

Obtaining consent for obstetric procedures

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Abstract

Consent is a process that involves information disclosure of a proposed treatment or intervention. It includes a discussion of the risks relevant to that particular patient as well as the benefits and alternative options. The process must be clearly documented to provide a legal justification for treatment. Obtaining informed consent can be a challenge when a labouring woman is in severe pain or under the influence of strong analgesics. High-risk women should be encouraged to attend pre-assessment clinics to enable adequate time to process the information discussed. Pregnant women are presumed competent and are entitled to refuse treatment even if this risks their life or the life of their fetus. Rarely, if a woman is not considered competent to make decisions for herself, clinicians should take into account the underlying reasons and consider proceeding in their best interests under the doctrine of necessity or apply to the courts for approval of an intervention. This article summarizes current guidelines in relation to consent that have been updated to reflect recent case law.

Keywords Autonomy; informed consent; Mental Capacity Act 2005; pregnant

Royal College of Anaesthetists CPD Matrix: 1F01

Consent

In modern practice the law of consent is grounded in the philosophical concept of patient autonomy and the right to self-determination. National guidelines for consent by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) have been updated to reflect current case law that emphasize a more patient-centred approach respecting patient autonomy.¹ The General Medical Council (GMC) are also in the process of updating their guidance to provide doctors with contemporary advice in order to conform to the standards of Good Medical Practice.²

Consent is defined as the 'voluntary and continuing permission of the patient to receive a particular treatment'.³ It is a process whereby information is conveyed to the patient and the options around a treatment or procedure are discussed. Every opportunity should be taken to support the patient to make an

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Learning objectives

After reading this article, you should be able to:

- define consent and understand that it is a process of information sharing between a patient and clinician
- explain the components of capacity
- understand the unique aspects to consent in obstetrics

informed decision, such as ensuring appropriate modalities of communication, at a level suitable for each individual.

The important elements to consent include:

- the format may be oral or written, explicit or implied
- patients should understand the purpose of the treatment including the risks, benefits and alternative options
- the patient must have capacity
- the process is a legal requirement to help provide a justification for treatment. Consent provides a defence to a criminal charge of battery but not negligence.

Material risk and the law of consent

In March 2015, the landmark case of *Montgomery v Lanarkshire Health Board* set the new legal standard relating to consent to medical treatment in the UK.⁴ The judgment by the Supreme Court gives an excellent overview of the evolution of the law on consent. The legal standard is now aligned with the professional guidance as stipulated by the GMC and the AAGBI whereby the *Bolam* test is replaced by the 'patient-centred' test.^{1,5} The focus has moved from a 'reasonable' doctor to what a 'reasonable' person would deem a significant risk.

The case concerned Mrs Montgomery, who had a complicated vaginal delivery that resulted in her child being diagnosed with cerebral palsy and a brachial plexus injury. Mrs Montgomery claimed there was a failure to provide full information disclosure and the actions of her obstetrician were questioned. The Supreme Court found the obstetrician was negligent in her practice for not disclosing the 1.6% risk of shoulder dystocia, a complication that materialized and resulted in her child being born with cerebral palsy. In the opinion of the court, this risk, although relatively small, was significant to the patient and thus should have been highlighted.

The judges declared: *'The test of materiality is whether a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor should reasonably be aware that the particular patient would be likely to attach significance to it.'*

If information is material, doctors should disclose it. Both generic and significant risks to a *particular* patient must be stated. Case law since *Montgomery* has helped provide practitioners with guidance on the application of material risk. A 1% risk is considered material and thus should be disclosed but not necessarily negligible risks.⁶ Alternative therapies should be discussed but the patient must not be bombarded with information. Furthermore, doctors should not wait for the patient to ask about specific risks. In the judgment, the exceptions outlined include those patients who prefer not to know the risks; if the

doctor reasonably considers that telling the patient something would cause serious harm to the patient's health ('therapeutic exception'); or in circumstances of necessity where no consent is needed.⁴ These privileges, however, should not be abused.

Capacity and the Mental Capacity Act 2005

In law, there is a presumption of capacity. A higher level of capacity is required for more serious decisions. Clinicians who wish to overrule a patient's decision must establish incapacity rather than the patient prove their capacity. Assessing mental capacity looks at whether the patient can:

- understand the information presented
- retain the information
- weigh the options of having the procedure or not
- communicate their decision.

The Mental Capacity Act 2005 formalizes existing case law for decisions to be made on behalf of people over the age of 16 years who lack capacity in England and Wales (Adults with Incapacity Act 2000 in Scotland).

Consent and the obstetric patient

In general, women in labour should be treated as any other patient. A separate written consent form is not required for anaesthetic intervention related to other procedures such as anaesthesia for operative delivery. The doctor undertaking the consent must be suitably knowledgeable and skilled in that procedure. The components to consider when obtaining consent are no different to any other patient, and must include an explanation of the risks, benefits and alternatives to the proposed treatment. Some authors have suggested the *Montgomery* ruling may have specific implications for obstetric anaesthesia where the option of general anaesthesia for an elective caesarean should be discussed with the patient instead of defaulting to a regional technique.⁵

Guidelines produced by the AAGBI for obtaining consent highlight several points in relation to the obstetric patient as shown in **Box 1**.¹ Pregnant women are presumed competent but their capacity may be compromised by, for example, the pain of labour, fatigue or agitation, or the sedative effects of analgesics. Any compromise in capacity will need to be severe if the patient is to be considered incompetent. During emergency situations on labour ward, time pressures can limit the pregnant woman's opportunity to consider all treatment options. It is therefore useful, and often preferred, to discuss treatment options with pregnant women in the antenatal setting.^{1,7} Patients undergoing elective procedures should receive information in a calm timely manner well before the proposed intervention with written information provided where possible. This is sometimes referred to as a 'two-stage consent' enabling adequate time for processing of information given which is repeated prior to the intervention. A detailed discussion in the emergency setting can be more of a challenge.

