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**Ethical Reflections on Nurse–Patient Communication in Obstetric Clinical Practice:
An Expanded Academic Revision**

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Abstract

Obstetric care involves the simultaneous safeguarding of maternal and neonatal well-being and is characterized by high risk, high emotional intensity, and persistent communication demands. In this context, nurse–patient communication is not merely a technical adjunct to nursing practice but a core ethical activity that shapes care quality, patient safety, emotional well-being, treatment adherence, and the overall climate of clinical trust. Pregnant and postpartum women constitute a distinctive patient group whose physical condition, psychological status, and decision-making needs shift dynamically across the antenatal, intrapartum, and postpartum continuum. Consequently, communication in obstetric settings requires a higher level of professional sensitivity, ethical discipline, and person-centered responsiveness than is often assumed in general inpatient care. Drawing on the four foundational principles of biomedical ethics—respect for autonomy, beneficence, nonmaleficence, and justice—this revised paper provides a more theoretically grounded and analytically rigorous examination of common communication problems in obstetric nursing. It argues that persistent weaknesses in informed communication, privacy protection, empathic engagement, language regulation, and equitable service delivery are not isolated behavioral lapses but manifestations of deeper structural tensions between efficiency-oriented care routines and the ethical demands of patient-centered maternity care. The paper further proposes a full-cycle ethical communication framework for obstetric practice, integrating graded informed consent, privacy-sensitive communication protocols, empathy-based psychological support, standardized low-harm language strategies, stratified yet equitable communication planning, and department-level quality governance. By strengthening

conceptual depth and practical applicability, this article aims to contribute to the construction of a more humane, ethically coherent, and clinically effective model of obstetric nursing communication.

Keywords: obstetric nursing; nurse–patient communication; biomedical ethics; respectful maternity care; humanistic nursing; clinical application

I. Introduction

With the continuing transition from a purely biomedical model to a biopsychosocial and person-centered paradigm, the quality of communication has become a central criterion for evaluating contemporary clinical care. In obstetrics, this shift is particularly consequential. Obstetric services concern not only disease management but also reproduction, embodiment, family transition, vulnerability, and the protection of two interrelated lives. Pregnancy and childbirth are therefore not routine physiological events alone; they are ethically charged, psychologically intensive, and socially embedded experiences that require careful communicative practice.

Compared with other hospital departments, obstetric units present a uniquely complex communication environment. Women receiving obstetric care may be planning pregnancy, experiencing antenatal hospitalization, undergoing labor, recovering from delivery, or coping with early postpartum adaptation. Across these stages, fear of pain, uncertainty about fetal health, changes in body image, concerns over maternal competence, and family expectations often converge. Such factors can heighten emotional sensitivity and reduce tolerance for ambiguity, making the quality, timing, and tone of communication clinically significant. In this setting, ineffective communication

may not only impair understanding but also intensify distress, weaken cooperation, delay intervention, and generate conflict.

Recent scholarship on respectful maternity care has further emphasized that communication is one of the defining components of dignified and rights-based obstetric practice. Systematic reviews have identified communication, privacy, informed consent, dignity, safety, and justice as overlapping dimensions of respectful maternity care, indicating that communication is simultaneously a relational process, an ethical obligation, and a determinant of care outcomes (Cantor et al., 2024; Kawish et al., 2023). Evidence also suggests that women's experiences of communication during childbirth strongly shape their sense of dignity, emotional security, and trust in caregivers (Collins et al., 2023). At the same time, large international studies have shown that mistreatment during facility-based childbirth remains a significant global problem, with poor communication and disrespectful treatment being recurrent features (Bohren et al., 2019; World Health Organization, 2019). These findings underscore that obstetric communication must be understood not as a soft skill peripheral to safety, but as a constitutive element of ethical and high-quality care.

From the perspective of biomedical ethics, nurse–patient communication in obstetrics must be anchored in four foundational principles: respect for autonomy, beneficence, nonmaleficence, and justice. These principles are especially relevant in obstetric care because the patient's needs are multidimensional and rapidly evolving. To respect autonomy is to ensure meaningful informed participation rather than ritualized consent; to practice beneficence is to support both physical and psychological well-being; to honor nonmaleficence is to avoid not only physical harm but also communicative injury; and to

uphold justice is to provide fair, comprehensible, and responsive communication across different social and clinical groups.

