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Communication in obstetrics: where and when it matters

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Abstract

Although most clinical outcomes in obstetrics are generally good, poor and inaccurate communication may lead to unwanted obstetrics complications and medico-legal litigation. Effective communication therefore, is an important and integral part of holistic approach to good patient care and management. We present a case in which communication breakdown led to adverse yet preventable sequel.

Introduction

Effective communication is fundamental for patient safety and satisfaction in obstetrics and is true for all other disciplines of medical practice (1). When an obstetrician communicates with her/his patient, the intention is not only to take an accurate history but also to help the patient understand their condition (2). This art has multifaceted advantages in encouraging continuous care, building trust between the patient, doctor and colleagues, increasing chances of quick intervention should there be need and inadvertently assisting in the healing process of the patient (1-3). Poor and inaccurate communication and documentation may lead to unwanted yet preventable complications that could result in medico-legal litigation. Indeed, the majority of lawsuits in obstetrics related to negligence are unlikely to be due to quality of clinical care but often prompted by derisory communication (4).

Case report

A 28-year-old Para 2+0 Gravida 3 at 37 weeks 5 days gestation was referred to our facility with complaints of pain at the previous incisional site, faintness and reduced fetal movement for one day. She had experienced these symptoms 16 hours earlier and had gone for a review at her usual antenatal clinic. She had attended prenatal care from 13 weeks gestation and her routine screening tests were all normal. Her previous two deliveries were both by caesarean section due to what was assumed to be cephalo-pelvic disproportion.

Despite persistence of the symptoms, she was not keen on going back to the clinic since she had a scheduled appointment with her doctor in a couple of days. So she obediently stayed at home awaiting her appointment as instructed. It took the intervention of her sister to convince her to seek help at our facility.

At the time of admission to our facility, the patient was apparently unwell and markedly pale. There was no icterus or cyanosis. Her blood pressure was 99/30 mmHg with pulse rate of 96 Bpm and afebrile. Her abdomen was uniformly tender with a symphysio-fundal height of 34 cm. There were no fetal heart tones picked on auscultation. In view of the abdominal tenderness, hypotension with a previous history of caesarean delivery, a diagnosis of possible uterine rupture and fetal demise was made.

Resuscitative measures and relevant investigations were undertaken as the patient was immediately taken to the operating theatre. Intra-operative, there was ruptured uterus with massive hemoperitoneum and a huge urinary bladder hematoma. Placental membranes were intact. A fresh stillbirth weighing 3390 grams was delivered. The placenta was easily separated. Hemostasis was difficult to achieve on the *couvelaire* uterus despite numerous attempts at repair to contain the bleeding. A decision was made for a supra-cervical hysterectomy. The estimated blood loss was 3.5 litres. The patient was taken to intensive care unit for further management with multiple transfusions of blood products. Her post-operative recovery was impressive and she was eventually discharged home after 3 weeks of hospital stay.

Discussion

There is a growing international consensus that emphasizes on appropriate doctor – patient communication in medicine and medical education (5,6), setting standards for professional practice and education aimed at fostering good medical outcomes (7,8).

Traditionally, the model of instruction had been along a *'boss – servant'* approach to decision making in medicine where a doctor dictated what should be done for a patient and the patient never questioned the doctors' recommendations. This approach is rapidly fading off as the population moves more towards consumerism and shared decision-making. A growing consensus encourages a patient-centred approach to care, which emphasizes communication based on both the patient's perception of her disease and illness experience (9,10). This process reckons the doctors' passive role in eliciting the patient's story of illness without meddling with patients' ideas, feelings, and values also allowing patients' active participation in decision making (11). An international group meeting in 1999 (12) agreed on six key pillars that should be born in a doctors' mind every time they attend to a patient for effective communication: (i) Open the discussion by allowing the patient to tell his/her story freely (ii) Gather information from the patient by encouraging the patient to talk using both verbal and verbal cues; (iii) Understand patient perspective by exploring the patient's belief, concerns and expectations; (iv) Share information with the patient in a language that the patient can understand and be as clear as possible; (v) Reach agreement on problems and plans with patient and (vi) Provide a closure by summarizing and affirming agreement with the patient and candidly discussing follow up visits including warning the patient to watch over unexpected outcomes and the expected response. All these should be clearly documented in the patients' medical record.

Ineffective communication in medicine tends to underlie a large number of professional indemnity claims. For example in 2010, a study on obstetrics malpractice indicated that 20% of claim cases involved failed communication amongst providers involved in prenatal care (12). Another study by the Joint Commission organization identified that communication was a factor in 68% of the reported adverse perinatal outcomes between 2004 and 2011 (14).

The case described in this report illustrates how communication breakdown could have catastrophic outcomes. In this case, the communication failure was about the intricacies of danger signs in a patient with two previous scars. As patients become increasingly involved in making decisions about their health care, it is crucial that they understand the implications of various choices. Of concern is that, some patients still follow the dogma that the doctor is always right. This calls for any information provided by the doctor to be presented in a precise manner as possible including explanation of unexpected outcomes and recommended mitigation measures.

In addition, all facets of the conversation need to be documented. The patient does have the right to make a decision that goes against that of the provider but that should clearly be documented and should also include the patient's stated reason for refusal. Effective communication, strong clinical skills, excellent documentation technique and inculcating positive rapport with patients are all ingredients of successful obstetric outcome and will go a long way towards preventing negligence litigation.

Conclusion

This report demonstrates the implication of unclear communication in patient management. There is need to advance training programs focusing on communication skills and documentation. This can be achieved through frequent health audits, in-service-training, continuous medical education and as part of the formal training curricula in medical institutions.

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