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PROBLEMS AND BARRIERS IN MIDWIFERY COMMUNICATION WITH THE PATIENT: SYSTEMIC FACTORS AND PSYCHOSOCIAL CONSEQUENCES

Abstract: *this research paper investigates the underlying causes of communication deficits in the interaction between midwifery staff and pregnant/parturient women within the hospital environment. The transition from traditional medical paternalism to the shared decision-making model is analyzed, with specific emphasis placed on the patient's emotional vulnerability and the concept of „emotional labor“ among midwives.*

The aim of the study is to analyze the leading causes of problems in obstetric communication and to define scientifically based strategies for overcoming them and for optimizing the patient-centered model of care. The main causes of communication deficits, barriers to effective communication and their impact on the quality of health care are the subject of the study. The paper classifies communication barriers into four distinct levels: systemic-institutional, professional-subjective (burnout), patient-centered, and socio-cultural. A methodological framework for a mixed-methods em

Keywords: *midwifery communication, patient-centered care, emotional labor, burnout, shared decision-making.*

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ПРОБЛЕМЫ И БАРЬЕРЫ В ОБЩЕНИИ АКУШЕРКИ С ПАЦИЕНТКОЙ: СИСТЕМНЫЕ ФАКТОРЫ И ПСИХОСОЦИАЛЬНЫЕ ПОСЛЕДСТВИЯ

Аннотация: *в этой исследовательской работе исследуются глубинные причины дефицита коммуникации во взаимодействии между акушерским персоналом и беременными/роженицами в больничной среде. Анализируется переход от традиционного медицинского патернализма к модели совместного принятия решений с особым акцентом на эмоциональную уязвимость пациентки и концепцию «эмоционального труда» среди акушерок.*

Целью исследования является анализ основных причин проблем в акушерском общении и определение научно обоснованных стратегий их преодоления и оптимизации модели оказания медицинской помощи, ориентированной на пациента. Предметом исследования являются основные причины дефицита коммуникаций, барьеры на пути эффективной коммуникации и их влияние на качество медицинской помощи. В статье коммуникационные барьеры классифицируются по четырем различным уровням: системно-институциональный, профессионально-субъективный (эмоциональное выгорание), ориентированный на пациента и социокультурный. Предлагается методологическая основа для эмпирического исследования с использованием смешанных методов, а также практические стратегии для оптимизации терапевтического взаимодействия (включая протокол SBAR, группы Балинта и симуляционное обучение). Плохая коммуникация определяется не только как этическая проблема, но и как значительный клинический и юридический риск.

Ключевые слова: *эмоциональное выгорание, забота, общение акушерок, ориентированная на пациента, эмоциональные роды, совместное принятие решений.*

Introduction

Modern Healthcare is undergoing a continuous transformation, characterized by a transition from the traditional paternalistic model to a patient-centered approach,

influenced primarily by modernist attitudes of consumer demand and the advancement of innovative technologies. In the context of obstetric care, this transition is particularly critical. Birth and pregnancy are not just purely medical or biological events, but deep psychosocial processes that require a specific emotional environment, security, and mutual trust. There is an increasing demand for individual approach and personalized care during pregnancy and childbirth, which sometimes does not correspond to the normative framework of medical care.

The medical significance of the problem is determined by the fact that effective communication is a direct determinant of patient safety. Disruptions in the information exchange between the midwife and the pregnant woman increase the risk of clinical errors, delay the diagnostic process and may lead to the omission of alarm symptoms. Poor communication compromises the process of taking informed consent, turning it into an administrative formality rather than a real partnership.

The social significance is rooted in the growing public sensitivity to the quality of maternity care and respect for Human Rights [77]. Worldwide, including in Bulgaria, there is criticism of the manifestations of the so-called «disrespectful care» or depersonalization of the woman giving birth. Communication deficits (rude tone, lack of explanations, neglect of the subjective sensations of the patient) are the leading cause of the accumulation of psycho-emotional trauma, postpartum depression and distrust of the health system as a whole.

The current development is provoked by the need to investigate the systemic and psychosocial factors that hinder the full dialogue in order to improve the therapeutic alliance «medical person – patient».

The following elements of the scientific apparate are defined: Subject: documentary sources existing in the scientific database on the process of professional communication and interaction between obstetric staff and pregnant women in the hospital environment. The process of professional medical communication and interaction between the obstetric staff and the pregnant, birthing and levter (the mothers) in the structure of hospital care. Subject of the study: the specific systemic, institutional, individual-psychological and socio-cultural reasons that generate barriers

to effective communication, as well as their direct consequences on the quality of health care. Objective of the study: to analyze scientifically and empirically the leading factors for the occurrence of deficits in obstetric communication and, based on the results obtained, to define a sustainable model for optimizing professional communication in practice.

The main tasks are.

1. To explore theoretical models of Medical Communication and the concept of patient-centered care in obstetrics.

2. To classify and detail the systemic, subjective and psychosocial causes of communication barriers.

3. To study the impact of burnout syndrome on empathy and communication quality in midwives.

4. To analyze the Clinical, Psychological and legal consequences of ineffective communication.

Exhibition

Obstetric communication is a key process of interaction between the midwife, the pregnant woman and her family. It is the foundation of trust and has a direct impact on the quality of obstetric care, the course of pregnancy, the birth itself and the postpartum period

1. Theoretical foundations of obstetric communication.

1.1. Evolution of medical models: from paternalism to Shared Decision-Making. The shift from paternalism to shared decision-making is a fundamental paradigm shift in medical sociology and bioethics. In obstetrics, this process has a specific dynamic, as it affects not just the management of disease, but the management of a natural, but high-risk life process. Change is about shared decision-making. Historically, the relationship between the healthcare professional and the patient has undergone a profound evolution, which is divided into three main models: the paternalistic, the informative (consumer), and the shared decision-making model.

