

## TRANSFORMING CONSENT IN MATERNITY CARE

**Report of the 11/10/17 Birthrights seminar, hosted by Green Templeton College Oxford as part of the Sheila Kitzinger Programme**

### Background

Founded in 2013, the human rights in childbirth charity Birthrights is led by a board of midwives, doctors, lawyers and service users united by the belief that all women are entitled to respectful maternity care that protects their fundamental rights to dignity, autonomy, privacy and equality.

Pregnancy and childbirth are a critical time for women and their families. Their experience of maternity care can empower and protect or cause damage and trauma. Maternity care engages fundamental human rights and provides a unique opportunity to engage with families from all backgrounds to ensure not only physical and emotional safety during pregnancy and birth, but also offer the optimal start to parenting and childhood.

Many women do not receive respectful care or choice in childbirth but those experiencing severe disadvantage will suffer disproportionately. Women in this group are less likely to access maternity care (and receive less maternity care overall), have poorer maternal and infant outcomes and are more likely to experience perinatal mental health problems.

We use our legal and healthcare expertise to:

- Tackle injustice on the frontline and empower the vulnerable: providing free advice to individual women, families and health care professionals on safe, quality, respectful maternity care
- Share knowledge and uplift frontline work: providing healthcare professionals (particularly midwives and doctors), frontline voluntary sector organisations and vulnerable communities with tailored human rights training, resources and tools
- Discover the barriers to change and shine a light on hidden issues: commissioning research and working collaboratively to improve outcomes, particularly for the most disadvantaged women through the development of deep partnerships with organisations working with targeted groups
- Change culture, influencing practice and bringing the voices of individuals to decision-makers: prioritising far-reaching policy work, often collaborative, to build local and national systems on a foundation of respect, justice and a desire for broader change

## The Montgomery v Lanarkshire Judgment

In March 2015 UK Supreme Court powerfully affirmed women's right to autonomy in childbirth in the case of *Montgomery v Lanarkshire Health Board*. Allowing the appeal from the Scottish courts by a woman whose baby suffered shoulder dystocia in labour, the Supreme Court held that women have a right to information about 'any material risk' in order to make autonomous decisions about how to give birth.

Mrs Montgomery, a pregnant diabetic woman with a large baby, was not informed by her obstetrician of the chance of shoulder dystocia. Although she had repeatedly expressed concerns about giving birth vaginally, the obstetrician said that she routinely chose not to explain the risk of shoulder dystocia to diabetic women because the risk of serious injury to the baby was very small and that if she did explain it, 'then everyone would ask for a caesarean section'. For diabetic women, the risk of the occurrence of shoulder dystocia is about 9-10% and the consequent risk of serious injury to the baby is less than 1%. However, shoulder dystocia poses a variety of serious risks to the woman's health, including post-partum hemorrhage (11%) and 4th degree perineal tear (3.8%). The doctor apparently did not consider that these risks were worth explaining to women.

The doctor's assumptions clearly disturbed the Court. As Lady Hale said (para 111): 'In this day and age, we are not only concerned about risks to the baby. We are equally, if not more, concerned about risks to the mother. And those include the risks associated with giving birth, as well as any after-effects. One of the problems in this case was that for too long the focus was on the risks to the baby, without also taking into account what the mother might face in the process of giving birth.'

Supreme Court Justice Brenda Hale: 'Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being.'

### The law

From a legal perspective, the decision brings English and Scottish law into line with that of the United States and other common law jurisdictions by separating the question of informed consent from the traditional test for clinical negligence. The Court expressed the legal duty on doctors as follows (para 87):

'An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.'

It is therefore no longer appropriate to assess the adequacy of the doctor's information sharing by reference to the standards of a reasonable medical professional; instead the relevant standard is whether the patient would attach significance to the risk. In its explicit recognition of patients' rights to autonomy and informed choice, *Montgomery* hammers the final nail in the coffin of medical paternalism.

## What are the implications for healthcare professionals?

Doctors will already be well-acquainted with the GMC guidance on consent, which was quoted with approval in Montgomery, and the case is a reminder of the importance of this guidance. The Court highlighted the following aspects of the process of informed consent that all healthcare professionals (and hospital managers) should take on board:

- (i) **Dialogue:** in order for a patient to make an informed decision, there must be a conversation between doctor and patient. The doctor must 'ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision.' The information cannot flow one way and the doctor's advice must be 'sensitive to the characteristics of the patient' (Montgomery, para 89). Hospitals cannot rely on printed information leaflets to provide information; there should always be a personal discussion.
- (ii) **Material risks:** a material risk is one to which a reasonable patient would attach significance. Statistics alone will not determine whether a risk is significant for a particular patient. For example, the risk of complications for future pregnancies after a c-section might be statistically small, but it would be more significant for a woman who wished to have multiple children than for a woman who did not.
- (iii) **Consent forms:** the Court emphasised that the doctor's obligation will only be discharged if the information is imparted in a way that the patient can understand. 'The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form' (Montgomery, para 90). This is important guidance. Hospitals cannot rely simply on a completed consent form as evidence that a clinician has fully appraised a patient of the risks of a procedure.

