuse treatment according to their values. Right to understand (language accessibility).

Safety as feeling

Sense of safety: being able to *relax and rest without worry*. Safe feelings came from *physical support*, (protection from falling); *social supports* (mentoring and help with baby care); and *attention* from spouses and partners, family members, and health care team members.

Safety as connection to resources & community

Access to safe home environment, resources such as diapers and food, family and community support within clinical settings and at home.

Safety as a negative right: the right to avoid harm

Amelia N. Gibson, PhD,¹ Alison M. Stuebe, MD, MSc,² Kristin P. Tully, PhD²

¹ College of Information Studies, University of Maryland at College Park
² Department of Obstetrics and Gynecology, University of North Carolina at Chapel Hill

Correspondence: ameliag@umd.edu



DISCUSSION

Participant definitions of safety were consistent with previous findings that patient satisfaction with childbirth derives from sense of control (Namey & Lyerly, 2010), defined as through self-determination, respect, personal security, attachment, and knowledge. They saw the responsibility for planning, decision-making, and executing safety processes and protocols as being shared by the birthing person, family members, and healthcare team members (as opposed to the result of following instructions given from clinicians to patients).

The rights to information, informed consent and decision making are fundamental human rights (UNESCO, 2010). Informed consent combines patient education and shared decision making, and has a counterpart-informed refusal (Benjamin, 2016).

It is vital that we center design of safety systems and interventions on patient *and* clinician definitions of safety. Incorporating this wider range of definitions for safety would give us metrics needed to begin describing and measuring qualitative disparities in care, patient trust, and understand defensive information practices, such as secrecy, dishonestly, and withholding information occurring in response to lack of patient safety.

FUNDING

This project was funded under grant number R18HS027260 from the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services (HHS). The authors are solely responsible for this abstract's contents, findings, and conclusions, which do not necessarily represent the views of AHRQ. Readers should not interpret any statement in this reporting as an official position of AHRQ or of HHS.