Institutional leaflets

AIMS Journal, 2017, Vol 29 No 2

Yolanda Forster looks at the difference between communication and manipulation

Antenatal literature is now available on the websites of many hospitals making them a window from which parents can access information about the services which are on offer. This method of sharing may be cost effective for hospitals, could provide visually attractive and possibly comprehensive information while avoiding the high cost of printing and distributing the same information in a range of leaflets. These booklets also potentially assist the hospitals in providing information that is *'centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.'*[1]

Previous research on patient information booklets has found that service users often ignore these leaflets for many reasons, which include the text being inaccessible due to low literacy skills, or alternatively, that those with high literacy levels find them to be patronising. Remarkably, research has also shown that that medical staff expect them to be ignored! The evidence on patient information literature focuses on the needs of the medical staff to provide enough information to achieve compliance to the treatment they propose rather than to focus on informing people, in this case typically healthy individuals who are experiencing a normal life event, to make personal decisions.

Booklets being accessible online makes for easy sharing within women's immediate social circles and with wider communities on social media and parenting message boards. As they can be shared they become potentially powerful documents in the impact they could make in the community. The language which is used is therefore worthy of critical analysis to illuminate the messages which they carry. Information can be revealed, hidden, and ignored in order to confer power to an institution or to individuals. Institutions and their agents, in this case the maternity units and the staff of consultants, midwives, radiographers and so on, are privileged to information which they reveal in ways which may prioritise the institution's interests over the interests of its users and indeed sometimes even its staff. Scholars of critical discourse studies (CDS) are 'committed to social equality and justice' and 'specifically interested in the discursive (re)production of power abuse and the resistance against such domination'[2] in real life settings, making the language of birth a topic ripe for CDS examination.

Ambiguity in language: risk

The word 'risk' is used routinely in antenatal language in peer to peer conversations and in maternity appointments. 'Risk' is also routinely used without clarity in definition as there is a layperson's definition

but also a legal one which is defined by the Health and Safety Executive (HSE).The HSE definitions of 'risk' and 'hazard' are frequently conflated in everyday conversations and this conflation is evident in antenatal language. Using the definitions provided by the HSE, pre-eclampsia, for example, is a hazard, that is, a condition or situation in pregnancy in which there is a risk, a probability, of injury.[3] Conflation of meanings outside the HSE definition becomes more problematic when the definition of risk includes hazard and 'liability', as one hospital's risk management strategy does.[4] Liability is entirely outside the scope of the HSE's legal definition of risk.

The Pregnancy Information booklet available online from City Hospital Sunderland[5] states, '*If you are medium risk you will be advised to deliver in Hospital.*'

In the quote, the hospital has labelled women as high, medium, or low 'risk'. Following the ambiguous definition of risk that is used by City Hospital Sunderland,[4] the woman is now designated as a hazard by the hospital. This conflation of terms also aligns with the common definition as seen in the Oxford English Dictionary which states, 'a person or thing regarded as a threat or likely source of danger.' Women then conceptualise this statement in antenatal literature and conversations with healthcare professionals as '*I am high risk.*' Instead of, '*I have a condition which increases risk in my pregnancy.*' In this statement there is no room to recognize that women in fact have a temporary condition which presents a complexity in her care and which can usually be mitigated with skilled care and monitoring. Instead, by conflating the definitions of a hazard and a risk with that of liability, her personhood is further threatened as her entire being is negatively objectified and she is now viewed as a potential liability to the maternity unit's interests.

The absence of language that supports her well-being reinforces the unbalanced approach to the information within the booklet. This focus on risk-based narrative contributes to feelings of anxiety that women experience and which further marginalises the woman and her ability to achieve informed consent. The midwife's role as 'with woman' is compromised as she is the representative of the hospital whose role is now to manage the 'risks', that is, manage the woman in order to reduce the hospital's liability rather than assisting a woman to make the decisions she wants for her care. During antenatal appointments, some maternity staff find ways to compensate for the paucity of workplace language that supports well-being and informed consent while reducing anxiety, however these practitioners are often taking the initiative without the explicit support of the workplace – and, sometimes, actively against it.

Leaflets – What they offer and what they tell you!

'The following observations will be offered to you:

- *'Listening to your baby's heart rate every 15 minutes until you are fully dilated, this will be every 5 minutes once you are fully dilated.*
- *Your vital observations will be taken as follows- Pulse rate hourly at a minimum, blood pressure four hourly at a minimum, and temperature 4 hourly at a minimum.*
- *'Vaginal examinations are usually offered at 4 hourly intervals.*[5]

While every aspect of maternity care is optional, the vast majority of women are unaware that they can decline any care which is offered by maternity services without compromising their rights to other support and care. The increasing social media chatter about care being optional may be a reflection of why the booklet discusses this aspect as an offer. While text that discusses physical observations is careful to state that these are offers, the language that surrounds this offer does not convey the fact that physical monitoring can be declined. The omission of information about declining a procedure reinforces a cultural perception that a course of action is more a prescription than an offer. Within the technocratic language of the text there is little opportunity to discuss making decisions which are personalised to the woman. This bias adds weight to the already powerful cultural norm to acquiesce to what a health professional offers. The surveillance of the woman's body and her cervix is representative of the surveillance of birth regardless of place of birth.