1.1.1. Traditional paternalistic model («the doctor/midwife knows best»). The historical root of medicine rests on the Hippocratic tradition, which is strongly

paternalistic (lat. dad). In this model, the distribution of roles is: the medical person acts as a mentor or parent who alone makes decisions for the patient, guided by the principle of «beneficence».

Here there is a dependence not only on competencies, but also on information about the diagnostic-therapeutic plan (strong asymmetry of information). The patient takes a passive, subordinate role, and is expected to fully agree and comply with the prescriptions. But in obstetrics there are a number of spicifixes, and the focus of childbirth is directed to the possible or already existing pathology and dependence on technological control. The woman is often deprived of information about the nature of the manipulations (e.g. episiotomy, amniotomy), since it is assumed that emotions and pain interfere with objective evaluative.

1.1.2. Informative (consultative) model. As a result of the leading role of paternalism, the informational model developed in the second half of the century (with the emergence of autonomy as a leading bioethical principle). This is due to increased knowledge in various fields of medicine, advances in technology and institutionalization of medical care. The healthcare professional becomes a technical expert who provides the patient with dry, objective information (often incomprehensible or insufficient), facts and statistics about available alternatives and risks. The model of market-driven mechanisms enters and the patient is a consumer of Health Services, who makes the choice himself and bears full responsibility for it. Despite the freedom of choice, access and the possibility of additional payment for services and conditions, there are a number of shortcomings in practice. This pattern often leaves the woman giving birth isolated at a time of great stress [28]. Does not allow for the presence of non-medical persons for support [42,75] in many medical institutions (Bulgaria does not regulate the access of an accompanying person in the medical institution). The sheer enumeration of medical facts without empathy and guidance increases anxiety and transfers too heavy a choice to the non-specialist.

1.1.3. Model of Shared Decision – Making (aposematic). The modern gold standard unites the expertise of the medical person and the value system of the patient through a two-way, equal dialogue [21]. This is a form of bilateral exchange of

information. Here all subjects are participants in the choice and decisions for specific treatment-diagnostic methods. The medical person brings their clinical expertise (risks, benefits, scientific evidence) and the patient brings their personal expertise (values, preferences, past experiences, life priorities) [23]. Overcoming asymmetry: communication is aimed at building a partnership (Apostille) [61]. The choice of behavior (e.g. method of analgesia, birth position, induction) is agreed jointly [62,63,64].

1.2. Specificity of communication in obstetrics and gynecology-emotional vulnerability of the patient.

The specificity of communication in obstetric-gynecological practice is determined by the fact that the object of care is a woman in a transitional, intense and deeply intimate life period. Unlike general medicine, here the psycho-emotional state of the patient is not just a side factor, but a leading element that directly affects the physiological course of pregnancy and childbirth [60]. Communication in obstetrics has unique characteristics that distinguish it from General Medical Practice [72]. This specificity is dictated by the intertwining of intense biological changes, psychological transformation, and high levels of social expectation [22].

1.2.1. The phenomenon of «reproductive vulnerability».

Pregnancy, childbirth, and the postpartum period constitute the so-called normative crisis of development (by Erik Erikson) [16]. A woman goes through a transition in her identity – from differentiation as an individual to accepting the role of a mother. This process is accompanied by a specific emotional vulnerability due to several factors:

Hormonal perturbation intensity: sharp fluctuations in progesterone, estrogen and oxytocin levels directly affect neurotransmitter systems, increasing emotional lability, anxiety and sensitivity to external stimuli [26].

Existential fear: the process of birth is associated with a collision with pain, suspense, and basic fear for one's own life and that of the newborn [66,67]. The lack of control over one's own body increases the feeling of helplessness.

1.2.2. Psychological regression during childbirth (Figure 1). In the delivery room, under the influence of pain and stress, in the woman in labor often triggers the psychological mechanism of temporary regression. The patient loses the ability to think coolly, rationally and abstractly. Information is mainly processed through the prism of emotions and nonverbal signals [67]. In this state, the woman is extremely sensitive to the tone of voice, facial expressions, gestures and even to the physical distance (Proxima) of the obstetric composition. Rude or uninteresting nonverbal communication is perceived as a direct security threat.

