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Beyond the individual: a qualitative case study into the systemic determinants of speaking-up behaviour in multidisciplinary team meetings

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ABSTRACT

Background Healthcare workers (HCWs) voicing their views (speaking up) is crucial for patient safety and care quality. Yet, this is underused, especially during multidisciplinary team meetings (MDTMs), where diverse professionals collaborate to optimise patient treatment plans. Despite the benefits of open communication, HCWs face barriers such as hierarchical dynamics, time constraints and psychological risks.

Aim This study examines factors influencing HCWs' speaking-up behaviours in MDTMs, focusing on motivators, barriers and dynamics across disciplines.

Method We conducted 21 semistructured interviews with MDTM participants of a gastrointestinal surgery ward, including surgeons, residents, nurses, nursing students, dieticians, ostomy nurses and physical therapists. Data were analysed collaboratively using thematic analysis.

Results Participants are highly motivated to advocate for patients and provide optimal care. However, barriers impact speaking up during MDTMs. Three major themes were identified: (1) time pressure, (2) perception of goals and roles and (3) familiarity among team members. Structural, relational and contextual factors affect HCWs' ability to speak up, with nurses and paramedics experiencing more hesitancy than physicians. Lack of preparation time, ambiguous objectives, no formal agenda and unfamiliarity among team members hinder contributions, leading to unbalanced input.

Conclusion Findings support a systems-based approach to addressing barriers. Interventions should focus on clear goals, reduced time pressures and enhanced team cohesion, rather than placing the responsibility solely on individuals. For instance, adjusting meeting schedules to accommodate diverse availability improves participation across disciplines. Strengthening familiarity among team members fosters trust and lowers the perceived risks of speaking up, ensuring more balanced contributions during MDTMs.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ To improve patient safety and quality of care, it is important to promote speaking-up behaviour by healthcare workers (HCWs), especially in multidisciplinary team meetings (MDTMs). While it is known that hierarchical structures and limited psychological safety can hinder open communication, this study highlights specific factors—such as time pressure, unclear goals and roles and lack of familiarity—that disproportionately impact non-physician HCWs.

WHAT THIS STUDY ADDS

⇒ The study suggests a shift from individual responsibility to a broader systems-based approach, advocating for structured interventions that promote team cohesion and adjust meeting dynamics to support inclusive participation.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ These findings have implications for future research, organisational policies and healthcare practices by emphasising interventions to create a safer, more balanced communication environment in MDTMs.

INTRODUCTION

Speaking up by healthcare workers (HCWs) is crucial for ensuring high-quality and safe patient care. Speaking up is defined as *a healthcare professional identifying a concern that might impact patient safety and using his or her voice to raise the concern to someone with the power to address it.*[1] When HCWs voice their views, this positively affects the patient, the organisation and themselves.[2] It is expected to have preventative effects on human errors, system errors and not following procedures. For instance, speaking up is associated with better hand hygiene and preventing infections,[3 4] better technical team performance during anaesthesia training[5] and organisational learning and innovation.[6] Despite these benefits, many HCWs often remain silent, making communication one of the most cited factors contributing to mishap incidents and medical errors.[7–9]

Speaking-up behaviour of HCWs is primarily addressed as expressing concerns about patient safety in the clinical context. Outside healthcare, the 'speaking up'

concept is understood more broadly and includes voicing ideas, suggestions, problems or opinions[10] and is positively related to impact innovation[11] and team safety performance.[12] Although the clinical context could benefit from such a broader understanding of 'speaking up', the current health-care-focused literature does not widely incorporate voicing suggestions and opinions to improve the quality of care.[13] By focusing mainly on voicing concerns in the clinical context, other important contributions that can improve patient safety and quality of care may be overlooked. Therefore, we define speaking up as a healthcare professional identifying an issue that might impact patient safety and quality of care and using his or her voice to raise a concern, suggestion, question or opinion to someone with the power to address it.

