Obstetric handling of a deaf patient

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ABSTRACT

We report our experience of obstetric handling of a deaf pregnant patient antenatally, in labor and postpartum. The patient was deaf from childhood. The attending obstetrician had no training in the necessary skills for communication with the deaf. Fortunately, the patient could read and write English very well and communication was carried out through pen and paper. This proved to be difficult, time-consuming and required a lot of patience. The clinical, psychological and human aspects of the management were gratifying. The patient brought up interesting aspects that need to be considered when dealing with similar patients. Experience of deaf mothers and their ingenious approaches in dealing with babies, in the postpartum period, are quoted in this communication.

Keywords: Obstetric, handling, deaf, pregnant, patient, communication.

Case Report. A 30 year old Saudi lady, deaf since she was 4 years of age due to childhood meningitis, presented to the accident and emergency department of the King Khalid University Hospital, Riyadh, Saudi Arabia in labor at term. She has been married for 12 years to a deaf husband who is not her relative. She was gravida 2 para 1. Her first 4 year old daughter was delivered through lower segment cesarean section at 38 weeks gestation in Al-Madinah-Al-Monawarah Hospital, Saudi Arabia, because of placenta previa. Her blood group was AB rhesus positive, she was rubella immune and all other booking investigations were normal. She has had 5 uneventful antenatal visits. It was noticed during the antenatal follow-up, that she reads, understands, and writes English perfectly well. She had 2 ultrasound scans. The first was at booking and agrees with her dates. The second ultrasound carried out, when she was 38 weeks by her dates, on March 1, 1999, showed a single, normal, live fetus with a biparietal

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Post-partum follow up. Six weeks postpartum, the same doctor who attended the delivery saw the patient in the follow-up visit. Again a written dialogue was carried out. The patient was advised about her baby-care, postnatal exercises, and family planning. She was also asked to write her impressions and suggestions about the care she had received during her pregnancy, labor and delivery. She stated that “some of the care was good and some was not-so-good”. She was generally embarrassed by the communication difficulties. She wished she had been seen by the same team every time she came to the hospital during her antenatal visits, and during subsequent management. She was especially annoyed when she almost missed her appointment one day while she was physically waiting to see the doctor. The reason was that she did not hear the nurse call her name and she was taken for no-show. Later she complained about the delay and discovered the problem. She wished people would recognize her problem and act accordingly. “Why didn’t the nurse write my name on a sign board or something?” she demanded. “Why doesn’t the hospital provide sign-language interpreters?”.

**Discussion.** Pregnancy, labor and delivery are physiological but distressful situations. Tender loving care and patience in communication are essential for all patients in labor. This is even more so for handicapped patients, particularly so if they are deaf. Much more time and effort are involved in caring for deaf than for normally-hearing patients. Deafness is a deficiency that none of the health-care providers that managed this patient had any prior knowledge in dealing with. Fortunately, our patient was fluent in reading and writing English. The written English dialogue used during the care of this patient was time-consuming and laborious. However, the results were gratifying. The views expressed by the patient were simple and of common sense. Yet it is surprising how simple things can be missed in the provision list of a hospital. Deaf patients more than others, need continuity of care in one to one clinic nursing, and to be seen by the same doctor each visit, so as to develop sufficient rapport, confidence and skills in communication. When the patient comes to the clinic she needs a companion who hears normally so that the patient responds when her name is called. Alternatively, she should be allowed to walk-in. This is mainly to avoid embarrassing the patient by showing she is deaf whenever she visits the clinic. On calling her name the clinic nurse should not obscure her face by the file to facilitate lip reading. Other factors that impair lip reading are accents, speech impediments, fingers, pencils, dim lighting, bright background lighting and situations involving more than one or 2
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Figure 1: (a) Crying sign in Arabic sign language. (b) Question sign in Arabic sign language for What, Why, Where and How.

Figure 2: (a) Crying sign in American-Indian sign language. (b) Question sign in American-Indian sign language for What, Why, Where and How.

Figure 3 - (a) “Me” (b) “Adult” (c) “his and her’s” (d) “you”.

Figure 4 - Arabic alphabet fingers spelling signs.
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In the written dialogue with a deaf patient, it is important to use simple plain language and avoid medical terms as much as possible, as was carried out in this case. Writing is time consuming and therefore inhibits facile communication. If available, a special interpreter for the deaf would therefore be preferable. Ideally each clinic should provide an interpreter who can communicate with deaf patients. Sometimes companions who know how to communicate with the patients may be very helpful. The fact that the patient is deaf, and the best possible means of communication with her, should be clearly written in the patient file and her cooperation card. This information made life easy when our patient was first seen in the labor room by the on-call attending midwife and the doctor. The management of labor in deaf patients requires a midwife who understands the aforementioned means of communication. Symptoms may not be expressed well by the patient, especially if the patient is also mute (due to childhood deafness). We had to depend on clinical signs rather than symptoms, for the most part, in suspecting or detecting problems to the mother or fetus. For this reason, in the first stage of labor, the patient needed continuous electronic monitoring and a partogram. During the late 2nd stage, it is recommended that deaf patients need 2 midwives; one to pass-on the instructions with her face up for the patient to see and the other to conduct the delivery. In the postpartum period, family help is crucial. Fortunately our patient lived with her parents in-law. A community midwife and a social worker are essential members of the caring team and they need to develop some communication skills with the deaf. In the postpartum period, deaf mothers may not wake up and respond to the needs of their babies. However, one patient who had twins, mentioned that she “sensed her babies’ needs” and instinctively woke up in exactly the right time. The same patient said that her husband (an electrical engineer) designed for her a light-system that flashed whenever the baby cried. The role of the social worker and community midwife is to try and provide such a device. The husband can be of great help if he is not deaf. The forms of communication with the deaf include Arabic sign language Figure 1A and B, American/Indian sign language, Figure 2A and B, vocalization, lip reading, head eye movements, facial expressions and hand gestures Figure 3A, B, C and D. Other useful forms of communication and learning for the deaf is finger spelling with the use of Arabic alphabet Figure 4 and English alphabet.

In conclusion, the obstetric care of a deaf patient is challenging. It needs a consistent team of the same doctors, clinic nurse, midwife, social and community workers. The ideal home environment is also essential. Labor should be a pleasant experience. Without the ability to communicate properly, the labor experience will be horrifying and frightening particularly so to deaf patients.

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