Against this background, the present paper revises and deepens the original discussion by moving beyond a descriptive account of communication defects. It seeks to show that common communication problems in obstetric nursing arise from the interaction of individual limitations, organizational routines, institutional metrics, and broader ethical blind spots. On this basis, the article develops a more systematic framework for improving communication quality in obstetric settings and for integrating ethical reasoning into everyday nursing practice.

II. The Ethical Foundations and Clinical Value of Nurse–Patient Communication in Obstetrics

2.1 Core Ethical Connotations of Obstetric Nurse–Patient Communication

The four principles of biomedical ethics provide a robust conceptual foundation for understanding communication in obstetric nursing, yet their application in this field requires contextual interpretation. Respect for autonomy in obstetrics extends beyond obtaining signatures on consent forms. It requires recognition of pregnant and postpartum women as moral agents entitled to dignity, bodily integrity, informed participation, and privacy. In practical terms, this means that communication should support understanding, not merely compliance; explain options, not merely announce decisions; and preserve confidentiality, especially regarding reproductive history, previous pregnancy loss, marital circumstances, and other highly sensitive information.

Beneficence, in turn, requires that communication actively promote the patient's overall good. In obstetric nursing, "benefit" should not be reduced to the successful completion of clinical procedures. Because pregnancy and childbirth are emotionally intense and identity-transforming experiences, beneficial communication also involves alleviating fear, enhancing coping capacity, strengthening trust, and facilitating adaptation to maternal role transition. Thus, communication is therapeutic when it supports both clinical safety and psychological resilience.

Nonmaleficence is traditionally associated with the avoidance of physical injury, but in communication-rich settings such as obstetrics, psychological and relational harms must also be taken seriously. A dismissive tone, shaming remark, coercive explanation, or abrupt disclosure of bad news can cause invisible but enduring injury. Such communicative harm may heighten labor distress, intensify postpartum vulnerability, and leave lasting negative memories of childbirth. Therefore, low-harm communication should be treated as an ethical minimum rather than an optional interpersonal refinement.

Justice requires fairness in both access to information and quality of interaction. In obstetric care, communication justice means that no woman should receive poorer explanations, less patience, or reduced emotional support because of age, educational background, socioeconomic position, marital status, language ability, or the perceived simplicity of her condition. At a deeper level, justice also requires equity-oriented adaptation: communication should be equal in moral worth yet responsive to differences in comprehension, risk, and psychosocial need.

2.2 The Clinical Significance of Ethical Communication

Ethically grounded communication contributes directly to maternal and neonatal safety. In obstetric emergencies and high-risk pregnancies, timely and comprehensible communication improves cooperation with monitoring, intervention, and symptom reporting. When women and their families understand risk trajectories and treatment rationales, adherence tends to improve and preventable complications may be reduced.

Ethical communication also plays a major role in mental health support. Pregnancy-related anxiety, fear of childbirth, and postpartum depressive symptoms are common concerns in maternity settings. A broader body of evidence indicates that high-quality patient-centered communication is associated with improved trust, satisfaction, and patient-centered outcomes (King & Hoppe, 2013; Oliveira et al., 2012; Sharkiya, 2023). In obstetrics specifically, effective communication has been identified as central to women's sense of dignity and positive childbirth experience (Collins et al., 2023). This suggests that communication can function as a protective factor against emotional destabilization.

In addition, communication quality is closely linked to medico-legal and relational outcomes. Many conflicts in obstetric care arise not solely from technical error, but from misunderstanding, unmet expectations, perceived disrespect, insufficient explanation, or privacy violations. Ethical communication can therefore reduce disputes by clarifying uncertainty, acknowledging emotion, and demonstrating procedural fairness. Finally, it is a cornerstone of humanistic and high-quality nursing. It supports the broader transformation of care models from task completion to person-centered accompaniment, thereby aligning obstetric nursing with global movements toward respectful maternity

care (Cantor et al., 2024; White Ribbon Alliance, 2011; World Health Organization, 2018).

