WHAT CAN I DO RIGHT NOW?

Reflect on your current practice. Are there any areas where you are highly emotionally attached to a certain decision? Are there any particular memories from past experiences that cause you to unduly want to pressure a person into a particular decision? If so, can you think of ways to help you provide information in a more unbiased way?

Begin to utilise resources that help to convey information for common interventions such as '
Choices When Pregnancy Reaches 41 Weeks'

Think about communication strategies you could use, if you observe a colleague unknowingly trying to put pressure on a person to make a decision. What could you say to them in the moment? Could you ask them to step out of the room for a discussion? Could you act as an advocate for that person and open up the dialogue to give that person space to speak up? See e-Learning for Healthcare (2019) for further guidance.

FURTHER READING

- e-Learning for Healthcare (2019) 'Freedom to Speak Up'
- Birthrights (2017) 'Consenting to treatment'
- General Medical Council (2008) 'Consent: patients and doctors making decisions together'
- Nursing and Midwifery Council (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'
- General Medical Council (2008) 'Consent: patients and doctors making decisions together'
- Hall WA, Tomkinson J, Klein MC (2012). Canadian care providers' and pregnant women's approaches to managing birth

Coercion in healthcare is using one's position of power to pressure someone into making a decision they may not otherwise make.

Working with pregnant people means that we have the additional risk of using the health of the unborn baby to sway someone into accepting a certain plan of care. It can be easy to use emotive language, such as 'increasing your risk of stillbirth' or 'causing harm to your baby' to elicit a response that is in line with what we believe is the best course of action.

We must also be aware that 'decreasing the risk' doesn't mean eliminating the risk altogether and we should always strive to share such information with adequate quantification (e.g. decreases the risk from 5 in 1,000 births to 2 in 1,000 births) and where possible pictorial representations of those figures to further help understanding.

This is not only important as it is part of both NMC (2018) and GMC (2008) guidance but it has a huge impact on patient experience.

KEY POINTS

- Both midwives and doctors are bound by their councils to tell the people under their care the benefits and risks of each proposed option, including the option of doing nothing. They must then respect the decision that person makes, even if they do not agree with it.

- In order to give consent the person must be well-informed and must not be pressured or bullied into giving their consent (Birthrights, 2017). This includes forcing repeat discussions of the risks, using family members in an attempt to sway the decision and suggesting a referral to social services. In these instances, informed consent would not be deemed to have been given.

- There is also a known but often unspoken-about culture within maternity care, whereby a healthcare professional may put pressure onto a pregnant person by "pulling the dead baby card" (Hall, 2012). This means simply stating that the baby could die, whether or not this is true or likely. This is never acceptable and must not be allowed within maternity care.