Anaesthesia or analgesic methods mentioned in a patient's birth plan may be considered an advance decision in the event of compromised capacity during labour and should be respected but the woman maintains her right to change her mind if presumed to have capacity.¹

Qualified consent refers to when a patient consents only to specific parts of a treatment. An example of this would be the case of a Jehovah Witness who chooses to refuse certain blood

Guidance by the AAGBI for obtaining consent from the obstetric patient¹

- Women in labour have the capacity to consent
- Women in labour should not be burdened with excess information. Ideally options should be discussed during the antenatal period
- Birth plans may be used as an Advanced Decision in the case of a woman losing capacity to consent in labour. However, a presumption of capacity remains. For example, if a woman has refused an epidural in her birth plan but then changes her mind in labour, this request should be respected. The consent process should be appropriately documented and countersigned by the patient to support this
- All competent women can refuse treatment during labour, even if there is a risk to the fetus. A court order to provide treatment will only be considered if the clinician can demonstrate the patient lacks capacity
- Younger parturients, aged 16 years and above may be treated as adults. Those under the age of 16 years may have capacity to consent but are at increased risk of temporarily losing capacity under the stress of labour. All obstetric units should have guidelines to support this group of patients

Box 1

products according to their religious beliefs. Their wish should be upheld if they are deemed to have capacity and their decision is made free from coercion.¹

The management of younger patients also raises the issue of mental capacity and maturity when delivering care. Those above the age of 16 years are assumed to have capacity to consent for treatment, but for patients under 16 years, a careful assessment should be performed to determine if the young person is *Gillick competent*. If they refuse treatment that might endanger their life or that of the unborn fetus, they may need to be made a ward of court, giving the High Court responsibility for that child. If there are concerns with regards to safeguarding, these should be referred to the hospital safeguarding team and clearly documented.

Lawful refusal of treatment or temporary incapacity

Competent adults are entitled to refuse medical treatment whether the decision is 'rational, irrational, unknown or non-existent'.⁸ This is providing the patient is fully informed, the decision is made free from coercion and not influenced by illness or medication. Although the fetus has no legal rights in UK law, conflict arises when maternal autonomy supersedes fetal well-being. The scenario is sometimes encountered when a pregnant woman who needs a caesarean section withholds her consent to the procedure. Although rare, this complex ethical dilemma has been considered by the courts, where judges are presented with incredibly difficult decisions to make often at short notice.⁹ These cases usually only go to court if the mother's capacity is questioned. There have been several cases where the woman has refused the anaesthetic because of severe needle phobia. In these cases, the courts have

considered the women to be temporarily incapacitated due to the severe anxiety. In general, when the courts have authorized a caesarean section they have often cited the best long-term interests of the mother is to deliver a healthy baby.

The department of health issued guidance for the management of patient's whose capacity is questioned.³ When these patients refuse medical treatment, they should be brought to the attention of the court before a medical emergency arises to enable evidence to be presented and all parties represented (Box 2).¹⁰

Psychiatric illness

Patients who suffer with chronic mental health conditions may make the process of information disclosure and consent especially difficult. Pregnant women who present with incapacitating conditions such as psychoses should be highlighted as early as possible. Clear communication with the psychiatric team is essential. During remission periods, women with mental health conditions should be encouraged to express their future birth plans and supported by their obstetric team.

Pregnant women detained under the Mental Health Act 1983 who require a caesarean section must still consent to the procedure. Section 63 of the act only permits non-consensual treatment if it is 'for the mental disorder from which [the patient] is suffering'. In these cases, the courts will need to determine if the patient's mental disorder is affecting their capacity to decide. In *Tameside and Glossop* the judge ruled in favour of proceeding with a caesarean section to enable treatment and prevent deterioration of the woman's psychiatric condition.⁹

Deprivation of Liberty

Guidance regarding the application of the Deprivation of Liberty Safeguards to pregnant women with mental disorders was provided in the case *NHS Trust v FG*.^{11,12} FG suffered from schizoaffective disorder, was non-compliant with treatment and believed those treating her intended to harm her baby. She was detained under the Mental Health Act 1983. The Trust applied to the court for reasonable steps to be taken to transport her to and from the maternity unit for her obstetric care, including reasonable physical or chemical restraint, which would constitute a deprivation of her liberty. Mr Justice Keehan outlined three circumstances in which a deprivation of liberty could be lawful without a court order:

- if necessary to give life sustaining treatment
- under the common law doctrine of necessity
- by a standard authorization under Schedule A1 of the Mental Capacity Act 2005.

The four areas identified when an application should be made were:

- the intervention proposed is likely to amount to 'serious medical treatment'
- there is a risk of forcible restraint
- there is a serious clinical dispute as to what obstetric care is in the subject's best interests
- there is a real risk that the subject will suffer a deprivation of their liberty which would be unlawful without court authorization.

These difficult cases should be brought to the courts in a timely manner in order to allow for a considered judgment.¹² ♦

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Good practice in the management of incapacitated patients who refuse treatment

- Obtain support from the Court of Protection
- Ensure patients have their own legal representation
- Involve a consultant psychiatrist early in order to regularly assess the patient. This can be presented as evidence to the court.

Box 2

Acknowledgements

We would like to thank Dr Sarah Nour for her contribution to the original article on which this article is based.¹³