One setting in which power relations and the importance of raising your voice can be predominantly clear is the multidisciplinary team meeting (MDTM). The MDTM is an important collaborative meeting where diverse disciplines come together to discuss various aspects of the patient's condition, leading to a well-informed treatment plan for the patient.[14] Therefore, it is essential that everyone speaks up and will be heard during the MDTM. However, a study on the role of non-physician HCWs shows that not everyone is actively engaged in a multidisciplinary oncology meeting.[15] HCWs' active participation is influenced by various team-related (eg, organisation of the meeting, interaction and personal) and external (eg, structural and process) barriers. Additionally, speaking-up behaviour of nurses was observed to have been influenced by various factors at the hospital (eg, hospital policy and time constraints), team (eg, team relationships, leadership and professional roles) or patient case level.[16] Many aspects of the MDTM make it difficult for HCWs to speak up during this meeting: the presence of an audience,[17] hierarchy[18 19] and limited time.[19] HCWs often perceive speaking up as risky[20 21] and find speaking up about patient safety-related issues difficult or perceive their environment as psychologically unsafe.[22 23] These challenges are particularly pronounced for those in nursing, palliative care or psychosocial roles, as the MDTM discussions are often dominated by those with surgical, medical or diagnostic expertise.[24–26]

The combination of the above-mentioned characteristics of the MDTM, unequal input of participating disciplines and experienced barriers to participation makes the MDTM an interesting setting to study the speaking-up behaviour of all HCWs involved. If individuals cannot speak up during the MDTM, this can hinder collaboration between HCWs and the delivery of optimal patient care.

The present study aims to explore and provide a detailed description of what influences the speaking-up behaviour of HCWs (physician and non-physician) during MDTMs. Most studies primarily focus on HCWs with a lower hierarchical position, such as nursing and medical students. However, as MDTMs include various speaking partners, those in higher hierarchical positions should also be included to avoid a lacuna in knowledge about participant interaction. This study subsequently focuses on the speaking-up behaviour of representatives of all participating disciplines.

METHODS

Design

We took a qualitative explorative approach toward the concept of speaking up in the context of MDTMs in hospitals. The MDTM is used as a case study of multidisciplinary communication in a medium-sized nursing ward. We use our definition of speaking up to discern influencing factors concerning speaking up between participants in lower and higher hierarchical positions. The rationale for this is that we wanted to understand how power relations relate to the factors contributing to or hindering speaking up of all HCWs.

Setting and participants

Participants were recruited from the gastrointestinal surgery ward of a medium-sized teaching hospital in the Netherlands. The wards' team comprises approximately 40 nurses, four surgeons, two residents (not in training) and paramedics: two physiotherapists, two ostomy nurses and two dieticians. The MDTM examined in this study is held every Tuesday morning in a separate room on the ward.

A total of 23 participants were included in the study: 12 ward nurses, two nursing students, three surgeons, one resident, one dietician, two ostomy nurses and two physiotherapists. Participants were recruited through convenience sampling by researcher DvD during ward visits. Participants were included if they had at least attended the wards' MDTM once in the last month. A total number of participants was determined based on data saturation judged by DvD during interviews (ie, no new information regarding the understanding of a certain perspective was heard) or if no additional participants from a specific discipline were available (ie, methodological constraint resulting from the setting).[27 28]

Data collection

Data were collected using semistructured interviews with the HCWs. Topics during the interviews were inspired by the conceptual frameworks of Morrison[29 30] and Okuyama and colleagues,[31] including (1) the objectives of the MDTM and the role of the participants, (2) factors hindering or enabling speaking up and (3) potential improvements for the MDTM. Our definition of speaking up was extended to include both enabling and hindering factors for speaking up, personal internal and external factors influencing speaking-up behaviour and ideas and suggestions for improvement.

Before data collection, DvD performed five non-participatory observations of the MDTM, shadowing two nurses and one surgeon on separate shifts on the ward, taking notes to explore the wards' setting and building rapport with HCWs. After piloting the topic list during

the first two interviews, 21 participants were interviewed using the same topics.

Interviews were around 35 min and held in a separate hospital room or online using Microsoft Teams. All interviews were audio recorded and transcribed verbatim. Afterwards, summaries of the transcripts were sent to the participants individually as a member check. Feedback was incorporated and presented to the team after the data collection period.

Data analysis

We took a collaborative approach to thematic analysis to interpret the data from 21 interviews.[32] We chose an inductive approach for the analysis as it aligns with the study's explorative aim. During the analysis, DvD and JT worked collaboratively to develop overarching themes that captured the influences of speaking-up behaviour of all HCWs during the MDTM. In this process, several strategies were used to enhance the trustworthiness of interpretations: peer feedback sessions, data and researcher triangulation and keeping an audit trail and research journal.