## More litigation?

Maternity care is already infamously litigious and accounts for nearly 50% of the value of all NHS negligence claims (see NHS Litigation Authority, '10 Years of Maternity Claims'). The Supreme Court recognised that there is a risk that the Montgomery decision will increase litigation by women who claim that they were not adequately informed of risks. The Court gave an interesting response to this (para 93):

'...in so far as the law contributes to the incidence of litigation, an approach which results in patients being aware that the outcome of treatment is uncertain and potentially dangerous, and in their taking responsibility for the ultimate choice to undergo that treatment, may be less likely to encourage recriminations and litigation, in the event of an adverse outcome, than an approach which requires patients to rely on their doctors to determine whether a risk inherent in a particular form of treatment should be incurred.'

Far from threatening doctors with more claims, proper disclosure of risks should protect the medical profession from litigation and lead to patients bearing responsibility for their own decisions. Respect for patient autonomy means that patients take responsibility.

## 11 October Sheila Kitzinger Programme Seminar

On 11 October 2017 Birthrights held a day-long seminar to bring together a small group of leaders in law and healthcare to proactively shape the implementation of *Montgomery v Lanarkshire* in the UK. The event was hosted by Green Templeton College Oxford as part of the Sheila Kitzinger Programme, which honours the life, and builds on the work, of the social anthropologist Sheila Kitzinger (1929-2015).

The *Montgomery* decision has profound implications for clinical practice around choice and consent. If the Court's judgment is to be upheld, professional carers must be given the time to discuss choices with women in their care and must respect the decisions that women choose to make. Professional bodies, academics, lawyers, policy-makers and frontline practitioners are responding to the judgment in a number of ways.

During the seminar we shared understanding and ideas and built a comprehensive picture of the changes that are taking place to develop a maternity culture that enables lawful consent. The group affirmed that the *Montgomery* judgment was reflective of established best practice and reflective of the standards of care that maternity professionals should be meeting. The judgment's foregrounding of personalised, two-way conversations is also concurrent with what the evidence base affirms that women want from their maternity care and dovetails with the need for continuity of carer.

We heard from Elizabeth Prochaska, Chair of Birthrights, about the implications of *Montgomery* and Suzanne White from law firm Leigh Day then gave a clinical negligence perspective on the case. Philosophers Fiona Woollard and Elselijn Kingma from Southampton University explained why autonomy matters from a philosophical perspective. There were also presentations from Lisa Ramsey (MVP Chair Reading) representing the perspective of women, and presentations from the RCOG (Alison Wright – Vice-President) and RCM (Kathryn Gutteridge – RCM President) as well as from individual consultant obstetricians and consultant anaesthetists covering both the strategic overview as well as the reality of working in a busy maternity unit. The challenges of consent in an intrapartum setting were acknowledged in discussion led by Margaret Matthews and Matthew Jolly (NHSE). The Maternity Transformation Programme's vision for truly personalised care was powerfully described by Stephen Anderson. The group shared examples and experiences of how unconsented interventions, poor communication and a lack of respect for women's dignity in birth could lead to poor physical and experiential outcomes as well as litigation.

At the end of a day of high-level discussion, information-sharing and debate on consent in maternity care post-*Montgomery* the group came together to discuss areas of focus, initiatives and ideas to pilot to harness the current opportunity for change and progress. Jacqui Dunkley Bent summarised this discussion emphasising that now was the time for change and that there was an opportunity for a programme of work on consent running alongside the five year forward view. There was a need to articulate why informed consent was important – it is not only a legal requirement, and an ethical imperative to uphold the rights of birthing women as equal citizens, but it is what women want, and results in safer, personalised and less traumatic care. There was a recognition that paternalism still existed and work to be done before informed consent was universally understood and practiced. Healthcare professionals needed regular and practical training on how to have these conversations with women; really listening to their concerns and exploring more nuanced options (eg low threshold for a caesarean for a woman who has had previous traumatic birth). There was discussion about how far doctors and other healthcare

