Communication with Families at the Family Birth Center

We are striving to provide excellent intrapartum communication and respect for patients' autonomy as we help to facilitate their informed choices related to labor and birth. Our language matters. This is not at all a comprehensive guide to communication, but more of a jumping-off point and gentle reminder to be thoughtful about the words we use.

Simulations are a perfect time to bring attention to the language we use and practice our communication skills. However, given the relatively few simulation opportunities we have, we acknowledge that most of us will be honing our communication skills with each other real time in the patient care environment. This will require courage and compassion from all team members.

The first chart below refers to speaking **WITH** a patient and the other is how we speak **ABOUT** a patient to our colleagues (directly or in documentation). Our language in and outside of the patient's room creates our culture on the unit, which in turn affects patient care and experience.

Reproductive health discussions and exams place people in inherently vulnerable positions. A medical visit should try in every way to minimize pain and never include a sense of violence or humiliation. Every way we can help patients feel that they are in control improves the chance they will avoid negative experiences and participate in future care. Triggers in language can be words that are associated with pain or associated with dismissing someone or judging someone as "doing great" while disregarding the patient's expressed pain. How we speak about patients to colleagues helps reinforce respectful care as well.

The following chart is adapted from "Humanizing birth: Does the language we use matter" by Mobbs, William and Weeks (2018). In their research, they identified several categories of language we should challenge: paternalistic/patronizing, dictatorial, objectifying, anxiety-provoking/overly-dramatic, discouraging and overly-medical/exclusive/coded. The suggested language that strives to convey respect towards the patient as an individual person with autonomous decision-making power over their own body and experience. In every interaction, we also must acknowledge the role that race, power, privilege, and preferred language impacts care. In addition, we are fortunate at ZSFG to work with many faculty who teach about the language we use in our profession and relationship-centered communication (RCC). Work from presentations by Nika Seidman and Karen Meckstroth are incorporated in the tables below as well.

Because the experience of discomfort and/or pain is almost universal for birthing people, a final section specifically addresses the ways we discuss pain and pain management--understanding that pain carries different meanings for patients and care providers. Studies show that detailed information about what to expect during a procedure decreases pain but describing and labeling pain in the moment makes it more likely the patient will feel pain, as opposed to neutral descriptors of what the clinician is doing.

Here is the link to their study, which we recommend reading (it's short):
https://blogs.bmj.com/bmj/2018/02/08/humanising-birth-does-the-language-we-use-matter/

ZSFG RCC Training http://zsfglearn.org/programs/staff-education-and-training/staff-education-training-courses/

Please email Mara Fox at mara.fox@sfdph.org if you have suggestions as this is a living document to be used at Zuckerberg San Francisco Hospital. Thank you to Karen Meckstroth, Kara Myers, and Nika Seidman for their contributions.

Communication WITH Patients and Families

Language to Avoid:	Suggested Language:	Comments
LABOR		
"I'm going to check you now."	"May I examine your cervix to help us check how your labor is going?" "Let me know if/when you feel ready. This is your decision."	
"Painful contractions"	"Strong/powerful contractions"	
"I'll allow you two more hours to labor before we call a c-section."	"Let's check in together in two hours and see how you, your baby and your labor are doing. It's possible that if I'm feeling concerned, I may recommend a cesarean birth and we will talk through what that may look like together. Until then, keep doing what you are doing because your strength is making such a difference for your baby (or make a suggestion)."	Avoiding paternalistic language. Create team decision-making.
"Fetal distress" "AROM"	"Changes in the baby's heart rate" "Release/open your bag of water"	Be aware of acronyms in general – no one knows what we are talking about!
"Trial of forceps"	"To see if we can help you birth your baby with the help of forceps," then informed consent	"Trial" suggests uncertainty, experimentation and emphasizes risk of failure.
"You're 6 centimeters!"	Are they really? "Your cervix has opened to 6cm. 10cm is considered fully open and you could start pushing to meet your baby."	
"You need a cesarean."	"I would suggest a cesarean birth because of X," then informed consent	
"You are high-risk."	"You have several medical conditions that affect your pregnancy."	
PELVIC EXAM		
"Put your feet in the stirrups."	"May I help you place your feel on the supports/foot rests?"	Avoid commands, use neutral words
"I'm going to do the exam now."	"Before we start, is there anything you'd like to know more about: what pelvic exam is for, how I'm going to do it?" "Is it ok if we do the exam now?"	Ask rather than tell whenever possible.
"Spread your legs for me," or, "Open your legs."	"Can you please let your knees fall to the side, or towards the walls, or like a butterfly..."	Never push a patient's legs apart to get them into position. Let the patient move into position or move to the width of your hands.