III. Common Ethical Problems in Obstetric Nurse–Patient Communication and Their Causes

3.1 Formalistic Respect: Weaknesses in Informed Communication and Privacy Protection

Although respect is widely endorsed in principle, it is often incompletely realized in daily obstetric practice. One common problem is the reduction of informed communication to administrative completion. Important issues such as labor analgesia, induction, monitoring of high-risk pregnancy, or changes in treatment planning may be explained briefly and in highly technical language, with limited assessment of whether the patient actually understands the information. Under these conditions, signed consent may exist without meaningful autonomy. Such practices become especially problematic for women facing complex risk profiles, who often require staged explanation, repeated clarification, and opportunities for questions.

A second problem concerns privacy. Obstetric care frequently involves deeply sensitive personal information, yet privacy breaches may occur through loud discussion of reproductive history, bedside disclosure in shared wards, careless placement of records, or insufficient shielding during examinations and procedures. These practices compromise dignity and may produce shame, embarrassment, or distrust. In ethical terms, the failure is not merely procedural; it reflects insufficient recognition that confidentiality and bodily privacy are integral to respectful care.

These weaknesses arise from several interacting causes. Some nurses receive limited systematic training in ethics and communication law, causing them to focus more on procedural completion than on substantive understanding. Departmental protocols may also lack graded communication pathways tailored to ordinary, high-risk, and critical cases. Furthermore, quality supervision often emphasizes technical performance and documentation accuracy more than communication adequacy or privacy-sensitive conduct.

3.2 Narrow Beneficence: Insufficient Empathy and Psychological Care

A second major problem is the overly narrow interpretation of patient benefit. In many settings, communication remains concentrated on physiological indicators and routine health education, while emotional suffering and existential concerns receive inadequate attention. Nurses may explain fetal heart monitoring, contractions, blood pressure, lactation, or wound care competently, yet devote far less time to listening to fears about labor pain, fetal abnormality, maternal role competence, or postpartum exhaustion.

This imbalance reveals a deeper conceptual issue: when benefit is understood primarily in biomedical terms, psychological care becomes secondary and often optional. However, obstetric patients frequently experience fluctuating anxiety, irritability, helplessness, and role insecurity. If these states are met with formulaic reassurance rather than empathic engagement, communication loses much of its therapeutic value. Women who struggle with breastfeeding, delayed recovery, infant-related stress, or unexpected clinical developments may then experience cumulative distress, which can interfere with recovery and adaptation.

The causes are partly structural. Obstetric units are often fast-paced, labor-intensive, and vulnerable to staffing shortages, leaving nurses with little discretionary time for in-depth emotional communication. Training systems may also prioritize technical competency over empathy, counseling, or trauma-informed interaction. In addition, institutional performance metrics frequently reward safety indicators and task completion more visibly than relational excellence, which can unintentionally marginalize humanistic communication.

3.3 Inadequate Nonmaleficence: Hidden Psychological Harm Caused by Language

Communication in obstetrics can cause harm even when no physical injury occurs. Under work pressure, fatigue, or frustration, nurses may resort to directive, impatient, comparative, or dismissive expressions, particularly when a laboring woman repeatedly asks questions, cries out in pain, or shows difficulty cooperating. Statements that minimize suffering or imply weakness can intensify fear, self-blame, humiliation, and isolation. Similarly, abrupt disclosure of negative news without emotional preparation may trigger acute distress.

The ethical significance of such language lies in its invisible consequences. Psychological harm may not be measurable like bleeding or infection, yet it can alter the woman's memory of childbirth, trust in caregivers, willingness to seek future care, and emotional recovery after delivery. Global evidence on mistreatment during childbirth has highlighted verbal abuse, neglect, and disrespectful interaction as widespread problems with serious consequences for women's experiences and rights (Bohren et al., 2019; World Health Organization, 2019).

These communicative harms are often sustained by limited emotional self-regulation among staff, the absence of scenario-based low-harm communication guidelines, and managerial underestimation of the ethical seriousness of verbal and nonverbal injury. Where only technical safety is monitored, harmful language may remain normalized or invisible.