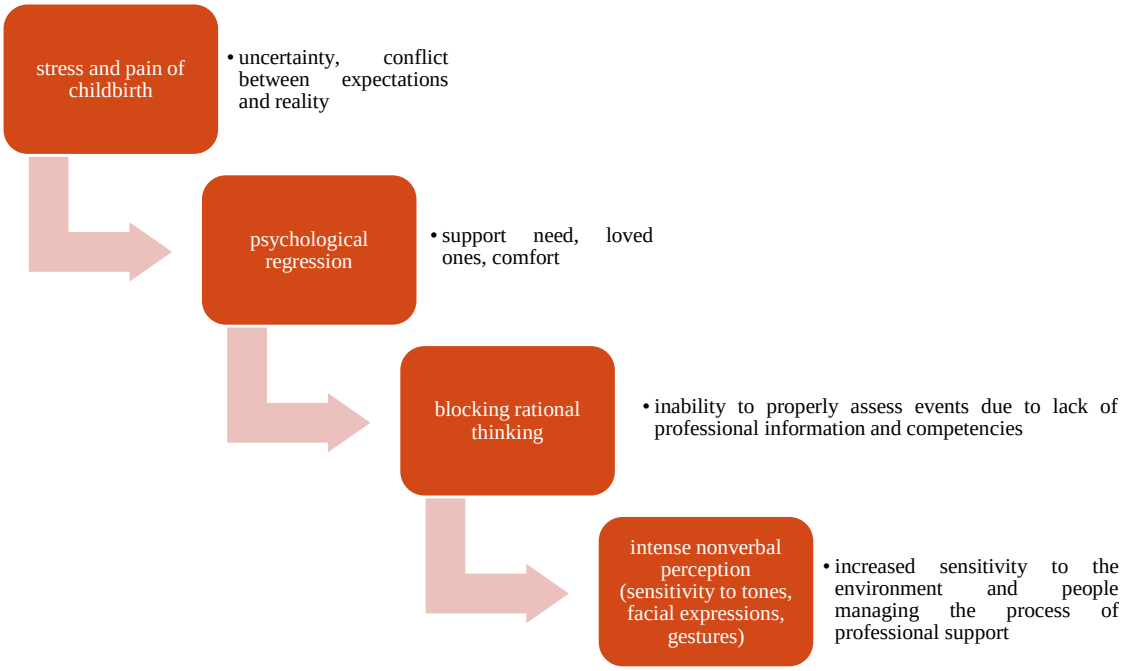

Fig.1. Psychological change in the course of childbirth

1.2.3. Taboo, intimacy and shame. Obstetric-gynecological examinations and manipulations are associated with entering the most intimate physical and psychological space of a woman.

Violation of body boundaries: the examination position (on a gynecological chair) itself puts the patient in a vulnerable and defensive position.

Shame barrier: worrying about nudity, body fluids, and physiological manifestations often causes women to save important symptoms or questions. The midwife must possess a high capacity for empathy and tactfulness to demystify and destigmatize the process, creating a protected environment.

1.2.4. Communication triangle: mother-fetus/newborn-medical team. Unlike the classic «medical person – one patient» model, in obstetrics communication is always aimed at a dualistic subject (mother and unborn/newborn child). Any diagnostic or therapeutic choice (e.g. taking medication, performing a C-section or forceps) affects two lives simultaneously. The anxiety of a pregnant woman is often a projection of fear. If the midwife communicates the indications of the condition of the fetus (e.g. in case of delayed cardiotocograph tones) panicked or unprofessional, this may induce acute psychological shock in the patient.

Clinical relevance to midwifery practice: understanding emotional vulnerability requires the midwife to apply Trauma-Informed Care (ubiquitously). Each Communication Act must validate the woman's fear and pain in advance, turning them into a resource for cooperation rather than a cause for conflict or paternalistic oppression.

1.3. The concept of «emotional labor» (Emotional Labor) in obstetric composition. The concept of «emotional labor» is key to the scientific understanding of burnout and communication barriers in midwives. It explains how the requirement to constantly demonstrate empathy depletes a medical person's emotional resource. It was first introduced by sociologist Ari Russell Hochschild in 1983. It describes the process by which employees must manage, regulate, and suppress their own real feelings in order to demonstrate the behaviors and emotions required by professional standards and organizational culture. In the context of obstetric practice, emotional labor is just as intense and mandatory as physical or intellectual labor.

Specificity of emotional labor in obstetrics

A midwife is traditionally expected to exude calmness, confidence, warmth, and deep empathy, regardless of her own physical exhaustion, personal problems, or stress levels in everyday work. This work is carried out through two main mechanisms of regulation:

- superficial action (Surface Acting): The Midwife simulates emotions (e.g. smiles, uses a flattering tone), which she does not feel at the moment, while

internally she feels tired, irritated, or indifferent. This creates T.pomegranate. emotional dissonance;

- deep action: The Midwife makes a conscious effort to change her inner feeling in order to truly experience the patient's emotion (e.g. he's trying to really feel compassion for the frightened birthing woman, so that the response is authentic).

Emotional dissonance as a communication risk

When the Midwife is forced to apply a «superficial action» for a long time due to overwork or lack of support, a high emotional dissonance develops (a difference between the emotion experienced and the emotion shown) (Figure 2). It has been shown in the scientific literature that chronic emotional dissonance leads to:

- loss of authenticity in communication: patients sense a false or mechanical attitude that blocks trust building. The placement of the profession and the acquired professional competences in the provision of obstetric care in Bulgaria, according to the requirements of the legislative framework, have a negative impact on the development of patient – midwife relations [27,33,49]. The problem is formed already during the period of study, as students are limited, under the regulatory framework for medical activities, to carry out activities independently with a mentor, including in acquiring practical skills, due to the divergence of practical training and the real hospital environment [31];

- psychological alienation: as a defense mechanism against overload, the midwife begins to depersonalize patients (to perceive them as «cases» or «beds», rather than as individuals).

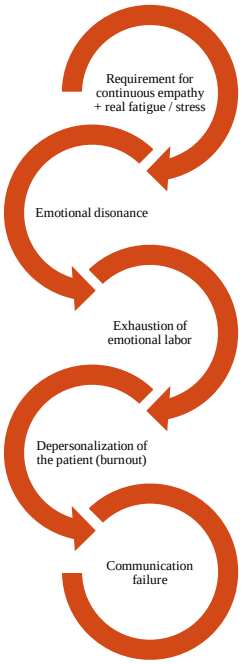

Fig.2. Emotional inconsistency in the communication process

Resource depletion and burnout syndrome (Burnout)

Emotional labor requires a huge cognitive and psychological resource. When the medical establishment does not provide mechanisms for debriefing, psychological supervision or adequate rest, this resource is exhausted [73]. The result is entry into the three phases of burnout syndrome (by Christina Maslach) [45,46].

1. Emotional exhaustion: feeling completely empty and unable to empathize.

2. Depersonalization and cynicism: the appearance of a rude tone, irony, or indifference to the pain of the woman in labor (a major source of communication conflicts) [37].

3. Decreased professional effectiveness: a sense of worthlessness, which further worsens the desire for a full-fledged dialogue.

1.4. Ethical and legal aspects: informed consent and the right to dignity.

Legal and ethical aspects shape the regulatory framework within which obstetric communication takes place [34]. Modern medical law regards communication not just as a matter of good manners, but as a legal obligation of the medical professional. The relationship between the midwife and the patient is legally and ethically regulated.

Communication deficits in the delivery room often turn into legal cases when they violate the fundamental rights of the patient, enshrined in national and international law.