"Scoot your bottom down here on the bed until you feel like you'll almost fall off."	”When you’re ready, please move your hips to the edge of the exam table.” Or "There is more room here on the exam table for you to move down."	Note "**exam table**," not bed.
"I'm inserting the speculum into you now."	“Are you ready for the speculum exam? You’ll feel my glove and the pressure of the speculum.”	At some time prior, ask the patient, “Let me know if I cause you any discomfort so I can try to fix that right away.”
“It’s going to feel cold.”	“It might feel cool.”	
"Everything looks good." “Feels good!” “Beautiful!” “Perfect!”	"Everything looks normal and healthy."	
"I am going to clean your vagina now."	"I'm going to swab with antiseptic now."	Many people have concern about the “cleanliness” of their vagina.
“You did great.”	“You must have had practice with relaxation techniques” (if you feel you need to provide a compliment)	(…as opposed to those patients I judge to have done poorly.) One might consider compliments for patients who really struggled.
“Hmm” “Oops!” “What’s this?” “That looks awful.”	“That looks painful.”	A pelvic exam inherently is a vulnerable position. Its best to discuss the exam when you are face to face with your patient after the exam and the patient is covered completely with drape or clothes.
PROCEDURES		
"You're going to feel a pinch, cramp, pain..."	“You might feel a sensation (or a twinge…)” “Let me know if you are at all uncomfortable and I will stop and check in with you and try to make that better right away.” "I am gently stretching (or checking) your cervix."	Studies show that anticipatory guidance describing pain makes it more likely the patient will feel pain, as opposed to neutral descriptors of what the clinician is doing. Studies also show a wide variety of sensation with cervical manipulation, injection, dilation.
DECISION MAKING		
“We’ve told you our recommendation, and you need to decide.”	"I'm noticing that this is a hard decision for you. What concerns or questions do you still have? What else do you need to be able to make this decision? Is there anyone else on our team or in your family/community you would like to talk to before you make your decision? I am going to step out of the room for a moment so you have some time to think. My hope is that you can make this decision for yourself and we are here to help you."	Sometimes we can overload a patient with too much information. Patients may feel overwhelmed and can show this by going wavering or going back and forth on their decision. If it seems like they are struggling to decide, dig a little deeper and see how you can help.
DEMONSTRATING LISTENING		

	"I want to listen to you." (*Stop, sit, make eye contact.*) "What is important for us to know from your perspective?" "No one else is experiencing this the way you are right now. I want to hear your perspective." "I hear you. What I heard from you is… (*reflect back*)	
CONTRACEPTION		
"IUDs and the implant are the most effective, easiest to use and low risk options, so I recommend these." "I love mine!"	"What is most important to you in a method?" "Some people feel __ is important." "Because __ is important to you, you might consider __."	Shared decision-making respects patient preferences and offers information as it relates to priorities. Ask for permission to discuss contraception in general or a method they are not asking about.
(After abortion) "What kind of birth control do you want to use now so that this doesn't happen again?"	"Would you like to talk about birth control today?"	Studies show many patients are too overwhelmed the day of their abortion to make other complex decisions. Forcing a discussion about birth control is not patient centered.
PREGNANCY DIAGNOSIS		
"Congratulations--you're pregnant!"	"Your pregnancy test is positive; that means you are pregnant. How does this news feel for you?"	50% of pregnancies are unplanned.
"Do you want to keep the baby?"	"What are you thinking about in terms of continuing the pregnancy or not?"	Lets them know you are comfortable discussing abortion. "Pregnancy" is a neutral term.
(Miscarriage) "I'm sorry; it looks like the pregnancy has stopped/died/does not have a heartbeat"	"I think I may have some unexpected information from the ultrasound. Do you want to talk about this now?"	Ask before giving any potential bad or unexpected news. Check on emotions after short disclosure. https://www.vitaltalk.org/topics/disclose-serious-news/
MORE		
"Membrane stripping"	"Membrane sweeping" or "separating the edge of the membrane from the cervix"	Avoid language with vivid, negative associations
"Honey" "Sweetie" "Darling"	Ask patients how they would like to be addressed.	While some patients may feel this is endearing, many would feel it is belittling and disrespectful.
"Trust me."	"We're going to work hard to take good care of you."	Demonstrate you are trustworthy
Assuming "she/her"	Ask what pronouns a patient prefers. This can also be found in the demographics section of EPIC.	Reproductive health areas are often labeled "women's." Instead, aim to describe the services that are provided. https://uwm.edu/lgbtrc/support/gender-pronouns/
"Alcoholic" "Addict" "Diabetic"	**A person** "with alcohol addiction" or "who engages in substance use" or "has diabetes"	Use language that reinforces the person's identity outside of a medical or social issue. *See the "Power of Words" list below.