All interviews were transcribed verbatim and uploaded to Atlas.ti 24 by DvD, a qualitative data analysis software for thematic coding. Researcher DvD read and re-read all documents line-by-line to familiarise herself with the data. The first five interviews were open and axially coded by researchers DvD and JT separately and discussed during meetings every 2 weeks until a preliminary codebook was established. The preliminary codebook was then discussed with the entire research team during a 'peer debriefing' to enhance the trustworthiness of the interpretations made by DvD and JT (except DR because she did not have access to the interview data). The codebook (online supplemental appendix A) was then used by DvD to codify the remaining 16 interviews, which was again discussed with JT during 2 weekly meetings. During the data analysis process, DvD and JT kept a personal and shared analytical diary, writing down memos to capture ideas and thematic development and to maintain engagement with the data. Finally, the themes were again discussed with the research team during a peer feedback session.

Reflection

All members of the MDTM were informed about this research by the head of the department and invited to participate. Eligible participants could voluntarily sign up for an interview; however, in practice, all participants were recruited during ward visits by DvD. There was no preselection in interference about who was recruited; the selection process was merely determined by sheer chance of participants being present at the MDTM. Confidentiality and anonymity were assured by assigning a pseudonym to all participants.

RESULTS

The interview results are presented in three themes: (1) impact of time pressure; (2) perception of goals and roles and (3) to know us is to trust us. All themes follow the same structure: an introduction, the perspective of the surgeons, the perspective of the nurses, the perspective of the paramedics (physiotherapist, ostomy nurse and dietician) and the summary. With these themes, we describe the complexity of the MDTM structure and conversation, different perceptions of participants' roles and responsibilities and other factors that might influence HCWs to speak up during the MDTM. See figure 1 for an overview of quotes related to the themes.

Impact of time pressure

Setting the scene

The structure and setting of the MDTM contribute to time pressure and can discourage some participants from speaking up. The MDTM is held every Tuesday morning from 8.00 to 9.00 hours in a meeting room on the nursing ward, and the expectation is that everyone arrives on time. However, surgeons and nurses frequently arrive late due to other obligations before the meeting, and nurses often rotate in and out of the meeting to cover shifts, sometimes causing delays. Consequentially, other participants must wait, reducing the time available to discuss the patients or causing the MDTM to run over. Although there is no formal agenda, the meeting typically follows a similar structure. Many participants feel time-pressed both before the MDTM due to other obligations and during the meeting due to its organisation and flow.

Surgeons' perspective

For surgeons, it is important to discuss the treatment plans of all their current patients. They need to hear any pertinent problems and the most recent and accurate information from all professions to adjust the treatment plan. Moreover, they expect the nurses to be well-informed about their patients and come prepared for the meeting (eg, have interpreted patient data, made necessary inquiries and thought of questions). The surgeons experience annoyance when nurses arrive unprepared or late and sometimes express their irritation to the nurses. The surgeons indicate they do this because they just act in the patient's interest, and that they do not intend this to be personal. The surgeons keep a fast pace so that all patients can be discussed, and successive rounds can be made before they attend to other obligations at 10:00 hours. Surgeons indicate that despite the fast pace, there is room for other professions to contribute.

Nurses' perspective

Time constraints pressure nurses before and during the MDTM. Nurses indicate needing to be well-prepared to be able to actively participate, yet they experience not having enough preparation time. (See box 1 for the nurse's comment on the morning routine). This especially worries inexperienced nurses, as it causes a risk of receiving negative reactions from the surgeons and feeling rushed or cut-off by the surgeons. Both the lack of preparation time and vulnerability to surgeons'