1.4.1. Legal nature of informed consent Informed consent is a fundamental pillar of medical law and bioethics. According to the Bulgarian Health Act (positions 87 and 88), medical activities are carried out only after the informed consent of the patient [*government.bg*]:

- communication process, not form: from a legal point of view, informed consent is not just an act of signing a document, but a two-way communication process (Figure 3);

- mandatory information elements: The Midwife and the doctor are obliged to provide in understandable language data on: the diagnosis, nature and purpose of the intervention, risks, expected results and alternative methods (e.g. options for pain relief);

- emergency specificity: in obstetrics, situations can quickly escalate to life-threatening (e.g. placental abruption, shoulder dystocia). Even then, the requirement for timely and clear (albeit brief) communication remains in place to avoid a woman feeling that she is being abused [24].

1.4.2. The right to respect for human dignity and autonomy International documents such as the European Charter of patients ' rights [government.bg the World Health Organization (who) declares that the right to respect and dignity is paramount at birth:

- body autonomy: every woman has the right to refuse a procedure (e.g. routine amniotomy or forced birth by the Kristeller method). Carrying out manipulation despite the disagreement of the mother or intentionally saving information constitutes a serious offense;

- protection of personal space: communication must be carried out in terms of confidentiality. Discussing intimate medical details in front of bystanders or in shared corridors violates the right to privacy.

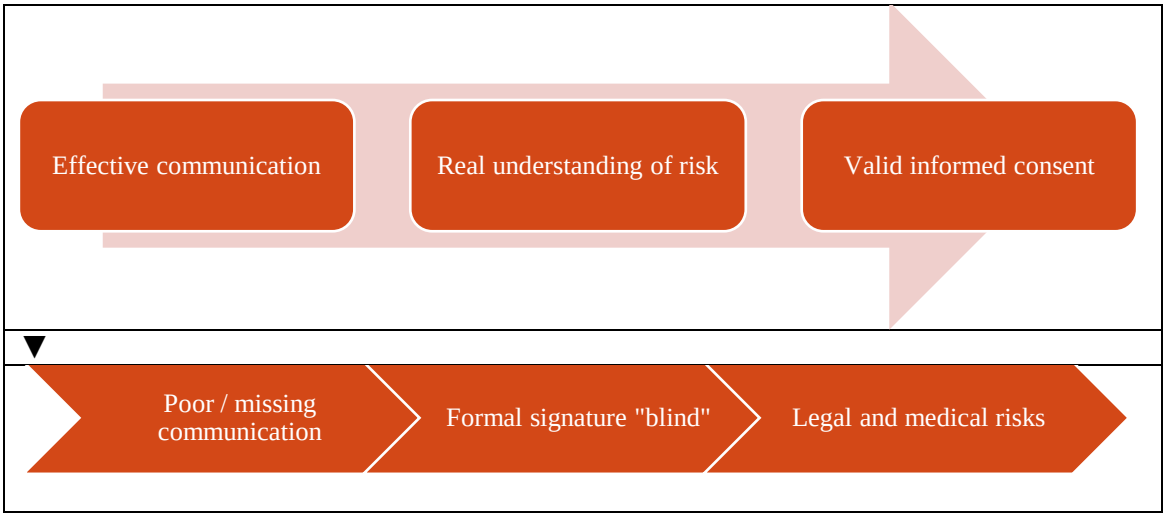

Fig.3. Factors affecting the process of communication between patients and healthcare providers

1.4.3. Obstetric aggression (Obstetric Violence) in a legal context.

In recent years, the concept of «obstetric aggression» has entered medical law. It describes the appropriation of a woman's body and reproductive processes by medical personnel through a paternalistic attitude, abusive tone, or uninformed procedures:

- violation of the code of ethics and rules of good medical practice in the field of communication leads to a loss of trust, which is a leading motive for patients to file medical negligence claims (malpractice);

- statistics show that the majority of complaints against obstetric and gynecological teams are not provoked by technical errors, but by poor attitude, lack of empathy and the patient's feeling that she has been misinformed or ignored.

1.5. Role of training in acquiring practical competencies at Medical University.

Practical training in a simulated and real hospital environment is key to building empathic and effective communication models in future healthcare professionals with pregnant and giving birth women. It helps prospective midwives and doctors master verbal and nonverbal approaches that reduce birth anxiety, and teaches them to adapt their communication style to each patient's individual needs.

Practical training is indispensable and specific, especially in a delicate field such as obstetrics and gynecology, where a woman's emotions and physical condition change in seconds.

Key advantages of practice that are not described in textbooks relate to:

- turning knowledge into a reflex: in an emergency, there is no time to think – the hands and mind must act automatically and synchronously;

- sense of touch and physical contact: the student learns how to touch the mother – when the pressure is too strong, how to inspire confidence just by grasping the hand;

- control of one's own emotions: students learn to suppress their personal fear and panic in order to exude absolute calm and authority over the woman in labor;

- flexibility in communication: in real life there is no «ideal patient» – the practice confronts future specialists with different personalities, language barriers and levels of fear. Mastering empathy and active communication: students learn to build trust, soothe a woman's fears, and support her decisions about childbirth.

Coping with crisis situations: through simulation training (role-playing), future specialists are prepared to respond adequately to complications, panic or unexpected changes in the birth process. Understanding nonverbal signals: the training helps students recognize the body language of the mother (pain, tension, discomfort), which is often more important than words.

Basic communication models in obstetric care in acquiring professional competencies are based on two communication models (widely used in developed European countries).

1. Patient-oriented model (Patient-centered approach): the woman is seen as a partner in the process. Her wishes, fears and preferences about childbirth are discussed in order to make informed decisions.

2. Family-oriented approach: the focus is on overall support for the family. Communication involves not only the woman in labor, but also her partner or companion during labor. Methods of training in medical universities in Bulgaria are carried out by:

- simulation centers: practice real case studies with high-tech mannequins and actors (simulated patients), allowing a safe environment for errors and corrections;

- clinical practice: direct work with pregnant women in hospital conditions under strict supervision and supervision of experienced mentors. Psychological training:

exercises for emotional intelligence, prevention of professional burnout (burnout) and techniques for overcoming stress when communicating with patients in a delicate state.