“Refuses” “Is unmotivated” “Is resistant”	“Declines” “Has not begun” “Opted not to”	Use language that recognizes the complex and competing issues in patients’ lives and promotes recovery.

Communication ABOUT Patients and Families

Language to Avoid:	Patient-Centered:	Comments
"Room 7" "The TOLAC" "The SROM" "The bleeder" "The methadone induction"	Use patient names. If unknown, "The patient with chorio (etc.) in room 7"	Patient-first language.
"Delivered"	"Gave birth"	Not a UPS package.
"I AROM'ed them."	"I did an AROM or amniotomy"	Avoid actions on or to patients. This can have a tone of violence.
"I'll go consent them."	"I will go offer them informed consent and invite their perspective about our recommendation"	It's not about your agenda.
"Pt refused"	"Pt declines" (*especially in charting*).	Refusal is paternalistic language.
"Poor maternal effort"	"The patient reports exhaustion and is finding it difficult to find the energy to push effectively."	
"Failed" IOL, VBAC	"Unsuccessful…"	

The Power of Words – by Nika Seidman

Stigmatizing words	Alternatives
Addict, abuser, junkie, user	Person with a substance use disorder
Clean	Substance-free, in recovery
Dirty (urine)	Substance/drug is in urine
Drug habit	Substance use disorder
Replacement or substitution	Treatment, medication, medication-assisted therapy
Homeless people	People experiencing homelessness
Non-compliant	Has barriers to care and/or to taking medications
Unfit to parent	Unable to parent at this time
Infected with HIV/HCV	Acquired HIV/HCV
HIV positive	Living with HIV
Prisoner/inmate	Person who is incarcerated/experiencing incarceration
Drug of choice	Drug of use

Communicating About Pain

Patients have different expectations about pain in labor. Our job is to make them feel supported in their choices and when needed, to offer suggestions based on the evidence and their specific labor. While labor pain is physiologically normal, we also work with unanticipated pain, such as breakthrough pain with epidurals and pain during surgery. It is important to recognize the difference between *coping vs. suffering* and *manageable vs. unmanageable pain.*

What if the patient asks for pain medications?

- What were the patient's prior wishes? Review the patient's birth plan if available.
    - Did they want an unmedicated birth?
    - How strongly did they feel about their plans?
    - Did they plan on pain medications as soon as contractions started?
    - Did they want help avoiding medications even if they verbalize they are considering medication use?

-Are they aware of all the available options both pharmacologic and non-pharmacologic?

- See ZSFG "How to manage your pain in labor" handout available on Sharepoint

-Is there a clear option considering where they are in their labor process?
-How rapidly are they progressing and how far do they still have to go?
-How well to they respond to more active coaching and hands-on labor support?
-If the patient is asking for medication themselves or are support persons uncomfortable witnessing labor pain?

- See "Ways to Support Partner with Labor Pain" handout available on Sharepoint

What if the patient has pain despite anesthesia during labor or surgery?
Occasionally patients will experience some pain despite their epidural or will be uncomfortable with the sensation of pressure as labor progresses. Surgical pain is something we hope to avoid, but at times happens anyway. In these situations, we should not to dismiss the pain but instead assist the patient in finding ways to cope (while simultaneously also working to treat the breakthrough pain pharmacologically). In the labor room, this person is often the primary nurse and in the OR this person is often with our anesthesia team. This is a good time to return to labor support language and methods of labor support that do not require ambulation.

Labor/Pain Support Language

"Come back to that breath. Exhale now. Inhale now. All of your mind is focused on your breath."
"Relax your shoulders down, roll them back. Relax your jaw. Let your forehead go."
"You can do this. Let it be strong."
"Make that nice low sound that matches your contraction."
"No one could do this better."
"That's right. Go towards that."
"You're doing beautifully."
"I'm amazed by you."
Keep your tone calm and confident. Talk to the patient between contractions. Help to ground the patient; try labor pressure points in the feet or shoulders. Walking the patient through a visualization can be therapeutic as well.

- See B.C. Policy 24.0 Pain management in labor and delivery