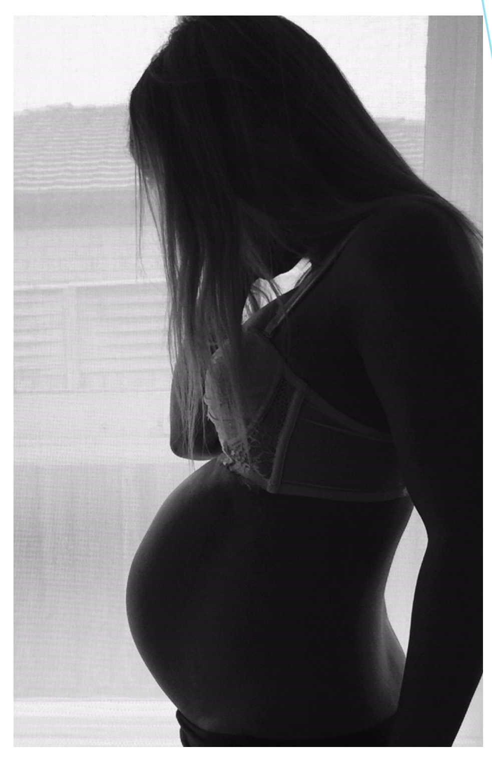
#Empowomant

Empowering women to make decisions about their clinical care



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Overview

- Designed to make you think and perhaps question your current approach
- Aim to identify and make you aware of conflict and issues that can arise when 'guiding' women in their clinical care
- Wont necessarily give you solutions!
- In the context of obstetrics for this talk

A clinical case

- G4P3
  - G1 – Caesarean for failure to progress and fetal distress at 6cm
  - G2 – Elective repeat caesarean
  - G3 – Elective repeat caesarean
  - G4 – Current pregnancy requesting Vaginal birth after caesarean

- You think that an elective caesar is the safest option for her and her baby based on evidence and your experience
- She had a very traumatic experience in her last birth and does not want another caesar

Patient experience

Perceptions are important

- Forceps
- Normal Birth

- Emergency Caesarean

Paternalism

/pəˈtəːn(ə)lɪz(ə)m/

noun

the policy or practice on the part of people in authority of restricting the freedom and responsibilities of those subordinate to or otherwise dependent on them in their supposed interest.
"attitudes in society reinforce a degree of paternalism among doctors"

- Standard practice in medicine until 1956 (Szasz and Hollender)
- *Activity—passivity* refers to the traditional version of paternalism, in which the doctor treats the patient as one who cannot or should not make decisions.
- *Guidance—co-operation* is a relationship used in more long-term situations. The doctor provides instructions to the patient, to which the patient is expected to comply.
- *Mutual participation* involves the physician making it clear that he or she is not infallible and does not always know what is best. This model is more of a partnership, in which the doctor helps the patient to help him or herself.

Personal judgment and values

- ‘I don’t agree with abortion, so you cannot have an abortion’
  - Seems ridiculous?

Informed consent

informed consent

phrase of consent

permission granted in full knowledge of the possible consequences, typically that which is given by a patient to a doctor for treatment with knowledge of the possible risks and benefits.
"written informed consent was obtained from each patient"

- Full knowledge
- Possible consequences
- Possible risks and benefits
- Knowledge of alternative options
- Media

How much to tell a patient?

- Consenting for a Caesarean
  - Mention common risks
- 'Material' risks
  - What might be considered important by that person
- Everything?

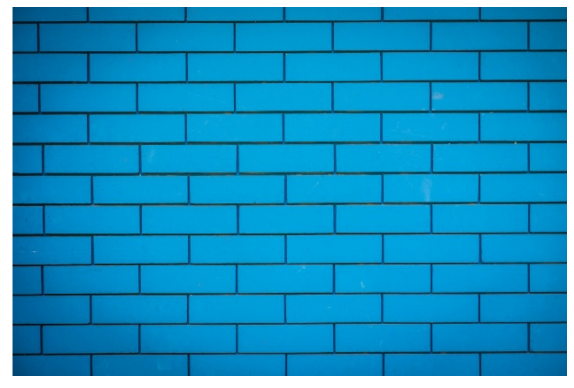
What if they choose something you don’t think is in their best interest?

- Paternalism
  - How do you really know what is in their best interest?
- Non maleficence
  - First do no harm
- How might you approach this?
  - Should you ‘convince’ them of your standpoint?

So how do we empower?

- Knowledge is power
- Inform, inform, inform
  - Seems easy right?
- If the patient makes their decision with ALL information that you have, they have control
- DEBRIEF
- So why don't we tell patients everything they need to know (and not just everything *we think* they need to know)?

Barriers



Clinician's Point of view:

- Time
  - 'I don't have time to teach you everything I know'
- Belief of Ignorance
  - 'Even if they know, they won't make the right decision'
- Arrogance
  - 'I have studied for longer than them, therefore I know better'
- Submissive
  - 'I will do whatever you tell me, Doctor'

Breaking barriers

Clinician's point of view:

- (Time) Timefull
  - 'Why don't we continue this discussion next week, after we have a chance to think about things a bit more?'
- (Ignorance) Understanding
  - 'It is a difficult decision, but it is yours to make'
- (Arrogance) Humility
  - 'It is your right to choose, I can only give you the information'
- (Submissive) Honesty
  - 'I would recommend this because of these reasons, but ultimately it is your choice'

Case

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Case

- What information do you give her?
  - All the risks, likelihood of success
  - Recommendation and why
- What do you advise?
  - Based on evidence, recommend caesarean
  - If she still wants a vaginal birth
    - Needs to be done as ‘safely’ as possible
- What do you do?
  - Negotiate

Summary

- Patients are allowed to make ‘bad’ decisions
- Be aware of the patients perceptions when discussing management options
- Dispel myths
- Be aware of your own values and opinions when discussing management options

Questions?

A brief history of Victorian women

Year	Event
1891	Age of consent raised from 13 to 16 yrs
1908	Women’s vote in Victoria
1969	First abortion rights granted
1972	COCP widely available
1973	Paid maternity leave
1983	International Bill of Rights for Women
1990	First female Premier
1995	Sexual harassment outlawed
2008	Abortion decriminalised
2010	First female Prime Minister
2015	Royal commission into family violence
2017	Launch of Women’s AFL