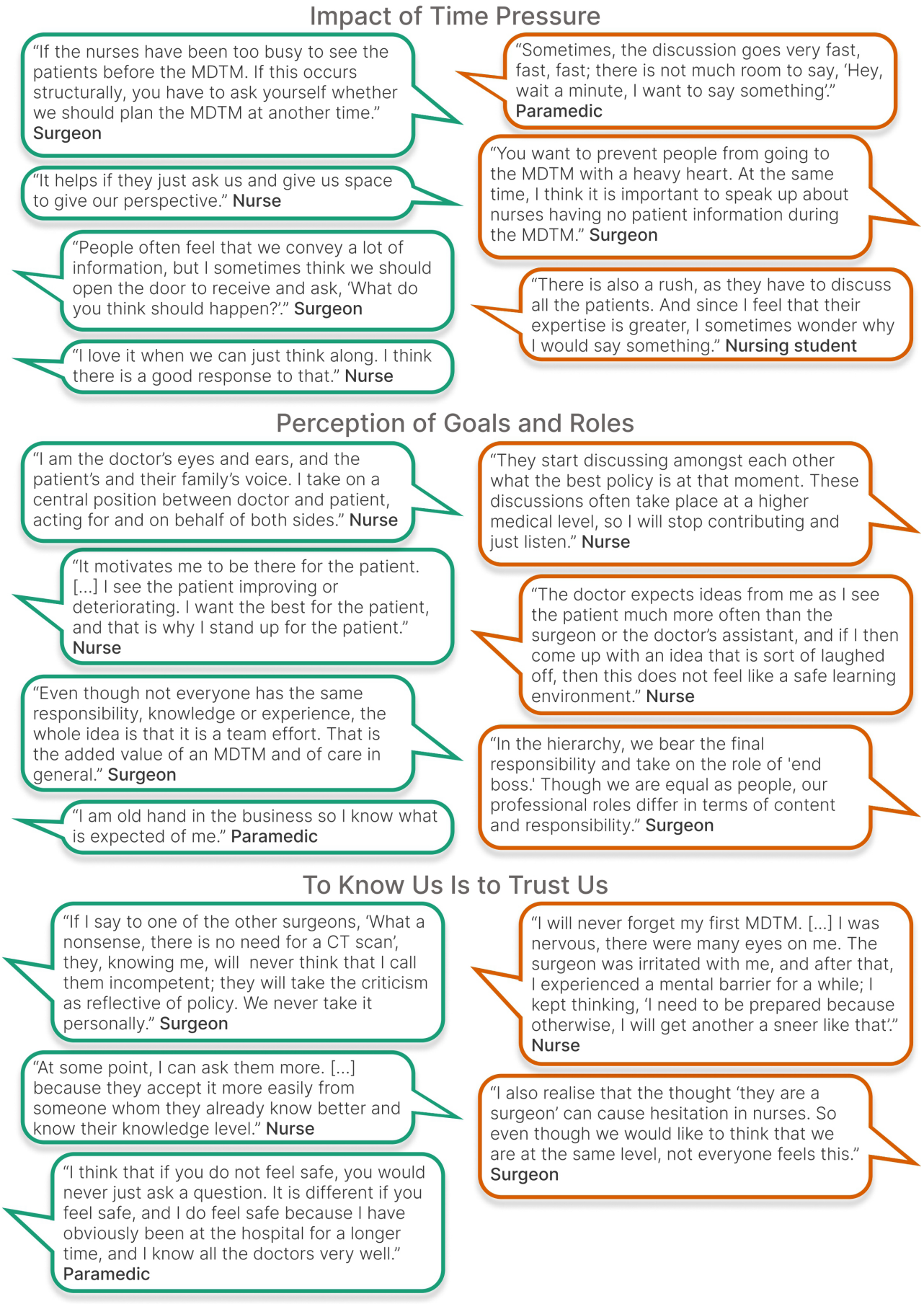

Figure 1 Overview of quotes related to the themes. MDTM, multidisciplinary team meeting.

Box 1 Nurse's comment on morning routine before the MDTM

"It [the MDTM] already starts at 8 AM. And we start work at 7.15 AM or 7.30 AM; then you have 15 minutes min to read. Relatively short, so most colleagues arrive before working hours at 7 AM to properly read the patient records. At 7.30 AM, you have the day start, to discuss the current status including the workload on the ward. We finish the day start at 7.40 AM, which leaves 20 minutes until the MDTM; although your patients are still sleeping, you have to quickly wake them and immediately ask everything to update yesterday's information. You have to do that straight away, under huge time pressure, meanwhile being interrupted by phone calls, a sick patient, or someone who needs rinsing after defecation that you have to take care of first. Yes, and then it is 8 AM. There is definitely a lot to do in terms of time. But I also understand the doctors; they have to start their ORs and clinics at 9 AM, so they do not have that long either. So that is really difficult." Nurse p.23

comments can hamper speaking up about patient care during the MDTM, and they feel like they are being overrun. Experienced nurses dare to say they did not have enough preparation time and still try to participate in the discussion. Furthermore, the fast pace of the discussion and its medical nature cause some nurses to struggle to understand the discussion, and they do not know when and how to interrupt. For less experienced nurses, the final treatment plan is not always clear at the end of the discussion, and they experience a social barrier to asking.