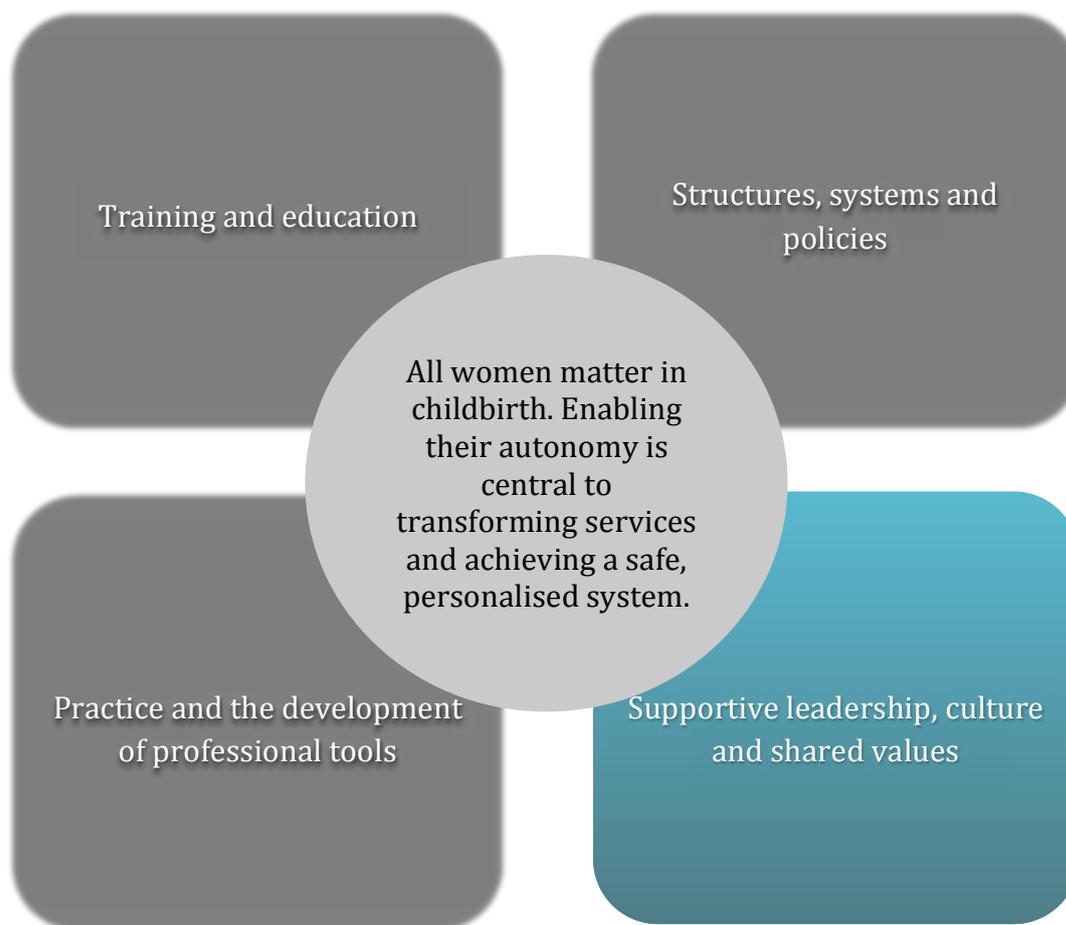
professionals needed to develop a “professional skin” to cope with their work and how they could retain their humanity/ability to understand a woman’s perspective. And there was a recognition that ensuring informed consent was given in fast paced, intrapartum situations was particularly challenging. Finally thoughts were shared about how we could empower women to play an active decision making role – what information did they want, when and in what format? How could we banish the language of allowed/not allowed?

Please see the annexed agenda (and links to the presentations – *to follow*) for a fuller understanding of the topics covered during the day.

## Seminar Group Recommendations:

1. The group **recognised and reaffirmed the importance of the Montgomery decision to improving maternity care in the UK** and the fundamental importance of respecting the autonomy of birthing women and upholding their human rights. The group believed that cultural change in systems and practice was needed to reach a Montgomery compliant NHS. Enabling lawful consent facilitates safer medical care by ensuring that it is tailored to the individual's needs, values and wishes, which in turn reduces litigation.
2. The group felt that, because of the importance of the issue and the current opportunity to feed in to existing transformation, quality improvement and safety strategy work, that work should be **taken forwards with urgency**.
3. There was a strong acknowledgment of **the importance of the Maternity Transformation programme** in achieving lawful consent in maternity care. Discussions highlighted the group’s support for the ambitions of the Better Births report and the need to implement it fully. Continuity of carer was felt to be particularly key to achieving lawful decision making. Getting to know a woman throughout her maternity journey meant healthcare professionals were more aware of a woman’s decisions, background, and attitude to certain interventions which reduced the need for prolonged conversations in labour to ensure informed consent. Healthcare professionals were also better able to judge the line between “bolstering” a woman to continue laboring a little longer for example, and “co-ercing” her when at least some of the team had built up a trusting relationship over time (concern over this distinction was expressed by HCPs during the day). This improves outcomes, experience and reduces litigation.
4. That **co-production and the involvement of Maternity Voices Partnerships, women’s organisations and other innovative approaches to involving service users** would be vital in developing and refining tools, addressing some of the culture and communications issues and providing evaluation and assessment of HCPs’ performance. These initiatives must ensure that vulnerable and underrepresented women are represented in these processes.