3.4 Deviations from Justice: Uneven and Insufficiently Tailored Communication

A fourth problem concerns justice. In practice, communication resources are not always distributed evenly. Women with more family support, higher education, stronger advocacy capacity, or more obviously severe clinical conditions may receive more detailed explanations and more patient responses. By contrast, those who appear medically stable, socially isolated, older, less educated, or slower to understand may receive compressed or delayed communication. Such inequality is ethically problematic because it allows subjective valuation of patients to influence communicative attention.

At the same time, justice is undermined by rigidly uniform communication. Equal treatment does not mean identical wording for all patients. Younger first-time mothers, older gravidas, women with limited literacy, and those with high-risk pregnancies differ substantially in informational need, emotional concerns, and decision-making burden. Communication that is standardized without being adaptive may formally appear fair while functionally failing large groups of patients.

The causes include implicit bias, lack of tiered communication guidance, and staffing constraints that force prioritization under time pressure. Thus, injustice in communication is not always the result of deliberate discrimination; it may also emerge from institutional

scarcity and unexamined routines. Nevertheless, its effects on patient experience, trust, and informed participation remain significant.

IV. Strategies for Optimizing Obstetric Nurse–Patient Communication Under Biomedical Ethical Principles

4.1 Upholding Respect: Strengthening Informed Communication and Building Robust Privacy Protection

An ethically credible obstetric communication system should begin with graded informed communication rather than one-time generic instruction. Patients can be stratified into ordinary, high-risk, and critical categories, with communication checklists adapted to the level of clinical complexity and urgency. For ordinary cases, explanations should cover care pathways, routine procedures, common risks, and self-management expectations. For high-risk and rapidly changing cases, communication should occur at multiple nodes—admission, change in condition, therapeutic adjustment, and preparation for delivery—so that understanding develops progressively rather than being compressed into a single episode.

Respect for autonomy also requires that options such as labor analgesia and mode of birth be presented in balanced language that clarifies benefits, limitations, indications, and uncertainties without coercion. Documentation remains important, but the ethical endpoint is genuine understanding. To support this goal, visual aids, simplified written materials, and teach-back methods can be incorporated into routine practice.

Privacy protection must be treated as a full-scene management task. Curtains, doors, and visitor control should be consistently used during examinations and procedures. Sensitive

discussions should be conducted away from public circulation areas. Access to records should be restricted, and special one-to-one communication arrangements should be made for women with particularly sensitive personal histories. Such measures transform privacy from a symbolic principle into an operational norm.

4.2 Practicing Beneficence: Constructing a Full-Cycle Empathic Communication Model

To embody beneficence in a richer sense, communication should accompany the patient across the entire obstetric trajectory. During the antenatal stage, nurses should not limit education to routine instructions; they should actively assess fear, uncertainty, and informational confusion. Individualized explanations about fetal movement monitoring, hospitalization expectations, dietary concerns, and warning signs can reduce anxiety and improve self-efficacy.

During labor, communication should become more immediate, supportive, and process-oriented. Real-time explanation of labor progress, guidance in breathing and coping, and repeated emotional affirmation can help women maintain orientation and a sense of participation. Because labor pain often narrows cognitive processing, short, calm, and encouraging communication is especially important.

In the postpartum stage, emotional care becomes central. Early feedback about maternal and neonatal status, targeted support for wound pain, lactation difficulties, sleep deprivation, and adaptation stress, and timely identification of depressive risk can promote recovery. Where needed, nursing teams should collaborate with psychology or psychiatry services. In this way, communication becomes a continuous form of care that bridges information, emotion, and recovery.

Departmental training should therefore include empathy development, reflective listening, validation skills, and basic psychological first response. The aim is not to transform every nurse into a therapist, but to ensure that all nurses can provide emotionally safe and therapeutically useful interaction within the scope of practice.

4.3 Safeguarding Nonmaleficence: Standardizing Low-Harm Language and Regulating Emotional Expression

Nonmaleficence requires explicit attention to language. Obstetric departments should establish lists of prohibited expressions, especially those involving blame, ridicule, comparison, emotional dismissal, or unnecessarily alarming wording. In parallel, scenario-based communication templates should be developed for common high-stress situations, including pain reassurance, repeated questioning, poor cooperation, family anxiety, and disclosure of adverse developments.