Paramedics' perspective

The paramedics start their shift earlier to prepare for the MDTM and to be on time, and they have other appointments after the MDTM. They understand why some patient discussions take longer, which can be inconvenient for them, yet they do not always articulate their annoyance. Paramedics do not have a fixed moment for their input, and the discussion pace can sometimes inhibit them from interrupting. Their expertise and experience with the MDTM have taught them when and how to participate.

Summary

The lack of dedicated preparation time, conflicts with other obligations and lack of structure cause the MDTM participants to be under unwanted time pressure, influencing their ability to speak up. Participants with a medical background or more experience learn how to cope with this and speak up more easily. However, many participants feel there is a need for better alignment and structure but feel these aspects are 'set in stone' and do not know how to make changes.

Perception of goals and roles

Goals and roles

Participants have different expectations of the MDTM and their role therein. The objectives of the MDTM are not formally defined, but most participants agree that the primary purpose is to evaluate and select patient treatment plans. Additionally, the MDTM serves other purposes for various participants, such as providing education, ensuring a safety check, aligning perspectives and addressing new patients. These different objectives, associated roles, tasks and responsibilities influence when and how participants speak up, sometimes leading to confusion, frustration and inconsistent communication during the MDTM.

Surgeons' perspective

Surgeons indicate that the MDTM serves multiple purposes, and they have multiple roles. Their main objective is to evaluate and formulate the current patient treatment plans for the long term. They have an overall picture of the patients, are ultimately responsible and lead the MDTM discussion. They need everyone's contribution and insights to acquire each patient's status and decide on the best treatment plan. As responsible physicians, their role is to communicate and explain their decisions to the other participants and answer their questions. The surgeons indicate that the MDTM also serves a didactic purpose, where they supervise their residents and explain their decisions to (student) nurses and paramedics. The third role is facilitating and creating a safe learning environment where everyone feels free to speak up.

The surgeons indicate that other professions play an important role during the MDTM because they provide additional patient information. In particular, the nurses function as the 'eyes and ears' of the doctors and have an important signalling function. They want the nurses to have an active role at the MDTM, yet do not understand why this does not always happen and regret that. Surgeons know that they can come across as direct and stern and need to pay attention to this.

Nurses' perspective

Nurses emphasise their crucial role in patient care, as they know their patients best. Providing 24/7 care, communicating with patients and their families, observing patients closely at the bedside and understanding their mental and emotional state. Nurses consider themselves the patients' advocates; their duty is to represent their patients during the MDTM and stand up for them. Patients are their top priority, and they are committed to providing the best possible care, which drives them to speak up. However, some nurses experience that their role in patient care does not match their role in the MDTM because there is little room for them to contribute.

The nurses indicate that they will always speak up about problems or concerns that might harm the patient. They can sometimes substantiate these concerns and sometimes express a gut feeling. Nurses feel more confident when they can support their gut feelings with patient data or experience. Nurses indicate that the surgeons listen to their concerns, yet they do not always feel taken seriously when they offer suggestions. Several nurses express hesitation to share ideas or suggestions, as surgeons may respond negatively by interrupting, dismissing their

input or making them feel ridiculed. Additionally, some nurses feel that surgeons sometimes overrule them when they believe they are correct. In these instances, they sometimes feel a lack of explanation from the surgeons about the disagreement, leaving them feeling unheard and missing the opportunity to learn from the situation. Interestingly, some nurses think their colleagues should demonstrate more leadership by seeking clarification.

Besides being patients' advocates, experienced nurses can also have a supervisory role during the MDTM. Supervisory nurses help nursing students prepare for the MDTM, coach them during meetings and ensure their input is effective. Supervisors and nursing students indicate that the MDTM is an important educational moment to become independent nurses. The nurses express the importance of a safe learning environment for the nursing students, residents and co-assistants. However, nursing students are still nervous about attending the MDTM because they are learning, inexperienced and look up to the surgeons. Some experienced nurses also indicated that they perceive tension during the MDTM, which affects their willingness to speak up.

Paramedics' perspective

Paramedics indicate that the objective of the MDTM is primarily to observe a patient's situation and treatment plan and translate it to their own practice. If they receive background information from the surgeons about the surgery's complexity, they can adjust the nutrition, mobility activities or stoma care accordingly. They recognise that their contribution is focused on a specific part of some patients' treatment. They do not have a fixed moment to do so but try to listen attentively to see when they can provide valuable input. Therefore, these disciplines have a more wait-and-see attitude, ask questions and provide answers or explanations when they feel it is necessary.