Looking at the words used, there is no actual person who is under taking the actions which are 'offered'. The midwife is disembodied and the woman is a passive recipient, erasing the woman as the person who is actually the one giving birth. The clinical vocabulary transfers institutional language into the birth setting, a normal life event regardless of where it occurs. Information gathering gains privilege to protect the institution's interests in the event of a legal dispute and takes primacy over the ancient midwifery skills of quiet attentiveness: listening, observing, intuition, and harnessing knowledge of midwifery experience. These ancient skills are not easily documented on paper notes and are excluded from the institutional birth story. A birth attendant is expected to 'do birth', but doing birth is more likely to bring intervention while doing 'nothing' opens the space for a woman to 'do birth' the way her body is designed to work.

Special Information

'*Once the baby is delivered and the midwife has finished providing care, you may remain at home and enjoy this special time as a family. It is essential that at some point the baby has a neonatal check performed by a member of the neonatal team, to minimise impact on your family time the neonatal unit have agreed that the neonatal check can be completed within 48 hours.*'[5]

The booklet states that the Newborn and Infant Physical Examination (NIPE) is 'essential' rather than the fact that this examination is an offer which can be declined, done by someone else or done in the home. It is worrying that the text regarding the NIPE Screening misleads parents into construing that the responsibility for the screening test lies with the parents. Instead of using language which fosters understanding of the goals of the test, parents are misled into believing that they are obliged to complete the NIPE. This is accomplished by an appeal to the authority of the 'neonatal team' and suggesting that the team has 'agreed' to a 48 hour window so that the family can enjoy this 'special' time at home. Seeing that birthing at home is the historic and prehistoric norm, the co-opting of hospital birth as the norm obscures the fact that nothing is special about home birth. It is an ordinary life event that unfolds in unexceptional settings.

Linguistic analysis of the text, '*the neonatal unit have agreed that the neonatal check can be completed within 48 hours*' confers decision-making rights from the parents to the neonatal unit. Furthermore, the text applies emotional pressure for parents to comply with a deadline well within the 72 hour range which Public Health England sets for hospitals. It is worth reflecting on the possible reasons that a hospital has decided to mislead parents regarding this aspect of the test.

Another example of misinformation in a booklet where emotional pressure on parents is applied was uncovered while conducting research for this article.
It states in italics: '*Please note that it is illegal for any person to deliver a baby other than a registered midwife or medical practitioner, or student midwife or medical student who is being supervised by a midwife or doctor, unless in an emergency,*'[6] alluding to the Midwifery Act 1902 to imply incorrectly that lay individuals present at a birth could inadvertently practice midwifery without a licence. This type of misinformation creates needless anxiety at a time which is already fraught with change and insidiously obstructs parents from making an informed decision on place of birth. While the booklet quoted above has been removed from the website,6 a leaflet from which it probably derives its provenance remains active.[7]

A more detailed review of the language in antenatal booklets would be useful to discern the patterns of language in the literature given to women. Language matters since it reinforces ideas in the public consciousness as well as creating the discourse through which midwives and women enact their roles.

Yolanda Forster

Yolanda is a modern foreign languages teacher with an MA in Applied Linguistics. Her interest is in the analysis of the language of home birth information.

References

1. NHS England (2016) National Maternity Review: Better Bir ths Improving Ser vices for Maternity Care in England.
2. Van Dijk, T. (2015) Critical Discourse Studies: a Sociocognitive Approach in Wodak, R., Meyer, M. Methods of Critical Discourse Studies. 3rd Edition. Sage.
3. Health and Safety Executive (HSE) (2001) Reducing Risk Protecting People. Available at: www.hse.gov.uk/risk/theor y/r2p2.pdf.
4. City Hospitals Sunderland (2014) Risk Management Strategy 2014- 2017 pp 3-4. Available at: chsft.nhs.uk/wp-content/uploads/2013/06/RM1.RMS_.V7-Risk- Management-Strategy-September-14.pdf.
5. City Hospitals Sunderland (2016) Pregnancy Information. Available at: http://chsft.nhs.uk/wp-content/uploads/2013/05/LP106106-Pregnancy- Info-and-Bir th-Plan.pdf.
6. Shrewsbury and Telford Hospital NHS Trust (2014) Pregnancy Information. Available at: www.sath.nhs.uk/Librar y/Documents/maternity/100692%20ShrewTelf%20PregInfoBook%20Final%20version.pdf (Now deleted from the internet).
7. Shrewsbury and Telford Hospitals (2015) Homebir th available at: www.sath.nhs.uk/wp-

content/uploads/2016/09/Home-bir th-v4-October- 2015.pdf.