Improving Communication in Obstetrics Practice

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There is an enduring theme that emerges from every risk management, critical review, open disclosure, or medico-legal document ever published: communication. We all think we, as expert clinicians, are wonderful communicators, yet we are surprised when seemingly simple requests or orders are misunderstood. At the start, we may consider that it is the other person's misinterpretation; as we grow in professionalism, we often realize that what we thought was simple can be understood in different ways. This then starts us on the lifelong road to learning how to communicate effectively in different situations, with different people, showing respect and empathy each time.

For the purpose of this commentary, three key areas in communication are chosen: handover, trainee to trainer, and written communication. These areas were chosen because they are common areas of miscommunication and are meant to stimulate discussion. Having worked together in Canada, two of the three authors have now returned to different parts of the world (Australia and Ireland), so we bring to this commentary our local perspectives with an eye always to the Canadian experience.

Handover

One of the most tragic outcomes of poor handover is mortality, and a recent case in Ireland of miscommunication at the time of handover had far-reaching and unsuspected consequences for the country as a whole.[1,2] As a result of the poor communication, the ultimate result was not only the tragic death of a previously healthy young woman, but also the introduction of multiple interventions to reduce the chance of recurrence with the development of guidelines on handover, sepsis management, and emergency care; a national educational course on obstetric emergency care; and the passing of a new act permitting termination of pregnancy for maternal medical issues.

Reduction in continuous working hours of trainees means many more handovers of care and possible opportunities for miscommunication. Techniques such as ISBAR (where one person identifies, provides the situation, background, assessment, and then a request)[3] and ISBAR[3] with the addition of read back and risk have been developed and are perceived to improve structure and consistency of handover without increasing duration.[4] It is recommended that handover be a face-to-face verbal process, supported by relevant documentation; other principles such as having a designated time and place for handover, having multidisciplinary senior-junior involvement, and minimizing interruptions seem obvious but have been shown to reduce error and improve patient safety.[5] In addition, the safety pause—asking the question, "What patient safety issues do we need to be aware of today?"—can highlight the concept that handover should not only be on clinical issues, but also review situational and operational factors (e.g., having no empty beds for new admissions).[6]

We can all be trained in this behaviour, and many of us already are. Where communication in handover becomes more humbling is the unconsciously incompetent communication—the areas in which clinicians are genuinely unaware of their differences in areas such as definitions, which may act as the foundation of the miscommunication. An excellent example of this in obstetrics is given in a study highlighting differences in the definition of *station* in assessing suitability for instrumental delivery.[7] At the time

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of the study, four different definitions were in common use: some defined station as level of the presenting part in relationship to the ischial spines in thirds; others related the presenting part to the ischial spines in centimetres; and two other groups used the relationship of the biparietal diameter to the ischial spines in either thirds or centimetres. Interestingly, few care providers were aware that others were using different definitions of fetal station. The concern arising from this was that a lack of standardization could lead to errors in the care of labouring women.

Consider the example of a resident assessing a patient for instrumental delivery. In the situation in which the cervix is fully dilated and the fetus in an occiput anterior position at station +1/+2, the resident may assess this as a mid-pelvis operative delivery, based on the position of the presenting part in relation to the ischial spines in centimetres. In discussing this with the staff obstetrician, if the resident's assessment was based on the rule of thirds, then the obstetrician may assess this as a low operative delivery. Alternatively, if the obstetrician used the definition of station using biparietal diameter, then he or she might assess the delivery as an outlet operative delivery. This assessment by the resident might then dictate the mode of delivery, the type of instrument used, the type of analgesia, the location of delivery (operating room vs. labour room), and even the level of supervision. We can all readily appreciate the significant differences in maternal and fetal outcomes, as well as the degree of success, between an outlet delivery and a mid-cavity operative delivery.

Trainee to Trainer (and Vice Versa)

A common area of nonclinical communication between trainee and trainer is in the development and review of rotation goals. Difficulties arise in trying to schedule these meetings when both participants work in busy jobs in which clinical needs come first. This is where leadership and clear communication comes to the fore, allowing the efficient manager and leader to make time for meetings, delegate some tasks to others, and postpone the distracters. Polite but assertive communication can help make these meetings a priority but can also make them worthwhile. Clear communication can develop SMART (specific, measurable, achievable, realistic, and timely) goals but, more importantly, can also make these goals SMART-ER (adding in enjoyment and reward).[8]

Occasionally trainers may not wish to give negative feedback, sometimes because of their own concerns about breaking bad news or tackling negative responses to the feedback. If there are concerns about breaking bad news to a previously oblivious trainee (the unconsciously incompetent or disengaged worker), then a similar approach to breaking bad news to a patient can be used. A strategy such as SPIKES, as proposed in oncology literature,[9] could be useful. Thus, just as we would strategically approach a patient to tell her that she has an intrauterine death by setting the scene (S), checking perception (P), gently giving information (I), providing knowledge (K), meeting emotions with empathy (E), and working together for a solution (S), we can perhaps approach midterm evaluations in the same way. Similarly, just as patients may respond to bad news with negative and difficult emotions, so too can a trainee after receiving a negative assessment; feelings of anger, helplessness, disappointment, and betrayal may occur. Fear of these emotions should not mean that a trainee is denied a chance for learning or redemption. This communication should involve two-way respect, with both trainee and trainer giving feedback in an open and constructive way with clear specific examples given in a kindly way and in a timely fashion.

Written Communication

The Royal College of Physicians and Surgeons of Canada describes the ability to "convey effective oral and written information about a medical encounter" as a key competency.[10] While verbal communication skills are often informally or formally assessed through interactions with supervising physicians and objective structured clinical examinations, written communication skills are given little formal attention in medical training.[11] In fact, medical students report limited training in documentation, and most of what they learn is through trial and error.[11,12] It is clear that documentation errors have been linked to errors in patient care,[13] and inadvertent omissions may have medico-legal implications. Written documentation may be the only opportunity we have to describe our thought process and the details of our interaction with a patient, and structured evaluation of this skill is not routinely performed. Furthermore, there is limited published information about specific interventions that may be used to improve this critical skill.

A study at McMaster University used a communication tutorial and resident feedback workshop to teach medical students how to write an internal medicine consultation note. The study had three arms: control, medical student communication tutorial only, and student tutorial and resident feedback workshop. Over six weeks, consultation note scores improved based on assessment checklists across all three arms, but significant improvements were found only in the group that received both interventions.[11] The findings of this study suggest that while all trainees improve over time in their ability to produce consultation