Summary

There appear to be too many conflicting objectives in one meeting that are not formally discussed and formulated. Lack of clarity about the different objectives and participants' role in them causes frustration for some and affects active participation and speaking up. Realising everyone's full potential requires clear agreements and an inviting attitude from the doctors as they lead the discussion.

To know us is to trust us

Introduction

The extent to which participants know each other influences how they experience the MDTM and their willingness to speak up. When HCWs are unfamiliar with the MDTM and its participants, they can be nervous about attending the meeting because they do not know what to expect, look up to the surgeons or are uncertain about their input. When participants get to know each other professionally and personally, they feel less nervous during the MDTM. Professionally, they understand each other's expertise, know which questions to ask and set mutual expectations. Familiarity helps reduce hierarchical barriers, fostering a sense of equality.

Perspective of surgeons

The surgeons can discuss and express themselves easily because they have been working together for years and share similar educational backgrounds. Engaging in in-depth medical discussions and offering pointed feedback is acceptable and sometimes even enjoyable. They understand what is appropriate to discuss during the MDTM or elsewhere. They intend not to put each other on the spot or cast anyone negatively in front of others. While surgeons note that lively discussions are routine, they recognise that others might perceive these exchanges differently.

Surgeons emphasise the importance of knowing and trusting other HCWs, as it helps them better assess input from different fields and incorporate it into their decisions. Regarding nurses, they stress the need to 'know your people'—understanding each nurse's level of expertise allows them to assess concerns more accurately. They say they take everyone seriously but find it easier to evaluate input when they know the individual. With the paramedics, the long-standing relationships foster trust that they will voice their concerns when necessary. To build rapport and be approachable, the surgeons regularly greet and chat with colleagues in the corridors or over coffee on the ward.

Nurses' perspective

When nurses have more experience with the MDTM and know other participants, especially the surgeons, they have more confidence in attending the meeting. Sometimes, inexperienced nurses are nervous about attending the MDTM because of insecurities or differences in hierarchical status or knowledge. Having a personal negative experience with the MDTM or hearing negative stories from colleagues can negatively impact nurses' willingness to speak up. Nurses have more confidence in the MDTM and themselves when they have more neutral or positive experiences, know the surgeons better and can estimate their reactions. Some nurses indicate that the surgeons think collaboration is better when they know each other.

Paramedics' perspectives

Paramedics emphasise that knowing the nurses and doctors is important for effective communication and collaboration. Close connections with nurses and residents make communication easier outside and during the MDTM. However, paramedics see surgeons less frequently, so they value the chance to familiarise themselves during the MDTMs or when they cross paths on the ward or in the outpatient clinic. Familiarity with one another makes it easier to speak up during the MDTM or address others elsewhere.

Summary

Investing time to build professional and personal connections is essential for effective communication and collaboration during MDTMs. This effort reduces perceived hierarchies and lowers barriers to speaking up. While surgeons believe they are approachable due to informal chats or coffee breaks on the ward, some participants still hesitate to approach them. Consequently, some participants recommended actively dedicating time and energy to fostering personal relationships.

DISCUSSION

With this study, we identified three important themes for HCWs speaking-up behaviour during MDTMs: (1) the impact of time pressure, (2) perception of goals and roles and (3) to know us is to trust us. Our results show that despite all HCWs' motivation to provide high-quality and safe patient care, structural and relational factors influence their willingness to speak up. Consistent with other studies, this is especially true for the nurses and paramedics, who indicated more barriers, doubts and considerations during the interviews than the surgeons did.[15 16]

Systems perspective and responsibility

Our findings highlight the necessity for a broader systems perspective when addressing speaking-up behaviour during MDTMs. Since doctors dominate the MDTM discussions and other professions have less input, a straightforward recommendation is to invest in assertiveness and speaking-up interventions.[24 25 33 34] However, current research shows mixed results, as these interventions mainly focus on theoretical advantages rather than work situations where people must apply these skills.[35 36] Applying skills in real situations is more challenging due to other conflicting interests and the context, as this study shows. Moreover, efforts to foster communication during MDTMs should extend beyond focusing solely on training individuals in speaking up or listening. By examining the perspectives of all disciplines involved, this study highlights the critical interaction across disciplines during MDTMs. Not many studies combine the perspectives of physicians and non-physicians and study their interpersonal communication, which we consider crucial in optimising MDTM outcomes.[15 16 25]