When communicating bad news or uncertainty, a buffered approach is preferable: stabilize the interaction first, describe the current situation clearly, explain the next steps, and preserve realistic hope without deception. This approach reduces shock and fosters partnership. Equally important is the management of nonverbal communication. Tone, facial expression, posture, and pacing can either reduce or amplify distress.

Because harmful communication often arises when staff are exhausted or emotionally overloaded, departments should also invest in staff well-being and emotional regulation training. Debriefing after critical incidents, supportive supervision, and attention to burnout are not merely workforce issues; they are part of an ethical strategy to reduce preventable communicative harm.

4.4 Realizing Justice: Combining Standardized Baseline Service with Individualized Precision Communication

A just communication system in obstetrics should combine universal baseline rights with tailored adaptation. Every patient, regardless of social or educational background, should receive the same minimum standard of explanation, answering time, privacy protection, and respectful interaction. This baseline should be codified and auditable.

At the same time, communication methods should be adjusted to individual needs. Older women or those with complex comorbidities may need slower pacing and repeated risk clarification; women with limited health literacy may need plain-language explanation and demonstration; first-time mothers may need more anticipatory guidance and emotional reassurance; and high-risk patients may need more frequent updates. Such adaptation is not preferential treatment but substantive justice, because it seeks comparable understanding across unequal starting points.

4.5 Establishing a Long-Term Departmental Governance Mechanism

Improvements in communication cannot rely solely on individual goodwill. They require institutionalization through training, quality control, feedback, and accountability. First, obstetric units should provide regular education on biomedical ethics, respectful maternity care, communication skills, trauma-informed care, and privacy-sensitive practice. Case-based learning drawn from real clinical incidents can enhance practical relevance.

Second, communication quality should be included in routine supervision and performance evaluation. Audits can assess the adequacy of informed communication,

privacy compliance, interaction style, and patient-reported respect. Indicators such as patient satisfaction, complaint patterns, and communication-related adverse events may be incorporated into departmental quality dashboards.

Third, multiple feedback channels should be established, including discharge surveys, follow-up interviews, and confidential reporting pathways. Such feedback should be analyzed not only descriptively but also diagnostically, so that recurrent weaknesses can be linked to staffing, workflow, training gaps, or leadership issues. A closed-loop model of training, implementation, monitoring, feedback, and improvement is essential if ethical communication is to become an enduring feature of obstetric practice rather than a temporary campaign.

V. Conclusion

Nurse–patient communication in obstetric care is far more than the transmission of clinical information. It is a site where biomedical ethics, humanistic nursing, psychological support, and patient safety converge. Because obstetric patients experience dynamic physical risk and emotional vulnerability across the full reproductive continuum, communication in this field carries unusually high ethical weight.

This revised discussion has argued that current communication problems in obstetric settings can be interpreted through four recurrent ethical failures: formalistic respect, narrowed beneficence, inadequate nonmaleficence, and incomplete justice. These failures are sustained not only by individual deficiencies in skill or awareness, but also by time pressure, staffing limitations, protocol design, managerial priorities, and insufficient integration of ethical reasoning into nursing governance.

Accordingly, improving obstetric communication requires more than exhorting nurses to “be kinder.” It requires a systematic ethical infrastructure: meaningful informed communication, rigorous privacy protection, empathy-based full-cycle support, standardized low-harm language, equity-sensitive communication design, and organizational mechanisms for training, quality assessment, and patient feedback. Such reforms would align obstetric nursing more closely with the principles of respectful maternity care and the broader goals of person-centered healthcare.

Ultimately, when ethical reflection is translated into everyday communicative action—during admission, explanation, accompaniment, reassurance, and discharge guidance—obstetric nursing can better protect maternal and neonatal well-being, reduce conflict, and foster dignified clinical experiences. In this sense, communication is not secondary to care; it is one of care’s most essential ethical forms.

Declarations

Conflict of Interest

The author declares no conflict of interest.

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