Leading international simulation centers have long since shifted the focus from the purely technical execution of manipulations to the *integration of soft skills* (*soft skills*) *and psychological support* in the delivery room. They combine high-tech mannequins, actors and structured analysis methods. Innovative practices from international simulation centers that change the training of Obstetrics and gynecology are based on.

1. The model «the four good habits» (Four Good Habits – 4GH). A number of European training programmes for midwives apply a medical model adapted for maternity care. Students are trained through simulation to go through four mandatory steps with each interaction with the woman in labor: [76] Investing in the beginning: quickly build trust (rapport) with the woman in the first minutes:

- extracting the patient's point of view: listening to her specific concerns and expectations about childbirth;

- demonstrating empathy: verbal and nonverbal validation of emotions and pain. Investing at the end: jointly planning the next steps to ensure that a woman feels safe and informed [76].

2. Hybrid simulation. Clean talking on a plastic mannequin seems unnatural to students. Therefore, leading centers in the United States and the United Kingdom use a hybrid approach [71]:

- a live actor (a standardized patient) plays the role of the woman giving birth. He communicates, cries, expresses fear, or asks questions in real time [71, 78];

- a specialized anatomical simulator is attached to the body of the actor (for example, for childbirth or for suturing lacerations). Effect: the student is forced to simultaneously perform complex medical manipulation and maintain continuous eye contact, calm the patient and explain what he is doing step by step.

3. Structured video-debriefing (Video-Assisted Debriefing) The action itself in the simulation room is only 30% of the training; the remaining 70% occurs during debriefing (analysis after the simulation) [71]:

- simulations are recorded from several angles with cameras and microphones;

- after completion, the mentor and students watch the recording. The focus is not on whether the baby was delivered correctly, but on the communication details: «*did you notice that when the woman asked why you put the system, you didn't answer?*“ or «*see how the tone of your voice rose when the patient started to panic – how did it affect her breathing?“* [79].

4. Interprofessional simulation training (IPSE) No one works alone in the delivery room. Centers in the Scandinavian countries and Germany conduct joint simulations involving medical students, midwifery students, anesthesiologists and pediatricians simultaneously [71]:

- the so-called «closed communication» (Closed-loop communication) is trained in emergency situations (e.g. shoulder dystocia or postpartum haemorrhage) [71,78];

- the doctor says: *«midwife Maria, please prepare 10 units of oxytocin*». The midwife replies: *«I prepare 10 units of oxytocin».* He then confirms: *«oxytocin has been injected»*. This prevents errors and chaos in a noisy and stressful environment [76,79].

5. Training on «bad news» and difficult conversations. Some of the most difficult simulations do not involve physical birth, but managing crisis conversations [71,79]. Students are placed in situations such as:

- reporting of unexpected complications with the fetus or the need for an emergency caesarean section that violates the woman's preliminary birth plan;

- dealing with an aggressive or overly anxious partner/escort in the delivery room;

- communication in the most severe scenario-perinatal loss (stillbirth). Students learn how to support a grieving family, which words to avoid, and how to offer psychological first aid.

These world practices are already actively entering Bulgaria through the modern simulation centers of our medical universities (Plovdiv, Varna and Pleven), where the work with high-tech mannequins for normal and pathological childbirth is increasingly relied on.

2. Analysis of the causes of problems and barriers in communication.

Effective communication in obstetric practice is a multifactorial process. Its compromise is rarely an isolated act of subjective reluctance to dialogue. It is the result of the intertwining of institutional deficits, the psychological state of the participants and sociocultural differences. These causes are classified into four main groups.

2.1. Systemic and institutional deficits the institutional environment in medical institutions puts a strong structural pressure on the behavior of the medical staff. The main systemic barriers in Bulgaria are [50,51,59]:

- chronic staff shortage: the acute shortage of Midwives leads to excessive workload (serving too many patients simultaneously in a prenatal and delivery room). This physically limits the possibility of individual attention;

- time pressure and administrative burden: the volume of mandatory medical documentation (birth histories, partograms, consent forms) takes up a significant part of the Working Time. Communication with the patient is often reduced or reduced to an administrative minimum at the expense of filling out documents. Organizational culture and environment architecture: lack of privacy (e.g. common prenatal halls with several beds, separated only by screens) compromise confidentiality. Women are afraid to share intimate information, and midwives are forced to speak in front of bystanders.

2.2. Professional-subjective factors (related to the medical team).

This group covers the factors arising from the preparation, attitudes and current psycho-emotional state of the obstetric staff:

- deficits in medical education: traditional curricula at medical universities emphasize clinical and technical skills, but neglect training in «soft skills», conflict management, and crisis communication;

- information asymmetry and excessive use of jargon: medical professionals often use complex terminology that is completely incomprehensible to laymen. The lack of language adaptation to the patient's educational level blocks the actual exchange of information;

- automation of care and routine: years of experience can transform high-risk processes for the patient into routine and mechanical actions for the team. Performing

manipulations (e.g. insertion of a catheter, abdominal examinations) without prior verbal warning and explanation damages the therapeutic connection;

- professional burnout (burnout): as explained in the concept of emotional labor, burnout leads to depersonalization of the patient. Harsh tone, cynicism, or emotional alienation is a direct manifestation of a depleted psychological resource for empathy [74].