Whilst there was not enough time on the day to have an in-depth discussion on specific initiatives there was a shared ambition **to develop a multi-layered, multi-disciplinary approach to embed lawful decision-making in our maternity services, systems, culture and practice**. In this approach specific interventions and recommendations for immediate impact mixed with longer-term education, professional development and policy goals would be essential.



## Next Steps: The Women's Decisions Toolkit

The Maternity Transformation team has acknowledged the importance of decision-making to achieving the Better Births vision. In NHS England document 170202 Paper B (circulated to the Stakeholder Council on 16/03/17) it is clear that equipping pregnant women, midwives, doctors and other caregivers with the information, communication skills, tools and resources to enable women to discharge their autonomy across the perinatal period is a key ambition of the Transformation team. This work sits across many of the workstreams but particularly workstreams 2, 3 and 5.

Taking this work forwards should be a priority in the light of national safety ambitions. As a key output of the "Transforming Consent" Seminar, and as part of the Maternity Safety Strategy and Maternity Transformation implementation, we are seeking to propose a co-produced "women's decisions" toolkit comprising of :

- A. development of an **intrapartum decision-making and two-way communication tool**, potentially based on an adaptation of the SBAR tool or the BRAIN tool.
- B. supporting regular communication and autonomy **training** (building on existing multi-disciplinary, mandatory and CPD opportunities) **for midwives and doctors** with a specific



“decisions conversations” focus

- C. supporting **information and resources for service users**, embedded in existing or in-development antenatal education and resources, including those with low reading-age, without English as a first language.

The project would draw of the expertise, reach and multi-dimensional team of:

- NHS Improvement’s Maternal and Neonatal Health Safety Collaborative
- NHS Resolution
- NHS England Maternity Transformation team (particularly work streams 2, 3 and 5)
- Maternity Voices Partnerships
- NHS England Patient Experience team
- National Maternity Safety Champions
- RCM and RCOG
- Birthrights

and others to ensure the work is embedded at the relevant places in the system and takes advantage of the existing structures and initiatives as well as reflecting the need for a multi-dimensional approach to this complex issue. Each of the three projects needs to be discussed and refined with the relevant parties above and with service user representatives, piloted, evaluated and rolled out, whilst ensuring consistency is retained between the three projects. The above groups, organisations and individuals have expressed an interest in or commitment to this work. Consideration should be given to the appropriate governance structure for this work given its direct relationship to other ongoing work in maternity.



## Programme Transforming Consent In Maternity Care

11 October 2017

Green Templeton College Oxford, Lecture Theatre

8.30-9.00: Registration and Coffee, The Stables Bar

9.00: Denise Lievesley (Green Templeton College): **Welcome**

9.10: Rebecca Schiller (Birthrights): **Housekeeping, introductions and group objectives**

9.20: Elizabeth Prochaska (Birthrights): **The implications of Montgomery**

9.40: Suzanne White (Leigh Day): **A clinical negligence perspective**

10.00: Fiona Woollard and Elseijn Kingma (Philosophers): **Why Autonomy Matters: A Philosophical Perspective**

10.20: Lisa Ramsey (MVP Chair): **Why consent matters to women - service user perspective**

10.40: Facilitated discussion: **The problems and opportunities presented by Montgomery**

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11.00: Coffee, The Stables Bar

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11.20: Margaret Matthews (Consultant Obstetrician): **Consent in the intrapartum setting - realities, challenges and teaching opportunities**

11.40: Kate McCombe and David Bogod (Consultant Anaesthetists): **"Paternalism and consent: has the law finally caught up with the profession?" - A pragmatic clinical perspective**

12.00: Alison Wright (RCOG): **RCOG and Montgomery - issues, initiatives and opportunities**

12.20: Kathryn Gutteridge (RCM): **RCM and Montgomery - issues, initiatives and opportunities**

12.40: Stephen Anderson (Maternity Transformation Programme): **MTP and**



## Montgomery

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1.00: Lunch, The Stables Bar

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2.00: Matthew Jolly (NHSE): **Communication in Labour to Deliver Autonomy**

2.20: **Break out groups.** Each asked to discuss issues, existing ideas/initiatives and come up with a concrete plan to tackle the issues. Focus on collaboration and feeding in to existing structures and initiatives.

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3.00: Comfort break. Coffee, The Stables Bar

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3.10: **Groups report back**

3.50: Whole group discussion on **seminar outputs and recommendations**

4.15: Jacqueline Dunkley-Bent (NHSE): **Discussion summary**

4.25: Rebecca Schiller (Birthrights) **Concluding remarks and next steps**

4.30: Ends