MDTMs' structure should empower all participants to speak up despite differences in hierarchy, roles and experience. Where HCWs have a duty to voice concerns and speak up for patients,[16 37] the organisation and agenda of the MDTMs can support this responsibility. Given the results, it is reasonable to change the structure and formalise the agenda of the MDTM. In the follow-up, when all different perspectives were considered and discussed, the responsible surgeon made several suggestions. This follow-up was essential to involve all HCWs in the process and to identify possible adjustments in the time schedule and a shared agreement on the meeting's objectives, formal agenda and responsibilities. For example, starting the meeting half an hour later gives HCWs more preparation time and the opportunity to participate in the discussion more actively. Establishing clear objectives, roles and responsibilities across disciplines is crucial for effective MDTMs[38 39] as it provides common ground for all participants.

Importance of familiarity with others

The theme 'to know us is to trust us' illustrates the importance of professional and interpersonal familiarity for open communication during the MDTM. Familiarity among HCWs appears to lower the perceived risks of speaking up,[40–42] thereby enhancing openness and trust. The importance of familiarity and trust is also shown in other studies. Psychological safety frequently recurs in the literature on speaking up, meaning that team members can speak up freely without fearing negative reactions or consequences (eg, retaliation).[22 23 43] Good teamwork—trusting each other and positive perceptions about collaboration—increases speaking-up behaviour.[16 44 45] Our findings reinforce the importance of relationship-building among MDTM participants, suggesting that regular interactions outside the meeting may contribute to more effective communication during MDTMs. Managers and policymakers should be aware of the potential negative side effects of decreasing team coherence through, for example, deployment of flex-workers. Future research could focus on determinants of team coherence in relation to speaking up and trust in healthcare.

Strengths, limitations and future research

This study offers a detailed description of the multifarious factors influencing speaking up in MDTMs, yet it is important also to acknowledge its limitations. The findings are drawn from one case study at a gastrointestinal surgery ward in a non-academic hospital in the Netherlands, which may limit generalisability to other settings and specialities. Due to privacy concerns, we did not differentiate between certain sociodemographic factors, for example, gender and education. Previous research suggests these factors may impact professionals' roles in the MDTM and warrant further research. Since HCWs were recruited through convenience sampling, it is possible that there was selection bias. HCWs who work fewer (day) shifts or could not be disturbed were less likely to be approached. However, everyone had the opportunity to participate. Nevertheless, since the MDTM is common practice, we believe our findings are relevant to better understanding physician and non-physician roles and speaking-up behaviour during MDTMs. Additionally, while other researchers advocate for a simplified approach by analysing factors influencing speaking-up behaviour,[46 47] our study suggests that a detailed, context-specific approach yields a richer understanding of these complex dynamics and results in more leverage points for improvements. Further research may explore how structural interventions might support more effective communication.

CONCLUSION

This study underscores the interplay of miscellaneous factors influencing speaking-up behaviour of HCWs in MDTMs. We highlight that addressing communication barriers requires more than individual initiatives by identifying three key themes: the impact of time pressure, the perception of goals and roles and to know us is to trust us. A broader system perspective is required to foster a psychologically safe environment where active participation is encouraged and becomes the norm. By prioritising strategies that enhance team cohesion, clarify roles and responsibilities and reduce time constraints, healthcare organisations can create a culture of openness and trust. This will enhance team effectiveness, improve patient outcomes and contribute to a more collaborative healthcare environment. Future research should focus on interventions that promote an inclusive and supportive atmosphere for all professions.

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Contributors DvD, FG, IG and JG designed the study. DR arranged everything within the hospital to conduct the study. DvD collected the data and initiated the analysis of the data in close collaboration with JT. The methods for analysis and preliminary results were frequently discussed with DvD, JT, FG, IG and JG. DvD drafted the first version of the manuscript. JT, FG, IG and JG gave input and suggested restructuring or reformulating parts of the manuscript. Based on this input, DvD revised the manuscript in close collaboration with the other authors. DvD is the guarantor. All authors read and approved the definitive version of the manuscript and agreed to be accountable for all aspects of the study.

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Patient and public involvement Patients and/or the public were not involved in the design, conduct, reporting or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by the Board of Human Research Ethics Committee Delft University of Technology (2512) Local science office at Reinier de Graaf Gasthuis (2022-070). Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

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