2.3. Patient-centered factors

Pregnant and giving birth are not passive recipients of care; their subjective status also shapes the dynamics of communication:

- acute distress, fear and pain: pain during childbirth triggers the sympathetic nervous system («fight or flight» reaction). This physiological condition narrows the cognitive field of a woman. It has difficulty concentrating, perceives information fragmentary, and may react defensively or aggressively;

- discrepancy in expectations (cognitive dissonance): many women enter the delivery room with an idealized or too specific «delivery plan». When the actual clinical situation requires a change (e.g. emergency medical induction or C-section), a psychological conflict occurs. If the team does not explain the need for change, the patient perceives it as violence or loss of autonomy;

- information noise (influence of the digital environment): patients often come with unrealistic or scientifically unsubstantiated attitudes formed by forums and social networks. This requires the midwife to make additional efforts to disprove myths, which sometimes meets resistance and distrust on the part of the pregnant woman.

2.4. Sociocultural barriers and epistemic injustice.

- language and ethnocultural differences: differences in language, religious taboos, and traditional beliefs about birth and the body can create serious barriers. The team's lack of cultural competence leads to a misinterpretation of the patient's behavior (Fig.4);

- the phenomenon of «epistemic injustice»: this is a specific sociological phenomenon in which the subjective complaints and experiences of a woman (e.g. claims that the pain is unbearable or that she feels something is wrong) are

downplayed or ignored by the team because the patient has no medical training. This asymmetry of power («*we know, you don't know*») is at the root of the worst communication failures in the delivery room.

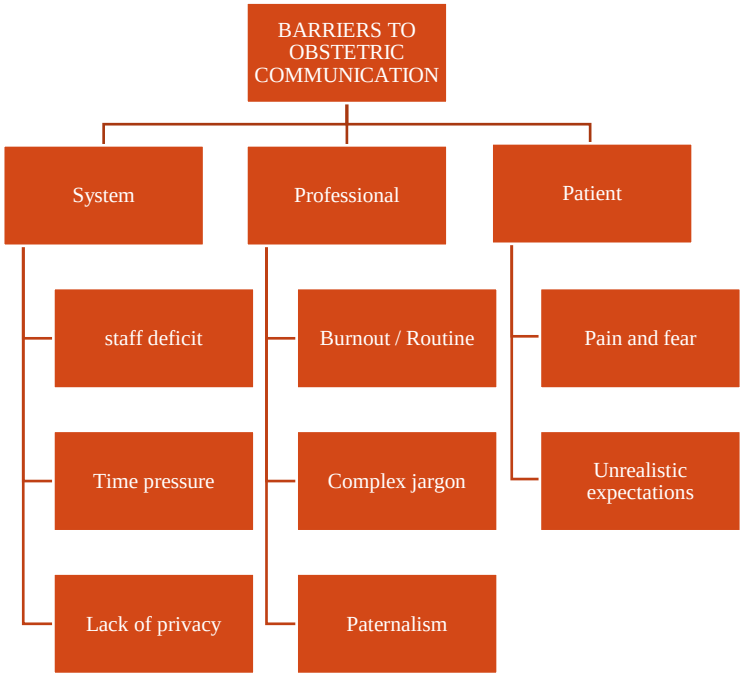

Fig.4. Barriers to obstetric communication

3. Model methodology and organization of empirical research.

The aim of the proposed model is to present the methodological framework, toolkit and organization of empirical research aimed at identifying and analyzing the problems in obstetric communication on both sides of the process – healthcare professionals and patients. Study design and sampling In order to achieve maximum objectivity, the study applies a mixed methodological design (triangulation), combining quantitative and qualitative methods:

- time range of the study: the study is conducted in a defined period;

- subject of study: two independent target groups.

Group A (obstetric staff): midwives practicing in prenatal, maternity and postnatal units on the territory of [Region/hospital].

Group B (patients): women who have given birth within the last 12 months in the respective medical institutions.

- Sampling method: unlikely, quota sample by place of employment (for midwives) and time/place of birth (for mothers). Data collection toolkit For the needs

of the survey, two specialized and anonymous questionnaires were developed, containing closed (with a Likert scale), semi-open and open questions.

4. Strategies to overcome communication deficits.

Overcoming communication problems in obstetric practice requires a multidisciplinary approach. It should combine organizational reforms at the levels of Health Management with the implementation of innovative tools and continuous training of personnel.

4.1. Introduction of standardised communication protocols To reduce the risk of information gaps and misunderstandings in the clinical environment, modern health management requires the application of structured communication models:

- protocol SBAR (Situation, Background, Assessment, Recommendation): This tool provides a clear and concise framework for conveying critical information within the medical team (e.g. from midwife to doctor on duty in case of deterioration of fetal tones) [47,54]. This prevents chaos and delay, which often reflect as a strain on the patient (Fig.5).

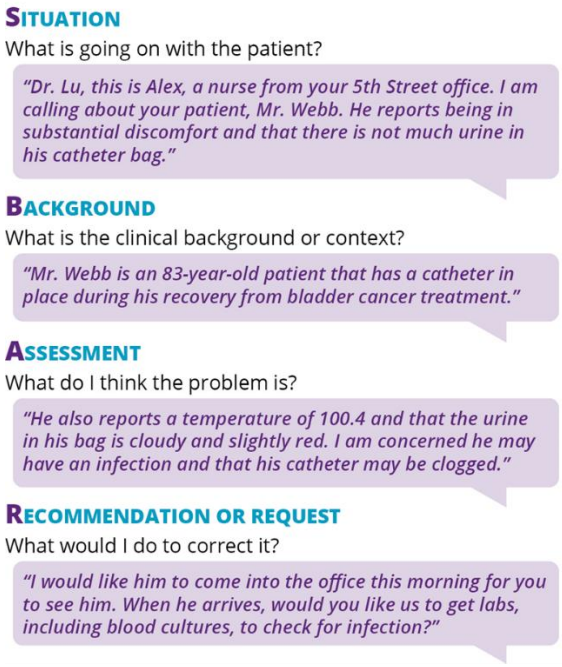

Fig.5. Protocol SBAR

(adapted from the model of AHRQ Department of Health and Human Services)

SBAR is a structured communication protocol widely used in healthcare and other industries for fast, clear and standardized information exchange. The acronym comes

from the English words Situation, Background (Context), Assessment (rating), and Recommendation. Step-by-step protocol includes:

- S – Situation: what is happening right now? Describe the problem briefly and clearly. Example: «*Patient X had a fever of 38.5^{0}C»,* and there was a drop in saturation of up to 90%;

- B – Background: What are the relevant facts? Provide important information about the patient's condition. Example: *«The patient is 65 years old, admitted 3 days ago for pneumonia, does not have allergies to medication»;*

- A – Assessment: What Is Your Assessment of the situation? Summarize what you think is the problem. Example: *«I think the patient is developing respiratory failure»;*

- R – Recommendation: What do you want to do? Propose or ask for specific actions. Example: *«Can you examine the patient and prescribe oxygen therapy or blood tests?"* The protocol helps prevent information gaps, saves time and avoids subjective deviations when transferring shifts or seeking medical attention. You can look at official templates and examples provided by reputable health organizations such as Institute for Healthcare Improvement (IHI) or the World Health Organization (WHO) [76];

- technique of callback: applicable when communicating with the mother, especially when giving instructions on breastfeeding, postoperative care or discharge. The midwife asks the woman to explain in her own words what she has heard (e.g. «*To make sure I've explained clearly, can you tell me how you're going to take care of the baby's pimple at home?").* This eliminates the risk of false consent due to worry or fatigue.

4.2. Institutional programs for burnout prevention Since emotional exhaustion is a major source of communication aggression and alienation, hospitals must provide psychological protection for their staff:

- introduction of Balint groups: regular sessions with a specialist psychologist in which midwives can share and analyze severe or emotionally burdensome clinical cases from their practice without fear of judgment;

- optimizing work schedules and ergonomics: reducing overtime and providing secure rest areas where staff can recover their resources for «emotional work» while on duty.

4.3. Continuing medical training (PMO) in «soft skills» (Fig.6).

We need to transform the approach to midwifery qualification through the inclusion of interactive trainings:

- simulation training with actors: playing scenarios with «difficult» patients» (e.g. a frightened mother, a partner with aggressive behavior or bad news) in a controlled environment. This helps build muscle memory for empathic and calm tone under pressure;

- training in Trauma-Informed Care: Training the staff to recognize the signs of previous psychological trauma in the patients and to adapt their body language and words so that they do not revictimize the woman during examination or childbirth.

4.4. Optimizing the physical environment.

Providing architectural privacy: reconstruction of prenatal halls into individual boxes. This guarantees the confidentiality of the obstetric interview and removes the barrier of shame in the woman giving birth.

STRATEGIES TO IMPROVE COMMUNICATION		
Clinics • SBAR protocol • Teach-Back method	Psychological • Balint groups • Prevention of bulnaut	Educational institutions • Simulation trainings • Soft skills

Fig.6. Strategies to improve communication

Discussion

The analysis of various publications reveals a deep causal relationship between the organizational workload of the obstetric staff and the quality of communication with the patient. In order to verify these findings, it is necessary to analyse them in the context of the existing scientific literature.

1. Systemic pressure on the quality of communication.

The finding that chronic time shortages and staff shortages are leading barriers to full-fledged dialogue perfectly coincides with large-scale international analyses. In an actual study of the *Amoah et al.* (2024) it has been shown that intensive schedules and physical exhaustion of medical personnel are the main determinants impeding therapeutic communication [1]. When a midwife serves several women in labor at the same time, the time for conversation is reduced to an administrative minimum. This confirms the study's first working hypothesis: communication failures are often not a matter of personal choice or lack of upbringing, but of structural institutional pressure.

2. Emotional dissonance and burnout as a destructive factor.

A review of the literature and existing studies show that burnout levels among obstetric staff correlate directly with the use of a colder, mechanical, or paternalistic tone. This conclusion is strongly supported by the multicentre survey of the *Papadopoulos et al.* (2021), conducted in 17 countries [2]. The authors found that when clinicians are overworked and focused solely on completing administrative tasks, they develop depersonalization of care. In this context, *Hochschild's* theory of «emotional labor» [29,30] explains why, in the absence of institutional support mechanisms (such as superintendents or Balint groups), midwives begin to use passive-aggressive or cynical behavior as an unconscious defense mechanism for self – preservation-a phenomenon extensively studied by and in detail (2004) in obstetric practice [3,37,45].

3. Psychosocial consequences for the mother: risk of PTSD.

Data from patient satisfaction studies show extremely high sensitivity of women to nonverbal communication and tone during childbirth. This result is exactly in line with the World Health Organization's (WHO, 2014) definition of «Disrespect and Abuse» during childbirth in hospitals [4]. In the long-term research of the *Ayers et al.* (2016) it has been shown that feeling out of control, rough treatment and misinformation in the delivery room act as a leading psychological trigger for the onset of postpartum post-traumatic stress disorder (PTSD) [5]. This scientific fact underlines that communication in obstetrics has a direct clinical impact on the mother's mental health, and is not just a matter of courtesy. Explorations of the *Madula et al.* found that when midwives showed warmth and respect, patient satisfaction increased sharply,

while verbal aggression and refusal to answer questions permanently damaged the perception of quality of health care [1, 2]

4. Information asymmetry and marginalized groups.

Discussion of the results confirms that the use of complex medical jargon increases the feeling of helplessness in patients. The latest reports of the 2024 NICE (National Institute for Health and Care Excellence) underline that communication remains one of the most common occasions for formal complaints in medical institutions, as patients are not provided with information in a way that they can understand it in a real way [6]. Studies on vulnerable groups (e.g. (2022) they also found that medical professionals often make incorrect assumptions and do not make sufficient efforts to adapt their language to a woman's educational level or specific needs, which compromises the informed consent process [7].

Table 1

Comparative matrix analysis of scientific findings

Source	Leading communication problem	effect
Amoah et al. (2024)	Heavy work schedule, documentation and lack of time.	Reduces the therapeutic effect of care.
Papadopoulos et al. (2021)	Focus on tasks, lack of leadership skills and support.	Development of cynicism and depersonalization of the patient.
Ayers et al. / C3O (2016)	«Disrespectful care» neglect of the mother.	Psychological trauma, risk of postpartum psychotic disorders-depression, panic attacks, emotional imbalance, and other disorders of mental state and perception
NICE / CQC Report (2024)	Lack of clear language and time for questions.	Formal consent, increase in official complaints.
Current Factor Study	The intertwining of burnout, personnel deficit and epistemic injustice.	Staff shortages lead to an accumulation of tension, risk of obstetric aggression, clinical errors and legal claims. Bad architecture does not predispose an individual approach. Lack of good preparation leads to prolonged adaptation and time to adapt

Problems and barriers for midwives in Bulgaria when working in hospital structures

The main barrier to midwives in Bulgaria is the deep staff shortage and the lack of professional autonomy in hospital structures. While government statistics sometimes

report a «sufficient» number of staff on paper relative to the declining birth rate, the reality in hospitals shows a critical shortage, aging staff and strong pressure on workers by the organization (internal organizational levels of strong division of Labor and poor pay) and normative (lack of autonomy, lack of established rules and protocols for work, unclear standard of health care that does not protect specialists, normative framework dealing only with doctors). The specific problems and Barriers are structured in the following areas:

1. Staff crisis and overload:

- severe staff shortage: according to a number of information sources (Bulgarian Association of health care professionals (BAPS), the system lacks thousands of midwives for the normal functioning of AG and neonatal units;

- ageing staff: the average age of midwives in Bulgaria is between 49 and 50, and many of them work beyond retirement age to fill schedules. Burnout syndrome: due to a lack of Staff, midwives are massed on off-duty and work in more than one place, resulting in physical and mental exhaustion;

- lack of young staff: most new graduates do not stay in the profession in Bulgaria or go abroad directly due to poor working conditions, non-recognition of the profession,

2. Financial and administrative barriers:

- low basic pay: despite the regulated collective agreements, in many municipal and state hospitals the starting salaries remain close to the minimum for the country, which demotivates specialists. Lack of adequate pay for a profession regulated by the state, especially after the introduction of the euro in the country, the basic salary does not reach 600 euros;

- dependence on clinical pathways: funding hospitals through the National Health Insurance Fund forces managers to prioritize doctors who «carry» the pathways, leaving midwives in the position of low-paid support staff.

3. Professional status and lack of autonomy:

- strict medical hierarchy: in Bulgarian hospitals, the medical model is strongly dominated. The Midwife is rarely perceived as an independent specialist who can lead a normal (physiological) birth, although she has the legal qualification for this;

- limited functions: their activity is often reduced to performing medical appointments, administrative work, filling out documents and technical tasks, instead of actual obstetric care and support for the mother;

- lack of obstetric model: unlike Western Europe, we lack a working model for continuing care, where a midwife follows a woman from pregnancy, through childbirth to the postpartum period.

There are no professional protocols and uniform guidelines for the performance of routine activities to ensure the legal certainty of the tasks performed. All activities are not documented in the framework contracts for the implementation of medical activities. There are no guidelines of the National Health Insurance Fund regarding the volume and concurrent health care, there are no written requirements for Health care in the Medical standard in Obstetrics and gynecology, there is no possibility to take into account the actual activities of midwives in carrying out the work tasks and providing medical care to patients.

4. Problems in communication and organization (context of SBAR) If you are researching the topic to improve the working environment, share: are you focusing on training in effective team communication, or are you looking for solutions to reduce the administrative burden on midwives:

- impaired communication «doctor-midwife»: the lack of standardized tools for the transfer of information (such as the SBAR protocol) often leads to misunderstandings, delayed responses to emergencies, or errors in the transmission of shifts;

- lack of time to transmit information: due to the huge amount of work and time constraints, medical reports are made in haste, often missing critical Background or clear Recommendations for Action (Assessment);

- intra-hospital pressure: midwives often feel insecure to express their own assessment to the receiving doctor for fear that their opinion will be downplayed due to hierarchical barriers.

The scientific literature unequivocally confirms that overcoming barriers in obstetric communication requires a transition from individual criticism of individual personnel to systematic organizational reforms. Training in «soft skills» and the introduction of communication protocols are critically needed to reduce clinical and psychological risk in delivery rooms.

Conclusion And Conclusions

The review of the scientific literature examines one of the most critical but often overlooked aspects of modern obstetrics – the quality of verbal and nonverbal interaction between the obstetric staff and the patient. The evolution of medical models strongly proves that effective communication is no longer a matter of subjective «good tone», but a fundamental clinical, ethical and legal determinant of the safety and quality of health care. Based on the theoretical analysis and methodological design, the following main conclusions can be formulated.

1. Multifactorial nature of communication failures: problems in the delivery room are rarely due to an isolated reluctance to dialogue. They are a direct result of institutional pressure (staff deficit, time deficit, administrative burden) and lack of systematic training in «soft skills» in medical universities.

2. The role of professional burnout (burnout): the depletion of the resource for «emotional labor» leads to depersonalization of the patient. The harsh tone and paternalistic approach are often triggered as an unconscious psychological defense mechanism on the part of the exhausted obstetric staff.

3. Reproductive vulnerability as a communication challenge: the specificity of the obstetric patient (pain, fear, psychological regression) requires the application of a specific type of communication. Lack of empathy and respect for Body Boundaries exacerbates psycho-emotional trauma in mothers, which is a leading cause of postpartum depression and medical malpractice claims.

4. The need for System Solutions: change cannot be limited to personal recommendations. It requires the introduction of standardised clinical communication protocols (SBAR, Teach-Back), psychological support for staff (Balint groups) and architectural provision of privacy in medical institutions.

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